Hutt Valley District Health Board

District Annual Plan
2010 to 2011

Healthy People, Healthy Families, Healthy Communities

Whanau Ora Ki Te Awakairangi

Towards a Healthier Hutt Valley

June 2010

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Letter of approval from Minister

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

11 AUG 2010

Mr Peter Glensor
Chair
Hutt Valley District Health Board
Private Bag 31 907
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Dear ~~Mr Glensor~~ Peter

Hutt Valley District Health Board: 2010/11 District Annual Plan

This letter advises you that I have signed Hutt Valley District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for three years.

Clinical and financial sustainability

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, while ensuring that New Zealanders get an improved delivery of services. The challenge for us all is to achieve this.

All DHBs must budget within their allocations and improve financial performance. I note your planned financial position which incorporates performance improvement actions and efficiencies totaling $6.9M in 2010/11. The DHB's actions to achieve efficiencies and control costs will be important in the current fiscal environment in 2010/11 and the out years. My approval of your DAP does not mean acceptance of your assumptions in the out years.

Health targets

The Ministry of Health has advised that it considers there are heightened risks associated with your achievement of the agreed health targets for Shorter Stays in the Emergency Department and Improved access to Elective Surgery. I expect that your DHB remains focused on improving performance in these, and that it will work closely with the Ministry of Health, and in particular, the Health Target Champions, to ensure good progress is made.

Mental health ring fence

While I am not viewing your mental health ring-fence spending as an impediment to the overall approval of your DAP, I expect the DHB to work with the Ministry during 2010/11 to ensure my expectations regarding the mental health ring-fence are met.

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This includes ensuring that funding not allocated in accordance with ring fence expectations is tagged for allocation on mental health and addiction services in out-years. It also includes ensuring any surplus against your 2010/11 mental health ring fence allocation is tagged for mental health and addiction services in out-years.

This should include the DHB working with the Ministry's Mental Health Group to determine the appropriate level of service delivery for the DHB's population; and in 2011/12 and out years allocating sufficient funding to support this. The NHB will ensure that this work is undertaken, as it forms part of my agreement to your 2010/11 DAP.

As part of this discussion, it will be important to work with the NHB to establish whether any proposed changes to mental health service models, including integrating primary and secondary mental health services, should be considered under the service change protocols outlined in the 2010/11 Operational Policy Framework (OPF).

Integrating services and working with other DHBs

New Zealanders want better access to a wider range of services closer to home. I understand that further work is required in your primary care sector to fully implement my "Better Sooner More Convenient" policy. I expect your DHB to make substantial progress in reconfiguring primary care organisations and integrating hospital services into community settings in 2010/11. The DHB will need to keep the Ministry of Health well informed of its progress in this priority area.

I note that your Board plans to work closely with other Central DHBs in continuing to support implementation of the Regional Clinical Services Plan with its current focus on vulnerable services (radiology and women's health) together with cardiology and renal services. Additionally, the developing sub-regional arrangements with Wairarapa and Capital Coast DHBs are moving in the right direction. I remain convinced that regional collaboration will assist with long term clinical and financial sustainability.

DAP approval

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 of Health 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 Capital Investment 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 2010/11 DAP, and thank you for your contribution and efforts towards a unified health system.

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

District Annual Plan Approval

The Hutt Valley District Health Board's District Annual Plan for the financial year 2010/11 is approved.

Hon Tony Ryall
Minister of Health

Peter Glensor
Chair
Hutt Valley District Health Boa

Statement from Chair and Chief Executive

We are pleased to present the Hutt Valley District Health Board's District Annual Plan for 2010/11. This plan demonstrates our continued commitment to delivering on the Government's priorities for better, sooner, more convenient health care, with an emphasis on front line services.

This plan also recognises the changed economic circumstances facing New Zealand. The global economic crisis has had an impact on Government revenues and the Government has clearly signalled that future increases in Vote Health will be smaller than in previous years. We must meet Government priorities and respond to our community's expectations within a tight fiscal environment.

The focus for our District Annual Plan is, therefore, very much on taking steps to adjust to the changed circumstances while maintaining frontline services. Our Board, management and clinical staff have recognised the need to make changes in order to reach the financial position of a $3 million deficit for the 2010/2011 financial year.

This has required a very honest and critical look at what we are doing as an organisation. Nothing has been ignored. This plan sets out initiatives aimed at achieving on-going savings and revenue earning opportunities in the order of $6.9 million per annum.

We understand, however, that we need to continue to improve the delivery of services and we have therefore focused on initiatives that maintain or improve services to our community while achieving better financial outcomes. We have paid particular attention to the new National Health Targets introduced in 2009/10r. As well, our Board has always particularly focused on those people with the most need and will continue with that emphasis within the changed environment

There are programmes that improve services and reduce waiting times for people. The re-introduction of delayed breast reconstructions for women who have had breast cancer is a significant improvement for women in the lower North Island and Nelson-Marlborough. This is possible because we increased capacity by building temporary 'clip-on' operating theatres while longer-term capacity is being built, and by smarter use of private hospitals.

The Ministry of Health and the newly established National Health Board have strongly signalled the need for increased regional co-operation. This is a major feature of this District Annual Plan. Strong relationships have been forged with both Capital and Coast DHB and Wairarapa DHB and we have accelerated work to improve collaboration with both DHBs that will see maintenance of, or improvement in, clinical services. Hutt Valley DHB has taken the view that regional co-operation must be clinically driven and we have worked hard to support our clinicians in reaching understandings with their colleagues in the other DHBs.

Clinical leadership is a reality in this DHB and the initiatives outlined in this DAP are a reflection of that.

Finally, there is running through this document an underlying willingness to make the hard decisions that ensure sustainable services are maintained in the Hutt Valley and surrounding areas.

This is directly in line with the Government's expectations.

Signatories

Peter Glensor
Chair
Hutt Valley DHB

Michael Hundleby
Acting CEO
Hutt Valley DHB

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Figures and Tables

1.0 Executive Summary

The Hutt Valley DHB District Annual Plan 2010/11 reflects the realities of a constrained fiscal environment for the health sector.

In 2009/10 we planned a deficit of $3 million in 2010/2011as we moved to a financial breakeven status in 2011/12. The impact of the global recession on Government revenue, however, has meant much less funding for the Hutt Valley DHB in 2010/11 than we expected.

This makes it much more of a challenge to reach a deficit of $3 million in 2010/2011, but our clinicians and management have worked hard in recent months to formulate a difficult, but realistic, plan in order to do exactly that.

Addressing this challenge means taking a focused approach to managing our costs and maximising revenue opportunities. An essential element in our ability to do this is the support of our clinical leadership and the wider community. Research shows 80% of health expenditure is driven by clinical decision making, so it is absolutely essential that clinical staff lead the necessary changes. We are committed to ensuring that our clinical leaders and managers work together to ensure we provide high quality yet cost effective services for our population.

Our focused approach includes:

- Ensuring we are focused on Government priorities, including National Health Targets
- Working closely with our neighbouring DHBs to reduce duplication and improve services to our population
- Increased productivity and efficiency, improved theatre utilisation, increased day surgery rates and day of surgery admission, made possible by the construction of the two temporary 'clip on' operating theatres which opened in October 2009
- Progressing our Emergency Department/Theatre redevelopment as we decrease waiting times in the Hutt Hospital emergency department and continue to increase elective surgery for our population.
- A review of contracted service provision and costs with all of our contracted providers to ensure we are getting maximum value for our health dollars
- Improved spending (better value, better quality) on community pharmaceuticals and mental health services
- Redirecting existing resources to improve primary and secondary care integration, in particular for people with long term conditions and for high needs populations
- Ongoing emphasis on the quality of our services, which will lead to financial benefits.

1.1 Government Priorities

Our District Annual Plan sets out how we intend to deliver on Government priorities for better, sooner, and more convenient healthcare. The Government priorities for 2010/11 place ongoing emphasis on:

- Delivery of agreed financial results
- Improving services and reducing waiting times
- The next steps in the implementation of the Primary Health Care Strategy
- Strengthened clinical leadership
- Greater regional co-operation
- Creating a more unified health system.

In addition, priority is given to achievement of the Government's six Health Targets:

- Shorter stays in emergency departments
- Improved access to elective surgery
- Shorter waits for cancer treatment

- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services.

It is expected that delivery of these priorities will take place from within existing resources (adjusted for demographic increases and inflation).

1.2 Our Operating Environment

Fiscal pressures
Given the deficit posted for 2008/09 and projected for 2009/10, returning to a financial breakeven position in 2011/2012 is a significant challenge for us. Our planned financial position for 2010/11 is a deficit of $3m - this includes a plan for $6.9 million in savings and extra revenue.

