Hutt Valley District Health Board

District Annual Plan 2009 to 2010

Healthy People, Healthy Families, Healthy Communities

Whanau Ora Ki Te Awakairangi

Towards a Healthier Hutt Valley

August 2009

Contact details:
Hutt Valley District Health Board
Pilmuir House, Pilmuir Street
Private Bag 31-907
Lower Hutt
Telephone (04) 5666 999
Website www.huttvalleydhb.org.nz

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

17 AUG 2009

Mr Peter Glensor
Chair
Hutt Valley District Health Board
Private Bag 31 907
LOWER HUTT 5040

Dear Mr Glensor

Hutt Valley District Health Board: 2009/10 District Annual Plan

This letter advises you that I have signed Hutt Valley District Health Board's (DHB) 2009/10 District Annual Plan (DAP) for one year.

I accept your DAP is the result of your Board's consideration of how your resources are best allocated, including the additional $19.52M or 6.75 percent increase provided to your DHB for the 2009/10 year.

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability. Given the severe impact of the international financial situation on the fiscal position, the 2010/11 and out-years funding increase for health will be lower than the FFT and Demographics' planning signals notified in December 2008. At the same time pressures from cost, demand, and technology remain. In this environment it is important that you achieve productivity gains and manage your services within your allocated funding. The Government's priority is for funding to be directed towards front line services.

Your Board's revised financial position following my rejection of your DAP is acknowledged. I note that Hutt Valley DHB is proposing a minimal reduction of $0.3M taking the planned financial position for 2009/10 to $4.6M deficit with a plan to breakeven in 2011/12. Improving the financial performance of your DHB is a key priority for your Board.

The emphasis your Board has placed on the Government's Health Targets and priority areas is noted. Both shorter stays in Emergency Departments and Shifting Services to Primary Care, are two areas that your DHB needs to focus on.

It is recommended that your Board ensures the collaborative approaches outlined in your DAP are implemented. I expect to see examples of this collaboration to include best practice sharing between DHBs, intersectoral cooperation and constructive engagement with non-Government organisations in the sector. In particular I expect to see a high degree of collaboration with other Central Region DHBs.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

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

I wish you, your Board and management every success with the implementation of your 2009/10 DAP, and thank you for your contribution and efforts to improve the health of New Zealanders.

Finally, please ensure that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

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 tranquillity 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 sets out specific responsibilities for providing equitable funding in the 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.

Statement from Chair and Chief Executive

We are pleased to present the Hutt Valley District Health Board's District Annual Plan for the 2009/2010 year. This District Annual Plan details our commitment to achieving the goals of our District Strategic Plan and to delivering on Government priorities.

We face a challenging year as we seek to return to a financial breakeven status. Ensuring sustainability of our services while continuing to meet the health needs of our community remains a significant challenge. Our CEO, senior management and clinical leadership team are committed to driving greater performance and ensuring that we deliver better, sooner, more convenient health care. In collaboration with others, and through our clinical leaders we will seek innovative solutions to address our challenges.

Our priorities provide a focus for delivering on Government priorities and achieving improved health outcomes. We will be focusing on increasing our elective volumes year on year and reducing waiting times for patients. To do this we will be progressing our essential hospital campus development. Although the expansion of our hospital will be well underway in 2009/10 the new facilities will not be open until 2011/2012. We have taken steps to provide some interim capacity and staff are working hard to ensure we maximise available theatre capacity and provide services as efficiently as possible.

Strong primary health care is key to ensuring healthier communities and improved heath equity and an important priority for us. We are working to improve access to primary health care services. We continue to focus on growing the primary health care workforce, but we will be extending our work to support the development of new models of service delivery and ensure better integration with hospital services. We will focus in particular on opportunities to shift services to primary health care where appropriate and improve the management of long-term conditions. In 2008/09 we developed a strategic framework to guide our work in improving the management of long-term conditions as one of the leading causes of avoidable hospital admissions.

An important piece of work for the DHB is the Improving the Patient Experience Programme. This programme provides an umbrella for our work to ensure that patients have access to high quality services in the most efficient and effective way. Already our work to date has included the redesign of a number of our services resulting in increased capacity and a better patient experience.

Late in 2008 the Board reaffirmed the Hutt Valley DHB's vision, mission, values, and high-level goals and strategies as documented in our District Strategic Plan 2006-11 (DSP). We believe that our goals continue to align with our assessment of health needs in the Hutt Valley and with the Government's priorities. We will be producing a refreshed DSP that will place additional emphasis on regional collaboration, the development of clinical networks, and future sustainability.

We intend to continue to grow our areas of excellence, strive for health equity for our population, and increase our collaboration with the many local, regional, and national organisations with whom we work and partner. We will continue to listen to our community and value their participation. We believe this to be one of our strengths.

Signatories

Peter Glensor
Chair Hutt Valley DHB

Chai Chuah
CEO Hutt Valley DHB

Hon Tony Ryall
Minister of Health

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Figures and Tables

1.0 Executive Summary

The District Annual Plan for 2009/10 is the fourth to reflect the goals and strategies of our District Strategic Plan 2006-2011. The District Annual Plan identifies the priorities and actions we intend to take to meet our commitments to our community and to deliver on the Government's priorities.

Late in 2008 the Hutt Valley DHB Board reaffirmed the DHB's Vision, Mission, Values, and high-level goals and strategies as documented in the District Strategic Plan 2006-11 (DSP)[1].

Vision	Healthy People, Healthy Families, Healthy Communities Whanau Ora ki te Awakairangi
Mission	Working together for health and wellbeing
Goals	Improved health equity Healthier communities A focus on prevention, early treatment and easy access Effective, efficient and high quality services Seamless integration An inclusive district

Late in 2008 the Board reaffirmed the Hutt Valley DHB's vision, mission, values, and high-level goals and strategies as documented in our District Strategic Plan 2006-11 (DSP). We believe that our goals continue to align with our assessment of health needs in the Hutt Valley and with the Government's priorities. We will be producing a refreshed DSP that will place additional emphasis on regional collaboration, the development of clinical networks, and future sustainability.

The Government has made it clear that it is seeking a more responsive health system able to deliver better, sooner, more convenient health care services. A particular focus for 2009/10 is on ensuring that there is high quality access to hospital services when patients need it. In order to improve our services, reduce waiting times, and ensure that our community retains confidence in us, we are committed to improving our hospital facilities. Our campus development plans include provision for an expanded emergency department and intensive care unit and 4 new theatres by 2011/12. Until the new facilities become operational we will face ongoing capacity pressures associated with increasing acute demand and expectations for increased elective procedures. We are working hard to make best use of current capacity and where necessary purchase additional capacity at local private hospitals and/or through regional collaboration and clinical networks.

Improving the quality, efficiency and effectiveness of our services, and increasing patient satisfaction has been a focus for our *Improving the Patient Experience Programme* of work. We will be continuing this work in 2009/10 and expanding it to cover more of our hospital services. Clinical leadership is fundamental to this work and to identifying priorities for where we should focus our efforts to shift resources to frontline services and create new capacity to see more patients and improve patient outcomes.

At Hutt Valley DHB we have fostered a culture of clinical leadership that is evident through our work to improve the quality of patient care, and through the mechanisms we have in place for key decision making. We take a whole organisational approach to developing our future clinical leaders, including ensuring that we build long lasting relationships with our trainee clinicians. At Hutt Valley DHB around 85% of recently recruited consultant staff were previously with us as junior doctors. We have also successfully established a deliberate and intensive process for recruitment

[1] For more information on our strategic direction, you can view our District Strategic Plan (DSP) on our website www.Huttvalleydhb.org.nz

of clinical staff for particular specialities where we compete nationally and internationally for a limited pool of skilled people.

With the other five DHBs in the central region, we have commenced the first phase of the implementation of a Regional Clinical Services Plan. This work includes the identification of vulnerable services in the region, and further development of clinical networks. Regional clinical networks are already established for Plastics, Renal and Cardiology services.

A significant challenge for us has been our ability to increase the number of General Practitioners and Practice Nurses in the Hutt Valley. The Government has identified the need to build on the Primary Health Care Strategy by shifting some secondary care services to more convenient primary care settings. Our secondary care specialists and primary health care providers will work closely to assess and grow capability and capacity in anticipation of services being shifted in 2010/11. We will also be focusing on improving the management of long-term conditions requiring the development of a strong clinical leadership model and network across our secondary and primary care services. This model will also assist us to make the shift in services to primary health care.

Although the Government has provided new funding to advance particular initiatives, the expectation is that we will need to deliver on the overall priorities from within existing resources (adjusted for demographic increases and inflation). Given the deficit posted for 2007/08 and projected for 2008/09, returning to a financial breakeven position, while delivering on new priorities and maintaining our ability to respond to centrally driven requirements (ring fenced funding), is a significant challenge for us. Our financial position for 2009/10 is a deficit of $4.6m.

The 2009/10 result is significantly affected by a large increase in inter-district outflows (volume and price), a number of employment settlements running into this financial year at a level far in excess of our base funding, and an increase in demand driven pharmaceutical expenditure.

We acknowledge the economic constraints and the need to for us to look hard at our performance. We also recognise that the need to do this comes at a time when the impact of the economic downturn is likely to affect the health status of our population and the demand for health services. We have planned a number of key initiatives aimed at bringing the Hutt Valley DHB to a break-even position over time. These initiatives include value for money reviews and productivity enhancements, as well as investment in new capital to increase revenue. We have identified opportunities for improving value for money where we can better map service funding to service utilisation and health outcomes, and where we can potentially consolidate the services being purchased across fewer providers.

Importantly, our focus on improving our financial performance, value for money and productivity, will not be at the expense of our focus on quality and safety. Quality and safety are fundamental to all that we do and will be a particular focus of our Board in 2009/10.

1.1 Our Challenges

In summary we have identified a number of challenges for 2009/10:

- The need to return to a financial breakeven status and ensure sustainability of our services
- Increasing our theatre capacity ahead of the new facility development
- Managing the demand on our Emergency Department services and reducing the number of avoidable hospital admissions
- Increasing access to primary health care services in order to increase opportunities for improving health status
- Addressing health inequalities for our population, particularly for Māori, Pacific and high needs groups
- Recognising the impact of the economic downturn on population groups that could affect their health status and access to health services, in particular primary health care.

These and other challenges have led us to identify some medium term planning outcomes and priority areas for focus. These priorities provide a focus for delivering on Government priorities and achieving improved health outcomes and health equity.

1.2 Our Priorities

Our priorities reflect our assessment of where we believe we need to focus in order to improve the health of our population, improve health equity and deliver on the Government's priorities.

1. **Clinical leadership**
   Our priority focus on hospital services includes our commitment to improving the patient experience and increasing productivity. Fostering clinical leadership within the DHB is a key aspect of our culture and key to our commitment to improve hospital services. We have extended clinical leadership locally and regionally through clinical networks and regional service provision. We will ensure that this clinical leadership extends to our work to better integrate services across primary and secondary care and in the planning for the shift of services to primary health care.

2. **Elective services**
   We want 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 in accordance with our elective service patient flow indicators. This means that we will need to increase the number of elective discharges to reflect our population growth and aging and address unmet need. To do this ahead of the construction of new theatres, we will maximise the available electives services capacity by improving the efficiency of our operation, and via private providers and regional collaboration. Our clinicians have signed up to a commitment to deliver this increased activity, and to provide leadership at a regional and local level, where we need to improve productivity and utilisation of capacity.

3. **Workforce development**
   A focus on workforce development as a priority contributes to achievement of all of our strategic and annual planning goals. Ensuring that our staff are valued and trusted is reflected in our values and the actions we take to promote and encourage a 'can do' and team based culture and to fully engage staff in how we improve patient care and address our challenges. Our workforce development plans include specific goals and actions aimed at improving clinical staff retention and further fostering clinical leadership.

4. **Implementation of our emergency department/theatre project**
   Improvements in facilities at Hutt Hospital are needed to address the increasing demand for services and to ensure that appropriate services can continue to be provided as close as possible to the Hutt Valley community. In 2009/10 we will be progressing our campus development plans, including provision for an expanded emergency department and intensive care unit and 4 new theatres by 2011/12.

5. **Quality and safety**
   A focus on quality and safety as a priority contributes to improved access to services, better service integration, more efficient and effective services, higher quality and safe services and improved infrastructure. Hutt Valley DHB supports the national Quality Improvement Committee's (QIC) five national quality programmes, and we are the lead DHB for the safe medication management project. Our *Improving the Patient Experience* programme is a key quality initiative, which focuses on improving assessment, diagnosis and treatment based on safe, reliable clinical systems and effective patient flows from home to hospital and back to the community. Our Board will be giving this area specific priority on its agenda this year.

6. **Primary health care**
   We will ensure better service integration across primary, secondary, mental health and public health, with a particular focus on long term conditions and reducing avoidable hospital

admissions. We will continue to focus on building improved infrastructure (workforce, service models, data) in primary health care to support improved access to services and delivery of better, sooner, more convenient services. The Government has identified that ensuring better, sooner, more convenient primary health care while freeing up capacity in secondary care is a key priority. The Government has made funding available in 2009/10 to kick start the devolution of secondary care services to primary health care from 2010/11 onwards. We will plan the devolution of services in collaboration with PHOs and other primary health care organisations via our primary care liaison, GP Reference Group, Valley wide forum, and PHO forum.

7. **Maintaining financial performance.**
   We have a number of initiatives under way to improve our financial performance. These include the building of two temporary day surgery theatres to increase our surgical throughput, improvements in service quality and productivity, and reviewing of our pharmaceutical expenditure with a view to reducing costs in this area.

8. **Keeping our people well**
   We will work in partnership with education, primary care, and local government and other sectors to increase knowledge and resilience in our population around healthy lifestyles and to support these choices. We will enhance our regulatory responsibilities to ensure we have good quality air, water and wider environment. We will work with local authorities and other key stakeholders to create environments that make the healthier choice the easier choice.

9. **Maternity, child and youth health**
   We will strengthen our focus on the delivery of child and youth programmes that identify health risk early. As a result we will ensure earlier intervention and improved access to services, particularly for high needs families/whanau. In our maternity services we will support women to stay longer post-natally, where needed in the transition to home, and where capacity allows.

10. **Services for older people**
    We will continue to develop the augmented Needs Assessment and Service Coordination Centre (NASC) to provide sustainable services to meet the health needs of older people. We will ensure improved access for older people to a wider range of community support services and to specialist geriatric services. We will increase our monitoring and audit activities to include more collaborative arrangements across the region, and include ways of better capturing client and carer feedback on service quality.

11. **Mental health**
    In response to national (*Te Tāhuhu* - Improving Mental Health 2005-2015) and regional strategies (Central Region Strategic Plan), we are implementing our local plan for mental health and addiction services referred to as *Make it Happen (Whakamahingia)* 2008-13. We will be reviewing and implementing improved service models incorporating best practice guidance and ensuring that we are providing effective and efficient services. We will ensure better monitoring of service user and service delivery information.

1.3 Our Values

It is important to us that the District Annual Plan reflects our values, the approach we take to our work and in our relationships with the wider community, including our partners in the delivery of health services. This includes:

Improved health equity
Our goal of improving health equity requires us to explicitly acknowledge and address health disparities between different populations groups and communities.

“Can do”, leading, innovating and acting courageously
Hutt Valley DHB is already acknowledged in the health sector as an organisation that will try new things in order to make a difference. We will continue to do that and to be ever more innovative, in

order to improve the health of the Hutt Valley people.

Working together with passion, energy and commitment
Hutt Valley DHB people work with passion, energy and commitment to each other, to our clients and the community

Trust through openness, honesty, respect and integrity
The trust of those we work with and those we work for is fundamental to achieving good results. To be trusted, we will be open, honest, and respectful and we will act with integrity in everything we do.

Striving for excellence
Striving for excellence in everything we do is a key Hutt Valley DHB value – we look for excellence in ourselves as individuals and collectively as an organisation. We look for it in the service we provide, the way we treat each other, the systems we put in place and the achievements we make.

Collaborating fully
Ensuring the best possible health outcomes for our communities can only be obtained through the building of positive partnerships and collaboration with our local community and primary care service providers, local and regional councils, and other agencies, and other DHBs.

2.0 Strategic Overview

The strategic context for our District Annual Plan includes our District Strategic Plan[1], which sets out our longer-term goals and strategies, national health strategies and health targets, the Government's priorities, and our assessment of our population health need (refer Appendix 1).

2.1 District Strategic Plan Goals and Strategies

In order to reach our vision for a healthier Hutt Valley; *Healthy People, Healthy Families, Healthy Communities,* we have set ourselves six key goals and eight strategies:

Key Goals:

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

Key Strategies:

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

Figure 1 overleaf shows the relationship between our Vision, Goals, and Strategies, and our key local priorities for 2009/10 as further discussed in Section 4.

2.2 Government Priorities 2009/10

The Minister of Health's annual 'Letter of Expectations' is sent to all DHBs and identifies the Government's expectations and priorities for the coming year. The Government has stated that it wants the public health system to deliver better, sooner, more convenient healthcare for all New Zealanders. The priority for 2009/10 is a focus on the availability and quality of hospital services.

Expectations of all DHBs:

- Improve hospital services and reduce waiting times to ensure that New Zealanders have timely, high quality access to health care services when they need it, and that patient outcomes and satisfaction is improved, specifically:
    - Increase elective volumes (refer Section 4.5)
    - Improve emergency department waiting times (refer Section 4.6)
    - Improve cancer treatment waiting times (refer Section 4.6)
- Improve workforce retention through trusting, valuing, and fully engaging health professionals, specifically:
    - Adopting good staff practices aimed at developing a culture that values and trusts clinical staff (refer Section 4.11.2)

Figure 1: Hutt Valley DHB Vision, Mission, Goals, Strategies and Annual Planning Priorities

Vision: ***Healthy People, Healthy Families, Healthy Communities***

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

Goals

Improved health equity		**Healthier communities**	
A focus on prevention, earlier treatment and access	**Effective, efficient and high quality services**	**Seamless Integration**	**An Inclusive District**

Strategies

Developing Primary Health Care	**Working with other agencies**	**Redesigning services and consolidating gains**	**Taking a whole person, whanau, and lifespan approach**	**Working in harmony with Maori**	**Sharing and measuring progress**	**Developing the workforce**	**Improving our hospital**

2009/10 Annual Planning Outcomes

Health protection is enhanced	**Health risk is reduced**	**Access to services is improved**	**Intervention is earlier**	**Services are better integrated**	**Services are provided more efficiently and effectively**	**Services are high quality and safe**	**Infrastructure is improved**	**Services are sustainable**	**Regional collaboration and positive partnerships**

2009/10 Annual Planning Priorities

Keeping our people well	**Primary Health Care**	**Elective Services, and Hospital Services**	**Services for Maternity, Child and Youth**	**Services for Older People**	**Mental Health Services**
Quality and safety		**Improved infrastructure**		**Financial performance**	

- Fostering clinical leadership, including supporting development of clinical networks and regional co-operation. (refer Section 3.2)

- Delivery of funded initiatives:
  - Boosting funding for medicines, including increased funding for cancer treatments
    - Hutt Valley DHB is working with Pharmac and all other DHBs to progress the agreement of the 2009/10 Community Pharmaceutical Budget in line with Ministerial expectations, comprising a $40m increase in the funding of medicines, including funding for Herceptin and other Pharmaceutical Cancer Treatments.
  - Improving the quality and supervision of nursing in rest homes
    - Hutt Valley DHB will provide the additional funding for aged residential care to improve quality and safety in accordance with the national contracting process. (Refer Section 4.8)
  - Kick-starting the devolution of services to primary health care
    - In consultation with PHOs and secondary care clinicians Hutt Valley DHB has developed an outline change management plan for the shifting of some secondary care services to primary care. (Refer Section 4.4)
  - Provision of dedicated respite care beds for older people
    - Hutt Valley DHB will improve access to respite care beds for older people and their carers by increasing the availability of respite care services, with available new funding; estimated at 2 beds (Refer Section 4.8).
  - Extending postnatal stays for women who choose to stay in a birthing facility longer so that they can establish breastfeeding and the confidence to return home.
    - The Hutt Hospital Maternity Service is committed to ensuring that women are able to extend their post natal stays as they choose. (Refer Section 4.7)

Table 1 below provides a summary of the Ministers priorities and allocated funding.

Table 1: Summary of funding for Ministers priorities

Ministers Priorities	Allocation basis	Funding (new)
Boost funding for new medicines	PBFF – Funder arm community pharmaceuticals budget	$1,001,300[2]
Improving quality and supervision of nursing in rest homes	PBFF via national contracts	$581,400
Kick start devolution of services to primary care	PBFF via budget for change management	$209,950
Respite care	PBFF via local provider contracts	$80,750
Post natal stays	PBFF via Provider arm maternity services budget	$177,650
Difference		$1,568,840
Total Funding allocated		$3,619,890

[2] For Community Pharmaceuticals. Excludes MoH Herceptin, PCTs

The Government has a clear expectation that DHBs will maximise the level of resourcing to be invested in front line services. The Government requires DHBs to therefore halt any growth in management and administration personnel (employees, contactors and consultants). As shown in Table 2 below Hutt Valley DHB has calculated a cap of 398 (rounded) management and administration FTE out of a total of around1800 FTEs.

Table 2: Target for Management and Administration Resources

Objective	Deliverables	Target		Timeframe
Contain the level of investment in management and administrative resources	Manage the FTEs categorised as management and administration within the DHB within the target FTE cap		Number[3]	Monthly
		FTEs employed (accrued)	369.10	
		Contractors	3.10	
		Advertised vacancies	24.23	
		Subsidiaries	0.00	
		Other	0.70	
		TOTAL	397.13	

Management and administration staff includes those staff employed to support regional, supra regional and national services, programmes and projects. A number of Ministry of Health contracts explicitly specify the requirement for management and administrative staff to support new programmes, including for Oral Health, Before School Checks, HPV immunisation programme, and the National Cervical Screening Programme Register Operations. New Ministry of Health contracts where they specify additional management and administration staff will mean that Hutt Valley DHB will need to revisit its FTE cap.

We are committed to delivering on the Government's priorities. These priorities are aligned with our long-term goals and local priorities as shown in Table 3 below.

Table 3: District Strategic Plan Goals, Minister's Priorities, and our Priorities

High level goals	Government priorities	Our priorities
Improved health equity Healthier communities A focus on prevention, early treatment, and easy access Effective, efficient and high quality services Seamless integration An inclusive district	*Shifting of some services to primary health care* *Fostering clinical leadership* *Boosting medicines funding*	Primary Health Care Keeping Our People Well Services for Older People Mental Health
	Improving hospital services and reduce waiting times *Increasing elective volumes* *Improving emergency department waiting times* *Improving cancer treatment waiting times* *Fostering clinical leadership* *Improving workforce retention* *Boosting medicines funding*	Elective Services Hospital Services Implementation of emergency department/theatre capital project Quality and Safety Workforce Development Maintaining Financial Performance
	Extending post natal stays	Maternity, Child and Youth
	Improving the quality and supervision of nursing in rest homes *Provision of dedicated respite care beds for older people*	Services for Older People

2.3 Health Targets

A set of national Health Targets has been identified to focus the efforts of DHBs and make more

[3] Figures as advised in Minister of Health's letter to Chair 28 April 2009 (397.13).

rapid progress against key national priorities as summarised in Table 4 below. These Health Targets are included within the performance measures associated with our priority areas and outcomes and are clearly identified in our DAP.

Table 4: Summary of Health Targets

Health Target	Description
Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours
Improved access to elective surgery	The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within 6 weeks by the end of July 2010 and within four weeks by December 2010.
Increased immunisation	85% of two year olds will be fully immunised by July 2010; 90% by July 2011; and 95% by July 2012.
Better help for smokers to quit	80% of hospitalised smokers are provided with advice and help to quit by July 2010; 90% by July 2011; and 95% by July 2012. Similar target for primary health care will be introduced from July 2010 or earlier through the PHO Performance Programme.
Better diabetes and cardiovascular services	a. Increased percent of the eligible adult population have had their CVD risk assessed in the last five years. b. Increased percent of people with diabetes attend free annual checks. c. Increased percent of people with diabetes have satisfactory or better diabetes management.

Further detail on the Health Target measures is included at Appendix 4.

2.4 Whanau Ora ki te Awakairangi

Improved health equity is a key goal of the Hutt Valley DHB District Strategic Plan. If Māori are to live longer with healthier lives and fulfil their potential to participate fully in our community, we need to adopt strategies that are effective at improving access to, and the quality, of health care for Māori. We have developed our Māori Health Strategic Plan, Whanau Ora ki te Awakairangi, in consultation with Iwi Maori 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. Guided by Whanau Ora ki te Awakairangi and Whakatātaka, Table 5 below summarises the goals, objectives and strategies we have focused on:

Table 5: Whanau Ora ki te Awakairangi; Goals, Objectives and Strategies

Goals and Objectives	Strategies
Partnership Manawhenua are partners with the Hutt DHB at the governance level	Establishment of a local Māori partnership board with Hutt Valley DHB. Ensuring local Iwi/ Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Maori health gain.

Goals and Objectives	Strategies
Improving participation Māori engagement in planning, development and delivery of health and disability services	We have established a Māori Health Service Development Group that works with the Chief Operating Officer, the Director of Planning, Funding and Public Health and their staff on the development of services that will better meet the needs of Māori. 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. Expanding Māori capacity through provider and workforce development. Support for Māori Student cadetship, Manu Tipuranga Awards.
Ensuring effective services Equity of participation, access and outcomes for all Māori Māori enjoy the same level of health as non Māori Safeguard Māori cultural concepts, values and practices	Facilitating service development initiatives and improvements for Māori with a focus on whanau ora and chronic disease care and management. Improving mainstream effectiveness through ongoing Māori responsiveness training for all staff in the DHB and community providers. Working with mainstream services to improve access and responsiveness for Māori when they encounter mainstream services, including for cancer screening, renal and cardiac services, general medical and surgical, emergency department services, and plastics. Conducting Māori consumer satisfaction surveys. Increasing our investment in Māori Health by 5% over 2008/09 baseline funding. Work with the PHOs to ensure that their Māori Health Plans align with our Māori Health Strategic plan Make it Happen (Whakamahingia), our Mental Health Service plan developed for Te Awakairangi places an emphasis on mainstream services providing more responsive services to Māori.
Working across sectors	Continuing our operational linkages with Māori health providers and community representatives through our Māori Health Service Development Group. Linking and connecting families to other agencies and organisations for improved care post hospital discharge. Development of specific plans such as Kia Pai Nga Kai – Ka Ora Te Tinana – providing a specific Māori focus for HEHA.

In 2009/10 we will ensure that measurable improvements for Māori are achieved across all of our DAP outcomes for all of the DAP priority areas (Refer Section 4)

2.5 Pacific Health Strategic Plan

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. In 2008 we engaged with Pacific Communities to develop a future direction for Pacific peoples' health in the Hutt Valley. We formed a Pacific Community Reference Group to work with the DHB to develop a strategy and plan reflective of our community needs and priorities. Our *Pacific Health Strategic Plan 2009-14* reflects the Hutt Valley DHB's commitment to improve the health of Pacific peoples in the Hutt Valley over the next 5 years.

Our vision is for a Hutt Valley Pacific population healthy in mind, body and spirit enjoying a long happy life with support and access to responsive health services. The plan identifies four strategic goals and a number of objectives as shown in Figure 2 below.

Figure 2: Pacific Health Strategic Plan; Goals and Objectives

Pacific Health Strategic Plan Goals	To support and strengthen community leadership			
	To improve responsiveness and accessibility of services			
	To build and develop a pacific workforce			
	To develop a strong Pacific service infrastructure to deliver effective holistic services			
Pacific Health Plan objectives	Pacific participation	Health literacy and education	Increased immunisation	
	Reduced hospital admissions	Improved access to primary health care	Improved oral health	Increased access to sexual health services
	Healthy Eating Health Action	Increased Breastfeeding	Reduced Smoking/ alcohol and Drugs	Better housing and living conditions
	Improved participation in cancer screening	Improved access to cancer treatment	Older persons	
	Disability services	Mental health services	Long term conditions	Diabetes
	Workforce	Coordinated, cost effective, cohesive services		

The specific strategies and actions aimed at realising our vision for the Hutt Valley Pacific population are further discussed under the each of our DAP priority areas (Section 4 refers). We will ensure that measurable improvements for Pacific people are achieved across all of our DAP outcomes and for all of the DAP priority areas.

2.6 Responsibilities to People with Disabilities

The services provided for people with disabilities are designed around 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 highly 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*".

Our focus is to progress the inclusion of disability perspectives in Hutt Valley DHB processes and activities. Requirements of people with disabilities 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.

3.0 Our Challenges and Areas for Focus

The following section summarises our key challenges, areas for focus, and risks facing Hutt Valley DHB during 2009/10.

3.1 Key Challenges

We have identified a number of key challenges going forward.

Our population health needs

Details of our Hutt Valley population demographics and health profile are included at Appendix 1. In summary our population demographic is projected to change over time. We will have more people who are older and more Māori and Pacific people. With respect to our population's health profile, inequalities exist in relation to the social determinants of health and in relation to particular health behaviours and risk factors, including prevalence of smoking, rates of breast-feeding and prevalence of obesity.

When compared with national figures, the Hutt Valley population experiences higher than average rates of chronic conditions; higher prevalence of diabetes, asthma, chronic obstructive pulmonary disease and chronic mental health disorders. Māori and Pacific people experience higher rates of death from cancer, cardiovascular disease and stroke, and much higher prevalence of diabetes and asthma. Hutt Valley DHB has significantly higher rates of avoidable hospitalisation when compared nationally, in particular for diabetes, cardiovascular disease, ischaemic heart disease, and asthma. Maori and Pacific people experience greater unmet need for a GP and poorer access to oral health checks, diabetes checks, and breast cancer and cervical screening.

In addition, a particular current challenge for us will be the impact of the economic downturn on all population groups in the Hutt Valley affecting their health status and access to health services.

The implementation of the *Keeping Well Strategy* (refer Sections 3.2.1 and 4.3) and our *Long Term Conditions Framework* (refer Section 4.4) are key to addressing the above challenges.

Primary health care

We currently have below the target number of General Practitioners and Practice Nurses required to serve the Hutt Valley population. This affects our population's access to timely primary health care when needed and results in higher hospitalisation associated with long term conditions. Growing the primary health care workforce, addressing the high rate of avoidable hospitalisations, and planning for future devolution of secondary care services, within current resources, present particular challenges for us. The implementation of our Long Term Conditions framework requiring strong collaboration and clinical leadership will be important for addressing our challenges in this area.

Electives and Hospital Services

Increasing our elective discharges and reducing our emergency department waiting times ahead of the completion of our campus redevelopment project is a challenge for the Hutt Valley DHB. Over the last five years Hutt Valley DHB has seen a 33 percent increase in acute surgical demand. This increased demand has placed significant pressure on services throughout the Hutt Hospital and in particular on our ability to carry out elective surgery. We will be progressing our plans to expand our hospital capacity with some urgency. We will also need to implement temporary measures that include constructing clip on theatres and purchasing additional services from private providers and through regional collaboration.

Maternity, Child and Youth Health

A significant challenge for us is our ability to meet targets for childhood immunisation and for children and adolescents accessing oral health services. In recent times the previous Government has required the implementation of numerous initiatives over the same timeframe; Before School Checks, Antenatal HIV Screening, Newborn Hearing Screening, HPV Vaccination, and Youth Health initiatives. These new programmes place additional strain on our resources as we seek to

implement them in accordance with national strategies and policies.

Older Peoples Health Services
The aging population places additional strain on these services. We have high utilisation of aged residential care beds compared with the national average. Our efforts to provide increased support to older people at home mean that we need to ensure that quality services are available and that they are integrated across community, primary and secondary services. Timely access to residential care and home support services is an issue that we are continuing to address through the augmented Service Coordination Centre.

Workforce Development
Along with the rest of the New Zealand health sector, Hutt Valley DHB is facing increasing shortages of skilled health professionals. 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 using new strategies recruit and retain staff and enhance our workforce development. We have established a targeted approach for recruitment and/or retention difficulties.

Maintaining Financial Performance
Returning to a financial break-even position is a key challenge for us. The main financial pressures we face are common across the health sector and include staff cost increases, particularly those resulting from national settlements at higher levels than funding increases, and increased demand for services due to the aging population and recent economic impacts. National pricing increases for hospital provider services, which exceed funding increases, place pressure on our funder financials. In addition, centrally driven ring fenced funding reduces our flexibility to address financial pressures across the board. We have planned a number of key initiatives aimed at bringing the Hutt Valley DHB to a break-even position over time. These initiatives include value for money reviews and productivity enhancements, as well as investment in new capital to increase revenue.

3.2 Areas for Focus

3.2 1 DHB Collaboration

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of Hutt Valley DHB in achieving the goals set out in our District Strategic Plan 2006-11. We are committed to sharing resources with regional DHBs and providers as well as collaboration with the Ministry, DHBNZ[4], NGOs[5] and other service providers. Examples of our collaboration are listed in Table 6 below:

Table 6: Examples of DHB Collaboration

National
- Participation in DHBNZ programmes
- Lead DHB for national Quality Improvement Committee initiative Safe Medication Management
- CEO membership of HISAC
- Membership of the Sentinel Events Working Party.

Regional[6]
- Central Region DHB collaboration and Central Region Technical Advisory Services
- Support for the implementation of a Regional Clinical Services Plan
- Participation in the Central Cancer Network, and clinical networks for plastics, cardiology and renal services

[4] DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.
[5] NGOs (Non-Governmental Organisations) for more information on NGOs go to http://www.moh.govt.nz/ngo
[6] The definition of Regional varies between areas of service provision and coverage – some regional services refer only to the greater Wellington region while others refer to a much larger central North Island region.

- Provision of regional plastics services, including collaboration for the provision of breast reconstruction services
- Provision of regional rheumatology service
- Provision of regional mental health services for eating disorders
- Provision of regional breast cancer screening services (BreastScreen Central)
- Provision of regional coordination services for cervical screening
- Provision of regional public health services
- Keeping Well 2008-20012, Wellington Region Strategic Plan for Population Health.

Intersectoral

- Hutt Valley Healthy Housing programmes through support for community based Healthy Homes-Healthy People programme and the Housing Corporation Healthy Housing programme
- Family Violence response programme
- Healthy Eating Healthy Action in collaboration with schools, and other agencies
- Providing Access to Health Solutions (PATHS) in partnership with Ministry of Social Development
- Implementation of the Wellington Regional Refugee Action Plan
- Working with ACC to support implementation of a sexual abuse assessment and treatment services
- Participation in:
    - Hutt Valley Governance Group
    - Hutt Valley Mayors and Chairs group
    - The Hutt Valley Disability Advisory Group (which provides shared support to both the DHB and local councils)
    - Wellington Regional Social Development Forum.

Regional Clinical Services Plan

The six Central Region DHBs have collaborated to prepare a draft Regional Clinical Services Plan (RCSP) intended to guide joint efforts over the coming years. Individual DHB boards received the final draft of the RCSP October 2008. The RCSP is a conceptual document setting out a vision for the future to the year 2020 and provides the framework for the region's future service development and investment.

The RCSP identifies a number of challenges common to the health and disability system going forward:

- By 2020 one in every five people will be aged over 65 in the Lower North Island
- Technological changes are happening faster than ever before
- Clinical teams may be spread too thinly across small vulnerable departments
- Growing public expectations will mean a shift from provider centred to patient centred approaches
- Better service design and service coordination and information sharing within and across DHBs will be needed to improve efficiency and effectiveness.

Key to addressing these challenges is the development of clinical networks where specialist teams work together across the region and in the community. Hutt Valley DHB has already recognised the benefits of collaborating for some time and participates in Central Region clinical networks for cancer, renal, plastic surgery and cardiology services (see below).

The first phase of initial implementation planning commenced with a paper approved by CEOs and the formation of a steering group, late 2008. Initial work programme priorities include:

- Further developing clinical networks
- Identifying vulnerable services (services at risk of failure) and contingency plans
- Seeking stakeholder feedback on the draft plan (within DHBs and externally as part of the review of our District Strategic Plan).

Clinical Networks

Regional clinical networks have been established for Cardiology, Renal and Plastics services.

These clinical networks provide specialist teams working together across the region and in the community. Further work and development of clinical networks planned for 2009/10 includes:

- The Plastic Surgery Clinical Network to implement the reconstructive breast surgery business case (dependent on business approval in 2008/09)
- The Cardiology Clinical Network to address workforce issues, develop new models of care for cardiac rehabilitation and heart failure, carry out research on inequalities in access to cardiac revascularisation services with the Wellington School of Medicine, and improve referral processes across the region
- Establishment of clinical networks for increased dermatology and ENT service capacity
- Development of a mental health services clinical network.

Regional Cancer Network

The Central Cancer Network (CCN) is one of four regional[7] cancer networks established to facilitate a number of the initiatives contained in the Cancer Control Strategy Action Plan 2005-2010. CCN provides leadership, coordination and facilitation functions with respect to cancer control across the region. To achieve its aims, the CCN engages with health and social care professionals, the voluntary sector and other key stakeholders including Maori, Pacific peoples and patients and carers.

Central Region DHB Collaboration

Central Region DHBs (Capital and Coast, Hutt Valley, Wairarapa, Whanganui, Midcentral, Hawkes Bay) work closely together in a number of areas and continue to invest in the shared service agency, Central Region Technical Advisory Services Ltd (TAS) to support much of this work.

In 2009/10, TAS will support the Central Region DHBs to progress a range of collaborative initiatives, including support for:

- Regional Clinical Services Plan implementation and work programme priorities
- Development of clinical networks
- Improve opportunities via videoconferencing for more regional collaboration
- The provider audit programme.

Regional Mental Health Plan

The Hutt Valley DHB has a long history of collaboration in relation to mental health services. We continue to implement the national strategy Te Tahuhu and the action plan Te Kokiri through delivery of the Central Region Mental Health and Addiction Strategic Plan, encompassing the plans of the six central region DHBs[8] (including our own plan referred to as Make it Happen, *(Whakamahingia)* 2008-13. Hutt Valley DHB is specifically responsible for leading the project to implement the regional plan, which provides a framework that aims to ensure the best possible configuration of local, sub-regional and regional services. From 2010 onwards the framework will guide the planning, development and funding of all services within the region.

Wellington Region Strategic Plan for Population Health, Keeping Well 2008-12

Keeping Well 2008-12 is a Wellington region strategic plan for population health for the Hutt, Wellington and Wairarapa regions. The plan is designed to inform the Hutt Valley DHB, Capital and Coast DHB, Wairarapa DHB and the Ministry of Health in their collaborative leadership for population health and improving outcomes for high needs groups, including Maori and Pacific and high needs geographic areas. Keeping Well is further discussed as part of our key priority area Keeping Our People Well in Section 4.3.

[7] Encompasses nine District Health Board areas: Taranaki, Tairawhiti, Hawkes Bay, Whanganui, MidCentral, Wairarapa, Hutt Valley, Capital and Coast, Nelson/Marlborough

[8] Refers to the central region's six DHBs; Hutt Valley DHB, Capital and Coast DHB, Whanganui DHB, Wairarapa DHB, Hawkes Bay DHB, Midcentral DHB.

Regional Public Health

Regional Public Health (RPH) is a regional service located within the Hutt Valley District Health Board. The geographical area of service delivery spans Hutt Valley DHB, Capital and Coast DHB and Wairarapa DHB. RPH is the third largest public health service in New Zealand in terms of population and geographic coverage. RPH delivers a range of population and personal health services, aimed at improving the health of communities throughout the greater Wellington region. An important part of RPH's work includes working with other organisations and agencies to address the many factors that contribute to health and wellbeing in our population, such as the physical environment, housing, transport and access to services and resources. RPH supports the implementation of the Keeping Well Strategy.

3.2.1 Fostering clinical leadership

Clinical leadership is a fundamental driver for improved patient care. Clinical leadership is a key contributor to increasing collaboration and teamwork within the organisation. These are critical if the Hutt Valley DHB is to prosper, both in the quality of its services and financially. At Hutt Valley DHB we have fostered clinical leadership through a number of mechanisms, including an *Improving the Patient Experience Programme*, a Patient Safety Leadership Group, Clinical Heads of Departments, Surgical Heads of Department and Clinical Nurse Managers meetings, Theatre user groups, Information Systems User Group's, campus development user group, joint Clinical Heads and Managers annual service planning presentations and signoff of service agreements, clinical leadership membership of our Exceptional Funding Committee and Funding Management Group. We have also appointed a deputy chief medical advisor to provide further strength to our clinical leadership model and promote succession planning.

Clinical leadership ensures that we have a shared vision of safe and quality care and that there is widespread commitment to a quality improvement culture. Our focus is to promote a multidisciplinary team approach and provide strong clinical leadership supporting key quality improvement strategies eg our *Improving Patient Experience Programme* of work (refer Section 4.10).

Clinical leadership underpins our work to improve hospital productivity and provide efficient and effective services. Our clinicians take the lead in identifying priorities for where we should focus our efforts to shift resources to frontline services and create new capacity to see more patients and improve patient outcomes. Membership of our Funding Management Group and Exceptional Funding Committee means that clinical leadership supports decisions regarding new funding and funding reallocation and disinvestment strategies. Clinical leadership also underpins our regional collaboration work and development of clinical networks. Our model for improving the management of long term conditions encompasses strong clinical leadership and networks across primary and secondary care services.

At Hutt Valley DHB we believe one of our strengths is the collegial relationship established between clinical and managerial leaders. Clinicians assigned to leadership roles within the organisation require support and training in the organisational aspects of their work. Managers through their knowledge and experience can make significant contributions thereby enhancing the effectiveness of clinicians in leadership roles.

Our values encapsulate our approach to fostering clinical leadership. We have actively built, encouraged and recognised clinical leadership, for its innovation, passion, energy and commitment. Importantly we have developed a culture that promotes trust, honesty, respect and integrity. We are committed to growing our clinical leadership and all hospital service plans include plans to foster and increase our effort in this area.

Table 7: Clinical Leadership Outcomes

Specifically the outputs and outcomes we seek for clinical leadership, include: • Clinicians identifying, developing and initiating improvements at all levels.

- Clinicians take the lead in decision making at a service unit level
- Clinical leaders as members of the Executive Management Team
- Reporting on nationally agreed clinical outcomes and clinical effectiveness and other measures of clinical governance and leadership
- Inclusion of quality and safety as part of regular Board reporting
- Regular assessment of the Hutt Valley DHB's performance in relation to clinical outcomes and support for clinical governance
- Identification of actual and potential clinical leaders
- Providing explicit development and training opportunities, coaching and mentoring for clinical leadership at all levels.
- Clinicians taking responsibility and accountability for issues that could have an organisational impact and proactively managing them.

3.2.2 Improving value for money

Improving value for money from the services we provide and purchase means ensuring that we invest appropriately for a given set of services delivered to achieve a particular health outcome, either for an individual or on a population health basis. The relationship between what we invest and the service delivered is termed service efficiency, and the relationship between what is delivered and the health outcomes achieved, is a measure of the service effectiveness. Together, improved service efficiency and improved service effectiveness provide improved value for money.

We have identified a number of challenges and risks (refer Sections 3.1 and 3.4) where improving health outcomes and maintaining our financial performance mean looking for opportunities to improve value for money, in addition to other measures. These include:

- Getting better value for money from the services we purchase
- Improving the efficiency and effectiveness of the services we provide
- Collaborating regionally.

There are opportunities for improving value for money where we can better map service funding to service delivery and health outcomes, and where we can consolidate the services being purchased across fewer providers. In 2009/10 this work will include:

Mental health services
Hutt Valley DHB currently purchases mental health services from over 30 different service providers via an even greater number of contracts. A recent contract review has identified gaps in our ability to measure service utilisation, which in some cases appears to provide poor value for money. We therefore intend to complete a review of mental health services to ensure better alignment between activity and resources, with a view to freeing up resources for the implementation of the recommendations of the Infant Child, Adolescent and Family mental health and addiction service review. We intend to complete this review by the third quarter 2009/10 ahead of the 2010/11 contract renegotiations.

Older Peoples Health Services
The aging population is placing additional strain on these services. The recent economic downturn means lower co-payments for these services with a commensurate increase in funding required from the DHB. In 2007/08 the Hutt Valley DHB prepared a business case aimed at improving value for money for these services and in particular addressing the financial risks associated with the our high utilisation of aged residential care beds. In 2009/10 we intend to continue to work closely with our augmented NASC provider in an effort to meet the original business case targets and better manage the increasing pressure on our funding.

Long term conditions
When compared with the national figures, the Hutt Valley population experiences higher than average rates of chronic conditions and we have higher rates of avoidable admissions to Hutt

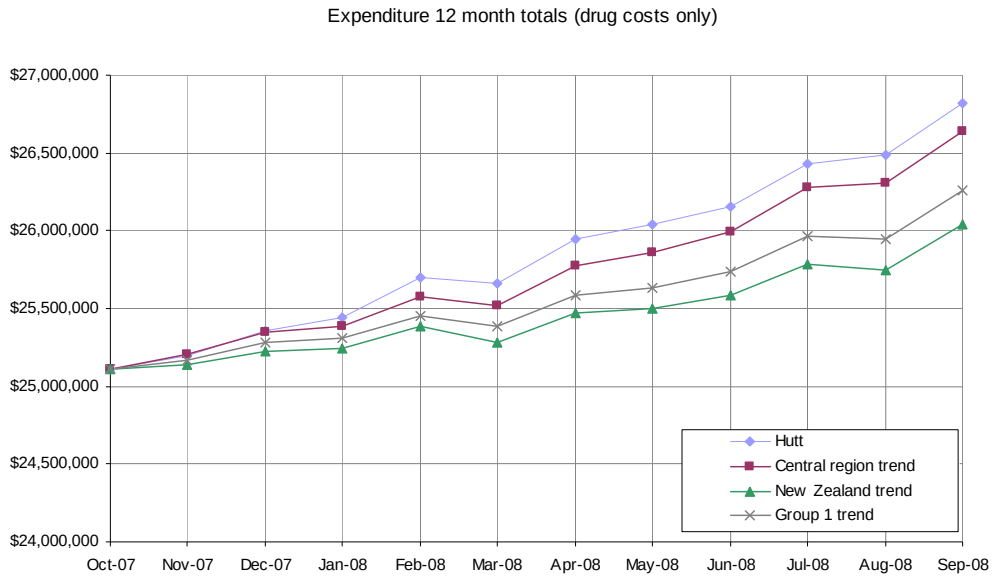
Hospital. Over the years we have funded a number of programmes and services aimed at addressing these issues. In the development of our Long Term Conditions framework 2008/09 we identified the need to improve the effectiveness of these programmes and services and ensure better value for money. A review of our long term conditions programmes and service purchasing to identify opportunities for consolidation and better integration will be carried out in 2009/10 with a view to informing our service planning and contracts for 2010/11.

Pharmaceuticals
We have identified the need to improve value for money in community pharmaceutical and hospital pharmacy expenditure due to:

- A large increase in volume and cost of some prescribing by hospital specialists over the last two years, in particular within mental health services
- Increased wastage of prescribed drugs due to changes in packaging of medication for rest homes, and as a result of "Stat" dispensing
- Limited demand management and awareness by prescribers.

Figure 3 below compares actual 12 month total expenditure, with what expenditure would have been had the Hutt Valley DHB followed the overall national trend, and what expenditure would have been had we followed the trend for this region.

Figure 3: Expenditure on Pharmaceuticals



Projects aimed at improving pharmaceuticals value for money in 2009/10 will include:

- Optimal prescribing in mental health services project
- Review of respiratory and rheumatology prescribing
- Working with pharmacies to reconcile claiming and payments
- Optimising pharmaceutical use by high cost and high volume users.

Improving service efficiency and effectiveness
At Hutt Valley DHB we will continue to seek improved service efficiency and effectiveness in the services we provide as part of improving patient care and the quality of our services, improving productivity (refer Section 3.2.4 below), and improving overall value for money. For example:

- Improving the Patient Experience Programme:
    - Providing a specific pain relief discharge pack for patients, enabling them to go home without a further overnight stay
    - The Progressive Ward Project for the Orthopaedic Ward focusing on processes

and physical aspects of the ward, identified by ward staff as having the potential to release or free up time, which can then be used to care for patients
    - Improving pre-operative assessment processes to reduce unnecessary patient attendances and improve workforce utilisation
    - Direct GP referral to CT Head diagnostic services avoiding unnecessary waits for specialist assessments.
- Reducing the number of children overdue for recall for oral health services from 34.3% waiting over 12 months at December 2007 to 12.6% by December 2008. Our aim is to further reduce this to 0% by December 2009, within existing resources.

Regional collaboration
Our increased regional collaboration is also aimed at improving value for money. Opportunities to improve our efficiency and improve outcomes include:

- Regional business case and procurement activities
- Regional cooperation around managing common service providers
- Sharing of funder and provider activity and outcomes data
- Sharing of best practice experience.

For 2009/10, we have identified, together with Capital and Coast DHB, areas of regional collaboration that could result in improved efficiency and outcomes. These include:

- Exploration of additional elective services theatre facilities in the region
- Increased cooperation in relation to mental health provider management
- Review of Ministry of Health requirements for local infrastructure for Immunisation, Antenatal HIV and Newborn Hearing Screening services.

3.2.4 Improving hospital productivity

Our hospital services have implemented a number of changes in recent years resulting in improved productivity and the freeing up of capacity to provide more services to increasing numbers of patients. Particular examples include our work in oral health and imaging services, where we have seen dramatic improvements in the number of patients able to be seen in a timely manner, within existing resources.

A number of the projects that fall within our Improving Patient Experience Programme are expected to deliver improved hospital productivity, releasing further capacity for increased frontline services:

- Emergency Department streaming project improving triage processes and reducing delays in admitting patients, i.e. working with wards to develop a “pull system”
- Improved collaboration across specialties for patients with multiple long term conditions
- Extending patient focussed booking
- Improved scheduling for acute surgical admissions to optimise patient flow and reduce length of stay
- Improved pre-operative assessment
- Improving rates for day of surgery admission
- Ensuring direct access to diagnostic services where appropriate
- Increase % of electives day surgery.

Hutt Valley DHB is a member of the Australasian Health Roundtable, which collects and analyses key benchmarking information, including information from Hutt Valley DHB. This benchmarking allows us to compare ourselves with other health organisations and look for ways to improve operational practices. The three areas of focus for benchmarking this year are emergency department utilisation, theatre utilisation and stroke services.

3.3 Service Reviews and Changes

We propose to undertake a number of service reviews and service changes during 2009/10:

- Implementation of the Oral Health Business Case
- Establish a Rheumatology Gout Clinic in primary care
- Implementation of fast-track colorectal surgery to increase access within existing capacity
- Implementation of a regional business case for the provision of reconstructive breast surgery, subject to funding
- Establishment of clinical networks for increased dermatology and ENT service capacity
- Community radiology is available free of charge only for Community Service Card holders and under sixes. In 2009/10 we intend to review these criteria
- Capital and Coast DHB to establish local services for urology, renal and ophthalmology surgery for the residents of Hutt Valley
- Implementing Make it Happen (Whakamahingia), 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
- Ongoing implementation of better coordination of services for health of older people via the augmented Needs Assessment Service Coordination (NASC service)
- Implementing the population health strategy, *Keeping Well 2008-2012*[21].

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 will work with other DHBs to identify any potential impacts of the reviews on their services and populations, and we will work to implement relevant recommendations from regional reviews and plans. We will follow the requirements of the Operational Policy Framework in relation to all service changes signalled.

3.4 Key Risks and Mitigations

The key risks for the DHB and the Hutt Valley population fall into three key areas: service effectiveness, infrastructure (workforce, facilities and information), and financial management. These three are often inter-related, with a failure in one leading to negative consequences in another. Specific risk areas and mitigation strategies are outlined in Table 8 below.

Table 8: Key Risks and Mitigations

Risk	Mitigation	Focus for Priority Area
Service Effectiveness		
Lack of theatre capacity until 2011/12 limits the ability to meet electives surgery targets	Short term – use of Clip on Theatres and Private Facilities and implementation of improved scheduling for acute cases.	Elective Services Hospital Services Emergency Department/Theatre project
An increase in acute surgical demand limits our ability to meet elective surgery targets	Short term – use of Clip on Theatres and Private Facilities and implementation of improved scheduling for acute cases Medium term – use of temporary clip-on facilities Long term – construction of new theatre capacity and new regional elective services facility initiatives.	Elective Services Hospital Services Emergency Department/Theatre project
Increased emergency department attendances place pressure on services	Improving Patient Experience work includes projects to improve patient flow, and improve utilisation of capacity Work with primary care to ensure	Primary Health Care Hospital Services Older Peoples Health Quality and Safety

Risk	Mitigation	Focus for Priority Area
	patients are being referred appropriately, to increase primary care workforce, and to improve availability of after-hours services.	
Emergency waiting time targets not achieved	Ensure that Improving Patient Experience projects provide a focus for patient flow from the emergency department to other hospital services in a timely manner.	Primary Health Care Hospital Services Older Peoples Health Quality and Safety
Delays in the establishment of a proposed new model for community based oral health for children and adolescents	Work with the Ministry of Health to ensure timely business case approval.	Hospital Services Maternity, Child and Youth
Inability to meet expectations for extending post natal stays due to capacity constraints	Work with the Ministry of Health to identify ways of providing support for women transitioning from post natal beds to home	Maternity, Child and Youth
Insufficient funding for the effective implementation of a universal programme of Before School Checks	Ensure a focus on most at risk children	Maternity, Child and Youth
Insufficient funding for the effective implementation of newborn hearing screening programme	Work with the Ministry of Health to negotiate additional funding	Maternity, Child and Youth
Ability to address ambulatory sensitive hospitalisations limited through lack of clinical support	Include focus in our work on long term conditions	Primary Health Care Hospital Services
Ability to ensure improved quality of services in older peoples services limited by the contracting model	Ensure focus on quality in our work with NASC	Older Peoples Health
Change management activities within Primary Health Care e.g Family Health Centres, Devolution and Workforce initiatives unsupported through lack of resources	Work closely with Primary Health Care to focus on priorities and quick wins and best use of resources	Primary Health Care Hospital Services
Lack of new Blueprint funding in 09/10 limits our ability to implement recommendations of ICAFS review.	Carry out VFM review of mental health services and reallocate resources as required.	Mental Health
Economic downturn creates increased demand on services	Maintain focus on high needs populations and their access to health services	All
Infrastructure		
Progress on construction of the new campus development is affected by resource consent issues, construction delays, or other	Executive level engagement throughout with close monitoring and risk mitigation plans.	Emergency Department/Theatre project
Workforce and skill shortages impact on access to services and the provision of high quality and safe services	Continue with projects aimed at growing the primary health care workforce. All Hospital Service Plans include a focus on workforce	Primary Health Care Elective Services Hospital Services Workforce Development

Risk	Mitigation	Focus for Priority Area
	development – creating a positive workplace culture, strategies for retention and recruitment, fostering leadership, maintaining a focus on ongoing professional development and coordinated clinical practice training.	
Efforts to increase primary health care workforce do not improve achievement of primary care targets for enrolment and access	Work closely with Primary Health Care to focus on priorities and quick wins and best use of resources	Primary Health Care Hospital Services
Delays in delivery of information systems developments impacts on our ability to improve service efficiency and effectiveness	Information system developments and delivery are fully planned with appropriate contingency and risk management.	Information Services Hospital Services Older Peoples Health Mental Health
Financial Management		
MECA settlements above FFT	Work closely with the Sector and bargaining agents to keep costs below FFT	Workforce Development Hospital Services
Inter-District Flows – as other DHBs seek to decrease their outflows and/or Hutt Valley outflows increase beyond planning assumptions	Work with the other DHBs on production planning and elective initiatives planning	Planning & Funding Elective Services Hospital Services
Plans for reducing provider arm costs and increasing revenue not met	Regular monitoring and discussion with the key business units	Finance Elective Services Hospital Services
Deficit plans for funder arm costs not met	Regular monitoring and discussion with the key business units	Finance Planning & Funding
Services for Older People – over expenditure due to high utilisation of ARC beds and reduced co-payments as a result of the economic downturn	Work closely with NASC on value for money focus.	Older Peoples Health
Pharmaceuticals expenditure – risk that unable to bring down and unable to meet planning assumptions	Ensure additional and sustained focus on pharmaceutical VFM project at senior level. Work with prescribers to ensure greater awareness of financial impacts.	Planning & Funding Primary Health Care Hospital Services Older Peoples Health
Assumptions regarding electives activity including assumptions regarding activity carried out across the region not met	Clip on theatres and regular meetings with other DHBs	Planning & Funding Elective Services Hospital Services

4.0 Our Local Priorities for 2009/10

The role of our DHB is wide and varied; in this section we detail our selected priority areas. The areas that have been selected for focus are based on the directions identified in our District Strategic Plan and on our assessment of where we believe there is opportunity to achieve improved outcomes in the health of our population. For example, we have selected Primary Health, a key priority area that influences many facets of the health of our population. Our District Annual Plan priorities, below, represent the key result areas that provide a focus for the outcomes we seek (medium term and long term outcomes).

Our Local Priority Areas of Focus:

1. Keeping our people well
2. Primary health care
3. Elective services
4. Hospital services
5. Maternity, child and youth services
6. Older peoples health services
7. Mental health services

And (enabling)

8. Quality and safety
9. Improved infrastructure (ED/theatre development, workforce development, information services)
10. Maintaining financial performance (refer Section 6)

In addition to the selected priorities above, where we have attributed specific outcomes, we have other priorities, which are important in enabling the DHB to achieve its overall goals. These priorities are described in more detail in Sections 4.10 to 4.11, and include a focus on quality and safety and improved infrastructure, including our Emergency Department/Theatre Development Project, workforce development and information services.

4.1 Outcomes framework

Consistent with our District Strategic Plan (DSP) goals we have identified two key long term outcomes:

Healthier communities:	A healthier community is one in which people are able to lead longer, healthier and more independent lives, and where their potential and contribution to society is maximised. A healthier community means that the demands on our health services as a result of health risk behaviours and poor service intervention are reduced.
Improved health equity	Reducing inequalities in health status between population groups will improve the overall health of our community.

In addition to our long term outcomes, we have identified some medium term planning outcomes that we are seeking to achieve as further described below. These medium term outcomes are based on the Government's priorities, our assessment of health need, and DHB performance against various health targets and indicators.

DSP Goal: A focus on prevention, early treatment and easy access:

Health protection is enhanced

We cannot achieve our goals if we do not protect the health of the population, such as when we control the spread of infectious diseases, or assure the quality of our water. Our priority focus on

Keeping Our People Well contributes to this outcome.

Health risk is reduced
Ensuring that our population is able to make healthy choices and that we support such choices is key to reaching our goals. Addressing health behaviours and risk factors is what we do when we implement tobacco cessation programmes and when we work to improve our breast-feeding rates. We also contribute to the development of healthy housing policy and long-term local government plans for our community. Our priority focus on *Keeping Our People Well, Primary Health Care,* and *Maternity, Child and Youth* contributes to this outcome.

Access to services is improved
Working to improve access to services within our community, primary health care, and hospital services ensures that we deliver health equitably, in a way and place that works for our population, and improves their health outcomes. Our efforts have included work to increase the primary health care workforce, funding for school based youth services, and improving our patient focus for elective services. A priority is ensuring increased access to health services for Māori, Pacific and high needs groups, where health inequities clearly indicate issues of access for these population groups. Improvements to mental health services is a priority and investment in primary mental health has been increased where early interventions in this area can go a long way to reducing the lifelong burden of disease associated with mental illness. Our priority focus on *Primary Health Care, Elective Services, Hospital Services, Maternity, Child and Youth, and Mental Health* contributes to this outcome.

Intervention is early
We know that the earlier we identify particular conditions and the earlier we intervene the better the health outcomes can be. A significant number of programmes have or are being implemented to improve the opportunities for early intervention. These programmes are supported and delivered by a range of health professionals and service providers, and include: diabetes checks and improved diabetes management, Before School Checks, and family violence screening. Our priority focus on *Primary Health Care, Keeping Our People Well, and Maternity, Child and Youth* contribute to this outcome.

DSP Goal: Seamless integration:

Services are better integrated
Service fragmentation across our district and beyond and between professions and organisations is a barrier to an effective continuum of care. Health service delivery has become increasingly specialised with a dividing up of functions, professions, services, and locations. As a result, a patient may receive services in a variety of settings from many different providers, particularly for people with long-term conditions and over the course of hospital treatment. To ensure high quality services to patients and clients, we need to function together more effectively. There are opportunities for us to ensure better service integration across services in order to improve health equity and health outcomes. Taking a more patient centred approach, better coordinating care pathways, and better supporting health professionals to work across service settings and share information, for the benefit of the patient, are important steps in working towards better service integration. A particular focus for us is the management of long-term conditions. Our priority focus on *Primary Health Care and Maternity, Child and Youth* contributes to this outcome.

DSP Goal: Effective, Efficient, and High Quality Services:

Services are provided more efficiently and effectively
We want to ensure that our population gets the best possible services within available resources. The weakening outlook for economic growth and its impact on the Government's finances will demand a stronger focus on value for money in the health and disability sector. Already two thirds of new funding is needed to maintain the quality and coverage of existing services, and the rate of cost increases will outstrip likely growth in available funding in the near future. Opportunities to further improve efficiencies include our work on *Improving the Patient Experience* and long term conditions. Our priority focus on *Primary Health Care, Elective Services, Hospital Services, and*

Mental Health contributes to this outcome.

Services are high quality and safe
Quality and safety is always one of our DAP priority areas of focus. Providing high quality and safe services underpins all of our work, and our *Improving Quality Approach* is supported by strong, positive, visible, and professional clinical leadership. Hutt Valley DHB supports the national Quality Improvement Committee's (QIC) five national quality programmes. We are the lead DHB for the safe medication management project. In addition, our '*Improving the Patient Experience*' programme and the implementation of our electronic healthcare incident reporting programme reflect the work at a national level. In addition to the overall quality and safety priority, ensuring high quality and safe services is a particular focus for *Elective Services, Hospital Services, Maternity, Child and Youth, and Services for Older People.*

Our infrastructure is improved
Ensuring that we have the right capacity and capability is key to achievement of our goals. We have already commenced on the redevelopment of the Hutt hospital campus in order to improve capacity for theatres and the emergency department. In addition, a focus on workforce retention and ensuring a culture that values employees and promotes trust is vital for the sustainability of our services. This outcome is a particular focus for our *Elective Services, Hospital Services, Quality & Safety, and Workforce Development* priorities.

Our services are sustainable
The sustainability of our services, both those we provide and those we purchase is key to ensuring that we continue to meet the needs of our population. As available resources become more constrained it is important that we look at ways we can generate additional revenue and/or get better value for money from the services we provide and purchase. Our priority focus on *Elective Services, Hospital Services, Services for Older People, and Mental Health* contributes to this outcome.

Regional Collaboration and Positive Partnerships
Working collaboratively with others, both across the sector and with other health and social service providers is integral to achieving our goals. We are committed to sharing resources with regional DHBs and providers as well as collaboration with the Ministry, DHBNZ[9], NGOs[10] and other service providers. Ensuring collaborative relationships and positive partnerships are developed and maintained is a key outcome for all of our DAP priorities.

[9] DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.
[10] NGOs (Non-Governmental Organisations) for more information on NGOs go to http://www.moh.govt.nz/ngo

Table 9: Addressing our challenges - Achieving our outcomes – Achieving our goals

Our Challenges	DAP Outcomes	DAP Priority Focus	DSP Goals
Maintaining our efforts to support healthier choices in our population, given financial constraints and the impact of the economic downturn. Making bigger step improvements in our immunisation rates, in particular for Māori and Pacific children, where the results of our actions have reached a plateau.	*Health risk is reduced*	- Keeping Our People Well - Primary Health Care - Maternity, Child and Youth	*Improved Health Equity* *Healthier Communities* *An inclusive district* *A focus on prevention, early treatment and easy access*
Increasing our collaboration with Primary Health Care organisations, within current resources, in an effort to reduce avoidable hospitalisations and emergency department attendances amongst high needs groups, where these may be further impacted by the economic downturn. Increasing the primary care workforce, given current models of primary care service delivery, and that the health workforce is generally in short supply, nationally and internationally. Increasing our efforts to reduce emergency department waiting times, ahead of the completion of the campus redevelopment project. Increasing our electives discharges, given our constraints on theatre capacity and workforce. Maintaining our efforts to improve mental health services and ensure ongoing service sustainability.	*Access to services is Improved*	- Primary Health Care - Elective Services - Hospital Services - Mental Health	
Making bigger step improvements in our management of diabetes, in particular for Māori and Pacific people, where the results of our actions have reached a plateau. Implementation of new Government programmes for Maternity, Child and Youth, while also addressing local priorities, within current resources.	*Intervention is earlier*	- Primary Health Care - Hospital Services - Maternity, Child and Youth	
Getting ahead of the burden of long-term conditions where we will need a strong foundation and collaboration in order change the way we do things across secondary and primary care, within existing resources.	*Services are better integrated*	- Primary Health Care - Hospital Services - Mental Health	*Improved Health Equity* *A focus on prevention, early treatment and easy access* *Seamless integration*
Increasing our efforts to improve the efficiency and effectiveness of our services, ahead of the campus redevelopment.	*Services are provided more efficiently and effectively*	- Elective Services - Hospital Services	*Effective, efficient and high quality services*
Ensuring that our plans to increase theatre and emergency department capacity remain on target and continue to be supported by our community. Recruiting and retaining workforce in a competitive market	*Our infrastructure is improved*	- Emergency department/theatre project - Workforce Development	
Improving the quality and safety of older people services, where quality requirements and funding are specified nationally.	*Services are high quality and safe*	- Older Peoples Health Services	
Improve the value for money and sustainability of older peoples services and mental health services, particularly where the impact of the economic downturn is likely to affect these people and the services they access. Our ability to manage Inter District Flows for services	*Services are sustainable*	- Older Peoples Health Services - Hospital Services	

4.2 Measuring performance

For each of our planning outcomes and priority areas of focus we have identified a range of performance measures, some of which are included in our accountability requirements for reporting to the Ministry of Health. These are summarised in Table 10 below. Further detail is provided in Appendix 4.

Table 10: Measuring our performance

DAP Outcomes	DAP Priorities	DAP Measures[11]	Reporting of Measures[12]
Enhanced health protection	Keeping Our People Well	• Control of infectious diseases	• Via Public Health reporting and notifications
Reduced health risk	Keeping Our People Well	• Immunisation coverage • Better help for smokers to quit • Nutrition and physical activity • Homes with adequate insulation and heating	• Health Target, DSP Target • Health Target • DSP Target • Target for assessments
	Primary Health Care	• Better help for smokers to quit • Immunisation coverage	• Health Target, • Health Target, DSP Target
	Hospital Services	• Better help for smokers to quit	• Health Target
	Maternity, Child and Youth	• Immunisation coverage • HPV vaccinations • Breast feeding	• Health Target, DSP Target • Service Plan • IDP[13]-POP-18
Improved access to services	Primary Health Care	• Avoidable hospital admissions • GP/PN numbers per population • High need/low need primary health care consultations • Primary Mental health	• IDP-POP-15 • DSP Target • DSP Target • IDP-POP-06
	Elective Services	• Electives targets	• Health Target
	Hospital Services	• ICU Transfers • First Specialist Assessments • Hospital based follow-ups • Oral health	• Service Plan • Service Plan • Service Plan • IDPs POP-04 and POP-05, DSP Target
	Maternity, Child and Youth	• Improving youth access • Oral health • Post natal stays • Avoidable hospital admissions for 0-4 years	• Service Plan • IDPs POP-04 and POP-05, DSP Target • Additional • IDP-POP-15
	Older Peoples Health Services	• Home based support utilisation • Respite Services • Avoidable hospital admissions for people 65 and over	• Contract reporting • IDP-POP-15
	Mental Health	• Mental health relapse prevention plans • % of population accessing services	• IDP-POP-17 • IDP-POP-06, DSP Target

[11] The DAP measures are specified in more detail at Appendix 4.

[12] Refers to the different reporting of various measures as set-out in Ministry of Health Reporting Requirements, District Strategic Plan Indicators, and/or other indicators as measured as part of planning and funding and provision of services.

[13] Indicator of DHB Performance (IDP) as specified in the DHB Accountability requirements issued by the Ministry of Health

DAP Outcomes	DAP Priorities	DAP Measures[11]	Reporting of Measures[12]
Earlier intervention	Keeping Our People Well	• Family Violence • Primary care mental health • Alcohol and Drug services	• IDP-POP-11 • IDP-POP-06 • IDP-POP-07
	Primary Health Care	• Diabetes and CVD targets • Cancer screening coverage • Before School Checks	• Health Target, DSP Target • DSP Target • Service Plan
	Hospital Services	• Cancer screening coverage	• DSP Target
	Maternity, Child and Youth	• Before School Checks	• Service Plan
Better service integration	Primary Health Care	• Long term conditions	• Service Plan
	Hospital Services	• Average length of stay • Reduction in duplicated visits for patients with long term conditions	• Hospital Benchmark • Service Plan
More efficient and effective services	Elective Services	• First specialist assessments • Day case rates • Day of Surgery Admission rates • Day of Surgery Cancellations • Standardised Discharge Ratios	• Service Plan • Hospital Benchmark/ DSP Target • Hospital Benchmark • Service Plan • IDP-SER-04
	Hospital Services	• Average length of stay • Emergency department waiting times • Cancer waiting times	• Hospital Benchmark • Health Target • Health Target, IDP-POP-10
	Older Peoples Health Services	• Avoidable hospital admissions for over 65s	• IDP-POP-15
	Mental Health	• Hutt hospital services utilisation • Residential beds utilisation • Community Support Services utilisation • Respite services utilisation • Regional and Sub-regional Specialist services utilisation	• Service Plan • Contract reporting
High quality and safe services	Hospital Services	• Patient Satisfaction	• Quality Plan
	Older Peoples Health Services	• Provider audits – quality and risk	• Contract reporting
	Mental Health Services	• Provider audits – quality and risk	• Contract reporting
Improved infrastructure	Keeping Our People Well	• Maori and Pacific Health workforce	
	Elective Services	• Business case targets	• Redevelopment Plan
	Hospital Services	• Business case targets • Staff retention • Staff satisfaction	• Redevelopment Plan • Service Plan, Hospital benchmark
Sustainable services	Elective Services	• Electives volumes	• Health Target
	Hospital Services	• IDF Flows	• Service Plan

DAP Outcomes	DAP Priorities	DAP Measures[11]	Reporting of Measures[12]
	Older Peoples Health Services	• Aged residential bed utilisation • Home based support services utilisation • Utilisation of community support services for older people with mental health and addiction needs	• Contract reporting
	Mental Health Services	• Services utilisation	• Contract reporting
Regional collaboration and positive partnerships	Keeping Our People Well	• Collaboration plans	
	Primary Health Care	• Collaboration plans	
	Elective Services	• Collaboration plans	
	Hospital Services	• Collaboration plans	• Service Plans • Clinical Network Plans
	Maternity, Child and Youth	• Collaboration plans	• Service Plans
	Mental Health Services	• Progress in implementing the Central Region Plan	• Project Plan

4.3 Keeping Our People Well

Keeping our people well is a priority for our DAP and key to ensuring we achieve our DSP goals. A focus on keeping our people well as a priority contributes to enhanced health protection, reduced health risk, earlier intervention, improved infrastructure and regional collaboration and positive partnerships.

Population Health Services are delivered through a range of providers within the Hutt Valley district. Regional Public Health, located within the Hutt Valley DHB is the largest provider of population health services for the Wellington region. In 2007/08 Regional Public Health worked with the three Wellington Region DHBs and the Ministry of Health to prepare *Keeping Well 2008-12,* a strategic plan aimed at strengthening the population health sector in the region. The Ministry of Health has funded a *Keeping Well* implementation team for the period 2008-10.