Maintaining service coverage
The Government expects DHBs to maintain core services for their growing populations and ensure continued electives growth. The DHB has taken the approach that this is fundamental to its activities and initiatives to achieve efficiencies.

Improved hospital productivity, safety and quality
In 2009/10 we put in place interim theatre capacity by building two temporary operating theatres because the Board, clinicians and management believed we could not meet our clinical and financial goals without them, ahead of the completion of the expanded emergency department and theatre block by the end of the 2011/2012 financial year. As a result we have improved our rate of day surgery and are able to better manage our acute theatre requirements and we can realistically focus on meeting the Government's requirements for increased elective surgery.

Improving our services' quality, efficiency and effectiveness and increasing patient satisfaction has been a focus for our *Improving the Patient Experience Programme* of work. We will be expanding this work in 2010/11 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.

Regional collaboration
Regional collaboration is one of the key ways that Hutt Valley DHB will deliver better results for the community in coming years. The DHB has been actively working with both Capital and Coast and Wairarapa DHBs to achieve this.

It should be noted that while the central region, encompassing the six lower North Island DHBs, have produced a regional clinical services plan, the three Greater Wellington DHBs - Capital & Coast, Hutt Valley and Wairarapa – see the most significant short-term gains being achieved by the three of them working much more closely together than ever before.

All three DHBs recognise that greater collaboration is fundamental to better clinical and financial performance for their communities in the future (Section 2.7). The work is evolving quickly but specific projects being worked on include:

- General Surgery / Anaesthetics: We are looking at opportunities for joint clinical work and a shared workforce between Wairarapa and Hutt Valley DHBs
- Paediatrics: We are exploring opportunities for joint clinical work and a shared workforce between Wairarapa and Hutt Valley DHBs
- Mental Health: We are progressing work already underway between Capital & Coast and Hutt Valley DHBs, to include Wairarapa DHB, with a particular emphasis on regional acute psychiatric cover
- Radiology: All three DHBs are working on initiatives to improve clinical sustainability which are likely to involve a much more co-ordinated approach to radiology across the region
- Emergency Department: Hutt Valley and Capital & Coast DHBs have announced a Chair of Emergency Medicine across both DHBs and we are exploring whether this might also include Wairarapa DHB

As well as a focus on clinical services, the DHBs are working on opportunities for back-office efficiencies in a number of areas, including:

- Consolidation of payroll, finance and certain aspects of IT management
- Human Resources: The Passport to Employment project, which involves streamlining pre-employment

protocol processes so that pre-employment checks allow employees to work seamlessly across the DHBs

- Planning and Funding: A review of operations is underway, to look at possible options for bringing Hutt Valley, Capital and Coast and Waiarapa DHBs' planning and funding units closer together. The review will concentrate on potential opportunities for streamlining processes and reducing duplication while maximising opportunities for health gains.
- Primary Health Care: There is potential for consolidation of PHOs across DHB districts.

It is anticipated that this work will lead to a greater level of co-ordination between the DHBs and that there will be significant developments around shared support services both regionally and nationally in the next 12-24 months.

Better, sooner, more convenient 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. In addition to our work to better integrate services across primary and secondary care, we are actively working with our PHOs in response to the Minister of Health's request to facilitate consolidation where appropriate, with a view to:

- Obtaining efficiencies in administrative costs
- Ensuring greater ability to make strategic investment in information systems and facilities
- Improving capacity for preventative health programmes
- Better use of scarce leadership and technical skills
- Easier integration of primary and secondary care services
- Increased potential for spread of innovation and best practice.

1.3 Our Local Priorities

Our local priorities for 2010/2011 align with Government expectations and reflect the Board's commitment to ensuring ongoing sustainability of our services for our community.

1. **Collective Leadership**
   Ensuring clinical leaders and managers are working together to ensure we provide high quality yet cost effective services for our consumers and our population.

2. **Financial Sustainability**
   Improving the delivery of services while coping with ongoing fiscal restraint requires improved financial performance.

3. **Collaboration with other DHBs**
   Engaging in meaningful collaboration with Capital and Coast and Wairarapa DHBs to improve services to our respective population and reduce costs.

4. **National Health Targets**
   Ensuring we focus on reaching the National Health Targets, in line with government and community expectations.

5. **Emergency Department/Operating Theatre Redevelopment**
   Ensuring the Emergency Department/Operating Theatre project progresses on time and on budget, and that the changes in practice and staffing necessary to allow it to function effectively when it opens (e.g. increase in day surgery) are advanced.

6. **Primary Care**
   Redirecting existing resources to projects agreed with primary care as being of most value, particularly those addressing long term conditions, and high need populations.

2.0 DHB Operating Environment

The Hutt Valley DHB is responsible for planning, funding and providing government funded health care and disability support services for the 143,460 people who live in the Hutt Valley.

2.1 Strategic Context

The Hutt Valley DHB vision is for:

Healthy People, Healthy Families, Healthy Communities.

Further details of our vision, goals and strategies can be found at Appendix 1 and in our District Strategic Plan 2006-11.

Notably, in 2010/11 we will be producing a refreshed District Strategic Plan that will reflect changed economic circumstances and changed national priorities.

2.2 Government Priorities

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 Minister of Health's expectations of DHBs have been clearly articulated and the priorities for 2010/11 are a focus on:

- Better financial management
    - DHBs must budget within their allocations and establish specific action plans to improve financial performance (Section 2.4 refers**)**
- Improving service and reducing waiting times
    - Resources must be focused on supporting frontline services to reduce excessive patient waiting times
    - DHBs are expected to implement productivity and quality and safety improvements, including increasing elective surgical volumes, improving emergency department waiting times, improving cancer treatment waiting times (Section 2.8 refers).
- Progress next steps in the Primary Health Care Strategy
    - DHBs are expected to work with community and hospital clinicians to provide a wider range of services in community settings as appropriate, at no cost to patients (Section 2.9 refers)
    - DHBs are encouraged to investigate and facilitate the opportunities that exist in your district to consolidate PHOs where appropriate acknowledging existing provider networks.
- Clinical Leadership
    - Clinical engagement from the governance level throughout the organisation should be strengthened. (Section 2.7refers)
- Regional Co-operation
    - Closer cooperation between neighbouring and close DHBs is an essential part of the future direction in order to maximise clinical and financial resources. This cooperation should be accelerated. (Section 2.6 refers)
- More Unified System
    - Working with the National Health Board to ensure that the public health system operates more effectively as a unified system.

We are committed to delivering on the Government's priorities.

2.3 Health Targets

A set of National Health Targets has been identified to focus the efforts of DHBs and make more rapid progress against key national priorities as summarised in Table 1 below. These Health Targets are included within the performance measures associated with our service outputs and outcomes and are clearly identified in our DAP.

Table 1: Summary of National Health Targets

Health Target	Description	Key Action
Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours	Implementation of the Hutt Valley DHB Delivery Plan for Shorter Stays in Emergency Department Linking with work on the management of long term conditions and integration of primary and secondary care services to progress issues relating to avoidable presentations to ED. (Section 3.3 refers)
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)	Working to increase Day Surgery rates, improving our Day of Surgery Admission rate, and improving our preoperative assessment model. (Section 3.3 refers)
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.	We will work closely with Capital and Coast District Health Board on the implementation of their plan to meet the new target of patients waiting less than four weeks for radiotherapy services. (Section 3.3 refers)
Increased immunisation	85% of two year olds will be fully immunised by July 2010; 90% by July 2011; and 95% by July 2012.	Continue to promote, fund and deliver immunisation programmes in collaboration with primary care, Maori and Pacific providers and well child providers, and the education sector. (Section 3.1 refers)
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.	Implement the Regional Tobacco Control Plan, including training for our clinicians (primary care and hospital based) to implement the effective brief intervention (EBI) model. (Section 3.1 refers)
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.	Complete a review of diabetes services (primary, community and secondary care), with a view to developing an integrated patient centred service model, that improves the patient journey, shifts services to primary care, reduces avoidable hospitalisations, and results in improved achievement of diabetes performance targets. (Section 3.2 refers)

Further detail on the Health Target measures is included at Appendix 2.

2.4 Living Within Our Means

Hutt Valley DHB will receive an additional $9.5m in funding in 2010/11 to relieve cost pressures and reflect demographic funding. Inter-district flows mean that we will receive an additional $1.2m for services we provide to residents of other DHBs, and we will pay out a further $6.4m for services provided by other DHBs

to our residents. The overall result is a $9.9m gap between funding available and expected costs of service delivery.

We have developed a plan for $6.9 million in savings and extra revenue. This leaves our financial position for 2010/11 as a deficit of $3m. The 2010/11 result is significantly affected by, and takes into account, the following:

- Growth in inter-district outflows
- Increased labour costs using national assumptions
- Limited growth in electives revenue as a result of the Ministry of Health's new approach to applying the Elective Initiatives Funding to DHBs with higher demographic growth rates
- The revaluation of land and buildings
- Growth in community pharmaceuticals expenditure for our district as forecast by PHARMAC
- Achievement of our $6.9m plan for savings in demand driven services, funder contracts, corporate costs, and for hospital productivity programmes and revenue generation.

The total revenue for the DHB is $436m and expenditure is projected at $439m. Table 2 below provides a breakdown of the $439m budgeted to spend on health services.

Table 2: Summary of Budgeted Expenditure for 2010/11

				Community Comprises -		
$m	**Total**	**Provider Arm / IDF Outflows**	**Community**	**Regional Contracts**	**National Contract Formula**	**Expenditure under DHB control**
Provider Arm	213.2	213.2				-
Governance Costs	3.3	3.3				
IDF Outflows	73.7	73.7				-
Ministry Funded Costs	6.3		6.3		6.3	-
Other Funder Costs:						
Primary Care services - PHOs	20.7		20.7		20.7	-
Primary Care services - Other	2.9		2.9		2.9	-
Personal Health	34.4		34.4	25.4	0.8	8.2
Maori Health	2.2		2.2			2.2
Mental Health	9.2		9.2	6.3		2.9
Health of Older People	37.2		37.2		29.1	8.1
Pharmaceuticals	36.0		36.0		36.0	-
TOTAL EXPENDITURE	**439.1**	**290.2**	**148.9**	**31.7**	**95.8**	**21.4**
% of Total Expenditure		66%	34%	7%	22%	5%

Expenditure on provider arm services (Hutt Hospital) and on services provided by other DHBs for our residents accounts for 66% of total expenditure. Expenditure on community services (services largely contracted from external organisations) accounts for 34% of our expenditure, of which around two thirds is expected to be spent on services that are nationally specified (either through an agreed national formula or through national price negotiation). Hutt Valley DHB has very little ability to reduce the price of services, e.g. Aged Residential Care and Primary Health Organisation contracts. In some areas we may be able to influence demand, such as for community pharmaceuticals or health of older people services.

We expect to spend a further $31.7m on regionally managed and funded contracts, where decisions to reduce price or quantity of service require regional decision-making and are often covered by long-term contracts.. These include the contracts for laboratory services, fertility services and regional mental health services.

Locally managed and funded contracts include local Non Government Organisation contracts for personal health, mental health, Maori and Pacific health, some health of older people (home based support services and Needs Assessment Service Coordination), reducing inequalities, primary care programmes, and well child services. In 2010/11, these are expected to cost around $21.4m.

The Hutt Valley DHB's efforts to reduce and control costs in response to fiscal pressures has included a review of all community services expenditure. The potential for savings is generally limited to locally managed contracts and demand led services where there is some discretion over funding. Potential areas of savings include where there is duplication of service, where we provide services over and above service coverage requirements (as prescribed by the Ministry of Health Service Coverage Schedule), or where there

is a poor match between funding and service delivered.

In our review we dismissed a number of options as potentially having too great an impact on crucial services or those that have a significant role in providing services to those most in need. However, there are a number of contracts that were put in place prior to the formation of Primary Health Organisations (PHOs) and which essentially fund services that should now be covered by PHO funding.

There are also several mental health contracts where reviews of client utilisation and outcomes have identified savings from better matching funding to the work done[1]. We will continue to address value-for-money issues in mental health, both locally and jointly with Capital and Coast DHB. As we identify further areas for improved value-for-money, we will maintain provision and quality of services within these services while reducing the investment. We recognise that our overall expenditure on mental health may fall below the identified ring-fence level, but we are confident that service levels and quality will be maintained.

We have established projects to improve service quality and ensure expenditure reflects need in community pharmaceuticals and health of older people services. In health of older people services, the focus on appropriate allocation of home support services will be maintained, and extended to appropriate placement of clients in residential care.

We also carried out a review of all provider arm services and costs. We have identified a number of areas where there are duplications of effort that we will eliminate. We are also undertaking significant regional and sub-regional collaboration discussions to identify opportunities for greater efficiencies. This plan incorporates significant reductions in FTE and associated costs without impacting on service delivery.

Our specific plan for savings and increased revenue is outlined in Table 3 below. These savings are further mapped to the Performance Improvement Action areas; Achieve financial security, Improve productivity and quality, and Enhance regional collaboration, as specified by the Ministry of Health, and summarised in Section 2.5 below.

Table 3: Financial Plan

Savings	$m
Funder contracts	1.5
Demand driven (funder)	0.5
Corporate cost reductions	0.5
Hospital productivity programmes	4.4
TOTAL	6.9

As well as the initiatives noted above the Hutt Valley DHB will also be supporting a number of national initiatives to manage and control costs as outlined in Table 4 below.

Table 4: National Savings Initiatives

- **High Cost Treatments** – options and a national service implementation plan by end of June 2011 in conjunction with the National Health Board Business Unit (NHBBU);
- **National Services Location** – options and a national service implementation plan by end of June 2011 in conjunction with the NHBBU;
- **Health Procurement** – deliver a set of savings projects in 2010/11 to a total of $30M.
- **Shared Services** –working jointly with the Shared Services Establishment Board (SSEB)
- **Low Evidence Activities & Treatments** – options and a national service implementation plan by end of June 2011 in conjunction with the Ministry of Health/NHBBU.

[1] Since 2008, we have been working with mental health providers to better understand what our population is receiving from the investment in these services. In addition to the national framework requirements for data about provider FTE and bed-days, we have been gathering information about the level of service provided, covering both the number of clients cared for and the quantity and quality of contact with clients. We have identified opportunities for improved value-for-money from these contracts and have implemented some contract changes as a result. We have been careful to maintain the provision and quality of services alongside the reduced investment.

2.5 Performance Improvement Actions

Hutt Valley DHB has identified key performance improvement actions that will have a material impact on performance over the next one to five years, to achieve focused delivery on Government policy priorities and maximum value for money across our expenditure (Table 5 refers).

Table 5: Summary of performance improvement actions

Objectives	Savings Impact
1. **Achieve Financial Security** by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.	$3.2m
2. **Improve productivity and quality** with a focus on hospital wards, theatre utilisation, increasing day surgery, and emergency departments.	$2.7m
3. **Enhance regional cooperation** through clinical regional service plans and through greater regionalisation of shared services and back-office functions.	$1.0m
TOTAL	$6.9m

Our performance improvement actions are further underpinned by our focus on collaboration with other DHBs, strengthening clinical leadership, improving the patient experience and primary and secondary care integration, and as outlined below.

2.6 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.

Collaboration with neighbouring DHBs takes on even more importance in the light of the changed economic environment and the changed national priorities within health, and this will be reflected when the District Strategic Plan is refreshed in 2010/2011.

It is without question that DHBs' future sustainability will be significantly dependent on those within each regional cluster being able to work together in the planning of regional services and the aligning of service delivery.

Particular areas of focus for 2010/11 include:

- Continuing to develop and strengthen clinical networks
- Progressing opportunities identified through increased collaboration with Wairarapa and Capital & Coast DHBs
- Reducing areas of service vulnerability across the central region.

Working closely with our neighbouring DHBs

A natural sub-regional cluster exists between Hutt Valley DHB, Capital & Coast and Wairarapa DHBs. Hutt Valley, Capital & Coast and Wairarapa DHBs have recognised that one of the key ways to deliver better results for our communities is to work closely with each other. For many years we have assisted each other in providing specific services for our respective populations. In many instances this has involved clinical staff providing services in multiple locations, leave cover, shared rosters, and joint approaches to the planning and funding of services. Some specific recent examples include:

- Hutt Valley DHB providing leave cover for Wairarapa's acute orthopaedics service
- Announcement of a joint chair of emergency medicine between Hutt Valley DHB and Capital & Coast DHB
- Joint approach to planning and funding of regional mental health services
- Oral health business planning

In the last quarter of 2009 Hutt Valley, Capital & Coast and Wairarapa DHBs began to work together with some urgency to identify further opportunities for streamlining functions, improving service outcomes, and financial sustainability. The three DHBs have recently signed a statement of commitment that commits the organisations to developing a clinically led programme of work over the next 1-2 years.

In Hutt Valley DHB's case the planning for greater collaboration has been linked directly into the planning to achieve $6.9 million in efficiencies and revenue earning opportunities for the 2010/2011 year.

A committee comprising clinical leaders and senior management has been meeting weekly to work through all proposals to achieve the savings and to achieve greater clinical and financial collaboration with our neighbouring DHBs.

The senior manager given responsibility for co-ordinating collaboration initiatives with the two other DHBs sits on that committee. It is through this mechanism that we have identified the $6.9 million savings and revenue programme and the collaboration opportunities for the 2010/2011 year.