Keeping Well 2008-12 identifies three strategic goals and eight strategic objectives; these can be mapped to the Goals and Strategies of the Hutt Valley DHB as shown in Table 11 below

Table 11: Keeping Well 2008-12 Goals and Objectives

Hutt Valley DHB Goals	Improved Health Equity		Healthier Communities	
	A focus on prevention, earlier treatment and access	Effective, efficient and high quality services	Seamless integration	An inclusive District
Keeping Well Goals	Reduce health inequalities for the population groups most at risk			
	Support the development of healthy communities			
	Reduce the incidence and impact of chronic conditions			
Keeping Well Strategic objectives	Equal opportunities to good health			
	Smoke free Living		Mental Wellbeing	
	Healthy Eating Health Action	Lives free from harm due to drugs and alcohol		Families enjoying violence free lives
	Living conditions that nurture human health			

The *Keeping Well* goals and strategies provide the framework for our population health and Regional Public Health planning. They are also aligned with the work to implement a Long Term Conditions framework.

Outcomes for Keeping Our People Well

In 2009/10 we will work in partnership with education, primary care, and local government and other sectors to increase knowledge and resilience in our population around healthy lifestyles and to support these choices. We will enhance our regulatory responsibilities to ensure we have good quality air, water and wider environment. We will work with local authorities and other key stakeholders to create environments that make the healthier choice the easier choice.

Table 12 below summarises the outcomes and planned actions that Hutt Valley DHB is seeking to achieve in Keeping Our People Well, and the measures we will use to determine progress. Further details on the specific measures and targets are included at Appendix 4.

Table 12: Outcomes, Measures and Actions for Keeping Our People Well

DAP Outcomes	DAP Measures[14]	Actions[15] ***Note: Keeping Well Strategic Priorities identified in italics***
Enhanced health protection	• Control of infectious diseases	*Control of infectious diseases* • Intersectoral work to implement programmes in high needs communities focusing on TB, Rheumatic Fever and Pandemic preparedness. • Maintain important environmental health controls (regulatory and education) including for food safety, water, and physical and border health.
Reduced health risk	• Immunisation coverage • Better help for smokers to quit • Nutrition and physical activity • Homes with adequate insulation and heating	*Equal opportunity to good health* • Provide public health leadership for the implementation of intersectoral programmes to increase social inclusion and reduce poverty. • Continue to promote, fund and deliver immunisation programmes in collaboration with Maori and Pacific providers, primary care and well child providers, and the education sector. • Implement relevant actions of the Wellington Regional Settlement Action Plan for refugees and migrants. *Smoke-free living*[16] • Implement the Regional Tobacco Control Plan, including training for our clinicians (primary care and hospital based) to implement the effective brief intervention (EBI) model. • Maintain the Hutt Valley DHB Smokefree policy and promote wider adoption of smokefree policies. • Improve coordination with youth programmes to protect young people from smoking. *Healthy Eating, Healthy Action* • Maintain and progress our community action projects for Māori and Pacific populations, inclusive of workforce development initiatives • Continued support for schools and early childhood education sector to promote healthy food and increased physical activity • Support primary health care initiatives through GrX (Green Prescription). • Influencing environments that support healthy food and physical activity options. • Increasing the uptake of breastfeeding for Maori and Pacific women and support the national breastfeeding campaign. *Living conditions that nurture human health* • Provide support for housing insulation activities as part of the Hutt Valley DHB Healthy Homes, Healthy People programme. • Fund public health nurse assessments for Housing NZ's Healthy Housing programme. • Work to increase the number of Maori and Pacific homes improved through the Healthy Housing programme. • Provide public health input to the Hutt Housing Forum, development of healthy public policy for housing, development of strategic transport policies and plans, identification of health impacts of urban design, and Safer Communities interagency work. • Continue support for early childhood education services, health-promoting schools.

[14] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.

[15] Incorporates the relevant strategies and actions set-out in Wellington Region Keeping Well Strategic Plan for Population Health, the Regional Public Health Business Plan, the Pacific Health Strategic Plan, and as part of the Hutt Valley DHB population health programmes and funding plans.

[16] In the district, in addition to Hutt Valley DHB funded and provided services, the Ministry of Health directly funds some targeted tobacco cessation programmes for Māori.

DAP Outcomes	DAP Measures[14]	Actions[15] ***Note: Keeping Well Strategic Priorities identified in italics***
Earlier intervention	• Primary care mental health • AOD Services • Family Violence	*Mental wellbeing* • Work with refugee communities to protect and improve mental well-being. • Ensure health promoting schools include mental well-being programmes. *Lives free from harm due to alcohol and other drugs* • Provide public health input to local authority alcohol policies. • Work with key community stakeholders via the Community Action Youth and Drugs programme to reduce the harm from alcohol and drugs in young people. *Families living violence free lives* • Implement a public health approach to reducing the level of family violence in the region. • Implement policies and practices and training to support implementation of family violence screening as part of the Violence Intervention Programme.
Regional collaboration and positive partnerships	• Collaboration plans	• Strengthen public health contribution to Long Term Council Community Plans. • Intersectoral collaboration as above: including for Housing, HEHA, Refugee Health, Social Development, Local Councils, schools and early childhood centres • Implement first stages of Keeping Well infrastructure improvement, including increased public health intelligence, and workforce plans.

4.4 Primary Health Care

Primary Health Care is a key priority area for our DAP, and one of the strategies identified within our DSP for achieving our strategic goals. A significant challenge for us has been our ability to increase opportunities for improving health status by increasing access to primary health care services and better integrating these with hospital based and other services.

Key challenges

Hutt Valley DHB faces a number of challenges with regard to Primary Health Care, specifically:

- The below target number of General Practitioners and Practice Nurses required to serve the Hutt Valley population
- The ability for the enrolled population to get timely access to primary care when they need care
- Sustainability of after-hours services
- High rates of avoidable hospital admissions
- Inequalities in relation to avoidable hospital admissions, immunisation, checks and follow-up management for people with diabetes
- The lower number of GP and Practice Nurse consultations for our high needs population when compared to New Zealand figures.

Hutt Valley primary health care environment

Primary Health Care in the Hutt Valley encompasses a wide range of professionals, services and organisations that bring health care as close as possible to where people live and work, to provide their first level health contact. For individuals, their families/whanau, and communities, these professionals and organisations offer continuity of care, often requiring coordination of different professionals and services across different organisations for a particular health episode, and/or throughout a person's life. The extent to which we can provide first contact, coordinated, comprehensive, and continuous care is a measure of what we can achieve in primary health care for the benefit our population.

There are five PHOs in the Hutt Valley. These PHOs encompass around 30 different practices. There are 69.5 FTE general practitioners operating in the Hutt Valley[17]. Over 96% of Hutt Valley population are enrolled with a PHO.

In addition, a range of NGOs and private businesses provide primary care services often targeted at specific population groups, or providing particular services in addition to those provided by their GP or Practice Nurse. These organisations and services include:

- Aged care services
- Well Child service providers
- Lead Maternity Carers
- Pacific health service providers
- Youth health service providers
- Māori health providers
- Kowhai Health Trust
- Palliative Care services
- Pharmacists
- Dentists
- Opticians

In addition to national programmes, the Hutt Valley DHB supports a number of local primary health care programmes including:

- School based youth health services
- Diabetes outreach services
- Community dental services
- Additional subsidy for services to high needs population groups
- After-hours services subsidy
- Refugee health
- Additional well child services

The Hutt Valley DHB also supports a range of infrastructure requirements for primary health care:

- Primary care access to information systems (14 practices currently access the hospital based patient information system)
- GP Registrar programme
- Practice nurse development, including primary health care nurse forum and development of clinical guidelines for primary health care nurses
- Pacific and Māori scholarship programmes
- Executive level Primary Care Liaison
- Access coordination services

Shifting some secondary care services to primary health care

The Government has identified that ensuring better, sooner, more convenient primary health care while freeing up capacity in secondary care is a key priority. The Government has allocated $6.5 million in 2009/10 and $13 million in outyears to 'kick start' the shifting of some secondary care services to primary health care. On a population basis this equates to around $210,000 in 2009/10 and $420,000 in outyears for the Hutt Valley DHB. It is intended that this funding will support the change management and transition processes that will be required to enable a shift of some secondary services to primary health care. The amount of funding required for the actual services to be delivered in primary care from 2010/11 will be determined as part of the change management work, and will be provided from within the Hutt Valley DHB Provider Arm baseline funding.

An important consideration in our planning for further shifts in secondary care services is the

[17] The numbers of general practitioners fluctuates. Reporting is provided to the DHB on a 6-monthly basis. Data as at January 2009.

capacity of our existing primary health care workforce. We are undertaking a number of workforce expansion programmes as well as work to support the development of new models of service delivery aimed at increasing capacity.

We will focus on shifting hospital-based services that best meet the needs of our population taking into consideration:

- Patient waiting times for relevant secondary care services
- Current and projected primary health care services facility and workforce capacity
- The location and spread of primary health care services capacity in relation to patient health needs and the ability to provide improved patient access, in particular for high needs groups.

We will place emphasis on those services that allow us to free up capacity within our hospital. Hutt Valley DHB has already recognised the benefits of shifting some secondary care services to primary health care and we have experience of a number of initiatives in this area including:

- Primary Care Skin Lesion Programme (see below)
- Primary Health Sterilisation Services
- Direct GP referrals for CT Head services, respiratory and cardiology testing
- Physiotherapy outreach services.

Primary Care Skin Lesion Programme
In 2002, a Primary Care Skin Lesion Programme was introduced to the Hutt Valley with the aim of reducing waiting times for hospital treatment of lower grade lesions. The programme has been very successful in improving access to services and reducing waiting times. The programme is open to all general practitioners in the Hutt Valley who have completed the formal training provided by Hutt hospital specialists. GP claims for payment must be accompanied by histology results and reporting on complications, for quality monitoring purposes. A Skin Lesion Reference Group, comprising secondary and primary care clinicians and managers, meets regularly to review quality and provide expert guidance to the programme. A programme evaluation was carried out in 2006/07 and patient satisfaction has also been surveyed with good results. The programme has produced a guidelines book for use by GPs in the Hutt Valley, which has also been adopted regionally.

Recent discussion with our PHOs, primary health care providers and secondary care clinicians has identified a range of further possibilities for shifting services, including:

- Direct GP referral to some diagnostic/investigations and provision of GP follow-up to free up secondary care services capacity and reduce waiting times for first specialist assessments
- Direct GP referral to some procedure lists, for example for colonoscopy for services for high risk surveillance
- Integrated long term conditions management, incorporating nurse led and specialist outreach services, to better manage acute demand
- Cardiac rehabilitation programme
- Respiratory rehabilitation programme.

Consideration of direct GP referrals to diagnostics, investigations and procedure lists and provision of GP follow-ups will be further examined within the Electives workstream of our Improving the Patient Experience Programme (IPEP). Exploring other possible shifts in secondary care services will form part of our work to improve the management of long term conditions (LTC). We have established a long term conditions inter-disciplinary “think tank” with consumers, clinicians and other stakeholders to develop specific projects under the long term conditions programme.

The IPEP and the LTC think-tank, and their working groups, will maintain links with and make recommendations to our regular DHB/PHO and primary health care provider forums in relation to plans for shifting services to primary care. In addition, we will collaborate with other DHBs across the region and nationally to share the learnings from previous experience of shifting services to

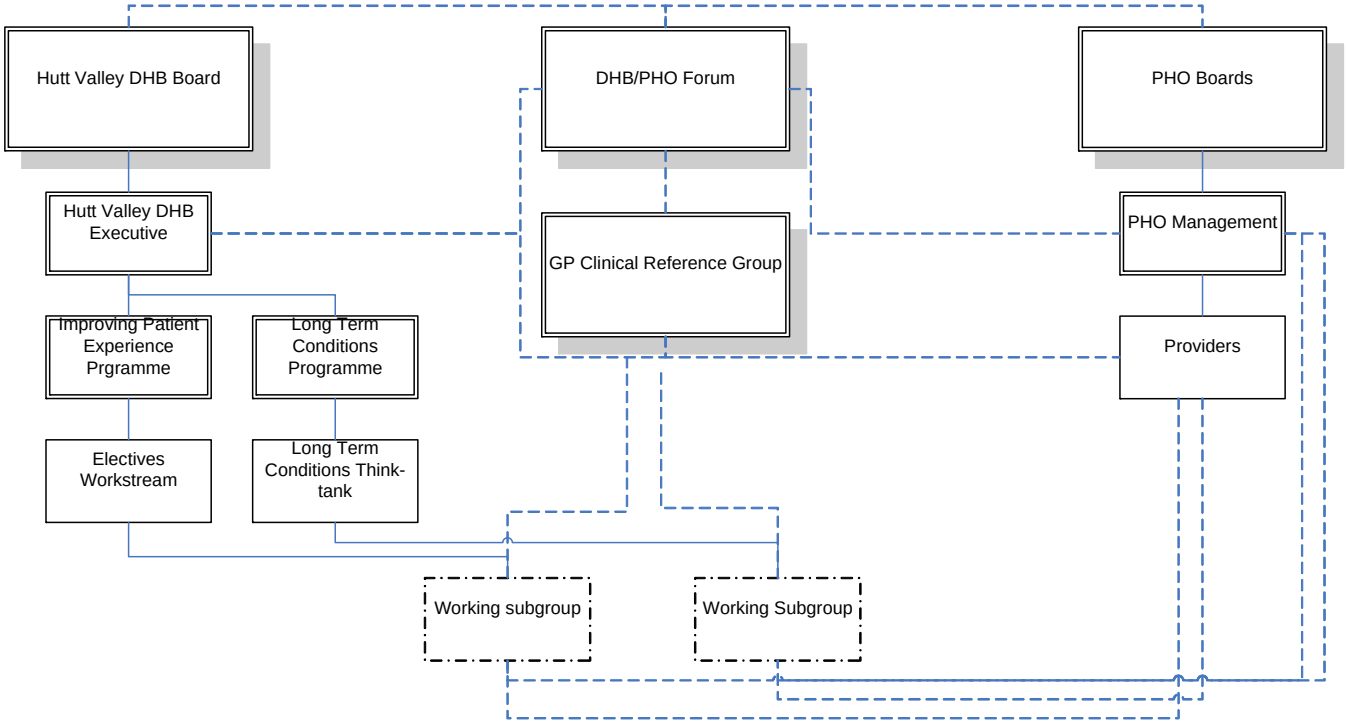
primary health care. We propose the following change management process as outlined in Table 13 below.

Table 13: Shifting some secondary care services to primary care change management process

Key Activities	Budget	Milestones
Exploration of secondary care shifts to primary health care explicitly included in the work programmes of the IPEP and the LTC think-tank.	Internal, logistics	2008/09
Survey of GP and Primary Health Care Nursing interests	Logistics	2008/09
Clinical engagement process – primary and secondary care clinicians	Logistics	2008/09 onwards
Establishment of IPEP and LTC working groups as appropriate to provide more detailed analysis and planning: Collective DHB experiences reviewed and analysed Analysis of Hutt Valley needs - population needs, service waiting times, capacity, workforce, service models Development of criteria for assessing options Identification of options and assessment against criteria	Internal, logistics, technical support	Quarter 1
Consultation on possible options for shifting services	Internal, logistics	Quarter 1
Development of outline proposal and plan for preferred options	Internal, technical support	Quarter 2
Proposal to DHB and PHO Boards – agreement on preferred option	Internal	Quarter 2
Development and implementation of detailed plan for preferred option, including: • governance arrangements • implementation activities; development of new referral pathways, operational policies, service protocols, quality framework • resource requirements; workforce, infrastructure, service budgets and funding and payment mechanisms • training infrastructure and programmes • communications • evaluation framework.	Logistics, project management, technical support	Quarter 3 & 4
Service oversight; DHB/PHO/provider/professional groups providing expert input to standard setting, quality monitoring and service evaluation.	Logistics	Quarter 3 onwards
Service evaluation; assessing overall quality and effectiveness and providing feedback into the quality improvement approach for services and programmes.	Logistics, project management, technical support	2010/11 onwards

We propose the following governance and working arrangements to support the change management process as shown in Figure 4 below.

Figure 4: Shifting some secondary care services to primary care governance arrangements



One of the key change management activities is the establishment of appropriate oversight for the secondary care services that are shifted to primary health care. This includes workforce training, the setting of service standards and plans for quality monitoring and evaluation for the particular services. Our experience with the skin lesion programme has included ensuring that GPs have the necessary training and that claims for service payments are accompanied by service information and results, which can be used for monitoring purposes. A clinical reference group meets regularly to review quality and provide expert advice. We envisage that similar type arrangements could be put in place for new services incorporating appropriate clinical leadership and expert input for training, standard setting and ongoing quality monitoring arrangements.

Preventing and improving management of long term conditions

Long-term conditions[18] affect up to two thirds of our Hutt population. They have a major impact on our health services and are estimated to be the leading cause of avoidable hospital admissions. Around 45% of all admissions to the hospital, up to 80% of GP visits, 37% of outpatient visits and 68% of community nurse visits are thought to be the result of a long-term condition. Around $15m of our community pharmaceutical expenditure is for people with long-term conditions. Long-term conditions increase health disparities and cause increasing poverty and distress within families.

Effective long-term condition management for our district includes strategies to prevent long-term conditions occurring as well as improved management of existing conditions. Improved management includes early intervention, screening and a proactive, planned management of people with existing conditions. The DHB developed a strategic framework for long term conditions in 2008, following a four month engagement process involving service users, community groups, primary and secondary care clinicians, and Maori and Pacific focus groups. The aim of the framework is to guide the development of sustainable programs that:

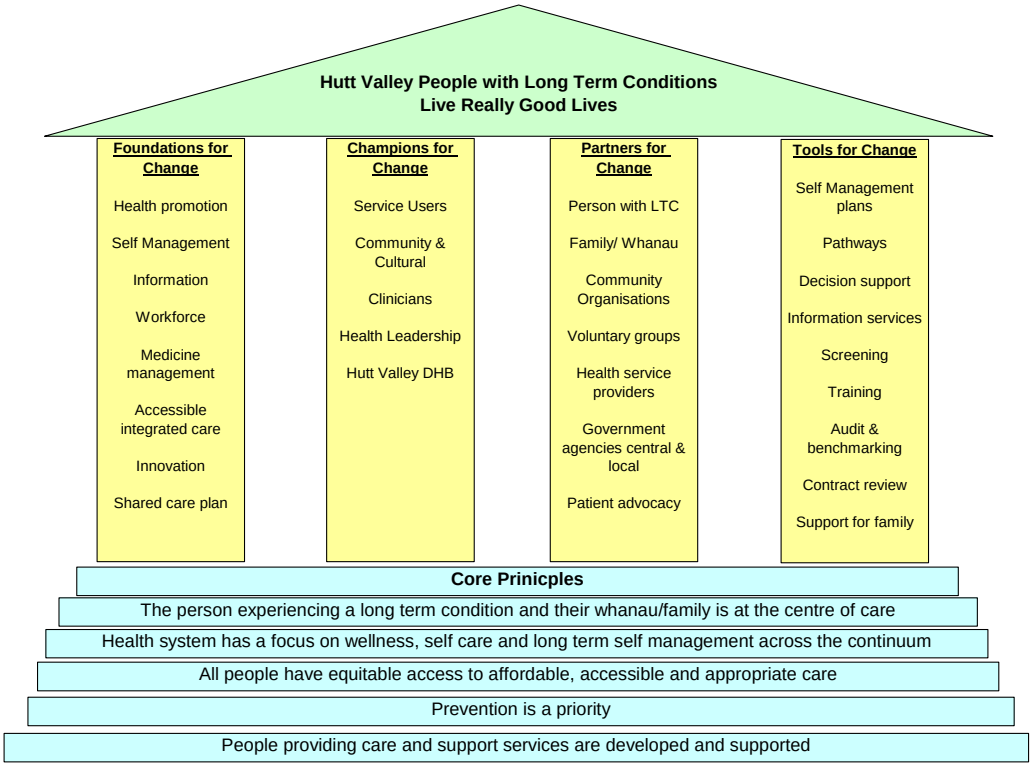
- Help people with long term conditions live really good lives
- Reduce the impact and burden of long term conditions within the Hutt Valley
- Improve health and community based supports and services for people and whanau with long term conditions

[18] Long term conditions are defined as: Any ongoing or recurring health issue that has a significant impact on the lives of a person and/or their family, whanau or other carers.

- Reduce the risks of people developing long-term conditions.

The framework identifies core principles that will underpin long term condition management in the Hutt region as illustrated in Figure 5 below. In 2009 we are establishing a long term conditions inter-disciplinary "think tank" with consumers, clinicians and other stakeholders to develop specific projects under the long term conditions programme.

Figure 5: Long term conditions framework



Outcomes for Primary Health Care

A focus on primary health care as a priority contributes to achievement of the key outcomes of reduced health risk, improved access to services, earlier intervention, better service integration, more efficient and effective services, higher quality and safe services, improved infrastructure and regional collaboration and positive partnerships.

In 2009/10 we will ensure better service integration across primary, secondary, mental health and public health, with a particular focus on long term conditions and reducing avoidable hospital admissions. We will continue to focus on building improved infrastructure (workforce, service models, data) in primary health care to support improved access to services and delivery of more efficient and effective services. The Government has identified that ensuring better, sooner, more convenient primary health care while freeing up capacity in secondary care is a key priority. The Government has made funding available to "kick start" the devolution of secondary care services to primary health care from 2010/11 onwards. We will plan the devolution of services in collaboration with PHOs and other primary health care organisations via our primary care liaison, GP Reference Group, Valley wide forum, and PHO forum.

Table 14 below summarises the outcomes and planned actions that Hutt Valley DHB is seeking to achieve in primary health care, and the measures we will use to determine progress. Further details on the specific measures and targets are included at Appendix 4.

Table 14: Outcomes, Measures and Actions for Primary Health Care

Outcomes	Measures[19]	Actions[20]
Reduced health risk	• Better help for smokers to quit • Immunisation coverage	• Implement Tobacco Control Plan across primary health care.
Improved access to services	• Avoidable hospital admissions • GP/PN Numbers/population • High need/low need primary health care consultations • Primary Mental health	• Continue workforce expansion programmes – GP Registrar, summer studentship, and primary care nursing development. • Implement a collaborative approach to the delivery of after-hours services, including implementation of a nurse telephone triage service. • Complete an evaluation of the performance of SIA, HP, and additional local funding aimed at improving access and earlier intervention. • Implement an access coordination service, supported by the Māori and Pacific units, to ensure that Māori and Pacific people are able to enrol and access primary health care in a timely manner • Implement the change management and transition plan for the shifting of secondary care services to primary health care. • Work with PHOs and other community and primary care organisations and other agencies to explore the development of a Family Health Centre model of primary health care for the Hutt Valley. • Work with PHOs to implement primary mental health services for people with mild to moderate mental illness.
Earlier intervention	• Diabetes and CVD targets • Cancer screening coverage • Before School Checks	• Work with primary and secondary health care to ensure Maori and Pacific people are able to access diabetes checks and are included in the Diabetes Register and are supported to improve outcomes. • Foster the development of new models of service delivery to increase early intervention and outreach services for people with long term conditions (including cardiovascular, diabetes and respiratory disease). • Support Maori and the Pacific community in taking a leadership role, working with mainstream and primary care providers to identify ways of improving cancer-screening participation.
Better service integration	• Long term conditions	• Establish a long term conditions inter-disciplinary “think tank” with consumers, clinicians and other stakeholders to develop specific projects under the long term conditions programme. • Use opportunities as they arise to align services with the long term conditions framework, within business-as-usual processes such as contract review, workforce development and training, information systems developments and collaboration on consumer information.

[19] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.

[20] Includes reference to strategies and actions set-out in Hutt Valley DHB Pacific Health Strategic Plan, Long Term Conditions Strategic Framework,

Outcomes	Measures[19]	Actions[20]
		• Development of training and education programmes to improve insulin management skills for practice nurses and GPs, and for community carers of people with diabetes. • Review Rheumatology care provided to Māori and Pacific – and establish Rheumatology Gout clinic in primary care • Work with Maori and Pacific communities to increase use of services supporting improved management of Long Term Conditions. • Explore ways of better sharing information between primary health care and secondary care services to enable better follow-up and targeting.
More efficient and effective services	• Primary care utilisation	• Work with PHOs to progress the expansion of roles and opportunities for primary care nursing and primary care nursing leadership. • Continue to use the Hutt Valley Palliative Care Forum to provide advice on how best to support GPs and other generalist providers to provide palliative care. The additional funding for the new palliative care components are being used to trial a "Partnership Nurse" from Te Omanga Hospice, to liaise with primary care physicians.
Regional collaboration and positive partnerships	• Collaboration plans	• Facilitate increased opportunities for the DHB and PHOs to share best practice information and collaborate on programmes and to address common issues.

4.5 Elective Services

Elective services (booked surgery) are non-acute services for patients who do not require immediate hospital treatment. Hutt Valley DHB is committed to meeting the Government's expectations for elective services, particularly the key principles underlying the electives system:

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

The Hutt Valley DHB Elective Services Plan provides for a sustainable increase in elective services for our population. We have taken into account demographic growth, current levels of access, the national intervention rate, and local factors. Alongside this there has been a comprehensive analysis of current capacity in theatre, outpatients and inpatient facilities, support and diagnostic services and staffing.

Our population projections indicate a relatively stable population for the period of the plan. The plan has therefore focused on those areas where there has been restricted access due to past capacity constraints, for example restriction of access to first specialist assessments in General Surgery and Orthopaedics and for certain surgical procedures in Plastics.

Elective Services Plan

Elective Services are a key priority for our DAP. A focus on electives as a priority contributes to achievement of the key outcomes of improved access to services, more efficient & effective services, improved infrastructure and sustainable services. In 2009/10 we plan to increase the number of orthopaedic, dental, ear nose and throat, gynaecology and general surgery cases for our community. We have asked Capital and Coast DHB to significantly increase the number of

ophthalmology cases they provide on behalf of our community. Smaller increases are also required in urology and vascular cases.

Our plastics service will be increasing access to people living in the central region and Nelson Marlborough communities particularly for Wellington, Palmerston North and Wanganui. We will be including 13 delayed breast reconstruction cases in our plastics plan which means we will begin treating the 25 women regarded as the "backlog" prior to accepting new referrals for this procedure.

We will comply with required standards on Elective Services Patient Flow Indicators (ESPIs), which demonstrate that we are managing patients in accordance with the three principles (clarity, timeliness and fairness), matching our commitments to capacity, and meeting the 6-month timeframe for provision of assessment and treatment. Clinicians and service teams have developed clinically appropriate waiting times, within Elective Service Patient Flow Indicator (ESPI) timeframes. For the second quarter 2008/09, the Hutt Valley DHB received an **Outstanding** measure for progress towards achieving targets for Elective Services Patient Flow Indicators (ESPIs). We are confident that ESPI compliance will be maintained.

A priority for the Hutt Valley DHB in 2009/10 is to commence the construction of new theatres. New clip-on temporary theatres will be constructed this year in advance of the construction of our main new build theatre/emergency department scheme. The availability of these temporary theatres will enable us to improve utilisation of our facilities and increase day surgery rates.

Regional engagement

We have ensured that our planning processes have directly involved Capital and Coast DHB and other central region DHBs and Nelson Marlborough DHB. The process of engagement with our DHB colleagues has included meetings with Capital and Coast DHB followed by a letter confirming the number of discharges we can provide for their community for plastic surgery and the number of discharges we would like them to provide on behalf of our community. Ongoing discussions with Capital and Coast DHB include the development of a plan to increase the number of ophthalmology discharges to a level more in line with the national intervention rate for this speciality, and the delivery of secondary surgery such as ophthalmology and urology closer to the where the Hutt Valley population resides.

We have also written to all of the other DHBs in the central region and Nelson Marlborough confirming the number of plastic surgery discharges we can offer. Until the new theatres are commissioned in 2012 we do not have surplus capacity to offer other DHBs.

Discharges

Hutt Valley DHB plans to deliver **4841** elective surgical discharges in 2009/10. This includes an increase in access to plastics for the people living in the central region including 13 delayed breast reconstruction cases. This means that we will begin treating the 25 women we know are awaiting secondary breast reconstruction but whom we have been unable to treat due to constraints in theatre capacity. In addition, we plan to deliver 391 dental discharges and 172 cardiology discharges. Interdistrict flows out of the Hutt Valley district account for **1473** elective discharges provided by other DHBs.

The total elective services plan is for a total of **5,404** elective surgical discharges as shown by specialty in Table 15 below (including dental & cardiology)

Table 15: Electives Services Plan

PU Code	Description	Base Discharges	Total 09-10	Total 10-11	Total 11-12
D01001	Dental	236	391	404	417
M10001	Cardiology	141	172	178	183
S00001	General surgical	738	948	979	1011
S15001	Cardiothoracic	59	74	76	79
S25001	Ear, nose and throat	565	662	684	706
S30001	Gynaecology	543	668	690	713
S35001	Neurosurgery	45	46	48	49
S40001	Ophthalmology	470	564	582	602
S45001	Orthopaedics	435	604	624	644
S55001	Paediatric surgical	94	99	102	106
S60001	Plastics	768	841	869	897
S70001	Urology	156	214	221	228
S75001	Vascular surgery	93	121	125	129
Total		**4,343**	**5,404**	**5,581**	**5,764**

Our Elective Services Plan has been developed in conjunction with our clinicians and service teams in each of the specialties. The plan has been approved by each of the surgical heads of department. Our plan also includes an increase in first specialist assessments by 5%.

Capacity

The plan for 2009/10 is based on additional theatre capacity in two interim day surgery theatres from October 2009. We are currently advertising for anaesthetist, nursing and support staff for these theatres. An additional orthopaedic surgeon has been appointed and two additional plastic surgeons (one to focus on breast reconstruction surgery) are being recruited. We will continue to contract private theatre facilities at Southern Cross hospital within case weight price until the commissioning of these theatres. The two interim theatres will mean increased acute surgery time ensuring timely treatment of acute patients and reducing the number of acute procedures being carried out in elective sessions.

The Hutt Valley DHB plans to increase capacity in support of a sustainable increase in elective volumes include working with Capital & Coast DHB on the development of four new theatres in the Wellington region as well as initiatives to;

- Build four new theatres at Hutt hospital to be operational from 2012
- Increase day surgery rates for both elective and acute patients
- Increase Day of Surgery Admissions
- Improve the management of medical acute patients
- Decrease DNA rates for outpatient appointments
- Increase direct access to diagnostic services by primary care.

Improved Service Quality

Improving the quality, efficiency and effectiveness of our services, and increasing patient satisfaction has been a focus for our *Improving the Patient Experience Programme* of work (refer Section 4.10). As a result of this work and in consultation with clinicians, nursing and allied health staff we have identified three areas of quality improvement for inclusion in our Electives Services Plan.

- **Day Surgery Rate**
  The Hutt Valley DHB is placing an emphasis on improving the quality of the service provided by our Day Surgery Unit as well as increasing the day surgery rates across all specialities and procedures. Our actions so far have included:

  - Benchmarking day surgery rates for selected procedures against the British Association of Day Surgery (BADS) targets. Table 16 below shows the current Hutt Valley DHB rate and the BADS target rate for five selected procedures. The target for 2009/10 is to increase the day surgery rate for these five procedures. This target is consistent with the New Zealand Chief Operating Officers' priorities based on the data available through the Australian

Health Round Table.

Table 16: Day Surgery Rates

	Dupuytrens	Tonsillectomy	Laparoscopic Cholecystectomy	Primary Repair Inguinal hernia	Septoplasty
Hutt DHB	57%	41%	2%	56%	39%
NZ National	64%	44%	5%	57%	28%
BADS	95%	80%	50%	95%	60%
Hutt DHB 2009/10 Target	66%	56%	20%	66%	42%

- Supporting clinical leadership in this area through the appointment of two new positions, Clinical Nurse Manager and Anaesthetic Lead, Day Surgery.
- Moving from a Day Procedures Unit to a Day Surgery Unit by managing medical days stay patients in medical areas rather than in the day surgery area.
- The development of the interim theatres as primarily day surgery theatres.
- A project, lead by the Pharmacy Manager, to provide analgesia to day surgery patients on discharge in line with international best practise.
- Developing networks including visits to other DHBs and use of other expertise to work with staff in developing and improving our processes.
- Supporting a multidisciplinary team to attend the International Association of Ambulatory Surgery Conference in Brisbane in July 2009.

As part of the *Improving the Patient Experience Programme* we will be establishing a project to further identify the barriers to procedures being managed as day surgery and once identified work on removing these barriers, as part of a multidisciplinary team approach. The design of the two interim theatres as primarily day surgery theatres will enable the project team to trial and test new processes in advance of the commissioning of the new theatre complex. The *Improving the Patient Experience Programme* Steering Group will monitor progress towards the project goals and assist the project team.

- **Day of Surgery Admissions (DOSA)**
  Our aim is to increase the Day of Surgery Admission rate. The DHB has benchmarked the DOSA rate for each surgical speciality against the New Zealand Rate* and a 2009/10 DOSA target has been set for each speciality. The DOSA rate is reported monthly to the Service Managers and Surgical Clinical Heads of Department. Speciality specific plans will be put in place to increase the current DOSA rate. The Improving the Patient Experience Steering Group monitors progress towards the target.

Speciality	**HVDHB current**	**Benchmark**	**Target**
ENT	84%	90%	85%
General Surgery	66%	76%	70%
Gynaecology	81%	87%	85%
Orthopaedics	44%	76%	60%
Plastics	50%	66%	60%

*Ministry of Health benchmarking

- **Day of Surgery Cancellations**
  The aim is to reduce the number of preventable day of surgery cancellations; cancellation reasons where the majority have been identified as preventable are:

  - Cancellations because of theatre list overrun
  - Cancellations because of urgent acute cases
  - Cancellations because patients decide not to go ahead with surgery or DNA
  - Cancellations because patients are unfit or unwell

  The 2009/10 target is a 30% reduction on the 2008/9 incidence of these cancellations as shown in the table below.

Cancellation Reason	Number 2008/09*	% Reduction	Target Number 2009/10
Total	221	30%	155

  *A record of Day of Surgery cancellations has only been accurately recorded since July 2008. This figure is an extrapolation of the July 08 – April 09 actual.

  Day of Surgery cancellations are reported quarterly to the Service Managers and Surgical Clinical Heads of Department. The reason for the cancellations are analysed and service specific actions put in place to reduce the incidence. The Improving the Patient Experience Steering Group monitors progress towards the target.

Table 17 below summarises the outcomes and planned actions that Hutt Valley DHB is seeking to achieve for Elective Services, and the measures we will use to determine progress. Further details on the specific measures and targets are included at Appendix 4.

Table 17: Outcomes, Measures and Actions for Electives Services

DAP Outcomes	DAP Measures[21]	Actions
Improved access to services	• Electives targets	• Continue to outsource theatre capacity from local private providers where appropriate.
More efficient & effective services	• First Specialist Assessments • Day case rates • Day Of Surgery Admission rates • Day of Surgery Cancellations • Standardised discharge rates	• Extend patient focussed booking for outpatient appointments • Increase direct access to diagnostic services by primary care. • Improving pre-operative assessment to ensure patients are not attending hospital unnecessarily, and staff are being utilised more efficiently • Implement improvements identified from the Improving Patient Experience Programme projects, including – Staggered admissions to day procedure unit – Increasing the day surgical rate - working with each relevant surgical service to meet the benchmarked day case rate for each procedure.
Improved infrastructure	• Business case	• Progress construction of new temporary

[21] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.

DAP Outcomes	DAP Measures[21]	Actions
	targets	theatres. • Progress new theatre/ED construction project. • Progress workforce development projects.
Sustainable services	• Electives volumes	• Surgical production plan will be met or exceeded each month.
Regional collaboration and positive partnership	• Collaboration plans	• Progress Regional Business Case for Breast Reconstruction services. • Work with Capital & Coast DHB to progress work on 4 new theatres for region. • Regular meetings with DHBs regarding regional elective services' performance.

4.6 Hospital Services

Hospital Services encompass all services provided via the Hutt Hospital, other than Elective Services initiatives (refer Section 4.5), Maternity, Child and Youth (refer Section 4.7), and Mental Health Services (refer Section 4.9), including:

- Acute and Chronic Care services
- Plastic, ENT, Audiology and Dermatology services
- Gynaecology services
- Community Dental services
- Cancer services, including regional cancer screening services.