It is also out of these discussions that the need for greater collaboration and the opportunities it offers has been carried out to other forums throughout the DHB. Our clinical heads of department, our service management team, our clinical nurse managers and our multi-disciplinary teams are all part of the wider programme to make real gains, both clinically and financially, in making service changes which incorporate the other DHBs.

The first areas of focus for the 2010/2011 year are outlined below, but it should be noted that the pace of development is rapid and that within the organisation many opportunities are being looked at, at a lower level, and are expected to come forward as more detailed proposals through the 2010/2011 year. The first areas of focus have been agreed as:

- General Surgery / Anaesthetics: We are looking at opportunities for joint clinical work and a shared workforce between Wairarapa and Hutt Valley DHBs
- Paediatrics: We are exploring opportunities for joint clinical work and a shared workforce between Wairarapa and Hutt Valley DHBs
- Mental Health: We are progressing greater integration between Capital & Coast, Hutt Valley and Wairarapa DHBs' mental health services, with an initial emphasis on regional acute psychiatric cover
- Radiology: All three DHBs are working on initiatives to improve clinical sustainability which are likely to involve a much more co-ordinated approach to radiology across the region
- Emergency Department: Hutt Valley and Capital & Coast DHBs have announced a Chair of Emergency Medicine across both DHBs and we are exploring whether this might also include Wairarapa DHB

As well as a focus on clinical services, the DHBs are working on opportunities for back-office efficiencies in a number of areas, including:

- Consolidation of payroll, finance and certain aspects of IT management
- Human Resources: The Passport to Employment project, which involves streamlining pre-employment protocol processes so that pre-employment checks allow employees to work seamlessly across the DHBs
- Planning and Funding: A review of operations is underway, to look at possible options for bringing Hutt Valley, Capital and Coast and Waiarapa DHBs' planning and funding units closer together. The review will concentrate on potential opportunities for streamlining processes and reducing duplication while maximising opportunities for health gains.
- Primary Health Care: There is potential for consolidation of PHOs across DHB districts.

It is anticipated that this work will lead to a greater level of co-ordination between the DHBs and that there will be significant developments around shared support services both regionally and nationally in the next 12-24 months

Impact of Regional Clinical Services Plan

Hutt Valley DHB has worked closely with the Central Region DHBs on the Regional Clinical Services Plan (RCSP) and associated implementation plan. The RCSP sets out a vision and framework for the region's health services to the year 2020. The vision involves a regionally co-ordinated system of health service planning and delivery, thus creating lasting improvements in the sustainability, quality and accessibility of clinical services.

There are three areas that will receive significant attention during the 2010/2011 year – radiology services in the region; maternity services; and aged care. Hutt Valley DHB is supporting greater collaboration in these three areas where the issues faced by all six DHBs are essentially the same.

Strengthening Hospital Services

The RCSP identified a number of services that required strengthening. This was initially assessed on the basis of medical workforce shortages and over 2009 further assessment occurred to better understand service vulnerabilities across a broader criteria. The result was a summary action plan, "Strengthening Hospital Services: Regional Action Plan" and which, when added to existing regional projects has agreed the following priority areas by way of the work programme for 2010/11:

- Clinical services – Cancer, Cardiac, Mental Health, Older Adults (AT&R and Specialist Rehabilitation for under 65 years), Plastics, Radiology, Renal, and Women's Services (Maternity, Gynaecology, Gynae Oncology Surgery and Maternal Foetal Medicine)
- Long Term Conditions (chronic conditions management)
- Regional Credentialing of Medical Clinicians
- Information Communication and Technology (ICT)

Clinical Networks

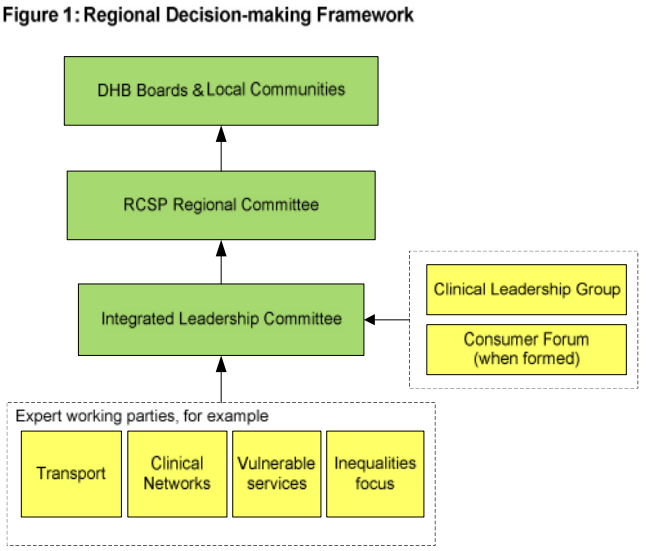
Enabling the implementation of the RCSP requires clinical leadership and direction. In addition to this occurring through the regional governance and decision making framework, regional Clinical Networks have been established for Cancer (part of the national cancer programme), Cardiology, Mental Health, Plastic Surgery, and Renal Services. These networks solve identified regional issues for a service or group of 'like' services through an agreed work programme. They provide the opportunity for clinical leadership, coordination and information sharing across the continuum of care (primary, secondary and tertiary level settings).

Regional Governance and Decision Making

Being able to implement the RCSP requires a framework that supports regional decision making whilst still recognising the autonomy of the local DHB Boards.

We believe that the majority of decisions will be operational matters that will not require sign-off at board level but that for major decisions that require it, the following decision making committee framework has been put in place.

Figure 1: Regional decision making framework



A regional governance group (called RCSP Regional Committee) comprising Board Chairs and CEOs has been established to lead regional decision making for the region. An independent chair will be appointed in the first quarter of 2010 to facilitate a consensus approach to decision making by DHB Boards. Decisions will be based on expert recommendations from the RCSP Leadership Committee (RLC), a group representative of different disciplines from across the region and DHBs. The RLC is a clinical and managerial partnership that will provide direction to the programme and ensure regional proposals are of the highest quality and

have undergone rigorous review.

Supporting the RLC is a regional Clinical Leadership Group (CLG). CEOs directed in 2009 that a clinical group be formed to ensure a broad base of clinical participation and leadership. The CLG has a membership of primary and secondary clinicians from across the region and has worked in partnership with the interim RCSP Steering Group (and future RLC when formed in 2010) to shape the direction of the work programme.

2.7 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 Collective Leadership Forum
- Patient Safety Leadership Group
- Clinical Heads of Departments, Surgical Heads of Department and Clinical Nurse Managers meetings
- Allied Health Professional Leaders Group
- Nursing & Midwifery Executive Leadership Group
- Theatre user groups
- Information Systems User Groups
- Campus development user group
- Joint Clinical Heads and Managers signoff of service agreements,
- Clinical leadership membership of our Exceptional Funding Committee and Funding Management Group,
- Our Chief Medical Advisor Deputy Chief Medical Advisor, Primary Care Liaison, Director of Nursing and Director of Allied Health all sit on our Executive Membership Team and actively participate in all strategic discussions and decision making.

Clinical leadership underpins our work to improve hospital productivity and provide efficient and effective services. Our clinicians take the lead in identifying priorities for 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 input to Board decision making is provided via contribution to Board papers and regular presentations and participation in Board meetings and discussions.

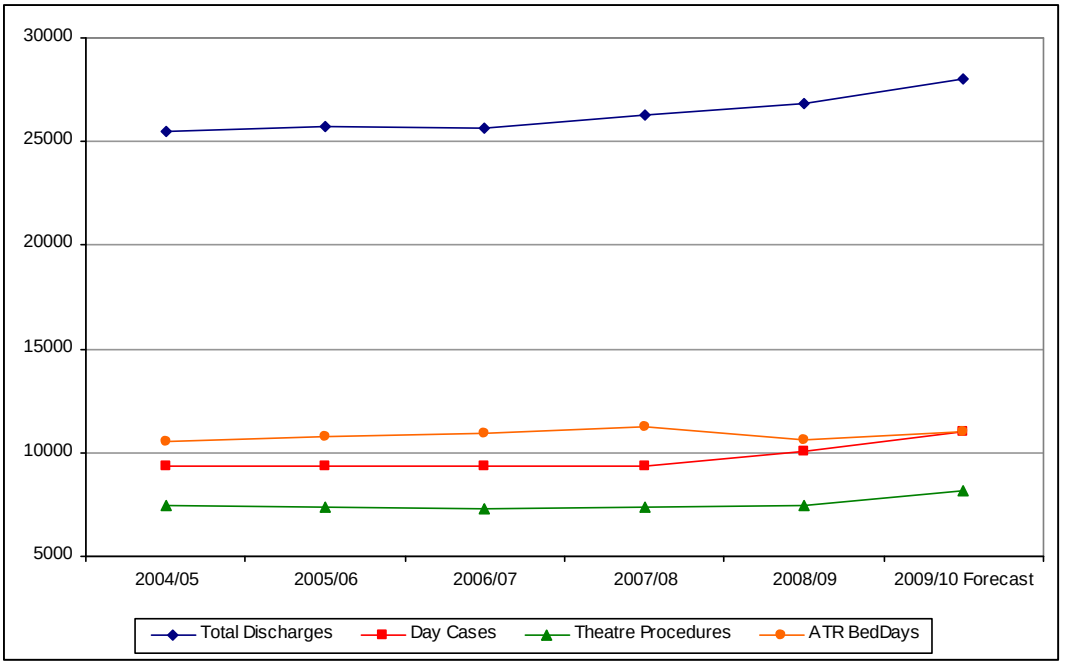
2.8 Improving Hospital Productivity

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 (Figure 3 below refers). 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.