Key challenges

Hutt Hospital faces a number of challenges, including:

- Managing workforce and skill shortages that impact on access to services
- Improving productivity and releasing more capacity to increase activity, ahead of the new campus developments
- Managing acute demand on services in a planned way where possible
- Ensuring that hospital services are aligned (capacity, staff and patient flow) to achieve new targets for emergency department waiting times
- Reducing ambulatory sensitive attendances to emergency department and their admission to hospital
- Progressing work to reduce the number of follow-up appointments and ensure better discharge planning and support for primary care
- Maintaining a focus on our production plans to ensure we meet targets for activity and patient flow improvements
- Progressing plans for service development, improving the patient experience, and providing better service integration, while also managing day to day demands
- Developing and supporting our clinical leaders and networks
- Maintaining credentialing requirements.

Acute and chronic care services[22] involve nine business units that manage patients with chronic illnesses, those that present to the hospital with an acute illness or injury and those requiring general surgical services. The services involve both inpatient and outpatient streams.

Hutt Valley DHB provides a regional **Plastic Surgery/Maxillofacial and Burn Unit** covering a population

[22] General Medicine, Cardiology, Rheumatology, Respiratory, Diabetes Education and Management, General Surgical Services, Intensive Care Unit, Emergency Department

(Wairoa to Blenhiem) of over 1 million people. Some of our services are also provided to Canterbury and Otago. We are also the only public hospital in New Zealand providing treatment for vascular birthmarks.

We are the central region providers of reconstructive surgery for breast and head and neck cancers and we provide the regional breast cancer screening (**BreastScreen Central)** and cervical screening coordination and national programme register services. Hutt Valley DHB participates in one of four regional cancer networks established to facilitate a number of the initiatives contained in the Cancer Control Strategy Action Plan 2005-2010. Hutt Valley DHB does not deliver a full **cancer service** and patients are referred to Capital and Coast District Health Board for tertiary cancer treatment services, mainly chemotherapy and radiotherapy services.

Capital and Coast DHB provides a significant amount of the secondary and tertiary hospital specialist services for the population of the Hutt Valley.

Regional **Rheumatology** services covering the Hutt, Wellington and Wairarapa districts are based at Hutt Hospital. A multidisciplinary team provides outpatient services, and nurse led and chronic pain management services are key service components.

The Hutt Valley DHB **Otolaryngology (ENT) service, Audiology and Dermatology** service are experiencing increased patient demand. Recent improvements in workforce are allowing us to better address these pressures, and for some services there are opportunities to extend services.

The **Community Dental Service** encompasses the Hutt Hospital Dental Unit, the Regional School Dental Service and the Central Region Adolescent Oral Health Coordination Service. In 2008/09 the service set itself some ambitious targets for improving the oral health status for children and adolescents. The service reduced the number of children who has not been recalled for examination in over 12 months from 34.3% as at December 2007 to 12.6% by December 2008. This was achieved without the need for additional staff and resulted in a further 11,000 children receiving care during the 2008 calendar year.

Shorter Stays in Emergency Department

Hutt Valley DHB is committed to ensuring that over time we will meet triage time frames and provide shorter stays for patients in our Emergency Department (ED). As part of our commitment to ensuring faster and better services for ED patients, Hutt Valley DHB has recently received Ministerial approval (May 2009) for the $82 million expansion of Hutt Hospital, including a new ED with nearly three times the number of treatment spaces as the current department. The new department will be operational from 2012.

The achievement of the ED performance targets and construction of the new ED/theatre have been identified as priority projects for monitoring by the Board. The Board will be provided with monthly progress reporting.

In the 12 months to March 2009 the Hutt Hospital saw 39,500presentations in its ED, an increase of 2.5% compared to the previous year. Alongside this increase there has been a marked improvement in triage waiting times for all categories of patients as shown in Table 18a below. The average triage waiting time for triage 5 patients did not exceed 3 hours, while waiting times for our most urgent patients improved significantly.

The significant improvement in our triage waiting times is the result of a number of new initiatives and changes in practice that were implemented over the last year. These have included:

- Implementation of a nurse led Minor Injuries/Illness Clinic
- Use of an approved pathway by senior Emergency Department Registered Nurses to record initial treatment of patients (as described in MoH Doc. HBI pg11 (2006))
- Participation in the Improving the Patient Experience Programme; specifically the work on the trolley to bed transfer time for patients admitted from the Emergency Department to the wards/units (i.e. pull system).

Table 18a: Emergency Department Triage Level Waiting Times

ED Triage Service Level – as at March 09

Arrival Mth	Mar-09

	Data			
Triage	Number of Presentations	As % of Presentations	Triage Service Level	Triage Avg Time (mins)
1	23	0.7%	100.0%	0
2	298	8.8%	74.2%	9
3	945	27.9%	59.7%	39
4	1528	45.0%	50.2%	81
5	598	17.6%	68.4%	171
Grand Total	**3392**	**100.0%**	**58.5%**	**79**

ED Triage Service Level – as at March 08

Arrival Mth	Mar-08

	Data			
Triage	Number of Presentations	As % of Presentations	Triage Service Level	Triage Avg Time (mins)
1	16	0.5%	100.0%	0
2	366	10.4%	54.6%	16
3	924	26.4%	24.6%	67
4	1471	42.0%	32.9%	112
5	726	20.7%	64.7%	100
Grand Total	**3503**	**100.0%**	**39.9%**	**87**

We will endeavour to sustain and build on these improvements; however, our ability to significantly improve our triage waiting times is constrained by the lack of available space in our ED. In addition, our expectation is that the number of ED attendances will grow even further in 2009/10 to around 40,500. Within our current capacity, sustaining and improving ED triage waiting times will require:

- Achieving accreditation by the ACEM for teaching purposes so that we can attract training registrars to the service and reduce reliance on overseas locums.
- Reducing the number of ED attendances through better availability of primary care services, including after-hours nurse triage services (refer section 4.4)
- Reducing ED waiting times for admission to inpatient services (refer below).

Reducing our triage waiting times further, ahead of the construction of the new ED, will be a challenge for us.

We are committed to reducing a patient's length of stay in ED. Reduced ED length of stay means better services and procedures further up the line in the wards and diagnostic departments. ED performance is therefore a measure of how well the different parts of the hospital work together.

The percentage of patients discharged or admitted from ED within six hours is shown in Table 18b below. We have identified that around 90% of ED patients who are treated and discharged or who are treated and referred have a length of stay less than six hours. Around 70% of ED patients requiring admission are admitted within six hours.

Table 18b: Percentage of patients who were discharged /admitted from ED within 6 hours

Admit Service	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	Grand Total
Admitted Total	76%	66%	64%	71%	79%	77%	76%	78%	74%	74%	73%
Treated & Discharged	94%	89%	91%	92%	94%	93%	93%	94%	92%	91%	92%
Treated & Referred	94%	88%	90%	93%	93%	89%	93%	93%	89%	91%	91%
MOH Statistics Total	**89%**	**82%**	**84%**	**86%**	**90%**	**89%**	**88%**	**90%**	**87%**	**87%**	**87%**

Around 25% of all attendances at ED result in an acute admission. Table 18c below shows that patients requiring inpatient care wait longer for admission to some specialities. Over 40% of acute admissions are to general medicine (50% including cardiology), and around 40% of these patients wait longer than 6 hours in ED (approximately 120 patients per month).

Table 18c: Percentage of patients who were admitted from ED within 6 hours for particular specialties

Admit Service	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	Grand Total
Cardiology	87%	64%	61%	73%	77%	82%	84%	86%	78%	78%	76%
General Medical	**64%**	**52%**	**47%**	**56%**	**69%**	**66%**	**64%**	**68%**	**63%**	**64%**	**61%**
General Surgery	71%	62%	65%	65%	78%	77%	78%	70%	71%	65%	70%
Orthopaedics	75%	73%	70%	82%	88%	82%	89%	84%	81%	84%	82%
Psychiatric	80%	85%	67%	100%	86%	100%	91%	67%	100%	50%	82%
Admitted Total	**76%**	**66%**	**64%**	**71%**	**79%**	**77%**	**76%**	**78%**	**74%**	**74%**	**73%**

The ED team has been working with the other departments in the hospital to ensure that appropriate priority is given to acute admissions and that medical staff are available to provide for more rapid admission to other services. A recent initiative involving the medical service has seen an increase in the numbers of medical registrars which ensures that a medical registrar is available in ED at all times to facilitate a timely decision to admit or discharge by the medical specialty. . Our Improving the Patient Experience Programme includes ongoing work to improve the patient "pull system" from ED for all specialties.

Given our space constraints we have set ourselves a realistic **2009/10 target of 90%** for the percentage of all patients admitted, discharged, or transferred from the ED within 6 hours (Health Target). This is based on achievement of individual targets for the different specialities admitting patients.

We are confident that Hutt Valley DHB Emergency Department's overall performance will continue to demonstrate improvement as we work toward the commissioning of the new build department by 2011/12.

Outcomes for Hospital Services

Hospital Services are a key priority for our DAP. A focus on these services as a priority contributes to achievement of the key outcomes of improved access to services, better service integration, more efficient and effective services, high quality and safe services, improved infrastructure and sustainable services. Table 19 below summarises the outcomes and planned actions that Hutt Valley DHB is seeking to achieve for Hospital Services, and the measures we will use to determine progress. Further details on the specific measures and targets are included at Appendix 4.

Table 19: Outcomes, Measures and Actions for Hospital Services

DAP Outcomes	DAP Measures[23]	Actions[24]
Reduced health risk	• Better help for smokers to quit	• Implement Tobacco Control Plan across secondary care services
Improved access to services	• Number of patients transferred out to other ICUs • Targets for First Specialist Assessments • Number of hospital based follow-up appointments	• Progress Intensive Care Unit Business Case. • Improve management of post-operative and follow-up patients to increase capacity for first specialist assessment appointments. • Extend the use of electronic discharge summaries to improve communication with primary care. • Progress the Oral Health Service Provision for Child and Adolescents Project.

[23] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.

[24] Includes reference to the Acute and Chronic Care Service Plan, the Plastics, ENT, Audiology and Dermatology Service Plan, and the Community Dental Service Plan, and Cancer Control Network Plan.

DAP Outcomes	DAP Measures[23]	Actions[24]
	• Oral health targets for recall	• Implement pilot project in a school to increase adolescent use of dental services.
Earlier intervention	• Cancer screening coverage rates	• Implement digital mammography for breast cancer screening. • Work with PHOs, Mana Wahine and Te Runanga O Taranaki Whanui to continue the improvement in our cancer screening rates for Māori and Pacific women. • Continue to support the national cervical screening programme register data input on behalf of the National Screening Unit.
Better service integration	• Average length of stay • Reduction in duplicated visits for patients with multiple LTCs	• Improve the management of long term-conditions: – Increase collaboration between specialties for patients with multiple LTCs – Development of training education programmes to improve insulin management skills for practice nurses and GPs, and for community carers of people with diabetes – Review Rheumatology care provided to Māori and Pacific – and establish Rheumatology Gout clinic in primary care – Develop strategy for improvements to Respiratory Pulmonary function programme – Manage COPD patients to decrease length of stay.
More efficient and effective services, and	• Average length of stay • Emergency Department Waiting Times • Cancer waiting times	• Extend patient focussed booking for outpatient appointments to more specialities. • Improving pre-operative assessment to ensure patients are not attending hospital unnecessarily, and staff are being utilised more efficiently. • Implement improvements identified from the Improving Patient Experience Programme projects (see projects below). • Develop plans to meet the new ED effectiveness measurement criteria. • Implement fast track colorectal surgery for selected patients.
High quality and safe service	• Patient satisfaction	• Improving the Patient Experience projects: – Emergency Department patient streaming – Unplanned care workstream projects, including Respiratory project.
Improved infrastructure	• Business case targets • Staff retention • Staff satisfaction	• Progress new theatre/ED construction project. • Progress workforce development projects – All service areas have workforce development plans by Dec 2009 – Development of specialist/advanced nursing and allied health roles for relevant areas – Support skills lab development – Implement recommendations from service credentialing.

DAP Outcomes	DAP Measures[23]	Actions[24]
Sustainable services	• IDF Flows	• Service production plans will be met or exceeded. • Explore additional revenue opportunities for audiology. • Improve direct access to diagnostic services.
Regional collaboration and positive partnership	• Collaboration plans	• Progress Regional Business Case for Breast Reconstruction services. • Explore clinical network development for dermatology and ENT services. • Participation in the Central Cancer Network to progress: – Development of collaborative approaches to service planning and delivery – Working with stakeholders to improve cervical and breast cancer screening services, in particular for Maori and Pacific women – Working with stakeholders to implement guidelines supporting best practice, including referral guidelines for primary care, guidelines for early breast cancer, melanoma guidelines, and guidelines for cancer imaging – Implementing Patient Management Frameworks (benchmark patient journey) for common cancers in NZ.

4.7 Maternity, Child and Youth Health

Maternity, Child and Youth health is a priority for our DAP. A focus on Maternity, Child and Youth health as a priority contributes to a number of our DAP outcomes, including reduced health risk, improved access to services, earlier intervention, more efficient and effective services, improved infrastructure and sustainable services, and regional collaboration and positive partnerships.

Hutt Valley DHB faces a number of challenges with regard to Maternity, Child and Youth Health, including:

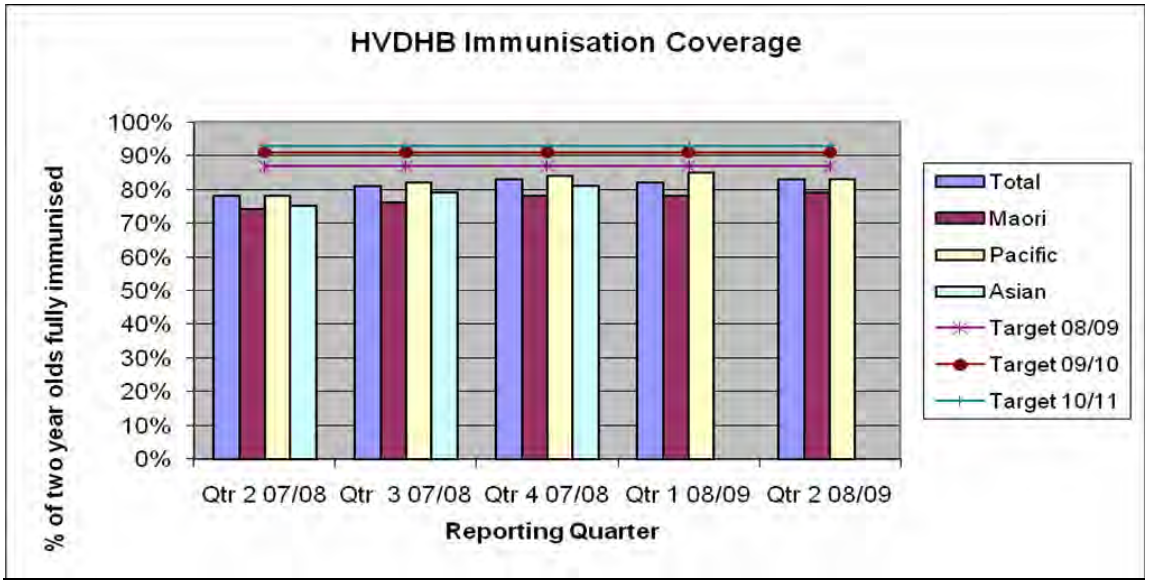
- Addressing health disparities for Maori, Pacific and Asian children and youth
- Asthma is a leading cause of hospitalisation for Maori, Pacific and Asian children aged 0 to 14 years
- Meeting targets for immunisation for Maori children (see below)
- Meeting targets for breastfeeding (see below)
- Meeting targets for adolescents accessing oral health services
- Implementation of numerous previous Government initiatives over the same timeframe; Before School Checks, Antenatal HIV Screening, Newborn Hearing Screening, HPV Vaccination, Youth Health initiatives
- Integration and coordination of child and youth services across Primary Health Care, Well Child Providers, DHB hospital services, education and social services, where these provider services are funded by different funders (DHB, Ministries of Health, Social Development, and Education)
- Maintaining a national and regional collaborative approach to providing access to tertiary level paediatric services
- Shortages of independent midwives requiring Hutt Hospital to provide primary maternity care

to 20% of pregnant women

Improving Immunisation Coverage

Figure 6 below shows Hutt Valley DHB's progress on the percentage of two year olds fully immunised for the last four reporting periods by ethnicity. The Ministry of Health has identified the Hutt Valley DHB as a Group 1 DHB (i.e. rates above 80% as at December 2008), however we are still to reach the national target of 95%, and improvements in our rates have slowed.

Figure 6: Immunisation Coverage



Opportunities for improvement include:

- Timely referral from Lead Maternity Carers to Well Child/Tamariki Ora providers and primary health care
- Proactive enrolment of new babies by primary health care, with reminders to bring them in for their immunisations
- Implementing strategies to reduce the drop off in uptake of the 3-month immunisation for Maori babies and babies living in households in high deprivation areas
- Increasing opportunistic immunisation in secondary care services
- Improving the system for immunisation outreach services.

Improving Breastfeeding rates

Plunket data for Hutt Valley for 2008/09 show 60% of infants were exclusively and fully breastfed at six weeks (Target of 74%), 49% at three months (Target of 57%), and 19% at six months (Target of 27%). The Hutt Valley DHB Breastfeeding Action Plan[25] captures several goals that support achieving the breastfeeding health target:

- Increase the uptake of breastfeeding for Maori and Pacific women and their families
- Improve the accuracy, reliability and collection of breastfeeding data, currently captured by Plunket.
- Support workforce capacity and capability development through the Mum-4-Mum Peer Support "train the trainer" programme
- Promote and raise the awareness of the benefits of breastfeeding at ante-natal, delivery and post-natal points of contact
- Support the implementation of the Baby Friendly Community Initiatives (BFCI)
- Align local messages with the national breastfeeding promotional campaign.

[25] A component of the HVDHB HEHA Implementation Plan 2007 - 2012

Child and Adolescent Oral Health

In 2008/09 Hutt Valley DHB and Capital Coast DHB submitted to the Ministry of Health a joint business case for improved Oral Health Service Provision for Children and Adolescents. Once the business case is approved we will establish a hub and spoke model, including construction of new clinics supported by mobile units. The proposed development is a collaborative approach between the two DHBs and has taken into account wide ranging public consultation. When established the new service model will:

- Increase enrolment
- Reduce disparities in DMFT and caries figures between Māori, Pacific and other children
- Increase the total number of examinations and treatments
- Reduce the arrears rates for recall to services
- Improve therapist productivity
- Improve workforce recruitment and retention
- Improve information collection, monitoring and communication.

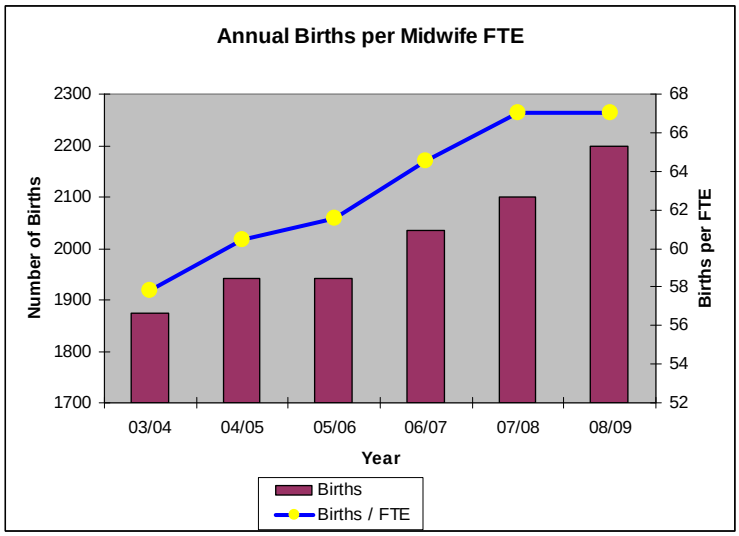
In 2008/09 the service reduced the number of children who has not been recalled for examination in over 12 months from 34.3% as at December 2007 to 12.6% by December 2008. We expect further improvement in 2009/10. For adolescents, the challenge is to improve uptake rates over the next 5 years to 75% coverage.

Extending Postnatal Stays

The Government's expectation is that DHBs will invest an additional $5.5m in 2009/10 rising to $11m in outyears to ensure that mothers have the choice to stay in birthing facilities longer in order to better establish breastfeeding and gain confidence to return home. On a population basis this equates to around $178k in 2009/10 and $355k in outyears for the Hutt Valley DHB.

Meeting the Government's expectation for extending postnatal stays is a particular challenge for the Hutt Valley DHB. Since 2004, births in the Hutt Valley have increased 20% to 2200 in 2008/09. When the Hutt hospital maternity facility was commissioned in 2000 it was predicted that birth numbers would be around 1800 by 2006 dropping to around 1700 per year by 2011. Figure 7 below shows the annual births per core midwife full time equivalent (FTE) since 2003/2004.

Figure 7: Annual births per core midwife FTE



Currently our postnatal ward has 18 beds and the occupancy rate for these beds is 92%[26]. The current average length of stay is 1.85 days for women following normal vaginal deliveries. Increasing postnatal stays to 48 hours post delivery for all women would increase our bed occupancy to 106% requiring additional beds. At present we do not have the physical space to

[26] As at April 2009

accommodate additional beds, however we will focus our efforts on ensuring that women are better supported while in hospital and in the community.

At Hutt Valley DHB we are committed to providing safe high-quality care for pregnant women, mothers, and their babies. We will endeavour to give all mothers the opportunity to stay longer in our birthing facility if they choose to. We will identify mothers and babies with particular needs as per the clinical criteria in the Maternity Service Specification:

1. Breastfeeding problems
2. Post-operative recovery
3. Ongoing medical problems
4. Psychological problems
5. Babies with special needs/prematurity
6. Geographical isolation/rurality
7. Coping with motherhood
8. Confidence in mothering.

We will ensure that resources are targeted to support at-risk mothers, with a focus on antenatal education and identification of the postnatal support required (e.g breastfeeding, social services, mental health services, and well child services). We will align maternity services within the hospital with those in the community to enable a more seamless transition for women. Examples of this alignment include our primary maternity care clinics targeting high needs populations, which are currently run in various locations in the Hutt Valley co-located with other health care providers.

Specifically, the new funding will be used to provide additional lactation support and additional support to primary maternity care. The main benefit for women will be in having assistance close at hand as they gain confidence in practical aspects of motherhood prior to going home, e.g. breast feeding and improved detection of specific support requirements, including for post-natal depression.

The implementation of the new funding initiative will comprise the following steps:

- Increase hours available for lactation support
- Establish protocols and processes for carrying out at risk assessments and offering additional support for women in hospital based maternity services
- Work with primary maternity care services to identify further opportunities to provide additional support in the community
- Update maternity patient satisfaction survey
- Implement monitoring framework.

We will continue to monitor average length of stay and regularly review our patient satisfaction survey against “given choice” to stay longer.

Outcomes for Maternity, Child and Youth Health

In 2009/10 we will strengthen our focus on the delivery of child and youth programmes that identify health risk early. As a result we will ensure earlier intervention and improved access to services, particularly for high needs families/whanau.

Table 20 below summarises the outcomes and planned actions that Hutt Valley DHB is seeking to achieve for Maternity, Child and Youth Services, and the measures we will use to determine progress. Further details on the specific measures and targets are included at Appendix 4.

Table 20: Outcomes, Measures and Actions for Maternity, Child and Youth Health

DAP Outcomes	DAP Measures[27]	Actions[28]
Reduced health risk	• Breast feeding • Immunisation coverage • HPV Vaccinations	• Support the delivery of Mum4Mum breast feeding support for Maori and Pacific and high needs communities using a community development model. • Implement HPV Vaccination Programme.
Improved access to services	• Improving youth access • Oral health • Post-natal stays • Avoidable hospital admissions for 0-4 years	• Develop our Maternity, Child and Youth Plan, *Growing a Healthy Community*, which will bring together existing services and newer initiatives to improve access and better integrate services for infants, children and adolescents. • Improve primary health care services to Child Youth and Family residences. A new service will be delivered to the Child Youth & Family 10 bed-residence from 1 July 2009 in accordance with the national service specifications (under development) and will improve access to both primary and secondary care. Measurement of the performance of this new service will be in accordance with the new service specification. • Support and maintain youth services that are regularly utilised by Pacific young people. • Implement Child and Adolescent Oral Health project. • Maintain targeted programmes for Pacific and Maori women accessing primary maternity services. • Support women to stay longer post-natally where needed in the transition to home and where capacity allows. • Continue to support our independent midwifery workforce and establish a primary care model that strengthens access to maternity services. • Improve data collection regarding primary maternity care provided by Hutt Hospital services. • Work with PHOs and Pacific health providers to improve access to primary care for Māori and Pacific children.
Earlier intervention	• Before School Checks	• Evaluate our model for the implementation of the B4 School Check programme and refine as needed. • Evaluate the implementation of antenatal HIV screening. • Implement the recommendations from our mental health Infant, Child, Adolescent and Family Service (ICAFS) review, if funding allows.
Regional collaboration and positive partnerships	• Collaboration Plans	• Work with Police to establish a multi-agency child/youth abuse centre, as funding allows. • Work with Child Youth and Family Services to improve responsiveness to child abuse reporting.

[27] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.
[28] Refer also to Sections on Primary Health Care and Keeping Our People Well and Mental Health

4.8 Older Peoples Health Services

Hutt Valley DHB is progressively implementing the national Health of Older People Strategy, which all DHBs are required to implement before 2010 to better meet the needs of older people now and in the future. Our local Health of Older People plans detail the development of more integrated health and disability services that are responsive to older people's varied and changing needs, with a focus on improving community-based services that enable older people to remain safely in their own homes.

Key challenges

Hutt Valley DHB has the same leading causes of hospitalisation and mortality for older people as those nationally and many of the challenges facing the provision of health of older people services are common across the country. Particular challenges for Hutt Valley DHB include:

- An aging population
- High utilisation of aged residential care hospital beds compared to the national average as shown
- Addressing inequalities in access to services
- Providing increased support for older people at home
- Ensuring quality of supervision and nursing in rest homes
- Integrating services for older people across community, primary, and secondary care services
- Building workforce capability.

Health of older people services

The population of older people (over 65s) in the Hutt Valley is 15,940 (2006 census) or 11.3% of our total population compared with 12.2% for New Zealand. The Hutt Valley over 65s population is projected to increase by 74% between 2006 and 2026.

Contracted providers include 18 aged residential care facilities, which provide a mix of rest home, hospital, dementia, psycho-geriatric, day support and respite care services. There are a total of1067 contracted beds available with an average occupancy rate of 97%
Three home based support providers cover the Hutt Valley area.

Recent service development projects have included:

- Improved evaluation and monitoring of service utilisation for aged residential care and community support services
- Improved management of demand for aged residential care and community support
- Established service and consumer advisory groups
- Audit of over 75s attending Emergency Department.

Outcomes for Older Peoples Health Services

Health of older people service development is a priority for our DAP. A focus on health of older people as a priority contributes to achievement of key outcomes of high quality and safe services, and sustainable services.

In 2009/10 we will continue to develop the augmented Needs Assessment and Service Coordination Centre to provide sustainable services to meet the health needs of older people. We will ensure improved access for older people to a wider range of community support services and to specialist geriatric services. We will increase our monitoring and audit activities to include more collaborative arrangements across the region, and include ways of better capturing client and carer feedback on service quality.

Table 21 below summarises the outcomes and planned actions that Hutt Valley DHB is seeking to achieve for Older Peoples Health Services, and the measures we will use to determine progress. Further details on the specific measures and targets are included at Appendix 4.

Table 21: Outcomes, Measures and Actions for Older Peoples Health Services

DAP Outcomes	DAP Measures[29]	Actions[30]
Improved access to services	• Home Based Support utilisation • Respite services • Avoidable Hospital Admissions for people 65 and over	• Develop a model for improving the range of services in the community to support older people with low to medium support needs, and identify potential providers. • Improve access to respite care beds for older people and their carers by increasing the availability of respite care services, with available new funding; estimated at 2 beds. • For older people assessed with 'low needs' improve access to a wider range of community support services options in a collaborative model across the community, health and other sectors eg MSD. • Expand the reach of specialist geriatric consult/liaison roles to include medical, orthopedic, surgical and the emergency department to increase geriatrician assessments for older people with complex health needs.
More efficient and effective services	• Avoidable Hospital Admissions for people 65 and over	• Establish a multi-disciplinary team to provide specialist advice and support for older people presenting to the emergency department.
High quality and safe services	• Provider audits – quality and risk	• Implement a collaborative joint funders (DHB/MoH/ACC) approach to the monitoring and audit of the quality and safety of community support and residential care services across the region. • Develop a system to get and evaluate feedback from clients, their carers, primary health care, the NASC and advocacy organisations, about the quality of the continuum of older peoples services in the Hutt Valley. • Implement Inter-RAI assessments for 65 years and over across specialist services.
Sustainable services	• Aged residential care bed utilisation • Utilisation of Community support services for older people with mental health and addiction needs	• Improve our monitoring of service utilisation and client outcomes across community, primary, secondary and long term support services, including the length of time to transfer older people from the provider arm to residential care. • Reduce over allocation of support services where this is evident. • Continue to manage entry to long -term aged residential care services by working closely with the augmented Needs Assessment and Service Coordination (NASC) service and other agencies within a developmental model.

[29] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.
[30] Refer also to Sections on Primary Health Care, Hospital Services and Mental Health

4.9 Mental Health Services

Hutt Valley DHB provides mental health and addiction services on the basis of the national Mental Health Strategy, *Te Tāhuhu - Improving Mental Health 2005-2015*. Te Tāhuhu broadens the focus on the mental health to the inclusion of all New Zealanders, while continuing to place emphasis on ensuring that people with the highest need can access specialist services. The strategy sets out the leading challenges or action priorities that Hutt Valley DHB is working to achieve, to ensure continued improvement in mental health and addiction outcomes for our population.

Hutt Valley DHB is working with the other five central region DHBs to implement the Central Region Strategic Plan for the development of mental health and addiction services (2007-2016)[31]. The project for implementation of the Central Region Mental Health and Addiction Strategic Plan provides a framework that aims to ensure the best possible configuration of local, sub-regional and regional services. From 2010 onwards the framework will guide the planning, development and funding of all services within the region. Hutt Valley DHB's local plan for mental health and addiction services is referred to as Make it Happen *(Whakamahingia)* 2008-13*.* This plan guides our local response to the national and regional strategies.

Key challenges:

- An aging population
- Meeting the needs of children and adolescents and their families, in particular for improving infant mental health and mental health prevention, improving continuum of community and secondary care, increasing capacity and capability for secondary ICAFS services, and improved crisis response and alcohol and drugs services
- Addressing inequalities in access to services
- Implementation of new information systems to support better monitoring
- Ensuring quality of supervision and support in residential care
- Integrating community, primary, and secondary care services
- Building workforce capability.

Mental Health and Addiction services

The Ministry of Health estimates that those at highest need of mental health services represent around 3% of the population. This equates to 4,200 people in the Hutt Valley.

Currently Hutt Valley DHB funds mental health and addiction services provided by the Hutt Hospital, fifteen NGO providers, eighteen sub regional and regional service providers, including a range of regional specialty services primarily delivered by Capital & Coast DHB.

Outcomes for Mental Health and Addiction Services

Mental Health Services is a priority for our DAP. A focus on mental health services as a priority contributes to achievement of key outcomes of improved access to services, more efficient and effective services, and sustainable services. In 2009/10, in addition to our work to lead the implementation of the Central Region Mental Health and Addiction Strategic Plan, we will be reviewing and implementing improved service models incorporating best practice guidance and ensuring that we are providing effective and efficient services. We will ensure better monitoring of service user and service delivery information.

Table 22 below summarises the outcomes that the Hutt Valley DHB is seeking to achieve for our Hutt Valley population mental health services and the measures we will use to determine progress.

[31] Refers to the central region's six DHBs; Hutt Valley DHB, Capital and Coast DHB, Whanganui DHB, Wairarapa DHB, Hawkes Bay DHB, Midcentral DHB.

Table 22: Outcomes, Measures and Actions for Mental Health Services

DAP Outcomes	DAP Measures[32]	Actions[33]
Improved access to services	• % of population accessing services • Mental health relapse prevention plans	• Continue implementation of the 5 yr mental health and addiction action plan Make it Happen (Whakamahingia). • Develop a model for improving the range of services in the community to support older people with low to medium mental health needs, and identify potential providers. • Implement the recommendation of the Hutt Valley Infant Child, Adolescent and Family mental health and addiction service review (2008), if funding allows. • Work with PHOs to implement primary mental health services for people with mild to moderate mental illness. • Work with secondary and primary mental health providers to ensure improved access and appropriate services for Māori and Pacific people with mental illness. • Support the central region to develop a second forensic step-down unit. *(Regional)* • Implement the recommendations of the Central Region Easting Disorders Plan (CREDS), as funding allows. *(Regional)*
More efficient and effective services	• Hutt hospital services utilisation • Residential beds utilisation • Community Support Services utilisation • Respite services utilisation • Regional and Sub-regional Specialist services utilisation	• Continue to implement the local component of PRIMHD. • Better align mental health and addiction services to our five year mental health and addiction action plan, Make it happen (Whakamahingia) • Improve our monitoring and reporting of service utilisation and client outcomes across community, primary, secondary, tertiary and NGO services both locally and regionally. • Implement the revised National Mental Health Service Framework and develop a local framework for measuring service outputs and outcomes to enable better measurement of value for money.
High quality and safe services	• Provider audits	• Implement the Mental Health Regional Workforce Plan for NGO training
Sustainable services	• Services utilisation (see above)	• Review the utilisation of services (see above) • Implement Māori and Pacific mental health services workforce development plans, including promotion of Māori and Pacific student scholarships.
Regional collaboration and positive partnerships	• Progress in implementing the Central Region Plan	• Collaborate with Capital & Coast DHB to improve services for infant, child, youth and family respite. • Support the Regional Clinical Leadership Forum for mental health. *(Regional)*

[32] The DAP measures are specified in more detail at Appendix 4. Not all measures will necessarily correspond with a specific action, where the measure is associated with ongoing or baseline activity.

[33] Refer also to Sections on Keeping Our People Well, Primary Health Care, Hospital Services, Older Peoples Health Services

4.10 Quality and Safety

Effective, efficient and high quality services are one of our DSP goals. Quality and safety is one of the DAP priority areas of focus. A focus on quality and safety as a priority contributes to achievement of key outcomes of improved access to services, better service integration, more efficient and effective services, higher quality and safe services and improved infrastructure.

The Quality Plan for Hutt Valley DHB[34] reflects the Ministry of Health's Improving Quality (IQ) Approach and the quality dimensions of access and equity, safety, effectiveness and efficiency. Our Quality Plan objectives focus on supporting staff to deliver high quality care through positive, visible and professional clinical leadership. The Hutt Hospital's clinical board and clinical committee structure provides this leadership in relation to patient safety, quality improvement, clinical standards and policies. Reporting on the Quality Plan objectives is provided quarterly to the DHB Board, management, and all staff.

Hutt Valley DHB supports the national Quality Improvement Committee's (QIC)[35] five national quality programmes. We are the lead DHB for the safe medication management project. In addition, our 'Improving the Patient Experience' programme (refer Page XX) and the implementation of our electronic healthcare incident reporting programme reflect the work at a national level. We will commence implementation of the Hand Hygiene programme in March 2009 and we are also working on a regional basis to establish a local Child and Youth Mortality Review Committee.

In 2009/10 our focus will be to:

- Continue to support staff to deliver high quality care within a quality improvement framework
- Participate fully in national quality improvement initiatives
- Increase our efforts to deliver more effective quality outcomes for Maori
- Manage risk of harm to patients through a culture of safe reporting, open disclosure, and a systematic approach to learning from causes of system failure
- Increase consumer input for the planning, redesign and delivery of hospital service improvements
- Extend our quality focus to include the services we fund externally to the Hutt Valley DHB:
    - Ensure that we have systems in place to capture client and consumer feedback regarding provider services
    - Make the results of our provider services audits publicly available
    - Encourage the adoption of accreditation and other quality initiatives with primary health care, e.g. Cornerstone and Te Wana.

The Hutt Valley DHB has adopted the Improving Quality goals and national initiatives as shown in Table 23 below:

Table 23: Improving Quality Goals and Initiatives

Improving Quality Goals[36]	**Key Quality Plan Initiatives**	**Key Measures**
Deliver more effective quality service outcomes for Maori	Patient Satisfaction Surveys, (including of Maori patients/whanau),	Survey measures[37].