We are increasing this effort and a number of the projects that fall within our *Improving the Patient Experience Programme* are expected to deliver improved hospital productivity, releasing further capacity for increased frontline services:

- "Our time to care" project is a hospital wide approach to decrease wait times in emergency department.
- Increasing access to elective surgery by increasing day surgery and day of surgery admission rates and standardising pre-operative assessment.
- Improving efficiencies in outpatient management by standardising systems across the hospital.
- Extending patient focused booking to follow up outpatient appointments.
- Increasing GP direct access to diagnostics.
- A focus on people with respiratory conditions as part of the long term conditions work with secondary and primary providers.

Figure 2: Hospital Productivity Improvements



2.9 Better, Sooner, More Convenient 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.

Hutt Valley DHB has engaged with our PHOs regarding opportunities to better integrate primary and secondary services and improve models of care. (Section 3.2 refers)

In addition, the Minister requested that the Hutt Valley DHB review the configuration of PHO services with a view to:

- Obtaining efficiencies in administrative costs
- Ensuring greater ability to make strategic investment in information systems and facilities
- Improving capacity for preventative health programmes
- Better use of scarce leadership and technical skills
- Easier integration of primary and secondary care services
- Increased potential for spread of innovation and best practice.

Hutt Valley PHOs have been encouraged to look at options for consolidation, including cross boundary consolidation with PHOs in the Capital and Coast DHB district. The principles guiding the Hutt Valley DHB's considered approach include:

- Supporting a PHO led approach
- Acknowledging the efficiency and effectiveness of our smaller PHOs, some of which are closer to the Government's vision of integrated family care centres
- Ensuring that we preserve or enhance overall performance
- Minimising any negative impact on high needs communities
- Supporting innovation in primary health care.

3.0 Key Outcomes and Priorities

For each of the DHB Output Classes[2] this section outlines the significant services, actions and programmes we intend to carry out to achieve particular impacts[3] and our long-term outcomes. Specific performance measures have been selected for each of the impacts and output class (Table 6 below refers). These measures are drawn from the DHB Non Financial Monitoring Framework covering Government priorities and targets, service coverage requirements, provision of quality services efficiently, and purchasing the right mix of services. Further details of the DHB Non Financial Monitoring Framework and the measures and targets for Hutt Valley DHB are provided at Appendix 2. Further measures are drawn from the Hutt Valley DHB District Strategic Plan and other priority areas.

Table 6: Alignment of long-term outcomes, impacts, measures and service outputs

Long term outcomes	Impacts	Measures[4]	Service Output Classes
Healthier communities **Improved health equity**	Health protection is enhanced; public trust, confidence and security	Disease outbreaks are controlled	Public Health Services
	Health risk is reduced; people are healthy, able to self manage and live longer	Better help for smokers to quit (*Health Target)* Immunisation coverage *(Health Target)* Increased number of infants breastfed	Public Health Services Primary & Community Services Hospital Services
	Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier	Number of Before School Checks Breast cancer screening coverage Increased number of oral health examinations Reduced number of people experiencing a mental health crisis Reduced avoidable hospitalisations	Public Health Services Primary & Community Services Hospital Services
	Access to services is improved; people with early conditions are treated and managed earlier and illness progression is reduced	Improved access to mental health services Reduced avoidable hospitalisations Electives surgical discharges *(Health Target)* Elective services standardised intervention rate Post natal length of stay	Primary & Community Services Hospital Services Support Services
	Services are better integrated; people with long term conditions have their care coordinated across a range of service providers leading to reduced premature disability and death	Diabetes/CVD management (*Health Target)* Reduced avoidable hospitalisations	Primary & Community Services Hospital Services Support Services
	Support services are appropriate; people and their whanau with end stage conditions are supported to live and die well	Ageing in place ARC hospital beddays	Support Services

[2] Output Classes are defined within the Statement of Intent 2010-13 as an aggregation of outputs (Public Finance Act 1989 and Crown Entities Act 2004), which are the final goods and services supplied to someone outside of the entity.

[3] Impacts are defined within the Statement of Intent 2010-13 as being attributed to DHBs outputs. An impact means the contribution made to an outcomes by a specified set of outputs.

[4] Refer DHB Non Financial Monitoring Framework

Long term outcomes	Impacts	Measures[4]	Service Output Classes
	Services are provided more efficiently and effectively	Expenditure on community pharmaceuticals Emergency department waiting times (*Health Target)* Theatre Utilisation Day Surgery rates Day of surgery admission Average length of stay	DHB capability and capacity
	Our infrastructure is improved	ED/Theatre development targets	DHB capability and capacity

3.1 Public Health Services

In 2010/11 we will maintain our response to disease outbreaks and preparations for pandemics and emergency management situations. We will increase our work with primary health care providers to reduce the risk of chronic diseases and cancer, reduce the burden of preventable hospitalisations and increase our immunisation and cancer screening rates. We will continue to work with our communities and local government to ensure healthier environments (e.g. clean air, safe water, healthy housing).

Key Areas of Focus
Hutt Valley DHB will continue to work in key public health areas to:

- Respond to disease outbreaks, pandemics and emergency management requirements as they arise
- Reduce chronic diseases such as diabetes, cardiovascular and respiratory conditions, and cancer
- Improve immunisation coverage
- Improve breast feeding rates
- Increase the number of eligible women participating in BreastScreen Aotearoa, in particular Maori and Pacific women
- Maintain the viability of core public health services in a constrained fiscal environment.

Priority Actions for Public Health Services

Table 7 below summarises the priority actions that Hutt Valley DHB is seeking to achieve in Public Health Services. The full extent of Public Health Services can be found in more detail in the Regional Public Health Business Plan 2010/11.

Table 7: Public Health Services Priority Actions

Significant services, actions, programmes or initiatives[5] (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts
Continue to promote, fund and deliver immunisation programmes in collaboration with primary care, Maori and Pacific providers and well child providers, and the education sector.	Immunisation coverage *(Health Target)*	Health risk is reduced
Implement the Regional Tobacco Control Plan: <u>Secondary Care</u> (hospital based): • Improve systems that support staff to document ABC for inpatients. Improve the electronic data systems so that smoking status is a mandatory field. • Train clinicians in the use of ABC for Smoking Cessation • Visit wards and promote systems to achieve the health target • Monitor the use of NRT through pharmacy and monitor the number of Maori, receiving advice to quit, for equitable	Better help for smokers to quit *(Health Target)*	Health risk is reduced

[5]Includes reference to 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.

Significant services, actions, programmes or initiatives[5] (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts
outcomes Primary Care: • Train primary care providers in ABC for use in every day practice • Raise awareness of the approach needed for the health target for 'better help for smokers' • Assist and support the development of systems the will capture the health target reporting • Support health providers, with resources and toolkits • Offer guidance on smokefree policies • Identify opportunities to support primary care to build on the work of clinicians		
Pandemic planning – strengthening our response readiness for an upsurge in H1N1 and encouraging the establishment of regional response structures for health emergencies.	Response to pandemics	Infrastructure is improved
Before School Checks	Number of B4SC checks	Intervention is early
Support the delivery of Mum4Mum breast-feeding support for Maori and Pacific and high needs communities using a community development model.	Breast feeding rates	Health risk is reduced
Breast and cervical 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.	Screening coverage targets	Intervention is early
Alcohol and Tobacco – increasing our focus on conducting Controlled Purchasing Operations (CPOs) within the district to reduce harm from alcohol and tobacco.	Number of alcohol and tobacco controlled purchasing operations completed	Health risk is reduced
Provide family health assessments to support the delivery of healthy housing programmes	Number of homes assessed	Health risk is reduced
Placement of a Public Health Nurse in the WINZ Porirua office to provide health advice, support and clinical interventions to Work & Income NZ (WINZ) clients	Number of clients supported	Intervention is early

3.2 Primary and Community 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. In 2010/11 we will ensure better service integration across primary, secondary, mental health and public health services, 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. Hutt Valley DHB's local plan for mental health and addiction services Make it Happen (Whakamahingia) 2008-13 guides our local response to the national and regional strategies. The priorities for service improvements are in services for children and youth, older people and in primary care.