34 Note the Hutt Valley DHB Quality Plan is primarily focused on the hospital provider services. Quality requirements for other funded providers are included with contracts and contract monitoring, including a regular audit programme.

35 The National Quality Improvement Committee (QIC) has 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.

36 Reported to the Ministry of Health in 3rd Quarter

37 Also measured via the Hospital Benchmark Information Report produced quarterly by the Ministry of Health

Improving Quality Goals[36]	Key Quality Plan Initiatives	Key Measures
Ensure a shared vision of safe and quality care engendered through committed leadership at all levels	Leadership committed at Board and senior management level, clinical leadership provided via Clinical Board, sub committee structures and clinical leadership roles in each service.	Quarterly quality reports to Board level. Clinical Board and sub committee structures operating effectively. Clinical leadership positions in place in all services.
Support and encourage people to participate in the planning and delivery and assessment of services	Consumer advisory roles established, Patient Satisfaction Surveys, (including of Maori patients/whanau),	Consumer advisors engaged with key quality initiatives. Survey measures[38].
Ensure that there is widespread awareness and commitment to a quality improvement culture	Increase in availability of training in quality and quality tools. Engagement of staff at all levels in the Improving Patient Experience Programme	Increased participation in training for quality and use of quality tools. Results of Employee Survey reflect positive culture.
Redesign services where needed to support delivery of improved quality	Improving Patient Experience Programme (IPEP) (see below), Campus redevelopment plans – new Theatre/ED construction project.	IPEP measures[39]. IPEP measures at individual project level. Patient Satisfaction Survey.
Manage adverse outcomes in an open and supportive manner	Patient Safety Group meetings, Electronic Reporting System, specific projects as a result of quality and safety monitoring, open disclosure policy	Management of healthcare incidents reporting.
Ensure effective and open communication, coordination and integration of service activities, and teamwork	Improving Patient Experience Programme	IPEP measures at individual project level.
Provide a supportive and motivating environment that provides the workforce with the appropriate tools	Credentialing, Employee Survey Education for quality processes and tools	IPEP measures at individual project level.
Build useful information that is readily available and shared to support a quality conscious culture	National mortality review systems, Focus on data quality Davis Balestracci approach to reporting data	Child and youth mortality review group established Data quality indicators eg: ethnicity, NHI duplicates show reduced error rates

[38] Also measured via the Hospital Benchmark Information Report produced quarterly by the Ministry of Health

[39] Also measured via the Hospital Benchmark Information Report produced quarterly by the Ministry of Health; include reducing average length of stay, day surgery rates, day of surgery admission, did not attends emergency department waiting times

Improving Quality Goals[36]	Key Quality Plan Initiatives	Key Measures
Meet [regulatory] protections that assure safe care is in place to support people and service providers.	Health and Disability Sector standards certification, (including Infection Prevention and Control, restraint minimisation and mental health standards) ACC workplace accreditation, Magnet Recognition credentialing, Safe Medicines Management	Regulatory protections met, other credentialing and safety targets met

Improving the Patient Experience Programme

The *Improving the Patient's Experience* programme focuses on improving assessment, diagnosis and treatment based on safe, reliable clinical systems and effective patient flows from home to hospital and back to the community. Six work streams have been chosen for improvement as they involve large patient volumes and numerous processes and systems; outpatients, diagnostics, pre-operative assessment, day surgery, unplanned care, information systems.

Outpatients

- Patient Focussed Booking.

Diagnostics

- Direct Access for non-contrast CT head/sinus to reduce the waiting time for patients to receive a CT scan.
- RIS/PACS - electronic imaging system.

Unplanned Care

- Improve patient flow from emergency department to medical ward.
- Improvements in medical inpatient care planning and follow-up support.
- Chronic care – respiratory patients - focused on enhancing outcomes for adult patients with a respiratory condition, by optimising their length of stay, community support and diagnostic testing.
- Length of stay matches patients' care needs - focused on reduction of time delays and improvements to the patient journey.

Pre-operative Assessment

- Establishment and implementation of pre-operative assessment model of care.

Day Surgery

- Staggered admissions to day procedure unit.
- Increasing the day surgical rate - working with each relevant surgical service to meet the benchmarked day case rate for each procedure.

The Progressive Ward – Orthopaedic Ward Project

- The Progressive Ward Project commenced at the end of August 08 in the Orthopaedic Ward and is part of the national Optimising the Patient Journey programme. The project focuses on processes and physical aspects of the ward, identified by ward staff as having the potential to release or free up time, which can then be used to care for patients.

4.11 Improved Infrastructure

Three District Strategic Plan strategies are aimed at improved infrastructure and building our capability; *Developing the workforce, Improving our hospital and Redesigning services and consolidating gains*. Improving our infrastructure is key to improving access to services, delivery of more efficient and effective services, and ensuring that our services are sustainable. Recently we have focused on progressing our plans to improve our hospital campus as set out in our *Integrated Campus Plan.* The implementation of our new emergency department/theatre project is a priority for our DAP.

4.11.1 Emergency Department/Theatre Project

Ministerial approval of the $82 million expansion of Hutt Hospital in June 2008 was a significant step in this crucial development. The addition of four more operating theatres, a new emergency department sized to be able to cope with the 40,000-plus attendances that the Hutt Hospital deals with (and allowing for future growth), a new intensive care unit and other related facilities, are fundamental to the long-term clinical and financial sustainability of Hutt Hospital. Construction of the new facilities is expected to start at the beginning of the 2010 financial year.

Because the new operating theatres will not be operational until the end of the 2011-year, Hutt Valley DHB has commissioned two temporary 'clip on' day surgery operating theatres, adjacent to its current day surgery unit. These will be functional by October 2009 and will be critical in allowing us to meet our elective surgery targets in the coming two years

Key milestones for 2009/10 include:

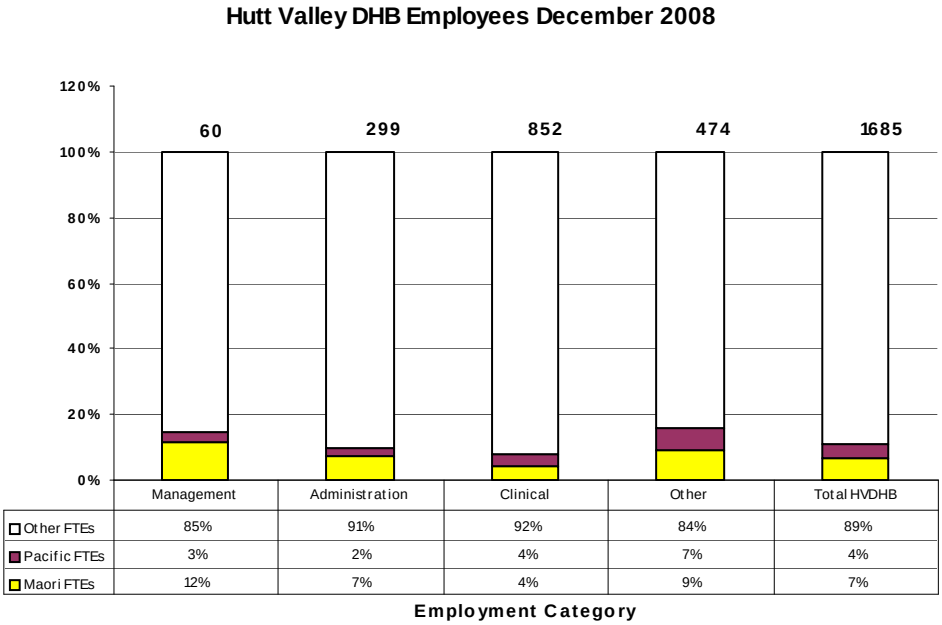
- Resource consent approval April 2009
- Clip-on theatres commence operations October 2009
- Increased car parking facilities from December 2009
- Construction commissioned January 2010
- New ED theatres commissioned late 2011-mid 2012.

4.11.2 Workforce Development

Workforce development is a key priority for our DAP, and one of the strategies identified within our DSP for achieving our strategic goals. A focus on workforce development as a priority contributes to achievement of the key outcomes of enhanced health protection, reduced health risk, earlier intervention, improved access to services, better service integration, more efficient and effective services, higher quality and safe services and improved infrastructure.

The composition of Hutt Valley DHB employees is shown in Figure 8 below. A copy of our organisational structure is provided at Appendix 3.

Figure 8: Composition of Hutt Valley DHB employees



Key challenges

There are generally recognised challenges in the area of health workforce development, including:

- An international shortage of health workers
- Developing a workforce that reflects the growing diversity of the population
- Responding to the changing demand for services as population needs change
- Development of new service models incorporating more flexible workforce arrangements, team approaches, increased workforce mobility, and adoption of new technologies.

At a local level Hutt Valley DHB is facing a number of challenges as outlined below:

Capacity

- Addressing the shortages of general practitioners, practice nurses, and midwives in the region
- Increasing the Maori and Pacific health workforce
- The ability to increase capacity through more efficient and effective use of workforce – via new roles and new models of service delivery

Recruitment

- Competing in a global market
- Low pay scales for aged care services

Retention

- Increasing numbers of the workforce approaching retirement
- High staff turnover compared with the national figure *(Hospital Benchmark Information to December 2008)*
- Maintaining accreditation in key areas to support training programmes

Capability

- Increasing expectations of workers providing aged care services
- Developing leadership and encouraging innovation
- Improving health workforce information
- Maintaining our focus on the Magnet principles

Clinical staff retention
The Government has made it clear that it expects DHBs to improve clinical staff retention. The expectation is that clinical staff retention will be improved through adopting good staff practices aimed at developing a culture that values employees and promotes trust. Improved staff retention will be demonstrated through measures of increased retention, genuinely reduced vacancy rates and greater staff satisfaction.

For the year ending 31 December 2008 the Hutt Valley DHB turnover rate for clinical staff was 14.92%. We intend to reduce this level of turnover in the short-medium term through a range of measures designed to address the contributing causes. We are currently carrying out further analysis of our turnover rate and examining in detail the possible causes. This will provide the basis for developing a specific strategy and action plan to address the situation, which will be submitted to the Board late 2009. The work to improve clinical staff retention goes hand in hand with our work to further foster clinical leadership at Hutt Valley DHB (refer Section 3.2.1).

Some of our strategies and actions are likely to include:

- Working closely with clinicians to realise the need to enhance clinical leadership in ways that are meaningful to them
- Identifying further avenues for empowering clinicians to act with autonomy and to participate actively in problem-solving efforts throughout the DHB
- Identifying leadership-development opportunities that are specific to and meaningful for the individual clinical leaders
- Identifying avenues to incentivising the take-up of leadership roles within clinical areas
- Analysing the outcomes of the most recent staff satisfaction survey and acting on the findings related to clinical engagement and satisfaction factors
- Identifying clinical staff interests and endeavouring to enable them, to the extent feasible: these may be found to include some or all of:
    - Further support for continuing medical education
    - Attendance at international conferences
    - Support to assume teaching roles and/or research to complement their clinical work
    - Support for professional networking
    - Support for trialing service delivery innovations
    - Support for attainment of national advisory roles on various committees within the DHB Sector, within or associated with the Ministry of Health or within professional groups
    - Support to achieve better work/life congruence, to enable private work and family commitments to be satisfied along with those within the DHB.

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.

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

Workforce Development Outcomes

The delivery of the DAP outcomes and targets within each of our priority areas requires a focus on workforce development and organisational health. For 2009/10 key areas of focus are:

Table 24: Workforce Development Outcomes and Actions

DAP Outcomes	Workforce Development Actions
Enhanced health protection	• Implement actions from Public Health Workforce Development Plan and facilitate access to training that supports community capacity building. • Emergency preparedness training
Reduced health risk	• Public Health Workforce Development Plan • Nutrition training for community workers
Improved access to services	• Primary care workforce programmes – GP registrar programme. Summer studentship, primary care nursing development
Earlier intervention	• New workforce capability for Before School Checks and Newborn Hearing Screening
High quality and safe services	• Magnet Recognition Programme • Nursing Leadership roles developed and supported • Clinical Leadership roles developed and supported • Clinical guidelines for primary health care nursing • Health of older people workforce development • Mental Health Regional Workforce Plan – NGO Training
Improved infrastructure	• Development of a clinical staff retention strategy and action plan • Staff satisfaction surveys • Manager training programmes • Mentoring programmes • Clinical training unit development • All Hospital Service areas have workforce development plans by Dec 2009 • Development of a DHB locum pool of junior doctors • Development of specialist/advanced nursing roles for relevant areas • Support skills lab development • Maori and Pacific health workforce development; – Scholarship programmes – Manu Tipuranga and Tupu Pasifika Scholarships for Māori and Pacific students – Implement scholarships for Maori and Pacific students for public health course of study.
Regional collaboration and positive partnerships	• Participation in the national Future Workforce framework • Partnership with the NZ Nurses Organisation – recruitment, employee relations and learning development • TAS Review projects for development and training of cardiology technicians • Maori health workforce development • Pacific health workforce development

4.11.3 Information Services

The demand for reliable and improved information services continues to increase. Information systems enable better service integration, more efficient and effective services, support for high quality and safe delivery of patient care, earlier intervention, and support for improved access to services.

Staff and service providers are increasingly reliant on systems and electronic information for their day-to-day operations, including resource allocation, performance monitoring and future service planning. There is a demand for both new information system capability and improved reliability of services leading to an increased requirement to invest in core IT infrastructure and staff skills.

Clinical Information Systems

The advantage of using the clinical information systems for patient care and reference has led to widespread use by hospital clinical staff and is an on-going success story. We now have over 1400 users of the Concerto Electronic Medical Record, up from around 900 two years ago. Concerto, which now holds electronic records for more than two thirds of Hutt patients, is also used by many General Practices in the Hutt and more recently by the Wellington Free Ambulance.

Such high usage, with 100% of doctors using the system for routine clinical checks such as viewing and signing off lab results, has led to demand for improved functionality and reliability. The computer system is often the sole source of information in an outpatient clinic, and so any downtime during business hours can compromise patient care.

The computerised patient record system has enabled improved communication between clinicians, better integration between primary and secondary care, reduced risk to patients of incorrect or missing data, and improved efficiency allowing clinical staff to meet greater demands for their capacity.

Since April 2007, GPs and specialists have had access to an electronic referrals system to create, send and process patient referrals on-line. Over 10,000 referrals have been processed in this way. This is a first for NZ is seen as a model for other DHBs to follow.

Clinicians like using the electronic referral system because it provides them with better quality information on which to make decisions, and gives them faster and more reliable feedback on the status of their patients. This technology is enabling the DSP goals of seamless integration, and effective, efficient and high quality services. It is also an example of a successful project that has been clinically led. GPs and specialists worked together to agree on the content of the referral forms for 28 different specialties provided by the hospital.

The Information Systems Strategic Plan aligns new business initiatives and on-going requirements from the DSP and DAP to information system capability and development. These requirements are fine-tuned monthly through approval of business cases and reporting of strategic projects to the Information System Steering Committee (ISSC) which guides and monitors investment in IT systems on behalf of the DHB.

In 2009/10 the main focus for information services will be on:

- Achieving better operational stability by upgrading our current hardware and software platforms where required, and addressing the key challenges of staff retention and skills development.
- Providing services to support incremental enhancements to the capability of our current information systems, including patient alerts, better formatted discharge summaries, and improved access for remote users. Several issues that were raised by the Health and Disability Commissioner regarding the visibility of alerts and clinical notes will be addressed by these changes.
- Supporting national and regional initiatives, including CEO membership of the Health Information Strategy Advisory Committee (HISAC), and contributions towards Health Information Standards Organisation (HISO) standards.

Investment planned for 2009/10 is summarised in Table 25 below:

Table 25: Information Services Outcomes and Actions

DAP Outcome	Development/Investment
Reduced health risk	HPV Vaccination supported by an upgraded School Based Vaccination System.
Improved access to services	On-going development of improved patient workflow processes supported by electronic referrals and direct patient booking.
Earlier intervention	Advice and support for the Before School Check system.
Better service integration	Continued improvements in the clinical information system and rollout to primary care and other community health providers.
More efficient and effective services	Better IT infrastructure to improve security, data integrity, reliability and performance.
High quality and safe services	Continued enhancements to the clinical information system to make it easier to use, and incorporating more diagnostic information electronically. The system will display links to drug allergies and infection control alerts to help improve patient safety. Improved system for Mental Health staff integrating HoNOS scoring into their clinical workflow and upgrading the system to allow collection of PRIMHD measurement data.
Improved infrastructure	System upgrades to improve reliability, capacity and capability of information systems. This will also lay the foundations for a more regional approach to information sharing.
Sustainable services	Development of regional systems to support regional clinical networks based on the Central Region's Regional Clinical Service Plan. An example is the Regional PACs Archive, which will provide diagnostic imaging for patients referred in the central region, and also better IT operating efficiency through the use of shared storage and IT management services. Implementation of InterRai assessment tools for Health of Older People.

5.0 Service Coverage

The activities of the DHB fall into three categories[40]:

- Governance (refer Appendix 2)
- Provision of Services (Provider)
- Funder of Services (Funder)

In this section we provide details of the full service coverage provided (Provision of Services) and/or purchased (Funder of Services) by the DHB. This section refers to the Provider and Funder Price Volume Schedules provided separately to the Ministry of Health as part of our DAP submission.

5.1 Service Coverage

The Operational Policy Framework established by the Ministry of Health sets out the quasi-regulatory rules that all DHBs must comply, including an extensive service coverage specification. The OPF is executed via the Crown Funding Agreement between the Minister and each District Health Board. The service coverage specification describes the type of services and levels of access to services that the Ministry of Health requires DHBs to provide.

Table 26: Operational Policy Framework

Operational Policy Framework		
Governance	Planning and Funding	Provision of Services
Service Coverage Schedule		
Provision of Services	Funder of Services	
Examples of outputs: Medical inpatient caseweights Mental health beddays Emergency Department attendances Maternity attendances	*Examples of outputs:* Aged Residential Care and Mental Health Beddays Mental Health Services FTEs PHO operations and services Community Laboratory tests Community Radiology examinations Community Pharmaceuticals dispensing and drug costs	

5.2 Provision of Services

The key contracted service outputs delivered by Hutt Valley DHB are based on a contract made between the Planning and Funding team of the DHB and the hospital and specialist services (provider role of the DHB) for the year. As part of this contract, the hospital(s) agree to provide certain 'outputs'. These outputs are detailed within the Provider Price Volume Schedule, which is provided to the Ministry of Health separately as part of the submission of the District Annual Plan.

[40] Referred to as output classes for the purposes of our forecast statement of service performance.

5.3 Funder of Services

The key contracted service outputs funded by Hutt Valley DHB are based on contracts (many of which follow the standard national template produced by the Ministry of Health) made between the Planning and Funding team of the DHB and a range of service providers external to the DHB. As part of this contract, service providers agree to provide certain 'outputs'. These outputs are detailed within the Funder Price Volume Schedule, which is provided to the Ministry of Health separately as part of the submission of the District Annual Plan.

5.4 Service Coverage Exceptions

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

- Community radiology is available free of charge only for Community Service Card holders and under sixes. In 2009/10 we intend to review these criteria.

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

6.0 Managing Financial Resources

Our financial position for 2009/10 is a deficit of $4.6m. We are forecasting an improving deficit position of $3.0m in 2010/11 and a breakeven position in 2011/12. The 2009/10 result is significantly affected by a large increase in inter-district outflows, a number of employment settlements running into this financial year at a level far in excess of our base funding, and an increase in demand driven pharmaceutical expenditure.

There are a number of activities underway across the DHB to ensure that we attain our budgeted position. These include the building of 2 "clip on" day surgery units to improve the flow of acute patients through our theatre and maximise the elective initiative delivery while we continue to build extra permanent operating theatres, which are due to be completed in 2011/12. In addition, we have a number of initiatives built into our budgets that will deliver productivity improvements in 2009/10 and ongoing.

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 (including increasing emergency department presentations) within Hutt Hospital continuing to impact on our ability to increase elective services delivery, in the face of severe resource constraints – only four operating theatres.

Our revenue projection for 2009/10 is based on the latest funding advice. We have applied base revenue increases of 3.5% for 2010/11 and 3.5% for 2011/12 as suggested in the funding advice. We have factored into the result the funding and expenditure for the new government priorities. The total budgeted management and administration FTEs are less than the agreed cap.

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. However, we anticipate that we will need to discuss with the Ministry of Health the best use and value for money associated with some of our ring-fence.

The budgets have taken into account the worsening economic environment and the known impacts. However, there remain significant downside risks related to the economic crisis which have not been quantified, such as the potential need to fund an increasing share of Aged Care costs due to lower asset values reducing individuals' contributions or more individuals relying on the public health sector instead of health insurance and the private sector.

6.1 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 at Appendix 5. 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).

Table 27: Forecast Statement of Financial Performance

Financial Performance

Hutt Valley District Health Board
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Revenue					
Revenue	362,363	390,848	422,469	436,904	449,321
Interest Revenue	1,469	859	504	336	150
Total Revenue	**363,832**	**391,707**	**422,973**	**437,240**	**449,471**
Expenditure					
Provider Expenditure	(192,442)	(204,130)	(218,453)	(226,209)	(231,339)
Operating Expenditure	(165,882)	(180,670)	(193,386)	(198,339)	(200,769)
Depreciation	(7,544)	(8,069)	(9,387)	(9,673)	(11,628)
Interest Expense	(1,222)	(1,255)	(1,566)	(1,640)	(1,644)
Capital Charge	(6,163)	(5,469)	(4,788)	(4,373)	(4,087)
Total Expenditure	**(373,253)**	**(399,593)**	**(427,580)**	**(440,234)**	**(449,467)**
Net Surplus/(Deficit)	**(9,421)**	**(7,886)**	**(4,607)**	**(2,994)**	**4**
Gain/(Loss) on Sale of Assets	(7)	(8)	-	-	-
Retained Earnings	**(9,428)**	**(7,894)**	**(4,607)**	**(2,994)**	**4**

Table 28: Forecast Statement of Movement in Equity

Movements in Equity

Hutt Valley District Health Board
Forecast Statement of Movements in Equity
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Crown Equity	28,020	27,813	27,606	27,399	27,192
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings at Beginning of Period	(647)	(10,075)	(17,969)	(22,576)	(25,570)
Net Surplus / (Deficit) for the Period	(9,428)	(7,894)	(4,607)	(2,994)	4
Closing Equity	**68,313**	**60,212**	**55,398**	**52,197**	**51,994**

Table 29: Forecast Statement of Financial Position

Financial Position

Hutt Valley District Health Board
Forecast Statement of Financial Position
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Public Equity					
Equity	28,020	27,813	27,606	27,399	27,192
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings	(10,075)	(17,969)	(22,576)	(25,570)	(25,566)
Total Equity	**68,313**	**60,212**	**55,398**	**52,197**	**51,994**
Represented by:					
Current Assets					
Bank in Funds	8,486	2,794	6	6	6
Receivables and Prepayments	13,943	18,429	18,428	18,429	18,429
Inventories	1,195	1,517	1,517	1,517	1,517
Total Current Assets	**23,624**	**22,740**	**19,951**	**19,952**	**19,952**
Current Liabilities					
Bank Overdraft	-	-	(604)	(2,822)	(1,933)
Payables and Provisions	(51,032)	(58,605)	(63,874)	(65,227)	(63,583)
Short Term Borrowings	-	-	-	-	-
Total Current Liabilities	**(51,032)**	**(58,605)**	**(64,478)**	**(68,049)**	**(65,516)**
Net Working Capital	**(27,408)**	**(35,865)**	**(44,527)**	**(48,097)**	**(45,564)**
Non Current Assets					
Property, Plant and Equipment	116,180	121,082	139,629	168,899	185,563
Trust Funds	848	798	798	798	798
Total Non Current Assets	**117,028**	**121,880**	**140,427**	**169,697**	**186,361**
Non Current Liabilities					
Borrowings and Provisions	(20,459)	(25,005)	(39,705)	(68,605)	(88,005)
Trust Funds	(848)	(798)	(798)	(798)	(798)
Total Non Current Liabilities	**(21,307)**	**(25,803)**	**(40,503)**	**(69,403)**	**(88,803)**
Net Assets	**68,313**	**60,212**	**55,397**	**52,197**	**51,994**

6.1.1 Summary of Operating Budget

Our operating forecast for 2009/10 is a deficit of $4.6m

6.1.2 Funding Advice

Funding advice was received in December 2008 that included additional funding for 2009/10. The additional funding consists of a 3.116% cost increase, called Future Funding Track (FFT). Our share of the demographic funding was 2.38%. The funding envelope also signalled a significant increase in IDF outflows.

6.1.3 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 increase in national prices by 8.8% has had a significant impact on the Funder Arm result. This has led to a significant increase in the amount the Funder arm has to pay the Provider arm for services and also to other providers by way of IDF outflows.

The likely costs for demand driven community services have been estimated based on current volumes with the exception of pharmaceuticals. We have assumed a combined volume and price growth of 5.8% for community pharmaceuticals based on current trends.

IDF Outflows are based on the volumes provided under the agreed IDF methodology and are

budgeted for at national prices.

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

As a result of these reviews we have projected a summary deficit for the Funder Arm of $3.2m for 2009/10.

6.1.4 Provider Financials

The financial projection for the Provider Arm includes a number of significant assumptions that are detailed in the next section (section 6.2).

Base funding for the Provider Arm is agreed through the Memorandum of Agreement (MOA) with the Funder Arm. In 2009/10 the base increase in funding is 3.116%. 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.

We have included a number of efficiency and quality improvement initiatives into the Provider arm budgets. These include the building of two temporary day surgery facilities to increase surgical throughput and a reconfiguration of staffing in a number of areas. National employment agreements continue to impact in 2009/10 with settlements at higher rates than our funding provides and the requirement for 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 $1.4m for 2009/10.

6.2 Assumptions

The following sections list the key assumptions we have included in our preparation of the forecast financial statements for 2009/12. Our Statement of Accounting Policies is included at Appendix 7.

6.2.1 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 (up to 2%).
- 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 based on national assumptions.
- 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.
- Interest on loans borrowed to finance the ED/ theatre project have been capitalised to the cost of the project in accordance with IAS 23

- Any revaluation of land and buildings is estimated to be insignificant with no resulting impact on the financial statements.
- 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.

6.2.2 Funder

- The budgets for all demand driven costs are based on our current volumes for 2008/09 with an allowance for expected price increases in 2009/10.
- No material growth in demand has been incorporated into the budgets except for community pharmaceuticals that have been based on an increase of 5.8% over our forecasted 2008/09 spend.
- No provision has been made for any funding of new initiatives except for the funding allocated for the new government priorities.
- Price increases for external service providers have been limited to a maximum of the FFT funding increase.

6.2.3 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 – There are a number of multi employer agreement expiring in this 12 month period. We have assumed that they will be settled within FFT. Workforce shortages may also lead to unbudgeted expenditure in outsourced costs.
- 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 increase 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.

6.2.4 Out Years 2010/11 to 2011/12

We have assumed base revenue increases of 3.5% for 2010/11 and 2011/12 years respectively. Both years reflect the impact of service reconfigurations and the additional 2 clip on theatres. The impact of the ED/Theatre redevelopment project is reflected in the 2011/12 position. We are budgeting for an improving deficit in 2010/11 and a breakeven position in 2011/12.

6.3 Capital Expenditure

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

Table 30: Capital Expenditure

Capital Expenditure

Hutt Valley District Health Board
Capital Expenditure
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Approved / Baseline Expenditure					
Property and Plant	3,205	1,525	1,805	1,800	1,800
Clinical Equipment	1,949	1,223	1,995	2,000	2,000
Computer Equipment	2,416	1,193	1,500	1,500	1,500
Other Equipment	218	200	200	200	200
Motor Vehicles	3	-	-	-	-
Total Baseline	**7,791**	**4,141**	**5,500**	**5,500**	**5,500**
Strategic (Approved)					
ED Theatre	-	5,803	15,398	34,212	22,023
Car Park	-	-	4,000	-	-
Clipon Theatre	-	-	3,037	-	-
Land	-	1,760	-	-	-
I T	-	1,589	-	-	-
Total Approved	**-**	**9,152**	**22,435**	**34,212**	**22,023**
Total Capital Expenditure	**7,791**	**13,293**	**27,935**	**39,712**	**27,523**
Financed By:					
Finance Leases	-	-	5,000	5,000	-
Depreciation	-	8,069	9,387	9,673	11,628
Other - Internal Cash Reserves	-	224	3,148	139	(3,505)
CHFA Debt	-	5,000	10,400	24,900	19,400
	-	**13,293**	**27,935**	**39,712**	**27,523**

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 re-valued our relevant assets at 30 June 2006.

6.4 Efficiency Initiatives

Details of our improving hospital productivity and improving value for money initiatives are included in Section 3.2. The following initiatives are in progress and will impact on our results for the 2009/10 planning period:

- Implementation of the Emergency Department/Theatre business case during this period
- Construction of Clip On theatres to increase our theatre throughput
- A review of mental health services to ensure better alignment between activity and resources
- Working closely with our augmented NASC provider to improve value for money for older people's health services
- A review of our long term conditions programmes and service purchasing to identify opportunities for consolidation and better integration to improve effectiveness and value for money
- Hospital productivity improvements arising from our Improving the Patient Experience Programme
- Reducing the number of children overdue for recall for oral health services from 12.6% in December 2008 to 0% by December 2009, within existing resources.
- Addressing our high expenditure on community and hospital pharmaceuticals through the review of optimal prescribing in mental health, respiratory and rheumatology services.

- Increased regional collaboration in relation to business case and procurement activities, managing common service providers, reviewing Ministry of Health contracts where these specific local infrastructure and workforce requirements
- Exploration of additional elective services theatre facilities in the region.

6.5 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.

6.6 Business Cases

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

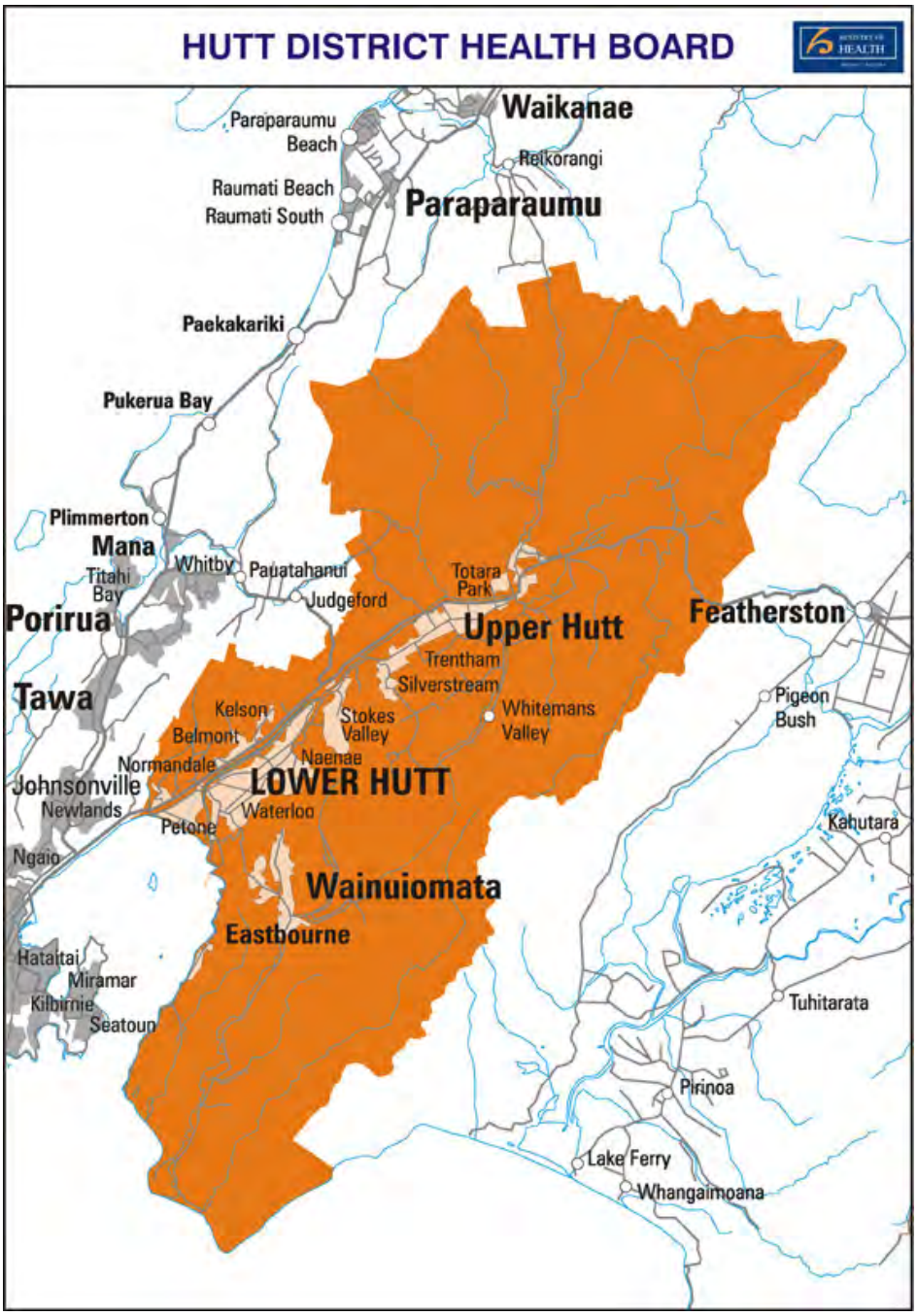
6.7 Debt and Equity

The CHFA is the key lender to Hutt Valley DHB with current loans of $19M at a fixed rate of 6.535% to December 2017. The CHFA facility has an end date of 2018. It is planned to apply to CHFA for additional loans up to $60 million, 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 DHB is investigating the applicability of lease financing for clinical equipment of up to $10m over the next two years.

Appendix 1: Our People

This section describes the Hutt Valley DHB region's population and population health needs. 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.

Figure 9: Hutt Valley DHB district



Population Information

Table 31 below shows the Hutt Valley DHB population distribution by age group in 2006 compared with the New Zealand population distribution[41].

Table 31: Population Distribution 2006

	0 - 14	15 – 24	25 – 44	45 – 64	65 – 84	85+	Total
HVDHB	31,550 (22.4%)	19,520 (13.9%)	40,420 (28.7%)	33,500 (23.8%)	14,190 (10.1%)	1,750 (1.2%)	140,930
NZ	21.2%	14.5%	28.2%	23.9%	10.8%	1.4%	

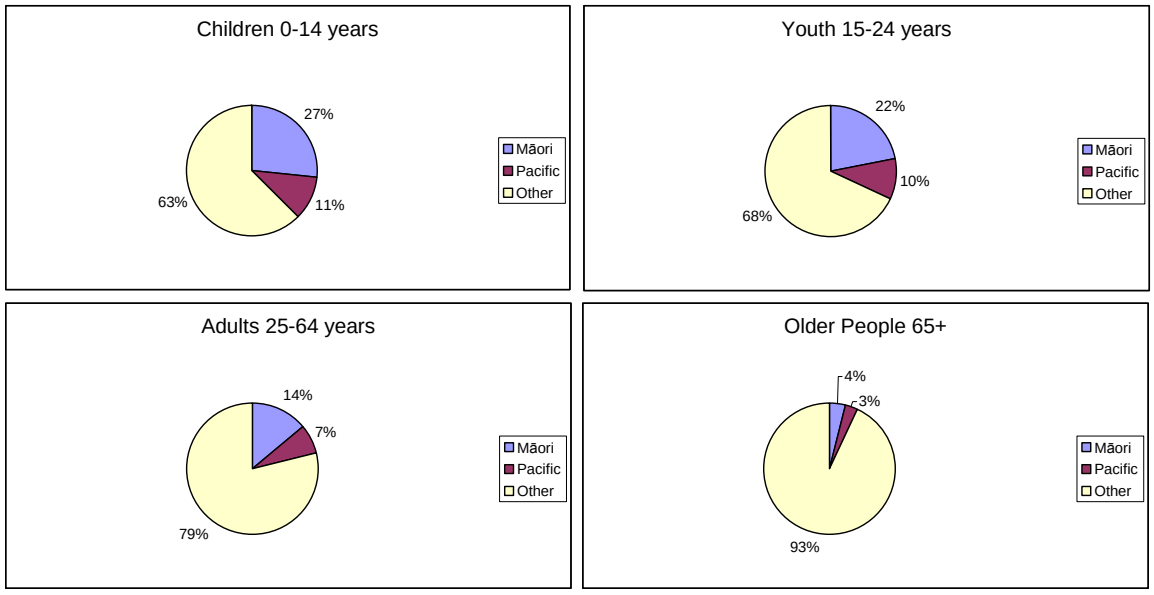
Both the age and gender composition of the Hutt Valley DHB population are similar to the New Zealand population. The ethnic composition of the overall population is similar to overall New Zealand figures, although in contrast with the national population, Hutt Valley DHB population had a slightly higher proportion of Pacific people.

Table 32: Population by ethnicity[42] 2006

	Maori	Pacific	Asian	European Other
HVDHB	16.4%	7.2%	6.8%	70.2%
NZ	14%	5.6%	8.5%	71.9%

While Māori and Pacific make up over 16% and 7.2% of the Hutt Valley's total population respectively, the proportion of Māori and Pacific 0 to 24 years is much higher as shown in Figure 10 below.

Figure 10: Population Age Groups by Ethnicity



The proportion of people residing in urban areas (98.1%) is higher than the national rate (86%). Over 70% of the population reside in Lower Hutt with another 28.5% residing in Upper Hutt. The population in Hutt Valley DHB is projected to increase by a smaller percentage than the national population between 2006 and 2026 (refer Table 33). Recent figures estimate that the population

[41] TAS Report: source: Ministry of Health projections, Statistics New Zealand – estimated usually resident 2006 Census Population.

[42] PHI - using prioritised ethnicity

will increase from the 140,930 in 2006 to around 147,240 in 2026. Like the national population, the population is aging, although projections vary across ethnic groups as shown in Figure 11 below. In contrast to the non Māori, non Pacific population projections, significant population growth is predicted for all Māori and Pacific population age groups, in particular children and youth and young adults.

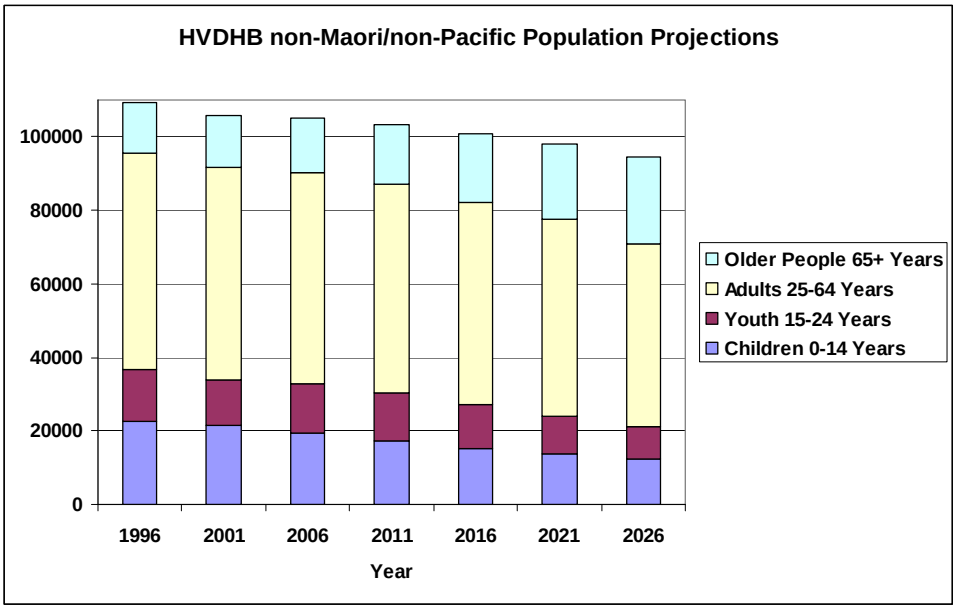
Table 33: Population Projections By Age Group - % Change 2006 - 2026

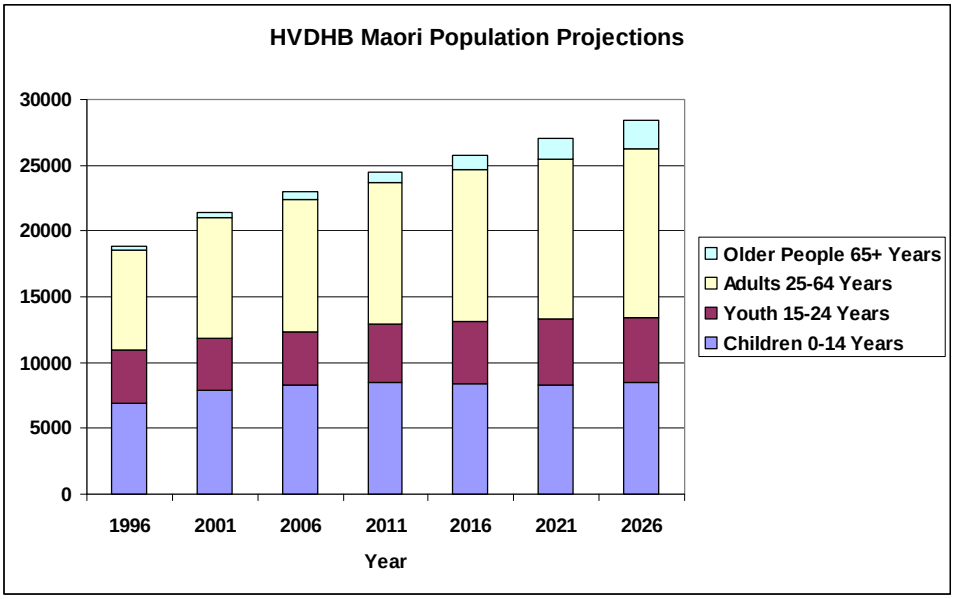
	0 – 14	15 – 64	65+	Total
HVDHB	- 11.4%	3.3%	74.4%	4.5%
Total NZ	1.1%	16.4%	87.5%	18.1%

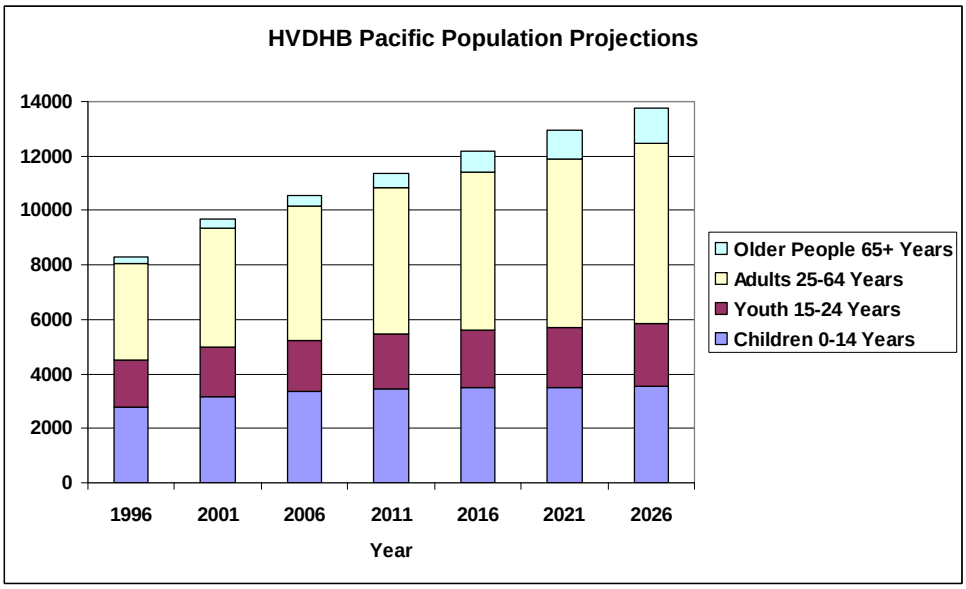
Table 34: Population Projections by Ethnicity - % Change 2006 – 2026

	Maori	Pacific	Other
HVDHB	27.3%	30.6%	-3.1%
NZ	29.9%	42.9%	13.9%

Figure 11: Population Projection By Age Group and Ethnicity



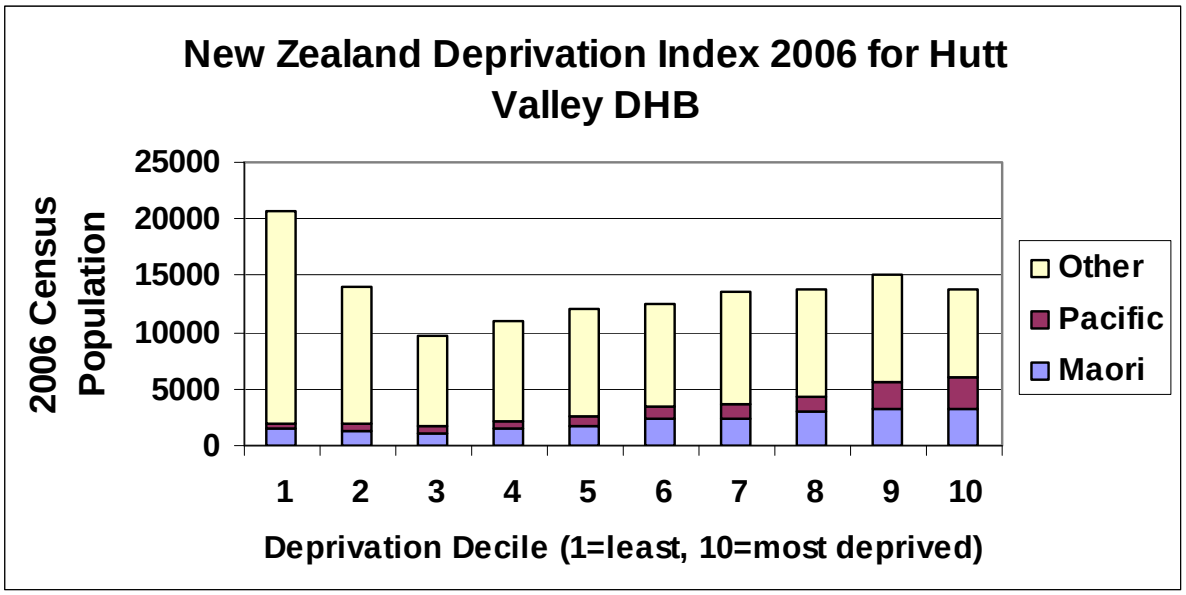




Deprivation

The determinants of well health and/or ill health are complex, and include social, economic, cultural and environmental conditions. Research has shown that the New Zealand Index of Deprivation 2006 (NZDep2006) scores are closely associated with health outcomes; the higher the scores the worse the outcomes. Compared with the New Zealand average, where distribution is fairly even across the NZDep2006 deciles 1 to 10 categories, the distribution in the Hutt Valley DHB population shows that 15% of the population live in areas with the lowest scores associated with better health status (Figure 12 below refers).

Figure 12: Population by Deprivation Decile and Ethnicity



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. Māori and Pacific people are over-represented in the most deprived areas. 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.

Health Profile

The Hutt Valley DHB's health profile is gained through a comprehensive Health Needs Assessment (HNA) that describes our population and their health status. The understanding of our population's health status and the conditions and illnesses prevalent in our district ensures that we focus on the right priorities to meet the needs of our population.

Key local health issues/challenges:

Health behaviours and risk factors:
For HVDHB the population rates for health risk factors are broadly similar to the national rates, i.e. for smoking prevalence, physical activity, hazardous drinking, obesity, high cholesterol, and high blood pressure. Worse or significantly worse rates, when compared with national figures, occur for:

- Consumption of fruit and vegetables
- Breastfeeding.

Health status:
When compared with national figures, the HVDHB population experiences:

- Higher population rates of chronic conditions; diabetes prevalence, stroke mortality, asthma prevalence, chronic obstructive pulmonary disease prevalence, and chronic mental health disorder prevalence
- Similar leading causes of mortality, with the addition of stroke.

Health service utilisation
When compared with national figures, the HVDHB has:

- Similar leading causes of hospitalisation, with the exception that asthma is a leading cause of hospitalisation for Maori, Pacific and Asian children aged 0 to 14 years, and diabetes is a leading cause of hospitalisation for Maori and Pacific people over 65 years
- Significantly higher rates of avoidable hospitalisation, in particular for diabetes, cardiovascular disease, ischaemic heart disease, and asthma
- Significantly higher rates for unmet need for a GP
- Significantly higher rates for prescriptions in the last 12 months
- Lower rates for diabetes checks and management

- Significantly higher rates for emergency department attendances
- Significantly lower number of GPs per 10,000 population.

Health targets
When compared with national figures for 2007/08, the HVDHB is on track to achieve targets for immunisation, improving oral health, elective services patient flow, and improving mental health services.

The HVDHB is still to reach targets for reducing avoidable hospital admissions, improving diabetes services, and breastfeeding.

Māori Health

The current Hutt Valley Māori population is around 24,000 people, or 16.4 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. If Maori are to achieve the same level of health as other New Zealanders their health status should be understood in the context of the broader determinants of health, particularly social, cultural and economic status. Strategies to improve Māori health should be effective at improving access to quality health care services for Maori. The Hutt Valley DHB Health Needs Assessment identifies a range of conditions where significant disparities exist for Māori (refer below). In addition, performance to date against Health Targets shows limited signs of significant progress in addressing the poorer health status of Māori in the Hutt Valley.

Key local health issues/challenges:

Social determinants
Inequalities exist in relation to life expectancy, educational achievement, income and household overcrowding.

Health behaviours and risk factors:
When compared with non Māori in the region, Māori experience:
- Higher prevalence of smoking
- Lower consumption of vegetables and fruit
- Lower rates of breastfeeding
- Higher rates of hazardous drinking
- Higher prevalence of obesity.

Health status:
When compared with non Māori in the region, Māori experience:
- Higher rates of death from cancer (especially Lung), cardiovascular disease, stroke, and suicide
- Higher prevalence of asthma, diabetes, and depression
- Poorer oral health.

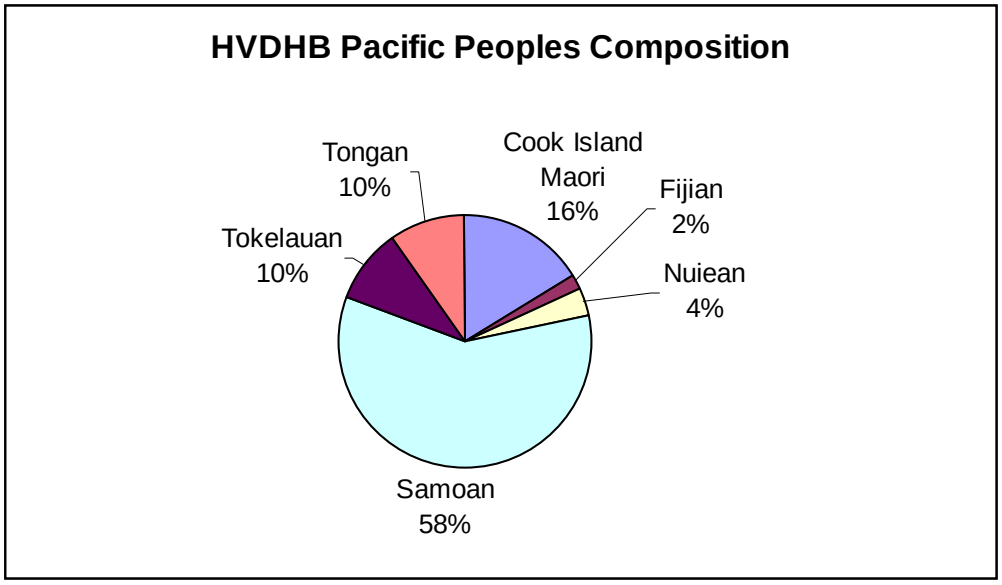
Health service utilisation
When compared with non Maori in the region, Māori experience:
- Higher rates of avoidable hospital admissions
- Higher rates of hospitalisation of children for dental conditions and asthma
- Greater unmet need for a GP
- Poorer access to oral health checks, diabetes checks, breast and cervical cancer screening.

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 7.2percent of total 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. Around 60% of the Pacific population in Hutt Valley is Samoan, with the next biggest island groupings being Cook Island Māori and Tokelauan (refer Figure 13 below).

Figure 13: Composition of Pacific Population



Pacific people experience significantly poorer health than other New Zealanders, excluding Māori. In particular, they experience high rates of chronic diseases such as diabetes and heart disease.

Key local health issues/challenges:

Social determinants
Inequalities exist in relation to life expectancy, educational achievement, income and household overcrowding. Nearly half of Pacific people living in the Hutt Valley fall into the two most deprived groups (Decile 9 and 10).

Health behaviours and risk factors:
Inequalities exist in relation to:

- Lower consumption of vegetables and fruit
- Higher prevalence of obesity.

Health status:
When compared with non Pacific/non Maori people in the region, Pacific people experience:

- Higher rates of death from cardiovascular disease, stroke, cancer,
- Much higher prevalence of diabetes, stroke, depression, and TB
- Poorer oral health.

Health service utilisation
When compared with non Pacific/non Maori people in the region, Pacific people experience:

- Higher rates of avoidable hospital admissions
- Higher rates of hospitalisation of children for dental conditions and asthma
- Greater unmet need for a GP
- Poorer access to oral health checks, diabetes checks, breast and cervical cancer screening

Disability Profile

Information available from Census data indicates that an estimated 27,000 Hutt Valley residents have 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.

Appendix 2: DHB Statutory Objectives and Governance Arrangements

Hutt Valley District Health Board (Hutt Valley DHB) is responsible for improving the health of Hutt Valley residents within available financial resources. We plan and fund most health and disability support services in the Hutt Valley. We directly provide health services through the Hutt Hospital and many DHB community services, but just as importantly we purchase a range of other services from independent primary health care and community organisations. The Ministry of Health is responsible for planning and funding public health, disability services for young people and some other national services.

Hutt Valley DHB:

PLANS in consultation with key stakeholders (Iwi, PHOs and NGOs) and our community, the strategic direction for health and disability services within our district.

PLANS in collaboration with other DHBs, regionally and nationally.

FUNDS health and disability services through the contracts we have with providers.

PROVIDES hospital and specialist services that include medical and surgical services, mental health, and older person's health services, maternity, child and youth health services.

PROMOTES community health and wellbeing through health promotion, health education and population health programmes.

District Health Boards were established and function under the New Zealand Public Health and Disability Act 2000, which includes DHB objectives and functions as discussed below.

Legislative

District Health Boards were established and function under the New Zealand Public Health and Disability Act 2000, which includes DHB objectives and functions. The objectives of DHBs are covered by the NZPHD Act (2000), as follows:

(a) to improve, promote, and protect the health of people and communities:

(b) to promote the integration of health services, especially primary and secondary health services:

(c) to promote effective care or support for those in need of personal health services or disability support services:

(d) to promote the inclusion and participation in society and independence of people with disabilities:

(e) to reduce health disparities by improving health outcomes for Maori and other population groups:

(f) to reduce, with a view to eliminating, health outcome disparities 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:

(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:

(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:

(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:

(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:

(k) to be a good employer in accordance with section 118 of the Crown Entities Act 2004.

Each DHB is required to pursue its objectives in accordance with its District Strategic Plan, its District Annual Plan, its Statement of Intent to Parliament, and any directions or requirements given to it by the Minister. Every year DHBs complete a District Annual Plan, which reflects their District Strategic Plan and Government and Local priorities. The District Annual Plan covers the level of services that will be funded, the services that are to be provided and the key actions that are to be advanced over the year. Performance targets and financial plans are also included within the annual plan.

Governance

Hutt Valley DHB has an established governance and organisational structure that enables us to carry out our responsibilities effectively. Our governance structure is based on the requirements of the NZPHD Act 2000. The Board consists of eleven members and has overall responsibility for the operation of Hutt Valley DHB. Seven of the members are elected as part of the three-yearly local body election process (last held in October 2007) and up to four are appointed by the Minister of Health.

There are four sub committees to the Board made up of Board members, DHB staff, and community representatives. These committees are requirements of the NZPHD Act 2000 and are statutory committees:

- **Hospital Advisory Committee (HAC) -** The HAC monitors the financial and operational performance of the hospital.

- **Community and Public Health Advisory Committee (CPHAC)** - The CPHAC provides the Board with advice on the health and disability needs of our region's population and reports on issues considered as having a significant effect on our population's health.

- **Disability Support Advisory Committee (DSAC) -** DSAC informs the Board about the needs of people with disabilities in our region. The committee makes sure that the services provided or funded, and the policies adopted, promote the inclusion and participation of people with disabilities in our society, to maximise their independence.

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

The public are welcome to observe the meetings of the board and statutory committees. The meetings are usually held monthly and details of the meetings (such as agendas, minutes, membership of the committee, people who attended a meeting) are publicly available on our website www.huttvalleydhb.org.nz.

Our Chief Executive Officer is accountable to our Board for the successful accomplishment of the district annual plan intentions, including meeting all of the performance targets. Our Board requires management to provide specific monthly performance reports so the Board can assess whether we will achieve our 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 would do in the District Annual Plan.

DHB Planning and Funding

The Hutt Valley DHB funds the following services:

- Primary health care

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

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. Government policies and priorities guide the planning and funding of health and disability services. The Planning and Funding function of the Hutt Valley DHB is responsible for ensuring that funding is applied as per the Ministry of Health's Nationwide Service Framework and Service Coverage Schedule. The core planning and funding activities include:

- 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.

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.

Decision-Making Framework

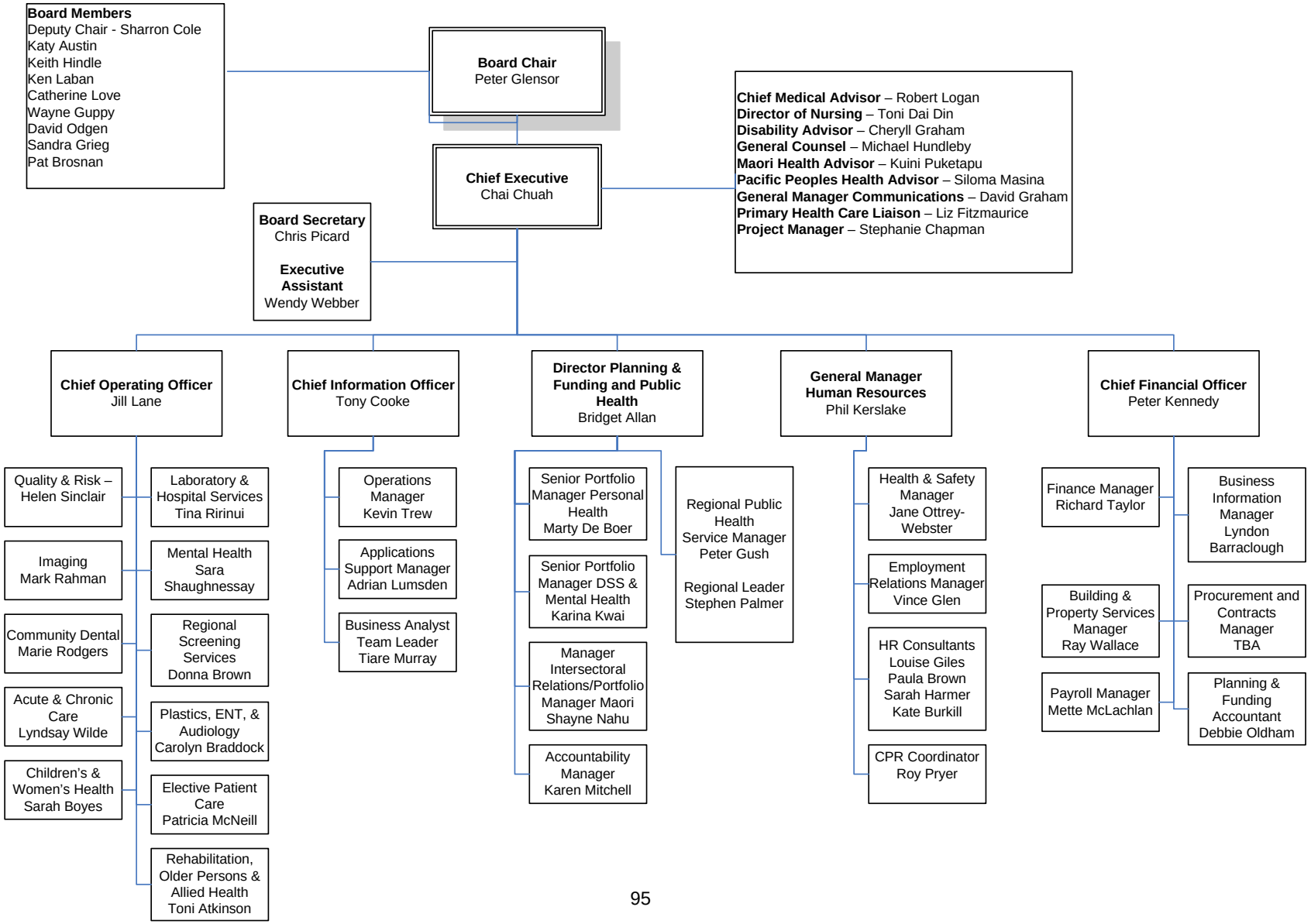
We cannot fund all the new services people would like us to fund. We need to decide what new services we should provide. We have developed a framework to help us decide what should get priority. The key principles of this framework are:

- Effectiveness.
- Equity.
- Acceptability.
- Consistency with the New Zealand Health Strategy and 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].

Appendix 3: Organisational Chart

Figure 14: Organisational Chart



Appendix 4: Measuring Performance

This Appendix summarises how we will evaluate and assess what we do in 2009/10 using performance measures and targets against desired outcomes and objectives[43]. The performance measures chosen are not a comprehensive list and do not cover all of the activity of the DHB, but they do reflect a picture of our activity against local and national strategies and priorities. Where possible, we have included past performance (baseline data) along with each performance target to give context of what we are trying to achieve and to better evaluate our performance.

The Ministry of Health has developed a framework of dimensions of DHB performance on which to base agreed 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 Measures a DHBs progress towards health outcomes: • better health • reduced inequalities • better participation and independence • trust and security	**Outputs** The DHBs performance in relation to providing services (or arranging services to be provided) for the local community. It covers the provision of services across the continuum of care: • preventing ill health • improving access to services • increasing provision of particular services • managing long term conditions • reducing inequalities between different population groups • improving incidence and/or impact of particular conditions • improving quality and patient safety.

Ownership
 	
The DHBs performance in the areas of ownership and stewardship:
• improving performance
• improving management
• leading and influencing
• improving clinical governance
• improving organisational health
• developing infrastructure
• managing finance and assets
• improving effectiveness of planning and funding processes
• improving efficiency and productivity
• improving quality
• encouraging innovation.
	System Integration
	
	The degree to which the DHB is able to:
	• create positive community partnerships with:
	  o the local community
	  o local Māori
	• create positive collaborative relationships with others in the health sector:
	  o local PHOs
	  o other DHBs
	  o other state sector agencies
	• contribute to health system coordination
	  o improving coordination between primary and secondary care
	  o improving coordination across continuum of care
	  o improving health system coordination

[43] As stated in the CE Act 2004 (s 142 (1))

Health Targets

<table>
<tr><th>Dimension of DHB Performance</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Shorter stays in emergency departments
95% of patients will be admitted, discharged, or transferred from an emergency department within 6 hours.</td><td>More efficient and effective services:

DAP Priority: Hospital Services

Output Class:
Hospital Services</td><td>Number of patient presentations to ED with an ED length of stay less than six hours/total number of patient presentations to the ED.

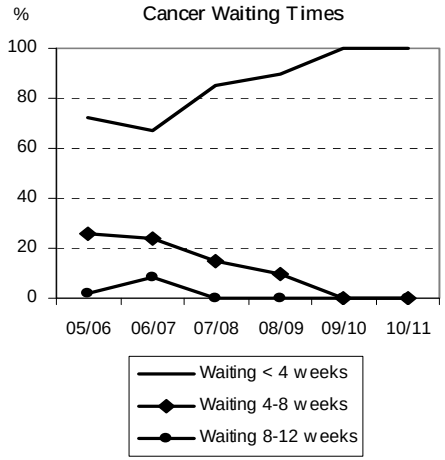
<table>
<tr><td>Admit Service</td><td>Baseline</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr>
<tr><td>Admitted Total</td><td>73%</td><td>84%</td><td>89%</td><td>93%</td></tr>
<tr><td>Treated & Discharged</td><td>92%</td><td>92%</td><td>93%</td><td>95%</td></tr>
<tr><td>Treated & Referred</td><td>91%</td><td>91%</td><td>95%</td><td>98%</td></tr>
<tr><td>Total</td><td>87%</td><td>90%</td><td>92%</td><td>95%</td></tr>
</table>

In 2009/10 we plan to:
• Implement improvements identified from the Improving Patient Experience Programme projects: Emergency Department patient streaming.</td></tr>
<tr><td>Improved access to elective surgery
The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)</td><td>Improved access to services: Fair operation of elective waiting lists and certainty around treatment

DAP Priority:
Electives,
Improved Infrastructure

Output Class:
Hospital Services</td><td>
<table>
<tr><th>PU Code</th><th>Description</th><th>Base Discharges</th><th>Total 09-10</th><th>Total 10-11</th><th>Total 11-12</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>S00001</td><td>General surgical</td><td>738</td><td>948</td><td>979</td><td>1011</td></tr>
<tr><td>S15001</td><td>Cardiothoracic</td><td>59</td><td>74</td><td>76</td><td>79</td></tr>
<tr><td>S25001</td><td>Ear, nose and throat</td><td>565</td><td>662</td><td>684</td><td>706</td></tr>
<tr><td>S30001</td><td>Gynaecology</td><td>543</td><td>668</td><td>690</td><td>713</td></tr>
<tr><td>S35001</td><td>Neurosurgery</td><td>45</td><td>46</td><td>48</td><td>49</td></tr>
<tr><td>S40001</td><td>Ophthalmology</td><td>470</td><td>564</td><td>582</td><td>602</td></tr>
<tr><td>S45001</td><td>Orthopaedics</td><td>435</td><td>604</td><td>624</td><td>644</td></tr>
<tr><td>S55001</td><td>Paediatric surgical</td><td>94</td><td>99</td><td>102</td><td>106</td></tr>
<tr><td>S60001</td><td>Plastics</td><td>768</td><td>841</td><td>869</td><td>897</td></tr>
<tr><td>S70001</td><td>Urology</td><td>156</td><td>214</td><td>221</td><td>228</td></tr>
<tr><td>S75001</td><td>Vascular surgery</td><td>93</td><td>121</td><td>125</td><td>129</td></tr>
<tr><td>Total</td><td></td><td>3966</td><td>4841</td><td>5000</td><td>5164</td></tr>
</table>

Hutt Valley DHB plans to deliver 4841 elective surgical discharges in 2009/10. The plan for each specialty is shown in the table below.</td></tr>
</table>

Dimension of DHB Performance	Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)	Baseline data and local targets
Shorter waits for cancer treatment Everyone needing radiation treatment will have this within 6 weeks by the end of July 2010 and within four weeks by December 2010.	*Improved access to services:* Timely cancer treatment *DAP Priority:* Hospital Services Improved Infrastructure *Output Class:* Hospital Services	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. 

<table>
<tr><th>Dimension of DHB Performance</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Improving immunisation coverage
95% of two year olds are fully immunised, with at least a 20% increase on the gap between current performance and 95%.</td><td>Reduced Health Risk:
Reduction in vaccine preventable disease

DAP Priority: Primary Health Care
Keeping Our People Well
Maternity, Child and Youth

Output Class:
Primary and Community Services</td><td>
<table>
<tr><th></th><th>Qtr 2 2008/09</th><th>Target 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>Total</td><td>83%</td><td>87%</td><td>87%</td><td>90%</td><td>95%</td></tr>
<tr><td>Māori</td><td>79%</td><td>83%</td><td>87%</td><td>90%</td><td>95%</td></tr>
<tr><td>Pacific</td><td>83%</td><td>87%</td><td>87%</td><td>90%</td><td>95%</td></tr>
</table>

Opportunities for improvement include:
• Timely referral from Lead Maternity Carers to Well Child/Tamariki Ora providers and primary health care
• Proactive enrolment of new babies by primary health care, with reminders to bring them in for their immunisations
• Implementing strategies to reduce the drop off in uptake of the 3-month immunisation for Maori babies and babies living in households in high deprivation areas
• Increasing opportunistic immunisation in secondary care services
• Improving the system for immunisation outreach services.

In 2009/10 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.</td></tr>
</table>

<table>
<tr><th>Dimension of DHB Performance</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Better help for smokers to quit
80% of hospitalised smokers are provided with advice and help to quit by July 2010; 90% by July 2011; and 95% by July 2012. Similar target for primary health care will be introduced from from July 2010 or earlier through the PHO Performance Programme.</td><td>Reduced Health Risk:
Reduction in smoking related disease

DAP Priority: Primary Health Care
Keeping Our People Well, Hospital Services

Output Class:
Public Health</td><td>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%. 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%).

The Hutt Valley DHB supports the achievement of this national target through the delivery of a range of tobacco control activities.

<table>
<tr><td>Hospital</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr>
<tr><td>Total</td><td>80%</td><td>90%</td><td>95%</td></tr>
<tr><td>Māori</td><td>80%</td><td>90%</td><td>95%</td></tr>
<tr><td>Pacific</td><td>80%</td><td>90%</td><td>95%</td></tr>
</table>

<table>
<tr><td>Primary Care</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr>
<tr><td>Total</td><td>N/A</td><td>80%</td><td>90%</td></tr>
<tr><td>Māori</td><td>N/A</td><td>80%</td><td>90%</td></tr>
<tr><td>Pacific</td><td>N/A</td><td>80%</td><td>90%</td></tr>
</table>

In 2009/10 we will be implementing our Regional Tobacco Control Plan agreed between Hutt Valley and Capital and Coast DHB, in conjunction with Regional Public Health. The Plan includes training for our clinicians (primary care and hospital based) to implement the effective brief intervention (EBI) model. Our plan will need to include development of information systems capability (hospital and primary care) to support the collection of required data for the reporting against this target.</td></tr>
</table>

<table>
<tr><th>Dimension of DHB Performance</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Better diabetes and cardiovascular services
a. Increased percent of the eligible adult population have had their CVD risk assessed in the last five years.
b. Increased percent of people with diabetes attend free annual checks.
c. Increased percent of people with diabetes have satisfactory or better diabetes management.</td><td>Earlier Intervention; Improved management of chronic disease and improved equity between population groups

DAP Priority; Primary Health Care

Output Class: Primary and Community Services</td><td>
Cardiovascular disease risk recognition
<table>
<tr><th>Target Group</th><th>Baseline</th><th>Actual to Dec 08</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>Maori</td><td>64.3%</td><td>65.2%</td><td>67%</td><td>69%</td><td>71%</td></tr>
<tr><td>Pacific</td><td>67.4%</td><td>68.4%</td><td>70%</td><td>72%</td><td>74%</td></tr>
<tr><td>Other</td><td>75.4%</td><td>76%</td><td>78%</td><td>80%</td><td>82%</td></tr>
<tr><td>Total</td><td>73.8%</td><td>74.3%</td><td>76%</td><td>78%</td><td>80%</td></tr>
</table>
Diabetes detection and follow-up rate
<table>
<tr><th>Target Group</th><th>Actual 2008</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>Māori</td><td>43%</td><td>55%</td><td>56%</td><td>57%</td></tr>
<tr><td>Pacific</td><td>56%</td><td>63%</td><td>64%</td><td>65%</td></tr>
<tr><td>Other</td><td>63%</td><td>64%</td><td>65%</td><td>66%</td></tr>
<tr><td>Total</td><td>59%</td><td>63%</td><td>64%</td><td>65%</td></tr>
</table>
Diabetes management – HBA1C <= 8%
<table>
<tr><th>Target group</th><th>Actual 2008</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>Māori</td><td>54%</td><td>59%</td><td>60%</td><td>61%</td></tr>
<tr><td>Pacific</td><td>48%</td><td>52%</td><td>53%</td><td>54%</td></tr>
<tr><td>Other</td><td>76%</td><td>81%</td><td>83%</td><td>85%</td></tr>
<tr><td>Total</td><td>70%</td><td>74%</td><td>76%</td><td>78%</td></tr>
</table>
In 2009/10 we plan to:

Work with primary and secondary health care to ensure Maori and Pacific people are able to access diabetes checks and are included in the Diabetes Register and are supported to improve outcomes.
Foster the development of new models of service delivery to increase early intervention and outreach services for people with long term conditions (including cardiovascular, diabetes and respiratory disease).
Establish a long term conditions inter-disciplinary “think tank” with consumers, clinicians and other stakeholders to develop specific projects under the long term conditions programme.
Development of training and education programmes to improve insulin management skills for practice nurses and GPs, and for community carers of people with diabetes.
Explore ways of better sharing information between primary health care and secondary care services to enable better follow-up and targeting.