Key Areas of Focus

Hutt Valley DHB is addressing a number of challenges with regard to Primary and Community Services, 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, annual 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
- The need to increase enrolment for child and adolescent oral health services; reducing disparities in DMFT and caries free figures between Māori, Pacific and other children, increasing the total number of examinations and treatments, and reducing arrears rates for recall to services
- Higher than average expenditure on community pharmaceuticals for our population.

Hutt Valley DHB has engaged with our PHOs regarding opportunities to better integrate primary and secondary services and improve models of care, building on our earlier work to develop a Long Term Conditions Framework in 2008 and the work of a Long Term Conditions Think Tank (LTCTT) in 2009. The Think Tank comprised primary, community and secondary care clinicians meeting to discuss and identify real opportunities for better integrating care. Nineteen potential projects or areas for improvement were identified. In 2010/11 we will be progressing the following projects seen as the highest priority:

- ***Breath Easy***; a pilot project involving primary and secondary care clinicians aimed at assisting patients to better manage their respiratory condition, providing clinicians with better tools for care planning, the sharing of patient information between clinicians, and provision of improved access to diagnostics and services in the community.

- ***Access to Diagnostic Imaging;*** a review of primary care access to diagnostic imaging services, where currently access is restricted to people with a community services card or high user card. Primary care clinicians have told us that they would like better access to diagnostic services, including access to specialist advice prior to referral. We have commenced with a review of imaging services and how we can better support primary care and ensure better access for more patients from within current resources.

- ***Cellulitis;*** a priority for one of our PHOs is the treatment of children with skin conditions and reducing avoidable emergency department attendances and hospitalisation. We are working with this PHO to look at ways we can provide further support for cellulitis services in the community.

- ***Diabetes;*** a review of diabetes services (primary, community and secondary care), with a view to developing an integrated patient centred service model, that improves the patient journey, shifts services to primary care, reduces avoidable hospitalisations, and results in improved achievement of diabetes performance targets.

In addition to the above project areas our ongoing work also includes:

- Support for the Primary Care Skin Lesion Programme
- Direct GP referrals for CT head services, and respiratory and cardiology testing
- Extension of the community spirometry service into more PHO practices
- Establishment of a regular integrated clinical review service between secondary care diabetes services and a PHO with a high needs population.

In addition, the Minister requested that the Hutt Valley DHB review the configuration of PHO services with a view to:

- Obtaining efficiencies in administrative costs
- Ensuring greater ability to make strategic investment in information systems and facilities
- Improving capacity for preventative health programmes
- Better use of scarce leadership and technical skills
- Easier integration of primary and secondary care services
- Increased potential for spread of innovation and best practice.

Hutt Valley PHOs are being actively encouraged to look at options for consolidation, including cross boundary consolidation with PHOs in the Capital and Coast DHB district. The principles guiding the Hutt Valley DHB's considered approach include:

- Supporting a PHO led approach
- Acknowledging the efficiency and effectiveness of our smaller PHOs, some of which are closer to the Government's vision of integrated family care centres

- Ensuring that we preserve or enhance overall performance
- Minimising any negative impact on high needs communities
- Supporting innovation in primary health care.

Hutt Valley DHB will work with its PHOs to deliver plans for PHO reconfiguration by 30 June 2010 with the aim of implementing changes by 31 December 2010.

Priority Actions for Primary and Community Services

Table 8 below summarises the priority actions that Hutt Valley DHB is seeking to achieve in Primary and Community Services.

Table 8: Primary and Community Services Priority Actions

Significant services, actions, programmes or initiatives (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts
Foster the development of new models of service delivery for people with long term conditions (including cardiovascular, diabetes and respiratory disease).	Diabetes/CVD measures *(Health Target)* Number of people enrolled in Care Plus	Services are better integrated Reduced avoidable admissions
Progress the Oral Health Service Provision for Child and Adolescents Project.	Increased number of pre and school children enrolled and examined Number of adolescents enrolled and examined	Intervention is earlier Caries free at 5 years, DMFT score at Year 8
Progress Respiratory Project; Breath Easy: • Review services available for people with respiratory condition including funding with a view to improving support for people in the community including better access to diagnostic services.	Reduce avoidable hospitalisations	Intervention is earlier Services are better integrated Reduced avoidable admissions
Progress next phase of after-hours primary health care business plan	Project progresses to plan	Improved access to services
Community Pharmaceuticals Value for Money Project	Reduced expenditure per capita on community pharmaceuticals	Services are provided efficiently and effectively
Progress Cellulitis Project • Increase targeted programmes in areas where high incidence and impact, including focus on children and men	Reduce avoidable hospitalisations	Intervention is earlier Services are better integrated Reduced avoidable admissions
Review diabetes services: • Review the wide range of diabetes services already available in the community - ensuring there is clinical input and involving the local diabetes team as appropriate - to identify whether any service gaps exist, identify whether any funding shifts are required and action these as appropriate in 2010/11. This will enable the DHB to further improve on its diabetes performance targets in 2011/12.	Make year on year increases in diabetes performance targets. Reduce avoidable hospital admissions associated with diabetes and CVD.	Intervene earlier in patient care and management Better integrate secondary and primary care diabetes and CVD service delivery.

3.3 Hospital Services

Hospital Services encompass all services provided via the Hutt Hospital, including:

- Medical services
- Surgical Services

- Plastic, ENT, Audiology and Dermatology services
- Gynaecology services
- Maternity services
- Mental health services

Key Areas of Focus
Hutt Hospital is working on a number of challenges, including:

- Improving productivity and releasing more capacity to increase activity, ahead of the new campus developments
- Focusing on quality improvements that lead to improvements in efficiency and effectiveness of services
- Working closely with our neighbouring DHBs
- Managing workforce and skill shortages that impact on access to services
- 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
- 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
- Developing and supporting our clinical leaders and networks
- Maintaining credentialing requirements
- 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 15% of pregnant women
- Changing the model of care for mental health services to one that delivers a collaborative and integrated service based on need.

Electives Services Plan

Hutt Valley DHB is committed to meeting the Government's expectations around 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 Government has set a national target of 2000 extra surgical discharges, although each DHB's contribution varies. In 2010/11 we plan to achieve a total of **5,459** elective discharges for our population as shown by specialty in Table 9 below (including dental & cardiology). This includes elective discharges provided on our behalf by other DHBs.

Table 9: Electives Services Plan

Elective Cases	09-10 plan	10/11	11/12	12/13
D01001 Dental Treatment	391	363	363	363
M10001 Cardiology	172	200	200	200
S00001 General Surgery	948	937	925	925
S15001 Cardiothoracic	74	107	107	107
S25001 ENT	662	565	565	565
S30001 Gynaecology	668	625	625	625
S35001 Neurosurgery	46	45	45	45
S40001 Ophthalmology	564	564	564	564
S45001 Orthopaedics	604	638	638	638
S55001 Paediatric Surgery	99	117	117	117
S60001 Plastics/Max/Burns	841	976	961	961
S70001 Urology	214	219	219	219
S75001 Vascular Surgery	121	103	103	103

Elective Cases	09-10 plan	10/11	11/12	12/13
Total	5404	5459	5432	5432

Within our surgical services production plan we are planning to complete 150 breast reconstructions. Of these 100 are delayed breast reconstructions. Around 25 of these are estimated to be for the Hutt Valley DHB domiciled women. In addressing the backlog, those women who have waited longest since their mastectomy will be given priority for surgery.

Our plan to achieve our Elective Services Plan includes increasing day surgery rates, improving our day of surgery admission and standardising pre-operative assessment. Our agreed target for day of surgery admission is 90%. Due to our higher plastic surgery, which traditionally has a low rate of day of surgery admission due to the nature of these surgical procedures, this rate will be challenging to achieve.

Day Surgery
Hutt Hospital has a new Day Surgery unit and the interim theatres have a day surgery focus and are designed for day surgery cases. Since their commissioning in October 2009 the day surgery rate has increased from 34% to 42%. Each speciality is identifying cases that can be done as day surgery and bench marking Hutt performance against appropriate Australasian or UK benchmarks. The Clinical Head of Day Surgery and the CNM Day Surgery are working with surgeons in supporting them to equal the benchmarked target.

DOSA
There has been a DOSA project in place for the last year and this has produced measurable results in orthopaedics (37% last year to 63% this year). The focus of the project is now on plastics and arrangements are being put in place to accommodate out of region patients outside the hospital the night before surgery. The new theatre complex has a dedicated DOSA admission area. We are also working with other DHBs to enable patients to have pre-operative assessment in their DHB of domicile rather than being admitted to Hutt hospital the day prior to surgery for pre-operative assessment.

Waiting Times
Currently Specialities have set waiting times for outpatient appointments and surgery to a maximum of six months, urgent within one month and semi-urgent within four months. Each speciality is reviewing the demand and capacity in their services to enable the longest waiting time for DHB generated reasons to be within four months.

Theatre Efficiency
Hutt hospital is measuring the efficiency of resourced theatre time in each of its theatres as the total time utilised as a percentage of the total time resourced. The benchmark is 85% utilisation and Hutt hospital is meeting this in all its theatres. The aim is to continue to meet this benchmark.

Shorter Stays in Emergency Department

Hutt Valley DHB is committed to ensuring that over time we provide shorter stays for patients in our Emergency Department (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.

A whole-of-hospital project has been established. The project is focussing on the patient journey from ED into the hospital and back out to the community, addressing blockages and constraints that impede efficient admission and discharge or transfer from the wards. We will be linking closely with our colleagues involved in the management of long term conditions and integration of primary and secondary care services to progress issues relating to avoidable presentations to ED.

We have developed a delivery plan and work programme with the following areas of focus:

- Improvements to the hospital's bed management system
- Ongoing development of the ED's quality indicators to measure time stamps and outcomes Dissemination of admission data with all wards and units to promote awareness and timeliness across the hospital
- Bringing forward the time of discharge in the medical ward to the late morning so discharges do not coincide with the afternoon peak in admissions
- Improvements to the referral process between Older Persons Rehabilitation Service and the Medical Ward

- Removing duplication in Allied Health assessments
- Identification of delays in access to aged care services in the community from the hospital.

As part of our commitment to ensuring faster and better services for ED patients, Hutt Valley DHB has commenced construction of 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 Government's ED Health Target and construction of the new ED/theatre have been identified as priority projects for monitoring by the Board. Despite our current space constraints, our target is that 95% all patients will be admitted, discharged, or transferred from the ED within 6 hours (Health Target).

Cancer Services

Cancer services are provided for the Hutt Valley population at Capital and Coast District Health Board's Wellington Blood and Cancer Centre. The Wellington Blood and Cancer Centre plan to meet the new target of patients waiting less than four weeks for radiotherapy services. This includes addressing issues associated with the co-location of services that currently limit capacity. Work force issues are also being actively addressed, including in Medical Physics, which is the specialty most at risk of impacting on capability. Hutt Valley DHB will work closely with Capital and Coast DHB to to identify and address any process issues, including access to procedures within each DHB, which have the potential to hold up the treatment start date.

Mental Health Services

During 2009/2010 Hutt Valley DHB completed its Knowing the People planning process for it's mental health services, which was designed to ensure that the service structures were meeting consumers' needs. As a result we changed the way our DHB-provided services operated.

In the coming year (2010-2011) we are progressing greater integration between Capital & Coast, Hutt Valley and Wairarapa DHBs' mental health services, with an initial emphasis on regional acute psychiatric cover.

Maternity Services

Hutt Hospital has been providing primary maternity care to pregnant women since 2007/08 due to a shortage of independent midwives. Some new independent midwives have recently moved into the area, so Hutt Hospital is now providing primary maternity care for a lower percentage of pregnant women (15%). We will continue our efforts to attract midwives to the valley and to support them in their professional practice (e.g. encouraging them to participate in various training programmes - free of cost, and offering flexible arrangements to LMCs who want to take a small independent load as well as working part-time in the hospital).

Priority Actions for Hospital Services

Table 10 below summarises the priority actions that Hutt Valley DHB is seeking to achieve in Hospital Services.

Table 10: Hospital Services Priority Actions

Significant services, actions, programmes or initiatives (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts
Progress Electives Plan	Electives targets (Health Target) Day surgery rates Day of surgery admission Theatre utilisation	Access to services is improved Services are provided more efficiently and effectively
Implement improvements identified from the Improving Patient Experience Programme projects	ED waiting times (Health Target)	Services are provided more efficiently and effectively
Shorter stays in Emergency Department project	ED waiting times (Health Target)	Services are provided more efficiently and effectively

Significant services, actions, programmes or initiatives (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts
Support women to stay longer post-natally where needed in the transition to home and where capacity allows.	Post natal length of stay (Govt Priority)	Access to services is improved
Progress new theatre/ED construction project	Theatre utilisation	Services are provided more efficiently and effectively
Progress Breast Reconstruction services plan.	Target numbers	Access to services is improved
Continue implementation of the 5 yr mental health and addiction action plan Make it Happen (Whakamahingia).	Improved information about services to allow benchmarking	Access to services is improved Services are provided more efficiently and effectively

3.4 Support Services

Hutt Valley DHB is progressively implementing the national Health of Older People Strategy, which all DHBs are to implement 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.

In 2010/11, we expect that the Needs Assessment and Service Coordination Centre will continue to improve its performance in assessing clients and managing entry to services to meet the health needs of older people, working collaboratively with DHB clinical staff. We will work with aged residential care providers and home based support services to improve the quality of service delivery, through staff training, client feedback mechanisms, medication reviews and other system improvements e.g. incident recording, audit and monitoring. Our work with Capital and Coast DHB will support these initiatives, reducing duplication of effort and enhancing integration across services. The focus on long-term conditions and improved prescribing of pharmaceuticals will have major benefits for older people, as they are major users of these services.

In 2010/11 we will support primary care to improve its capability to provide generalist palliative care services in collaboration with specialist palliative care services.

Key Areas of Focus

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 being addressed by Hutt Valley DHB include:

- High utilisation of aged residential care hospital beds compared to the national average
- Providing appropriate support for older people at home
- Ensuring quality of supervision and nursing in aged residential care facilities
- Ensuring quality and safety of services in home based support services
- Integrating services for older people with long term conditions across community, primary, and secondary care services
- Building workforce capability.

Priority Actions for Support Services

Table 11 below summarises the priority actions that Hutt Valley DHB is seeking to achieve in Support Services.

Table 11: Support Services Priority Actions

Significant services, actions, programmes or initiatives (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts

Significant services, actions, programmes or initiatives (Planned Outputs)	Performance Measures	Intended Outcomes/ Impacts
Improve the management of entry to long -term aged residential care services through increased involvement of clinicians and the Needs Assessment and Service Coordination (NASC) service.	ARC hospital bed-days per 1000 people 65 years and over (reduced to be	Services are better integrated Improve financial performance
Improve integration across primary health and HOP services especially for people with long term conditions	Number of people 65 years and over enrolled in Care Plus	Services are better integrated Reduced avoidable admissions for people 65 years and over
Improve quality and safety in residential facilities and community services through staff training, client feedback mechanisms, medication reviews and other system improvements.	Community pharmaceutical prescribing for older people	Health risk is reduced Reduced avoidable admissions for people 65 years and over
Developing a collaborative approach to the delivery of Health of Older People services with Capital & Coast DHB	Joint initiatives underway by Dec 2010	Services are provided more efficiently and effectively
Provide and support training to GPs in palliative care	One palliative care GP CME session and 8 practice based presentations, provided by palliative care specialists.	Improved opportunity for people with terminal illness to receive medical care from their GP and remain in their own home for as long as they are able.

4.0 Organisational Capability

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*. 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 the Hutt Valley DHB.

4.1 Workforce Development

Workforce development and strong organisational health are central to ensuring that we provide high quality and effective services. Through supporting flexibility and innovation; providing leadership and skill development opportunities; and being a 'good employer' Hutt Valley DHB aims to be a preferred employer of health workers. As a 'good employer' we have a number of policies that promote equity, fairness and a safe and healthy work environment. These policies address:

- Fair and transparent recruitment to ensure we meet current and future workforce needs and retain staff
- Our zero-tolerance of all forms of harassment and bullying
- Equitable training and development opportunities for all employees
- The management and disclosure of adverse events to ensure a safe quality working environment.

The DHB is committed to developing a workforce profile and understanding the needs and expectations of its workforce. We are committed to promoting leadership opportunities and a positive culture for our organisation. We intend to focus the majority of our workforce development efforts for the coming year on a contained group of activities. Those identified aim to improve staff recruitment, retention and development and in the process reduce turnover while improving the patient experience.

In the current climate the need for strong change management skills within the organisation is recognised and will be one of the key factors in maintaining a strong, motivated workforce, even as we make substantial changes to some areas of our operation.

Staff recruitment

Collaborate nationally on international recruitment: The government has set a priority for a 'one-stop-shop' for international recruitment into the health and disability sector. Given the current high cost (paying agency commissions) and the often-problematic exercise of securing key clinical skills (with scarce resources at times), collaboration is both sensible and potentially more cost-effective.