</td></tr>
</table>

Indicators of DHB Performance

In addition to the Health Targets and DSP Indicators, the following tables list the variety of indicators of DHB performance we monitor and report on. These include Indicators of DHB Performance (IDPs) and additional Ministry of Health reporting requirements. Baseline information and targets are provided where applicable.

Measure and Dimension of DHB Performance	Description	Quarter(s) Reporting Due	Deliverables and Targets 2009/10
HKO-01 System Integration	Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain.	Q2, Q4.	*Measure 1;* Percentage of PHOs with Māori Health Plans (MHPs) that have been agreed to by the DHB. **Target: 100%** *Measure 2;* Percentage of DHB members that have undertaken Treaty of Waitangi training: **Board members have not changed.** *Measure 3;* Provide a report demonstrating achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Māori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties. Provide a copy of the MoU. *Measure 4;* Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs). *Measure 5;* Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) *Measure 6;* Describe when Treaty of Waitangi training (including any facilitated by the Ministry) has, or will, take place for Board members. **Board members have not changed.** *Measure 7;* Identify at least two key milestones from your Māori Health Plan to be achieved in 2008/09. For reporting in Quarter 2, provide a progress report on the milestones, and for reporting in Quarter 4, provide a report against achievement of those milestones.
HKO-03 Services.	Improving mainstream effectiveness.	Q2, Q4.	*Measure 1;* Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Māori. *Measure 2;* Report on an example(s) of actions taken to address issues identified in the reviews. If possible, develop a reporting template based on the key points above.
HKO-04 Ownership.	DHBs will set targets to increase funding for Māori Health and disability initiatives.	Q4.	*Measure 1;* DHB to report actual expenditure on Māori Health Providers by General Ledger (GL) code. *Measure 2;* DHBs to report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU). *Measure 3;* Where information is available, DHBs to provide a table that reflects the DHB predicted expenditure for Māori health in the DHB 2009/10 DAP in comparison to actual expenditure, with explanation of variances. ***Targets*** *Measure 4;* **Additional 2009/10 Māori health expenditure 5% plus FFT.**

<table>
<tr><th>Measure and Dimension of DHB Performance</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2009/10</th></tr>
<tr><td>PAC-01 Ownership</td><td>Pacific Provider Service Contracts</td><td>Q4</td><td>The total number and type of service contracts delivered by Pacific providers/ divided by the total number and type of service contract</td></tr>
<tr><td>POP-04 Improving health outcomes.</td><td>Oral health - mean DMFT score at year eight.</td><td>Q3.</td><td>POP-04 Oral Health – Mean DMFT score at Year 8
<table>
<tr><th></th><th>Actual 2007</th><th>Actual 2008</th><th>Target 2009</th><th>Target 2010</th><th>Target 2011</th></tr>
<tr><td>Māori</td><td>1.2</td><td>1.37</td><td>1.2</td><td>1.2</td><td>1.2</td></tr>
<tr><td>Pacific</td><td>1.4</td><td>1.17</td><td>1.2</td><td>1.2</td><td>1.2</td></tr>
<tr><td>Other</td><td>0.7</td><td>0.84</td><td>0.7</td><td>0.7</td><td>0.7</td></tr>
<tr><td>Total</td><td>0.9</td><td>0.95</td><td>0.9</td><td>0.9</td><td>0.9</td></tr>
</table></td></tr>
<tr><td>POP-05 Improving health outcomes.</td><td>Oral health – percentage of children caries free at age five years.</td><td>Q3.</td><td>POP-05 Oral Health – caries free aged 5
<table>
<tr><th></th><th>Actual 2007</th><th>Actual 2008</th><th>Target 2009</th><th>Target 2010</th><th>Target 2011</th></tr>
<tr><td>Māori</td><td>36%</td><td>40.7%</td><td>53%</td><td>53%</td><td>53%</td></tr>
<tr><td>Pacific</td><td>29%</td><td>39.3%</td><td>44%</td><td>44%</td><td>44%</td></tr>
<tr><td>Other</td><td>61%</td><td>68.7%</td><td>75%</td><td>75%</td><td>75%</td></tr>
<tr><td>Total</td><td>50%</td><td>58.6%</td><td>67%</td><td>67%</td><td>67%</td></tr>
</table></td></tr>
<tr><td>POP-06 Services.</td><td>Improving the health status of people with severe mental illness</td><td>Q2, Q4.</td><td>The percentage of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for children and youth aged 0-19, adults aged 20-64 and older people aged 65+. Mental Health Information National Collection data
<table>
<tr><th>Ethnicity</th><th>Age group</th><th>Actual (quarter 3 2008)</th><th>Target 2009/10</th></tr>
<tr><td>Māori</td><td>0-19</td><td>1.37%</td><td>2.5%</td></tr>
<tr><td>Māori</td><td>20-64</td><td>3.73%</td><td>4.8%</td></tr>
<tr><td>Māori</td><td>65+</td><td>0.65%</td><td>1.5%</td></tr>
<tr><td>Pacific</td><td>0-19</td><td>0.48%</td><td>1.0%</td></tr>
<tr><td>Pacific</td><td>20-64</td><td>1.80%</td><td>2.5%</td></tr>
<tr><td>Pacific</td><td>65+</td><td>0.60%</td><td>1.0%</td></tr>
<tr><td>Other</td><td>0-19</td><td>1.34%</td><td>2.3%</td></tr>
<tr><td>Other</td><td>20-64</td><td>2.16%</td><td>2.9%</td></tr>
<tr><td>Other</td><td>65+</td><td>0.64%</td><td>1.5%</td></tr>
<tr><td>Total</td><td>0-19</td><td>1.33%</td><td>2.3%</td></tr>
<tr><td>Total</td><td>20-64</td><td>2.39%</td><td>2.9%</td></tr>
<tr><td>Total</td><td>65+</td><td>0.64%</td><td>1.5%</td></tr>
</table>
In 2009/10 we plan to:
Continue implementation of the 5 yr mental health and addiction action plan Make it Happen (Whakamahingia).</td></tr>
</table>

<table>
<tr><th>Measure and Dimension of DHB Performance</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2009/10</th></tr>
<tr><td></td><td></td><td></td><td>

Develop a model for improving the range of services in the community to support older people with low to medium mental health needs, and identify potential providers.
Implement the recommendation of the Hutt Valley Infant Child, Adolescent and Family mental health and addiction service review (2008), if funding allows.
Work with PHOs to implement primary mental health services for people with mild to moderate mental illness.
Work with secondary and primary mental health providers to ensure improved access and appropriate services for Māori and Pacific people with mental illness.
Continue to implement the local component of PRIMHD.

</td></tr>
<tr><td>POP-07 Services.</td><td>Alcohol and other drug service waiting times</td><td>Q2, Q4.</td><td>
Baseline 2008/09

Reporting by Maori ethnicity
<table>
<tr><td></td><td colspan="3">Longest waiting time in days for each month</td><td colspan="3">Longest waiting time in days for each month</td></tr>
<tr><td>Service Type</td><td colspan="3">Quarter 1</td><td colspan="3">Quarter 2</td></tr>
<tr><td></td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td></tr>
<tr><td>Inpatient Detoxification</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Specialist Prescribing</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Structured Counselling</td><td>30</td><td>31</td><td>31</td><td>10</td><td>10</td><td>10</td></tr>
<tr><td>Day Programmes</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Residential Rehabilitation</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>
Reporting by Other ethnicities
<table>
<tr><td></td><td colspan="3">Longest waiting time in days for each month</td><td colspan="3">Longest waiting time in days for each month</td></tr>
<tr><td>Service Type</td><td colspan="3">Quarter 1</td><td colspan="3">Quarter 2</td></tr>
<tr><td></td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td></tr>
<tr><td>Inpatient Detoxification</td><td>7</td><td>7</td><td>7</td><td>7</td><td>7</td><td>7</td></tr>
<tr><td>Specialist Prescribing</td><td>30</td><td>30</td><td>30</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>Structured Counselling</td><td>10</td><td>10</td><td>10</td><td>10</td><td>10</td><td>10</td></tr>
<tr><td>Day Programmes</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Residential Rehabilitation</td><td>28</td><td>28</td><td>28</td><td>0</td><td>0</td><td>0</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Measure and Dimension of DHB Performance</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2009/10</th></tr>
<tr><td>POP-10 Improving health outcomes.</td><td>Chemotherapy treatment waiting times.</td><td>Monthly</td><td>Chemotherapy treatment waiting times
Data supplied by Capital & Coast DHB.</td></tr>
<tr><td>POP-11 Improving health outcomes.</td><td>Family violence prevention.</td><td>Q2, Q4.</td><td>Overall score from Auckland University of Technology Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit to assess the progress made towards taking a systemic approach towards the identification and intervention of child and partner abuse and progress report on specific actions taken since the audit to progress the recommendations of the audit.
Target: Combined Audit Score = 140/200 or above</td></tr>
<tr><td>POP-14 Service</td><td>Utilisation of DHB funded dental services by adolescents from year 9 to 17 years</td><td>Q4</td><td>Adolescent utilisation data (completions, non-completions and additional adolescent examinations).
<table>
<tr><th>Prioritised Ethnicity</th><th>Target 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>Total</td><td>65.5%</td><td>68%</td><td>70.5%</td><td>75%</td></tr>
</table></td></tr>
<tr><td>POP-15</td><td>Reducing ambulatory sensitive admissions. Reduction in variation between DHBs and between different population groups</td><td>Q2, Q4</td><td>Ambulatory Sensitive Hospitalisations, indirectly standardised ratio of observed to expected.
<table>
<tr><th>Age Group</th><th>Ethnicity</th><th>Actual to Sept 2008 (New method)</th><th>Target 2009/10 (New method)</th></tr>
<tr><td>0-74</td><td>Māori</td><td>107</td><td><=105</td></tr>
<tr><td>0-74</td><td>Pacific</td><td>105</td><td><=103</td></tr>
<tr><td>0-74</td><td>Other</td><td>113</td><td><=109</td></tr>
<tr><td>0-4</td><td>Māori</td><td>121</td><td><=115</td></tr>
<tr><td>0-4</td><td>Pacific</td><td>138</td><td><=128</td></tr>
<tr><td>0-4</td><td>Other</td><td>145</td><td><=133</td></tr>
<tr><td>45-64</td><td>Māori</td><td>90</td><td><95</td></tr>
<tr><td>45-64</td><td>Pacific</td><td>83</td><td><95</td></tr>
<tr><td>45-64</td><td>Other</td><td>106</td><td><=104</td></tr>
</table>
In 2009/10 we plan to:
Implement an access coordination service, supported by the Māori and Pacific units, to ensure that Māori and Pacific people are able to enrol and access primary health care in a timely manner
Work with PHOs and hospital services to implement change management programme for shifting of some secondary care services to primary care from 2010/11.
Work with PHOs and other community and primary care organisations and other agencies to develop a Family Health Centre model of primary health care for the Hutt Valley.
Work with PHOs to implement primary mental health services for people with mild to moderate mental illness.</td></tr>
</table>

<table>
<tr><th>Measure and Dimension of DHB Performance</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2009/10</th></tr>
<tr><td>POP-17</td><td>Improving mental health services</td><td>Q2, Q4</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 (Q3 2008/09)</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Māori</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Māori</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Child and Youth</td><td>Māori</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Total</td><td>Māori</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Pacific</td><td>96.8%</td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Pacific</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Child and Youth</td><td>Pacific</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Total</td><td>Pacific</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Other</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Other</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Child and Youth</td><td>Other</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Total</td><td>Other</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Total</td><td>63%</td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Total</td><td></td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Child and Youth</td><td>Total</td><td>33%</td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Total</td><td>Total</td><td>59%</td><td>90%</td><td>90%</td><td>90%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Measure and Dimension of DHB Performance</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2009/10</th></tr>
<tr><td>POP-18</td><td>Increase the proportion of infants exclusively and fully breastfed at six weeks to 74% or greater; at three months to 57% or greater; and at six months to 27% or greater.</td><td>Q1, Q2, Q3, Q4</td><td>
<table>
<tr><th></th><th>Actual2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr>
<tr><td>Breastfed on discharge</td><td>85%</td><td>85%</td><td>85%</td><td>85%</td></tr>
<tr><td>Breastfed at 6 weeks: Total</td><td>60%</td><td>63.7%</td><td>74%</td><td>74%</td></tr>
<tr><td>Breastfed at 6 weeks: Māori</td><td></td><td>55.8%</td><td></td><td></td></tr>
<tr><td>Breastfed at 6 weeks: Pacific</td><td></td><td>63.5%</td><td></td><td></td></tr>
<tr><td>Breastfed at 3 mths</td><td>49%</td><td>57%</td><td>57%</td><td>57%</td></tr>
<tr><td>Breastfed at 6 mths</td><td>19%</td><td>27%</td><td>27%</td><td>27%</td></tr>
</table>
The Hutt Valley DHB Breastfeeding Action Plan captures several goals that support achieving the breastfeeding health target:
• Increase the uptake of breastfeeding for Maori and Pacific women and their families
• Improve the accuracy, reliability and collection of breastfeeding data, currently captured by Plunket.
• Support workforce capacity and capability development through the Mum-4-Mum Peer Support “train the trainer” programme
• Promote and raise the awareness of the benefits of breastfeeding at ante-natal, delivery and post-natal points of contact
• Support the implementation of the Baby Friendly Community Initiatives (BFCI)
• Align local messages with the national breastfeeding promotional campaign.
</td></tr>
<tr><td>QUA-03 Ownership.</td><td>Improving the quality of data provided to the National Collections Systems.</td><td>Q1, Q2, Q3, Q4.</td><td>Measure 1; NHI Duplications
Measure 2; Ethnicity not stated in NHI
Measure 3; Standard vs. specific descriptors in the NMDS
Measure 4; Timeliness of NMDS data
Ministry of Health will provide feedback to DHBs as to their achievement against measures</td></tr>
<tr><td>RIS-01 Services</td><td>Service coverage</td><td>Q1, Q2, Q3, Q4.</td><td>Report progress achieved during the quarter towards resolution of gaps in service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry.</td></tr>
</table>

Measure and Dimension of DHB Performance	Description	Quarter(s) Reporting Due	Deliverables and Targets 2009/10
SER-04 Services.	Continuous Quality Improvement – Elective services.	Q1,Q2, Q3, Q4.	• For publicly funded casemix included elective discharges in a surgical DRG, a target intervention rate of at least 280 per 10,000 of population will be achieved. • For major joint replacement procedures, a target intervention rate of 210 per 100,000 of population will be achieved. This should be comprised of the following rates: a. 105 per 100,000 of population for hip replacement b. 105 per 100,000 of population for knee replacement • For cataract procedures, a target intervention rate of 270 per 100,000 of population will be achieved. • For cardiac procedures a target intervention rate of at least 59 per 100,000 of population will be achieved. DHBs with rates of 59 per 100,000 or above in 2007/08 will be required to maintain this rate. DHBs with rates less than 59 per 100,000 will be required to increase the level of service to at least 59: 100,000. By 2011/12 all DHBs will be delivering at a rate of at least 65 per 100,000 of population. *NB - These target intervention rates are undergoing clinical validation and are subject to further refinement.
SER-07 Services.	Low or reduced cost access to first level primary care services.	Q1, Q2, Q3, Q4.	*Measure 1;* 100% of fee increases that should be referred (as per the Ministry of Health letter sent to DHBs dated 26 January 2007) are referred to a regional fee review committee and 100% of practices comply with the recommendations of the regional fee review committee, and in all cases, where practices fail to comply, the DHB applies appropriate sanctions. *Measure 2;* 100% of PHO practices ensure public access to local information on the fees PHO practices are charging patients.

Additional DHB reporting

<table>
<tr><th>Reporting Area (and Dimension of DHB Performance)</th><th>Quarter(s) Reporting Due</th></tr>
<tr><td>Reducing inequalities achievements -self assessment (Improving health outcomes).
DHBs should identify one or two examples of initiatives or services that are working well for their populations with regards to reducing inequalities, and tell the Ministry about them. Self-evaluation reports should be brief, providing a high level summary of DHB activity (maximum two pages).</td><td>Q2, Q4.</td></tr>
<tr><td>Oral health (Services).
1. Number of pre-school children enrolled: Total number of children aged under 5 years enrolled with DHB funded dental services/Ministry denominator
2. Number of pre-school and primary school children enrolled in DHB funded dental services who did not receive an annual examination: The total number of preschool and primary school children enrolled with DHB funded dental services (COHS and other contracted providers) who have not been examined within the previous 12 month period and the greatest length of time children have been waiting for their annual examination, and the number of children that have been waiting for that period./ The total number of preschool and primary school children enrolled with DHB funded dental services (COHS and other contracted providers).
3. For 2009/10 DHBs are expected to report on progress achieved in relation to oral health services (reporting template to be developed) specifically focused on:
• Progress in re-orientating child and adolescent oral health services.
• Oral health initiatives not related to child and adolescent service improvements.
• Oral health workforce development.

Number of children waiting for recall over 12 months
<table>
<tr><td></td><td>Actual 2007</td><td>Actual 2008</td><td>Target 2009</td><td>Target 2010</td><td>Target 2011</td></tr>
<tr><td>Total</td><td>34.3%</td><td>12.6%%</td><td>10%</td><td>< 10%</td><td>< 10%</td></tr>
</table>
In 2008/09 Hutt Valley DHB and Capital Coast DHB submitted to the Ministry of Health a joint business case for improved Oral Health Service Provision for Children and Adolescents. Once the business case is approved we will establish a hub and spoke model, including construction of new clinics supported by mobile units. The proposed development is a collaborative approach between the two DHBs and has taken into account wide ranging public consultation. When established the new service model will:

• Increase enrolment
• Reduce disparities in DMFT and caries figures between Māori, Pacific and other children
• Increase the total number of examinations and treatments
• Reduce the arrears rates for recall to services
• Improve therapist productivity
• Improve workforce recruitment and retention
• Improve information collection, monitoring and communication.</td><td>Q3.</td></tr>
<tr><td>Delivery of DAP in key priority areas (Ownership).
DHBs are to report confirming, by priority/health target area, that all the key services, actions, programmes or initiatives identified in their DAP linked to the progression of health sector targets and ministerial priority areas, are progressing according to plan (quarter two and four and quarter one and three) and have been delivered.</td><td>Q1, Q3</td></tr>
</table>

Reporting Area (and Dimension of DHB Performance)	Quarter(s) Reporting Due
Annual update report on Delivery of Te Kokiri: the Mental Health and Addiction Action Plan DHBs are to provide a summary report on progress made towards implementation of Te Kokiri: the Mental Health and Addiction Plan. A template for the report is available on www.nsfl.health.govt.nz	Q3
DHB confirmation and exception reports – risk management (Ownership). DHBs are to report confirming: • The DHB uses a formal risk management and reporting system to manage DHB risks and report them to its Board • The system meets current Australia / New Zealand Standard requirements relating to risk management • How frequently the DHB submits formal risk report updates to its Board (or a Board approved sub-committee).	Q2, Q4.
DHB self evaluation - provider arm efficiency (Ownership). Each quarter DHBs are to high level summary report (maximum one page) on the results of a self assessment in one of the areas of focus identified below, • Access to diagnostics • Day Surgery / Length of Stay • Patient flow and discharge planning • Unnecessary outpatient attendance/follow-up • Acute demand management • Primary secondary interface and referral management • Theatre utilisation • FTE configuration/productivity • Capacity Planning and Procurement • Management of Price Volume Schedule .	Q1, Q2, Q3, Q4.
Delivery of Mental Health Service volumes (Ownership). For Mental Health Services provided by the DHB's provider arm, the DHB must complete the Mental Health Volumes Reporting template, which is provided by the Ministry and included with the main quarterly reporting template. (Note: quarterly mental health financial reporting requirements are set out in the OPF.)	Q1, Q2, Q3, Q4.
Delivery of Personal Health Service volumes (Ownership). For Personal Health Services, the DHB must monitor delivery by Purchase Unit (PU) against the target volumes set out in the DAP PVS. Should the DHB identify an under- or over-delivery of greater than 5% against target in any Purchase Unit (PU) during any quarter, the DHB must provide a variance report showing: • Each PU identified as under- or over-delivered by more than 5% during the quarter, with the actual and planned delivery volumes and the resulting variances. • The dollar values of the variance(s). • For surgical PUs, the elective delivery component of any variance. • The reason / s for the variance(s). • How the DHB plans to manage the variance.	Q2, Q4.
Status Updates – Service Changes and Management of Service Risks (Outputs) Each DHB to indicate the status (according to template criteria) of each service change proposal identified in its 2009/10 DAP. Each DHB to indicate the status of the management plan for each service identified as vulnerable as part of the stocktake of vulnerable services conducted in early 2009 or subsequently identified to the Ministry.	Q1, Q2, Q3, Q4.
Introduction of Global Trigger Tool DHBs are to provide a report providing a plan outlining the DHBs plan for the introduction of the global trigger tool methodology leading to an implementation date of 1 January 2010. DHBs are to report on global trigger tool results for the six-month period 1 January 2010 to 30 June 2010.	Q1, Q4

<table>
<tr><th>Reporting Area (and Dimension of DHB Performance)</th><th>Quarter(s) Reporting Due</th></tr>
<tr><td>Post Natal Stays
Each DHB to report confirming that it is:
• Identifying women who meet the clinical criteria set out in the Maternity Facility Service specification who should be offered a longer post natal stay.
• Offering these women a longer post natal stay

Increase in average post natal length of stay for normal vaginal deliveries
<table>
<tr><td>Baseline</td><td>Actual 2008/09</td><td>Target 2009/10</td><td>Target 2010/11</td></tr>
<tr><td></td><td>1.85 days</td><td></td><td></td></tr>
</table></td><td>Q2, Q4</td></tr>
<tr><td>Kick start the shifting of services to primary care
Each DHB to report briefly outlining:
• how secondary care and primary health care clinical leaders are involved in the planning and change management process, how the engagement is occurring, and how agreement will be reached as to services to be shifted and processes to be followed
• which services are to be shifted from secondary care settings to primary care by 1 July 2010
• confirming how the DHB will spend the change management funding over the 2009/10 year .
• once a decision has been made on the service to be shifted, the DHB is to provide an outline summary identifying - a description of the transferred services, the new provider, the setting in which the shifted services will be delivered, and the anticipated date of commencement of the service.</td><td>Q2, Q4</td></tr>
</table>

District Strategic Plan Indicators

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Immunisation.
Percentage of children fully immunised by age two for different ethnic groups.</td><td>Reduced Health Risk: Reduction in vaccine preventable disease

DAP Priority: Primary Health Care
Keeping Our People Well
Maternity, Child and Youth

Output Class: Primary and Community Services</td><td>Refer Health Targets above</td></tr>
<tr><td>Oral Health.
Average number of decayed/missing/filled teeth (DMFT) at year 8 for different ethnic groups.</td><td>Improved access to services: Reduced decayed/missing/filled teeth) in adolescents.

DAP Priority: Maternity,Child & Youth

Output Class: Primary and Community Services</td><td>Refer DHB Indicators of Performance above</td></tr>
<tr><td>Primary Health. Services.
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>Improved access to services:

DAP Priority: Primary Health Care

Output Class: Primary and Community Services</td><td>The ratio of age-standardised rate of General Practitioner consultations per high need person to the age-standardised rate of General Practitioner consultations per non-high need person.
<table>
<tr><td>High need: non high need</td><td>Actual 2008</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr>
<tr><td>Ratio</td><td>1.03</td><td>>1.15</td><td>>1.15</td><td>>1.15</td></tr>
</table>
In 2009/10 we plan to:
Complete an evaluation of the performance of SIA, HP, and additional local funding aimed at improving access and earlier intervention.</td></tr>
</table>

Indicator and Measure	Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)	Baseline data and local targets
Diabetes. Uptake of annual diabetes checks, bi-annual retinal screening and diabetes management for different ethnic groups.	*Earlier Intervention;* Improved management of chronic disease and improved equity between population groups *DAP Priority;* Primary Health Care *Output Class:* Primary and Community Services	*Refer Health Targets above*

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Cancer Screening. Services.
Breast and cervical screening coverage rates for different ethnic groups.</td><td>Earlier Intervention:

DAP Priority:
Primary Health Care

Output Class: Primary and Community Services</td><td>
BreastScreen Central coverage for Hutt Valley residents
<table>
<tr><th>Ethnicity</th><th>Age Group</th><th>Actual Dec 2005</th><th>Actual Dec 2006</th><th>Actual Dec 2007</th><th>Actual Dec 2008</th><th>Target</th></tr>
<tr><td>All</td><td>45-49</td><td>20%</td><td>39%</td><td>45%</td><td>54%</td><td>70%</td></tr>
<tr><td>All</td><td>50-54</td><td>64%</td><td>64%</td><td>69%</td><td>65%</td><td>70%</td></tr>
<tr><td>All</td><td>55-59</td><td>62%</td><td>72%</td><td>75%</td><td>76%</td><td>70%</td></tr>
<tr><td>All</td><td>60-64</td><td>66%</td><td>75%</td><td>74%</td><td>75%</td><td>70%</td></tr>
<tr><td>All</td><td>65-69</td><td>56%</td><td>64%</td><td>70%</td><td>77%</td><td>70%</td></tr>
<tr><td>All</td><td>45-69</td><td>51%</td><td>60%</td><td>64%</td><td>67%</td><td>70%</td></tr>
<tr><td>Māori</td><td>45-69</td><td>35%</td><td>42%</td><td>48%</td><td>56%</td><td>70%</td></tr>
<tr><td>Pacific</td><td>45-69</td><td>28%</td><td>36%</td><td>44%</td><td>50%</td><td>70%</td></tr>
</table>
Cervical Screening coverage (hysterectomy adjusted) for Hutt Valley residents
<table>
<tr><th>Ethnicity</th><th>Age Group</th><th>Actual July 2006</th><th>Actual Dec 2006</th><th>Actual Dec 2007</th><th>Actual Aug 2008</th><th>Target</th></tr>
<tr><td>All</td><td>20-24</td><td>57%</td><td>58%</td><td>n/a</td><td>60%</td><td>78%</td></tr>
<tr><td>All</td><td>25-29</td><td>67%</td><td>69%</td><td>n/a</td><td>75%</td><td>78%</td></tr>
<tr><td>All</td><td>30-34</td><td>69%</td><td>71%</td><td>n/a</td><td>73%</td><td>78%</td></tr>
<tr><td>All</td><td>35-39</td><td>71%</td><td>71%</td><td>n/a</td><td>79%</td><td>78%</td></tr>
<tr><td>All</td><td>40-44</td><td>69%</td><td>72%</td><td>n/a</td><td>77%</td><td>78%</td></tr>
<tr><td>All</td><td>45-49</td><td>75%</td><td>76%</td><td>n/a</td><td>79%</td><td>78%</td></tr>
<tr><td>All</td><td>50-54</td><td>74%</td><td>77%</td><td>n/a</td><td>82%</td><td>78%</td></tr>
<tr><td>All</td><td>55-59</td><td>73%</td><td>72%</td><td>n/a</td><td>77%</td><td>78%</td></tr>
<tr><td>All</td><td>60-64</td><td>76%</td><td>71%</td><td>n/a</td><td>76%</td><td>78%</td></tr>
<tr><td>All</td><td>65-69</td><td>69%</td><td>68%</td><td>n/a</td><td>69%</td><td>78%</td></tr>
<tr><td>All</td><td>20-69</td><td>70%</td><td>71%</td><td>71.8%</td><td>75%</td><td>78%</td></tr>
<tr><td>Māori</td><td>20-69</td><td>51%</td><td>52%</td><td>n/a</td><td>59%</td><td>78%</td></tr>
<tr><td>Pacific</td><td>20-69</td><td>40%</td><td>43%</td><td>n/a</td><td>52%</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>64%</td><td>78%</td></tr>
<tr><td>Other</td><td>20-69</td><td>76%</td><td>80%</td><td>n/a</td><td>83%</td><td>78%</td></tr>
</table>
In 2009/10 we plan to:

Implement digital mammography for breast cancer screening
Work with PHOs, Mana Wahine and Te Runanga O Taranaki Whanui to continue the improvement in our cancer screening rates for Māori and Pacific women
Continue to support the national cervical screening programme register data input on behalf of the National Screening Unit.

</td></tr>
</table>

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Mental Health Services. Services.
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>Improved access to services

DAP Priority:
Primary Health Care
Keeping Our People Well

Output Class: Primary and Community Services</td><td>Refer POP-06 above</td></tr>
<tr><td>Information.
Percentage of primary care referrals and hospital discharges done electronically for different services.</td><td>Better Service Integration

DAP Priority:
Improving infrastructure</td><td>Electronic discharges and referrals
<table>
<tr><th rowspan="2">Service</th><th colspan="4">Discharges</th><th colspan="4">Referrals</th></tr>
<tr><th>2006</th><th>2007</th><th>2008</th><th>2009</th><th>2006</th><th>2007</th><th>2008</th><th>2009</th></tr>
<tr><td>Dental</td><td>57%</td><td>91%</td><td>85%</td><td></td><td>0%</td><td>n/a%</td><td>0%</td><td></td></tr>
<tr><td>Specialist Rehabilitation</td><td>99%</td><td>100%</td><td>90%</td><td></td><td>0%</td><td>n/a%</td><td>36%</td><td></td></tr>
<tr><td>Mental Health</td><td>84%</td><td>75%</td><td>86%</td><td></td><td>0%</td><td>n/a%</td><td>N/a</td><td></td></tr>
<tr><td>Gynaecology</td><td>81%</td><td>83%</td><td>50%</td><td></td><td>0%</td><td>15%</td><td>84%</td><td></td></tr>
<tr><td>Rheumatology</td><td>100%</td><td>100%</td><td>100%</td><td></td><td>0%</td><td>6%</td><td>21%</td><td></td></tr>
<tr><td>Emergency</td><td>51%</td><td>65%</td><td>72%</td><td></td><td>n/a</td><td>n/a</td><td>N/a</td><td></td></tr>
<tr><td>Ear, Nose and Throat</td><td>86%</td><td>67%</td><td>81%</td><td></td><td>0%</td><td>13%</td><td>66%</td><td></td></tr>
<tr><td>Orthopaedics</td><td>89%</td><td>87%</td><td>87%</td><td></td><td>0%</td><td>17%</td><td>90%</td><td></td></tr>
<tr><td>Cardiology</td><td>99%</td><td>98%</td><td>97%</td><td></td><td>0%</td><td>8%</td><td>59%</td><td></td></tr>
<tr><td>General Surgery</td><td>91%</td><td>82%</td><td>86%</td><td></td><td>0%</td><td>8%</td><td>65%</td><td></td></tr>
<tr><td>Obstetrics</td><td>62%</td><td>61%</td><td>49%</td><td></td><td>0%</td><td>26%</td><td>59%</td><td></td></tr>
<tr><td>Paediatric Medicine</td><td>99%</td><td>98%</td><td>98%</td><td></td><td>0%</td><td>12%</td><td>64%</td><td></td></tr>
<tr><td>Plastics and Burns</td><td>97%</td><td>94%</td><td>88%</td><td></td><td>0%</td><td>4%</td><td>26%</td><td></td></tr>
<tr><td>General Medicine</td><td>98%</td><td>98%</td><td>99%</td><td></td><td>0%</td><td>12%</td><td>75%</td><td></td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Workforce.
Ratio of Full-Time Equivalent General Practitioners (GPs) and Practice Nurses (PNs) to the population.
Note: GP figures exclude training Registrars but include locums. PN figures exclude Nurse Graduate programme nurses.</td><td>Improved access to services; assisting primary care to develop its workforce.

DAP Priority:
Primary Health Care

Output Class: Primary and Community Services</td><td>General Practitioner and Practice Nurse population ratios.
<table>
<tr><td></td><td>Actual Feb 2008</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr>
<tr><td># GPs</td><td>103</td><td></td><td></td><td></td></tr>
<tr><td>FTE GPs</td><td>66.1</td><td></td><td></td><td></td></tr>
<tr><td># PNs</td><td>92</td><td></td><td></td><td></td></tr>
<tr><td>FTE PNs</td><td>62.6</td><td></td><td></td><td></td></tr>
<tr><td>Population</td><td>141,400</td><td></td><td></td><td></td></tr>
<tr><td>Population per GP</td><td>2,139</td><td><1,850</td><td><1,850</td><td><1,850</td></tr>
<tr><td>Population per PN</td><td>2,259</td><td><2,775</td><td><2,775</td><td><2,775</td></tr>
</table>
In 2009/10 we plan to:
• Continue workforce expansion programmes – GP Registrar, summer studentship, and primary care nursing development.</td></tr>
<tr><td>Physical Activity.
Proportion of population using active modes of transport (walking or cycling) for trips shorter than 2 kilometres.</td><td>Reduced Health Risk: Working intersectorally to improve coordination and collaboration across agencies to support physical activity.

DAP Priority:
Keeping Our People Well

Output Class: Public Health Services</td><td>The Greater Wellington Regional Council (GRWC) has targets to increase walking and cycling for short trips and conducts surveys to measure this. Hutt Valley DHB supports GWRC targets.
<table>
<tr><td>GRWC survey data for active modes of transport</td><td>Actual2004</td><td>Actual 2006</td><td>GWRC Target 2016</td></tr>
<tr><td>0-1 kilometre</td><td>74%</td><td>74%</td><td>80%</td></tr>
<tr><td>1-2 kilometre</td><td>19%</td><td>27%</td><td>60%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Hospital Performance.
Proportion of day cases discharges.</td><td>More efficient and effective services:
Through increasing proportions of day cases by maximising the effective use of day-case surgery.

DAP Priority: Electives

Output Class: Hospital Services</td><td>Day Case Percentages
<table>
<tr><th></th><th>Actual 2004/05</th><th>Actual 2005/06</th><th>Actual 2006/07</th><th>Actual 2007/08</th><th>YTD Actual Apr 2008/09</th><th>Target 2009/10</th></tr>
<tr><td>Day Case Discharges</td><td>9,349</td><td>9,397</td><td>9,079</td><td>9164</td><td>8166</td><td>9539</td></tr>
<tr><td>Total Discharges</td><td>26,592</td><td>26,633</td><td>26,351</td><td>26931</td><td>22833</td><td>26157</td></tr>
<tr><td>Percent Day Cases</td><td>35%</td><td>35%</td><td>34%</td><td>34%</td><td>36%</td><td>36%</td></tr>
</table>

The target for 2009/10 is to increase the day surgery rate for five specific procedures. This target is consistent with the New Zealand Chief Operating Officers' priorities based on the data available through the Australian Health Round Table.

Day Surgery Rates
<table>
<tr><th></th><th>Dupuytrens</th><th>Tonsillectomy</th><th>Laparoscopic Cholecystectomy</th><th>Primary Repair Inguinal hernia</th><th>Septoplasty</th></tr>
<tr><td>Hutt DHB</td><td>57%</td><td>41%</td><td>2%</td><td>56%</td><td>39%</td></tr>
<tr><td>NZ National</td><td>64%</td><td>44%</td><td>5%</td><td>57%</td><td>28%</td></tr>
<tr><td>BADS</td><td>95%</td><td>80%</td><td>50%</td><td>95%</td><td>60%</td></tr>
<tr><td>Hutt DHB 2009/10 Target</td><td>66%</td><td>56%</td><td>20%</td><td>66%</td><td>42%</td></tr>
</table>

In 2009/10 we plan to:
• Progress construction of clip-on theatres
• Implement improvements identified from the Improving Patient Experience Programme projects.</td></tr>
</table>

DHB District Annual Plan Measures

In addition to the Health Targets, the DSP Indicators, and the Indicators of DHB Performance (IDPs) and additional Ministry of Health reporting requirements, the DHB will measure performance against the following indicators.

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Control of infectious diseases
The number of outbreaks of infectious diseases managed in accordance with public health service specifications and statutory and regulatory requirements.</td><td>Enhanced health protection

DAP Priority:
Keeping our people well

Output Class: Public Health Services</td><td>Health protection services include maintaining important environmental health controls (regulatory education) including for food safety, water and physical and border health.

<table><tr><td></td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr><tr><td>Outbreaks managed in accordance with public health requirements</td><td>100%</td><td>100%</td><td>100%</td></tr></table>
In 2009/10 we plan to continue our intersectoral work to implement programmes in high needs communities focusing on TB, Rheumatic Fever, and pandemic preparedness.</td></tr>
<tr><td>Number of Year 7 children (cohort) vaccinated in Schools in the Hutt District
Number of students fully vaccinated in the school year by Regional Public Health (RPH).</td><td>Reduced Health Risk

DAP Priority:
Keeping our people well

Output Class: Public Health Services</td><td>Number of Year 7 children vaccinated in a school year by Regional Public Health (children consenting to be vaccinated at School)

<table><tr><td></td><td>Baseline[44] Actual 2008</td><td>Target 2009</td><td>Target 2010</td><td>Target 2011</td></tr><tr><td>% of overall school year 7 roll vaccinated by RFP</td><td>77.1% (1496)</td><td>77.2%</td><td>77.5%</td><td>78%</td></tr><tr><td>% of year 7 children consenting to be vaccinated at School and where vaccination delivered by RPH</td><td>97.50%</td><td>97.50%</td><td>97.50%</td><td>98%</td></tr></table></td></tr>
</table>

[44] Based on calendar year (school year)

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Homes with adequate insulation and heating
Number of homes assessed</td><td>Reduced Health Risk

DAP Priority:
Keeping our people well

Output Class: Public Health Services</td><td>Insulating homes is a cost effective way to reduce the incidence of respiratory and other related illnesses and reduce the use of health services.

Number of homes assessed
<table>
<tr><td>Baseline</td><td>Target 2008/09</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr>
<tr><td></td><td>170</td><td>150</td><td></td><td></td></tr>
</table>
Funding commitments have only been made to the end of the 2009/10 year.

In 2009/10 we plan to:
• Provide support for housing insulation activities as part of the Hutt Valley DHB Healthy Homes, Healthy People programme.
• Fund public health nurse assessments for Housing NZ’s Healthy Housing programme.
• Work to increase the number of Maori and Pacific homes improved through the Healthy Housing programme.
• Provide public health input to the Hutt Housing Forum, development of healthy public policy for housing, development of strategic transport policies and plans, identification of health impacts of urban design, and Safer Communities interagency work.</td></tr>
<tr><td>HPV Vaccinations</td><td>Reduced Health Risk

DAP Priority:
Maternity, Child & Youth

Output Class: Public Health Services</td><td>Number of HPV Vaccinations provided
<table>
<tr><td>Baseline</td><td>Target 2008/09</td><td>Target 2009</td><td>Target 2010</td><td>Target 2011</td></tr>
<tr><td></td><td>2850</td><td>7125</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>ICU Transfers
Less than 5% of patients transferred to other ICUs due to lack of beds.</td><td>Improved access to services

DAP Priority:
Hospital Services

Output Class: Hospital Services</td><td>Percentage of patients transferred to other ICUs due to lack of beds
<table>
<tr><td>Baseline</td><td>Actual 2008/09</td><td>Target 2009/10</td><td>Target 2010/11</td></tr>
<tr><td></td><td></td><td>< 5%</td><td>< 5%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>First Specialist Assessments
Increase by 5%</td><td>Improved access to services

DAP Priority:
Elective Services

Output Class: Hospital Services</td><td>Percentage increase in First Specialist Assessments<table><tr><td>Baseline</td><td>Actual 2008/09</td><td>Target 2009/10</td><td>Target 2010/11</td></tr><tr><td></td><td></td><td>> 5% increase</td><td>> 5% increase</td></tr></table></td></tr>
<tr><td>Hospital based follow-up appointments
Improve discharge communication with primary care and reduce unnecessary hospital based follow-up appointments</td><td>Improved access to services

DAP Priority:
Hospital Services

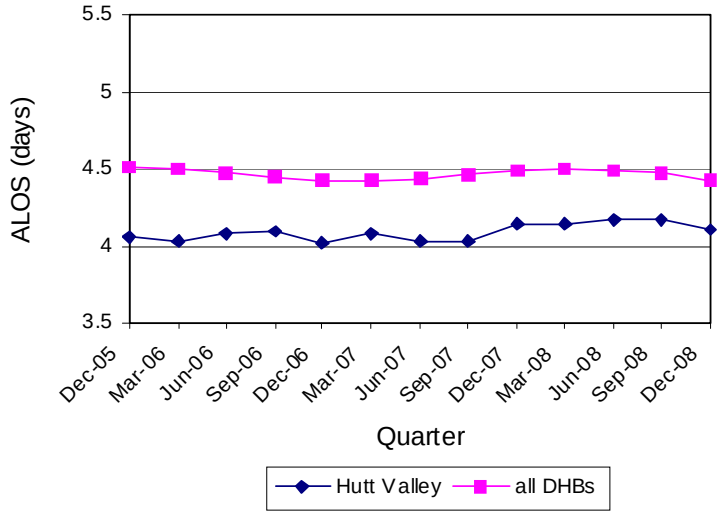
Output Class: Hospital Services</td><td>Reduction in average number of hospital based follow-up appointments</td></tr>
<tr><td>Improving access for youth to health services
Number of youth accessing school based services</td><td>Improved access to services

DAP Priority:
Maternity, Child & Youth

Output Class: Primary and Community Services</td><td>Number of youth accessing school based services</td></tr>
<tr><td>Before School Checks
Number of Before School Checks completed</td><td>Earlier Intervention

DAP Priority:
Maternity, Child & Youth

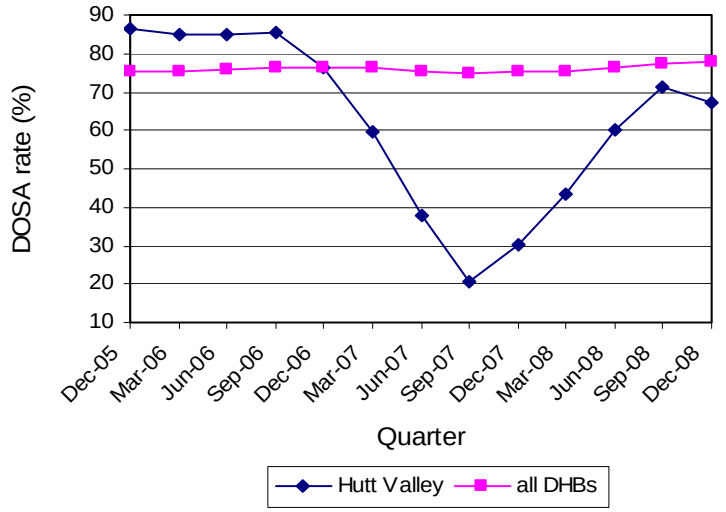
Output Class: Primary and Community Services</td><td>Number of before school checks completed<table><tr><td></td><td>Target 2008/09</td><td>Target 2009/10</td><td>Target 2010/11</td><td>Target 2011/12</td></tr><tr><td>Number of checks</td><td>1031</td><td>2000</td><td></td><td></td></tr></table></td></tr>
</table>

Indicator and Measure	Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)	Baseline data and local targets
Average length of stay	*Better service integration* *DAP Priority:* Hospital Services *Output Class:* Hospital Services	ALOS against time for Hutt Valley DHB hospital over the last three years compared with DHBs nationwide over the same period. Results are presented as a four quarter rolling average. (Hospital Benchmarking Report Quarter 2 to December 2008) 
Long term conditions Reduction in duplicated visits for patients with long term conditions	*Better Service Integration* *DAP Priority:* Hospital Services *Output Class:* Hospital Services	Reduction in duplicated visits for patients with long term conditions

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Day of Surgery Admission</td><td>More efficient and effective services

DAP Priority:
Hospital Services

Output Class: Hospital Services</td><td>DOSA rate against time for Hutt Valley DHB hospital over the last three years compared to the DOSA rate for all DHBs nationwide over the same period. Results are presented as a four quarter rolling average. The recent dip in DOSA stemmed from an error in information reporting from Hutt Valley DHB. This error has been corrected from the December 2007 quarter onwards. (Hospital Benchmarking Report Quarter 2 to December 2008)

The aim is to increase the Day of Surgery Admission rate. The DHB has benchmarked the DOSA rate for each surgical speciality against the New Zealand Rate and a 2009/10 DOSA target has been set for each speciality.

<table>
<tr><th>Speciality</th><th>HVDHB current</th><th>Benchmark</th><th>Target</th></tr>
<tr><td>ENT</td><td>84%</td><td>90%</td><td>85%</td></tr>
<tr><td>General Surgery</td><td>66%</td><td>76%</td><td>70%</td></tr>
<tr><td>Gynaecology</td><td>81%</td><td>87%</td><td>85%</td></tr>
<tr><td>Orthopaedics</td><td>44%</td><td>76%</td><td>60%</td></tr>
<tr><td>Plastics</td><td>50%</td><td>66%</td><td>60%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Day of Surgery Cancellation</td><td>More efficient and effective services

DAP Priority:
Hospital Services

Output Class: Hospital Services</td><td>Day of Surgery Cancellations: The aim is to reduce the number of preventable day of surgery cancellations.
The 2009/10 target is a 30% reduction on the 2008/9 incidence of these cancellations as shown in the table below.

<table>
<tr><th>Cancellation Reason</th><th>Number 2008/09*</th><th>% Reduction</th><th>Target Number 2009/10</th></tr>
<tr><td>Total</td><td>221</td><td>30%</td><td>155</td></tr>
</table>

*A record of Day of Surgery cancellations has only been accurately recorded since July 2008. This figure is an extrapolation of the July 08 – April 09 actual.</td></tr>
<tr><td>Mental Health Services – hospital utilisation</td><td>More efficient and effective services

DAP Priority:
Mental Health Services

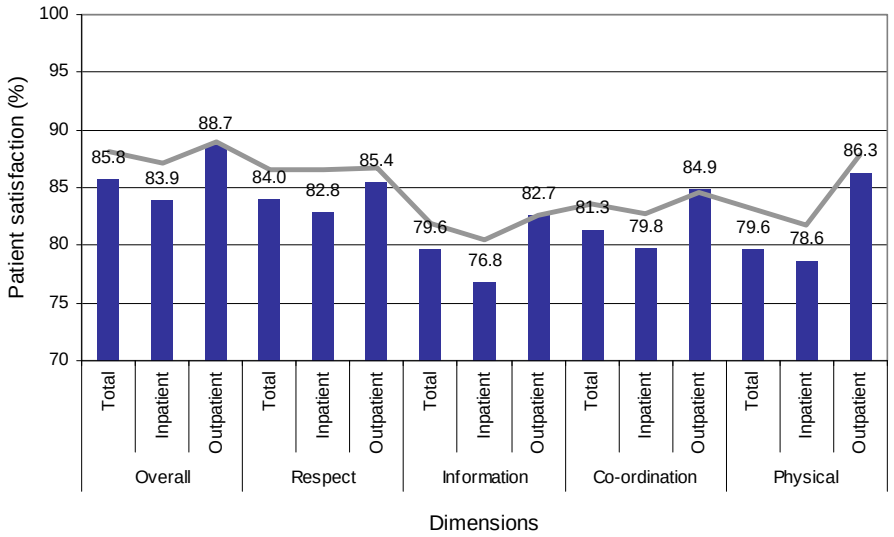
Output Class: Hospital Services</td><td>Hospital bed utilisation targets will be met in accordance with service plans.</td></tr>
<tr><td>Mental Health Services – residential bed utilisation</td><td>More efficient and effective services

DAP Priority:
Mental Health Services

Output Class: Primary and Community Services</td><td>Residential bed utilisation targets will be met in accordance with contract requirements.</td></tr>
<tr><td>Mental Health Services – community support services utilisation</td><td>More efficient and effective services

DAP Priority:
Mental Health Services

Output Class: Primary and Community Services</td><td>Community support services utilisation targets will be met in accordance with contract requirements.</td></tr>
</table>

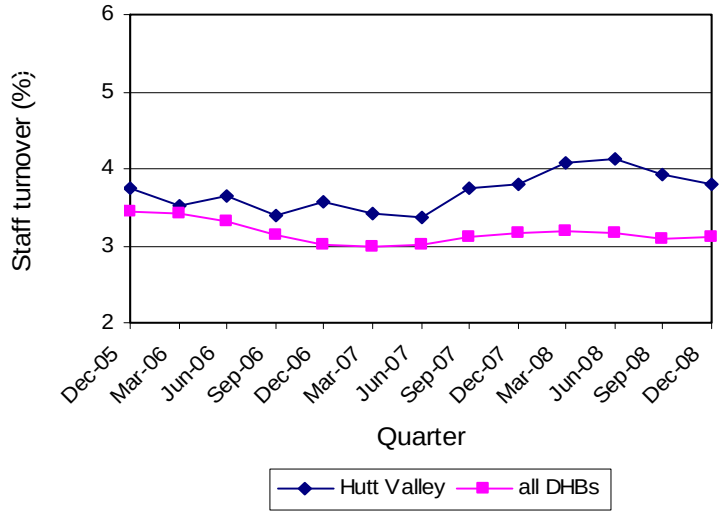
Indicator and Measure	Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)	Baseline data and local targets
Mental Health Services – respite services utilisation	*More efficient and effective services* *DAP Priority:* Mental Health Services *Output Class:* Primary and Community Services	Respite services utilisation targets will be met in accordance with contract requirements.
Mental Health Services – regional services utilisation	*More efficient and effective services* *DAP Priority:* Mental Health Services *Output Class:* Primary and Community Services	Regional services utilisation targets will be met in accordance with contract requirements.
Patient satisfaction	*High quality and safe services* *DAP Priority:* Hospital Services *Output Class:* Hospital Services	Overall patient satisfaction, as well as patient satisfaction across four dimensions of care, for the Hutt Valley DHB hospital. Total results are broken down into inpatient and outpatient populations, and displayed as bars with appended numerical results. National figures across the equivalent categories are denoted by the grey line. (Hospital Benchmarking Report Quarter 2 to December 2008) 

Indicator and Measure	Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)	Baseline data and local targets
Provider audits	*High quality and safe services* *DAP Priority:* Older Peoples Health Services, Mental Health Services *Output Class:* Primary and Community Services, Support Services	Provider audits are carried in accordance with the Hutt Valley DHB Planning and Funding Audit Programme.
Redevelopment Plan	*Improved infrastructure* *DAP Priority:* Hospital Services *Output Class:* Hospital Services	Business case targets and plan milestones will be met for the redevelopment of the Hutt Hospital campus – Theatre and ED development

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Staff Retention</td><td>Improved infrastructure

DAP Priority:
Hospital Services

Output Class: Hospital Services</td><td>Staff turnover against time for the Hutt Valley DHB hospital over the last three years. Also shown is the staff turnover rate for all DHBs nationwide over the same period. Results are presented as a four quarter rolling average. (Hospital Benchmarking Report Quarter 2 to December 2008)

 
</td></tr>
<tr><td>Aged residential bed utilisation targets
Utilisation of aged residential care services by older persons</td><td>Sustainable services

DAP Priority: Older peoples health services

Output Class: Support services</td><td>Number of subsidised beddays
<table><tr><th></th><th>Actual 2007/08</th><th>Budget 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr><tr><td>Total</td><td>306,260</td><td>304,339</td><td>305,244</td><td>306,393</td><td>312,751</td></tr></table>In 2009/10 we plan to:
Improve our monitoring of service utilisation and client outcomes across community, primary, secondary and long term support services, including the length of time to transfer older people from the provider arm to residential care.
Continue to manage entry to long -term aged residential care services by working closely with the augmented Needs Assessment and Service Coordination (NASC) service and other agencies within a developmental model.</td></tr>
</table>

<table>
<tr><th>Indicator and Measure</th><th>Linkage to DAP Planning Outcomes and Priority Areas and Output Classes (SOI)</th><th>Baseline data and local targets</th></tr>
<tr><td>Home based support utilisation
Utilisation of home based support services by older persons</td><td>Sustainable services

DAP Priority: Older peoples health services

Output Class: Support services</td><td>Number of home based support service hours
<table><tr><th></th><th>Actual 2007/08</th><th>Budget 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th><th>Target 2011/12</th></tr><tr><td>Total</td><td>265,020</td><td>251,160</td><td>329,006</td><td>345,563</td><td>371,298</td></tr></table>
In 2009/10 we plan to:
Develop a model for improving the range of services in the community to support older people with low to medium mental health needs, and identify potential providers.
For older people assessed with ‘low needs’ improve access to a wider range of community support services options in a collaborative model across the community, health and other sectors eg MSD.</td></tr>
<tr><td>Respite Care Services
Utilisation of respite beds by older persons</td><td>Sustainable services

DAP Priority: Older peoples health services

Output Class: Support services</td><td>Respite service utilisation targets will be met in accordance with contract requirements.

In 2009/10 we plan to:
Improve access to respite services by developing and implement an evidence based respite programme for older people and their carers.</td></tr>
<tr><td>Utilisation of Community Support Services
Utilisation of community support services by older persons</td><td>Sustainable services

DAP Priority: Older peoples health services

Output Class: Support services</td><td>Number of assessments for restorative services completed in last 12 months

In 2009/10 we plan to:
For older people assessed with ‘low needs’ improve access to a wider range of community support services options in a collaborative model across the community, health and other sectors eg MSD.</td></tr>
</table>

Appendix 5: Forecast Financial Statements

Financial Performance

Hutt Valley District Health Board
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Revenue					
Revenue	362,363	390,848	422,469	436,904	449,321
Interest Revenue	1,469	859	504	336	150
Total Revenue	**363,832**	**391,707**	**422,973**	**437,240**	**449,471**
Expenditure					
Provider Expenditure	(192,442)	(204,130)	(218,453)	(226,209)	(231,339)
Operating Expenditure	(165,882)	(180,670)	(193,386)	(198,339)	(200,769)
Depreciation	(7,544)	(8,069)	(9,387)	(9,673)	(11,628)
Interest Expense	(1,222)	(1,255)	(1,566)	(1,640)	(1,644)
Capital Charge	(6,163)	(5,469)	(4,788)	(4,373)	(4,087)
Total Expenditure	**(373,253)**	**(399,593)**	**(427,580)**	**(440,234)**	**(449,467)**
Net Surplus/(Deficit)	**(9,421)**	**(7,886)**	**(4,607)**	**(2,994)**	**4**
Gain/(Loss) on Sale of Assets	(7)	(8)	-	-	-
Retained Earnings	**(9,428)**	**(7,894)**	**(4,607)**	**(2,994)**	**4**

DHB Provider
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Revenue					
Revenue	166,236	185,963	204,095	210,744	215,454
Interest Revenue	607	859	504	336	150
Total Revenue	**166,843**	**186,822**	**204,599**	**211,080**	**215,604**
Operating Expenditure	(163,159)	(178,145)	(190,840)	(195,562)	(198,084)
Depreciation	(7,540)	(8,065)	(9,387)	(9,671)	(11,626)
Interest Expense	(1,222)	(1,255)	(1,566)	(1,640)	(1,644)
Capital Charge	(6,163)	(5,469)	(4,788)	(4,373)	(4,087)
Internal Allocations	454	552	544	558	573
Total Expenditure	**(177,630)**	**(192,382)**	**(206,037)**	**(210,688)**	**(214,868)**
Net Surplus/(Deficit)	**(10,787)**	**(5,560)**	**(1,438)**	**392**	**736**
Gain/(Loss) on Sale of Assets	(7)	(8)	-	-	-
Net Surplus/(Deficit)	**(10,794)**	**(5,568)**	**(1,438)**	**392**	**736**
Expenditure Breakdown:					
Personnel Costs	(120,266)	(131,712)	(142,280)	(146,141)	(152,724)
Outsourced Services	(7,732)	(8,150)	(4,733)	(4,330)	(2,623)
Clinical Supplies	(21,878)	(23,639)	(24,962)	(26,205)	(28,499)
Infrastructure and Non-Clinical Supplies	(28,208)	(29,433)	(34,606)	(34,570)	(31,595)
Internal Allocations	454	552	544	558	573
Total Expenditure	**(177,630)**	**(192,382)**	**(206,037)**	**(210,688)**	**(214,868)**

DHB Governance & Administration
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Revenue					
Revenue	2,282	3,126	3,090	3,337	3,260
Interest Revenue	862	-	-	-	-
Total Revenue	**3,144**	**3,126**	**3,090**	**3,337**	**3,260**
Expenditure					
Operating Expenditure	(2,723)	(2,525)	(2,546)	(2,777)	(2,685)
Depreciation	(4)	(4)	-	(2)	(2)
Internal Allocations	(454)	(552)	(544)	(558)	(573)
Total Expenditure	**(3,181)**	**(3,081)**	**(3,090)**	**(3,337)**	**(3,260)**
Net Surplus/(Deficit)	**(37)**	**44**	**-**	**-**	**-**
Expenditure Breakdown:					
Personnel Costs	(1,717)	(1,667)	(1,609)	(1,651)	(1,695)
Outsourced Services	(299)	(360)	(433)	(444)	(456)
Clinical Supplies	(2)	(1)	-	(1)	(1)
Infrastructure and Non-Clinical Supplies	(709)	(502)	(504)	(683)	(535)
Internal Allocations	(454)	(552)	(544)	(558)	(573)
Total Expenditure	**(3,181)**	**(3,081)**	**(3,090)**	**(3,337)**	**(3,260)**

DHB Fund
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Revenue					
Revenue	331,691	356,362	380,643	394,063	407,816
Total Revenue	**331,691**	**356,362**	**380,643**	**394,063**	**407,816**
Expenditure					
Provider Expenditure	(330,288)	(358,733)	(383,812)	(397,449)	(408,548)
Total Expenditure	**(330,288)**	**(358,733)**	**(383,812)**	**(397,449)**	**(408,548)**
Net Surplus/(Deficit)	**1,403**	**(2,371)**	**(3,169)**	**(3,386)**	**(732)**
Expenditure Breakdown:					
Personal Health	(245,840)	(268,311)	(289,681)	(300,406)	(309,287)
Mental Health	(37,145)	(40,010)	(41,065)	(42,461)	(43,897)
DSS	(42,716)	(45,068)	(47,677)	(48,828)	(49,564)
Public Health	(389)	(127)	(50)	(51)	(53)
Maori Health	(2,012)	(2,207)	(2,369)	(2,488)	(2,613)
Internal Allocations	(2,186)	(3,010)	(2,970)	(3,215)	(3,134)
Total Expenditure	**(330,288)**	**(358,733)**	**(383,812)**	**(397,449)**	**(408,548)**

Movements in Equity

Hutt Valley District Health Board
Forecast Statement of Movements in Equity
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Crown Equity	28,020	27,813	27,606	27,399	27,192
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings at Beginning of Period	(647)	(10,075)	(17,969)	(22,576)	(25,570)
Net Surplus / (Deficit) for the Period	(9,428)	(7,894)	(4,607)	(2,994)	4
Closing Equity	**68,313**	**60,212**	**55,398**	**52,197**	**51,994**

Financial Position

Hutt Valley District Health Board
Forecast Statement of Financial Position
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Public Equity					
Equity	28,020	27,813	27,606	27,399	27,192
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings	(10,075)	(17,969)	(22,576)	(25,570)	(25,566)
Total Equity	**68,313**	**60,212**	**55,398**	**52,197**	**51,994**
Represented by:					
Current Assets					
Bank in Funds	8,486	2,794	6	6	6
Receivables and Prepayments	13,943	18,429	18,428	18,429	18,429
Inventories	1,195	1,517	1,517	1,517	1,517
Total Current Assets	**23,624**	**22,740**	**19,951**	**19,952**	**19,952**
Current Liabilities					
Bank Overdraft	-	-	(604)	(2,822)	(1,933)
Payables and Provisions	(51,032)	(58,605)	(63,874)	(65,227)	(63,583)
Short Term Borrowings	-	-	-	-	-
Total Current Liabilities	**(51,032)**	**(58,605)**	**(64,478)**	**(68,049)**	**(65,516)**
Net Working Capital	**(27,408)**	**(35,865)**	**(44,527)**	**(48,097)**	**(45,564)**
Non Current Assets					
Property, Plant and Equipment	116,180	121,082	139,629	168,899	185,563
Trust Funds	848	798	798	798	798
Total Non Current Assets	**117,028**	**121,880**	**140,427**	**169,697**	**186,361**
Non Current Liabilities					
Borrowings and Provisions	(20,459)	(25,005)	(39,705)	(68,605)	(88,005)
Trust Funds	(848)	(798)	(798)	(798)	(798)
Total Non Current Liabilities	**(21,307)**	**(25,803)**	**(40,503)**	**(69,403)**	**(88,803)**
Net Assets	**68,313**	**60,212**	**55,397**	**52,197**	**51,994**

Cash Flow

Hutt Valley District Health Board
Forecast Statement of Cash Flows
For the Year Ended 30 June

$000s	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Operating Cash Flows					
Cash Receipts	364,749	391,748	422,973	437,240	449,471
Payments to Providers and Suppliers	(235,957)	(248,527)	(266,419)	(276,220)	(280,502)
Payments to Employees	(118,390)	(134,548)	(141,840)	(147,792)	(154,419)
Interest Paid	(1,174)	(1,255)	(1,380)	(1,390)	(1,394)
Capital Charge Paid	(6,878)	(5,469)	(4,788)	(4,373)	(4,087)
Net Operating Cash Flows	**2,350**	**1,949**	**8,546**	**7,465**	**9,069**
Investing Cash Flows					
Cash Received from Sale of Fixed Assets	-	-	-	-	-
Cash Paid for Purchase of Fixed Assets	(7,454)	(13,293)	(27,935)	(39,712)	(27,523)
Interest Received	1,469	859	504	336	150
Net Investing Cash Flows	**(5,985)**	**(12,434)**	**(27,431)**	**(39,376)**	**(27,373)**
Financing Cash Flows					
Equity Injections	-	-	-	-	-
Additional Loans Drawn	-	5,000	15,700	29,900	19,400
Loans Repaid	(2)	-	-	-	-
Net Financing Cash Flows	**(2)**	**5,000**	**15,700**	**29,900**	**19,400**
Equity Movement					
Other equity movement	**(207)**	**(207)**	**(207)**	**(207)**	**(207)**
Equity Movement	**(207)**	**(207)**	**(207)**	**(207)**	**(207)**
Net Cash Flows	**(3,844)**	**(5,692)**	**(3,392)**	**(2,218)**	**889**
Opening Cash Balance	12,330	8,486	2,794	(598)	(2,816)
Closing Cash Balance	**8,486**	**2,794**	**(598)**	**(2,816)**	**(1,927)**
Represented by:					
Bank in Funds	8,486	2,794	6	6	6
Bank Overdraft	-	-	(604)	(2,822)	(1,933)
Total Cash On Hand	**8,486**	**2,794**	**(598)**	**(2,816)**	**(1,927)**

FTEs

DHB Provider
FTEs by Class
For the Year Ended 30 June

	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Medical	197	213	217	222	227
Nursing	688	711	723	721	731
Allied Health	376	395	421	423	451
Non-Allied Health	93	105	122	123	134
Management/Clerical	312	342	374	372	365
Total FTEs	**1,666**	**1,766**	**1,857**	**1,861**	**1,908**

DHB Governance & Administration
FTEs by Class
For The Year Ended 30 June

	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Management/Clerical	20	19	18	18	18
Total FTEs	**20**	**19**	**18**	**18**	**18**

Hutt Valley District Health Board
FTEs by Class
For the Year Ended 30 June

	2007/08 Audited Actual	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Medical	197	213	217	222	227
Nursing	688	711	723	721	731
Allied Health	376	395	421	423	451
Non-Allied Health	93	105	122	123	134
Management/Clerical	332	387 *	392	390	383
Total FTEs	**1,686**	**1,811**	**1,875**	**1,879**	**1,926**

* FTEs at end of year (not average)

Appendix 6: Revenue Reconciliation

2009/10 DAP Revenue Reconciliation Version 11.0

Hutt Valley DHB

DHB FUNDS AND DHB PROVIDER

TOTAL FUNDS AND PROVIDER REVENUE LINES MUST AGREE TO THE DAP FINANCIAL TEMPLATE
GST EXCLUSIVE
NOTE: All elective funding MUST be included in the DHB Funds arm.
Add Lines as Necessary

DHB FUNDS	Service Area Code	Account Code	2009/10 Plan
PBF Vote Health			
Mental Health Ringfence	20	1004	-34,218
Funding Package (excluding Mental Health Ringfence)	20	1005	-274,615
PBF Adjustments	20	1085	-9,143
MOH - Funding Subcontracts	20	1086	-1,761
MOH Devolved Funding	20	1002	(319,737)
IDF inflows - Mental Health services	20	991	-6,847
IDF inflows - all other (excluding Mental Health)	20	992	-53,623
Inter-District Flows	20	1552	(60,470)
TOTAL DHB FUNDS REVENUE FROM MOH			(380,207)
FUNDING ENVELOPE ADVISED BY MOH			**-368,827**
VARIANCE			(11,380)
FULL BREAKDOWN OF VARIANCE: *(Add lines as necessary)*			
Hutt DHB Share of Electives Initiative Funding			**-6,411**
PHO Recovery of PMP, Care Plus and other programme costs			**-2,541**
MeNZB and HPV Vaccine Recovery			**-241**
Recovery of NRT costs			**-140**
B4SC Revenue			**-139**
Primary Mental Health Initiatives			**-738**
IDF Inflow - Difference between December funding envelope and final IDFs			**-341**
IDF Inflows - Service Changes not included in funding envelope			**-143**
EXPLAINED			(11,380)
UNEXPLAINED			-

DHB PROVIDER	Service Area Code	Account Code	2009/10 Plan
MOH Non-Devolved Contracts (Provider arm side contracts)			
Personal Health	10	1102	-15,847
Mental Health	10	1202	0
Public Health	10	1302	-8,947
Disability Support Services (Under 65s)	10	1402	-1,465
Maori Health	10	1502	0
Clinical Training Agency	10	1550	-3,026
Total MOH Non-Devolved Contracts	10	1101	(29,285)

Appendix 7: Statement of Accounting Policies

Reporting Entity
Hutt Valley District Health Board (HVDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. HVDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. HVDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004

HVDHB is a public benefit entity, as defined under NZIAS 1. HVDHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

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

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

The accounting policies set out below have been applied consistently to all periods.

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

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

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

Budgets
The budget figures are those approved by the Health Board in its District Annual Plan and included in the Statement of Intent as tabled in Parliament. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZ IFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Hutt Valley District Health Board for the preparation of these financial statements.

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

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

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

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

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

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

Cash Equivalents
Cash and cash equivalents include cash in hand and deposits with original maturities of less than three months held with banks.

Goods and Services Tax
All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Employee Entitlements
Short-term entitlements:
Employee entitlements that HVDHB expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

HVDHB recognises a liability for sick leave to the extent that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent HVDHB anticipates it will be used by staff to cover those absences.

Long-term employee entitlements:
Entitlements that are payable beyond 12 months, such as long service and retirement leave, have been calculated on an actuarial basis.

The calculations are based on likely future entitlements accruing to staff, based on years of service, years to entitlement etc, the likelihood that staff will reach the point of retirement and contractual entitlements information, and the present value of the estimated future cash flows.

The discount rate is based on the weighted average of interest rates for government stock with terms to maturity similar to those of the relevant liabilities. The inflation factor is based on the expected long-term increase in remuneration for employees.

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

Defined Benefit Contribution Scheme
HVDHB is a participating employer in the NPF Superannuation Scheme (“the Scheme”) that is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the employer could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers

ceased to participate in the Scheme, the employer could be responsible for an increased share of the deficit.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the Scheme, the extent to which the deficit will affect future contributions by employers, as there is no prescribed basis for allocation.

This means HVDHB has used defined contribution style reporting.

Debtors and Other Receivables
Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

Impairment of a receivable is established when there is objective evidence that HVDHB will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the statement of financial performance. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (i.e. not past due).

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

Obsolete inventories are written off.

Property, Plant and Equipment
Property, plant and equipment asset classes consist of land, buildings, site improvements, plant and equipment, fit-outs and motor vehicles.

Property, plant and equipment are shown at cost or valuation, less any accumulated depreciation and impairment losses.

Revaluations:
Land and buildings are revalued with sufficient regularity to ensure that the carrying value amount does not differ materially from fair value and at least every five years. Fair value is determined from market-based evidence by an independent valuer. All other asset classes are carried at depreciated historical cost.

The carrying values of revalued assets are reviewed at each balance date to ensure that those values are not materially different from fair value. Additions between revaluations are recorded at cost.

Accounting for revaluations:
HVDHB accounts for revaluations of property, plant and equipment on a class of asset basis.

The results of revaluing are credited or debited to an asset revaluation reserve for that class of asset. Where this results in a debit balance in the asset revaluation reserve, this balance is expensed in the statement of financial performance. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the statement of financial performance will be recognised first in the statement of financial performance up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

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

Disposal of Property, Plant and Equipment
Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sale price and the carrying amount of the asset. When revalued assets are sold the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

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

The costs of day-to-day servicing of property, plant and equipment are recognised in the statement of financial performance as they are incurred.

Depreciation of Property, Plant and Equipment
Depreciation is provided on a straight-line basis on all tangible property, plant and equipment, other than freehold land, at rates which will write off the cost of the assets, less their estimated residual value, over their useful lives.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Asset Class	Useful Life	Associated Depreciation Rates
Building structure	4 – 80 years	1.25% - 25%
Building fit-out and Services	2 – 36 years	2.8% - 50%
Plant and equipment	2 – 19 years	5% - 50%
Motor vehicles	5.5 – 12.5 years	8% - 18%
Computer equipment	3 – 5.5 years	18% - 30%
Leased assets	3 – 8 years	12.5% - 33%

Capital work in progress is not depreciated. The total cost of a project is transferred to a fixed asset category on its completion and then is depreciated.

Intangible Assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring into use the specific software.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs that are directly associated with the development of software for internal use by HVDHB are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each period is recognised in the statement of financial performance. The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Computer software – useful life 5 years, amortisation rate 20%

Taxation
HVDHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 2004.

Trust and Bequest Funds
Donations and bequests received are treated as revenue on receipt in the statement of financial performance, except where the restrictive conditions are such that the Board has a liability to the donor.

Cost of Services Statements (Statement of Objectives and Service Performance)
The cost of services statements, as reported in the Statement of Objectives and Service Performance report the net cost of services provided by each significant activity. The net cost is the significant activity's cost of providing the service, less revenue collected by the activity.

Cost Allocations
The net cost of service for each significant activity has been arrived at using the cost allocation system outlined below.

Cost allocation policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs
Direct costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs
The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as full time equivalent staff numbers, staff head count numbers and floor space used.

Statement of Cash Flows
Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the Board invests as part of its day-to-day cash management, net of bank loan facilities.

Operating activities include all transactions and other events that are not investing or financing activities.

Investing activities are those activities relating to the acquisition and disposal of non-current assets.

Financing activities comprise the change in equity and debt capital structure of the Board.

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

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

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

Financial Instruments
HVDHB is risk averse and seeks to minimise exposure arising from its treasury activity. The Board is not authorised by its treasury policy to enter into any transaction that is speculative in nature.

Financial instruments reflected in the statement of financial position include cash and bank balances, receivables, trade creditors and borrowings. These instruments are, generally, carried at their estimated fair value. For example, receivables are carried net of the estimated doubtful receivables. The particular recognition methods adopted are disclosed in the individual policy statements associated with each item.

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

ACC Partnership Programme
HVDHB belongs to the ACC Partnership Programme whereby HVDHB accepts the management and financial responsibility of work related illnesses and accidents of employees that are generally the result of an isolated event to an individual employee. Under the ACC Partnership Programme HVDHB is effectively

providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which HVDHB has responsibility under the terms of the Partnership Programme. HVDHB has chosen a stop loss limit of $750,000, which means HVDHB will only carry the total cost of claims up to $750,000.