Collaborate regionally and sub-regionally on recruitment: Hutt Valley, Capital & Coast, and other DHBs are looking at joint recruitment initiatives, particularly for clinical staff groups.

Staff retention

The Government has made it clear that it expects DHBs to improve clinical staff retention. The following measures are proposed to further improve the retention and satisfaction and engagement of all DHB staff.

- Develop and implement a new, user-friendly performance appraisal system that encourages clinical leadership and behaviours in line with our values.
- Participate in an appropriate regular staff survey to gauge staff satisfaction and engagement on an ongoing basis, and follow-up with staff on areas of concern, in order to put them right.
- Recruit nurses with a view to having them pursue a career in the Hutt. We will set up a process whereby we communicate our desire to retain the services of our nursing workforce for the long-term at induction and through their time with us, discuss career paths where appropriate at performance appraisal reviews and invite nurses leaving for travel to contact us on their return.

Staff development

How an organisation supports and develops its staff to fulfil their roles sends clear messages to them about how and whether they are valued.

- Identify and establish suitable training courses for those identified as near-future supervisors and managers and for newly appointed supervisors and managers.
- Expand and apply better controls and systems to the existing Mentoring Programme.
- Continue with and seek to enhance where possible our existing scholarship programmes.

- Establish more in-house training for managers at all levels re: succession planning – how to identify, coach and motivate staff for advancement within the DHB, in particular to supervisor and managerial positions.
- Continue with the Collective Leadership Forum Group established by the CEO. This forum is potentially an effective catalyst for further evolving collective leadership within the DHB.

4.2 Emergency Department/Theatre Project

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 the Hutt Valley DHB.

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 40,000-plus attendances (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 facility commenced in January 2010 and will be completed by August 2011. The new facility will be operational from October 2011, and final occupation of refurbished buildings as part of the overall development will occur from June 2012.

Because the new operating theatres will not be operational until the last quarter of 2011, Hutt Valley DHB commissioned two temporary 'clip on' day surgery operating theatres in 2009. These are critical to meeting our elective surgery targets.

4.3 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.

The Information Systems Strategic Plan (ISSP) 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. Details of the projects arising from our ISSP for 2010/11 are provided at Appendix 3.

4.4 Quality and Safety

The Quality Plan for Hutt Valley DHB[6] 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 collective leadership forum, the patient safety leadership group, and various clinical committees 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)[7] national quality programmes. We are the lead DHB for the safe medication management project. In addition, our 'Improving the Patient Experience' programme and implementation of the hand hygiene project reflect our involvement at a national level.

In 2010/11 our focus will be to:

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

[7]The National Quality Improvement Committee (QIC) has ministerial sign off for five national improvement programmes: 1. Optimising the patient's journey, 2. Mnagement of healthcare incidents, 3. Infection prevention and control, 4. National mortality review systems, 5. Safe medication management

- Continue to support staff to deliver high quality care within a quality improvement framework
- Participate 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
- Improve management of medications through the drug and therapeutics committee
- 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.

5.0 Service Coverage

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.

5.2 Provision of Services

A summary of the agreed provider-arm outputs for the Hutt Valley population is provided in Table12 below:

Table 12 Contracted service outputs for the Hutt Valley population[8]

Contracted ouput/service	Measure/Unit	2008/09 Amount provided	2009/10 Amount forecast	2010/11 Amount Planned	Variance %
Medical in-patient	Caseweights	9,546	9,212	9,735	6%
Surgical in-patient - Acute	Caseweights	5,672	5,754	5,640	-2%
Surgical in-patient - Elective	Caseweights	6,200	5,860	6,399	9%
Medical out-patient	Attendances/Procedures	45,237	46,272	47,859	3%
Surgical out-patient	Attendances/Procedures	45,180	44,827	45,499	1%
Mental health	FTE/Bed days	11,239	11,239	11,239	0%
Emergency department	Attendances	30,702	29,991	30,765	3%
Maternity	Attendances/Procedures	1,974	14,678	14,667	0%
Health of older people	FTE/Bed days	11,707	15,983	16,550	4%
Personal/Community Health		144,720	152,963	149,613	-2%
Total		**312,177**	**336,781**	**337,966**	0%

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 Reviews and Changes

We propose to undertake a number of service reviews and service changes during 2010/11 as outlined below:

[8] Counting for maternity services has changed from a capacity base to outputs

- Reviews with Capital & Coast and Wairarapa DHBs over a range of services as part of our increased focus on collaborating to deliver key services
- Implementation of the Oral Health Business Case
- Establish a Rheumatology Gout Clinic in primary care
- 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 2010/11 we intend to complete a review of these criteria
- 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)
- Currently CCDHB Wellington Blood and Cancer Centre outreach outpatient clinics are held at Hutt Hospital. In 2010-11 we will investigate the possibility of delivering chemotherapy at Hutt Hospital on a day-patient basis.

These reviews and plans may lead to service reconfigurations, the extent of which is unknown at this stage. 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.

5.5 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 2010/11 we intend to complete a review of 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

We have outlined our plans for living within our means at Section 2.4. In summary our financial position for 2010/11 is a deficit of $3m with a forecast breakeven position in out years.

6.1 Budgeted Financial Statements

The full sets of financial statements for Hutt Valley DHB for the planning period are included at Appendix 4. 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).

6.1.1 Summary of Operating Budget

Our operating forecast for 2010/11 is a deficit of $3m.

6.1.2 Funding Advice

Funding advice was received in December 2009 that included additional funding for 2010/11. The additional funding consists of a 1.73% for relieving cost pressures. Our share of the demographic funding was 1.37%. 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. Overall the Funder has increased funding to the Provider arm by 3.6% over the 2009/10 budget.

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 for community pharmaceuticals in line with PHARMAC forecasts.

IDF Outflows are based on the volumes provided under the agreed IDF methodology and are budgeted for at national prices. There is an increase in the cost of IDF outflows of $6.4m over the 2009/10 budget.

Our projection for the costs of contracts with external service providers includes a provision for price increases as provided for in the contracts for those providers.

As a result of these reviews we have projected a summary deficit for the Funder Arm of $0.988m for 2010/11.

6.1.4 Provider Financials

Base funding for the Provider Arm is agreed through the Memorandum of Agreement (MOA) with the Funder Arm. In 2010/11 the base increase in funding is 3.6%. 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.

There are planned savings of $4.9m assumed in these budgets. These savings come from a range of efficiency programmes within the Provider Arm. We are estimating a deficit for the Provider Arm of $1.994m for 2010/11.

6.2 Assumptions

The key assumptions have been included in our preparation of the forecast financial statements for 2010/13. Our Statement of Accounting Policies is included at Appendix 5.

General Assumptions

- No external deficit funding will be required during the planning period
- Capital expenditure of up to $36 million is planned for 2010/11
- Build programme for the ED theatre redevelopment will continue during 2010/11. Interest incurred on funds borrowed of $24.9m will be capitalised against the project
- The last full revaluation occurred on 30 June 2004. A further valuation is planned for 2010 on a Optimised Depreciated Replacement Costs basis. We estimate the revaluation based on 2009 desktop to be a land increase of $3.8M and buildings increase of $3.2m. This is expected to be cost a further $800k in capital charge and depreciation
- No new ownership investments in other businesses are included in this Plan
- Early payment of funding from the Ministry of Health will continue
- Changes to the value of the Provider Arm Volume Schedule will be accommodated within the application of the memorandum of agreement rules with the Funding Division. Any new or additional costs will be offset by equivalent cost reductions elsewhere in Hutt Valley District Health Board
- Interest rates are assumed to remain at 2009 levels until mid 2010 when they are expected to rise
- Exchange rate fluctuations may materially impact the cost of supplies and will be offset by clinical supply saving initiatives, and the use of hedging contracts by suppliers
- Hutt Valley DHB's share of the national population based funding formula will be 3.16%, 3.15% and 3.13% in 2010/11, 2011/12 and 2012/13 respectively
- Revenue increase from population based funding and demographic changes have been included of 3.1% in 2010/11, 3.01% in 2011/12 and 2.92% in 2012/13
- No change in capital charge rate of 8%.
- Additional compliance costs e.g. Archives Act changes may be met out of retained earnings
- There will be no changes to intervention rates and inter-district flows, with no significant impact on net costs with the exception of the return in house of urology and ophthalmology in 2011/12 as signalled in our ED Theatre business case
- No material costs have been included for a pandemic
- The national procurement programme will deliver $1.2m of bottom line savings to this DHB.

Personnel

- Personnel cost increases will be in accordance with nationally agreed financial assumptions. Any increases above these levels must be accompanied by an agreed funding mechanism

- Any restructuring costs incurred in implementing the deliverables contained in this Plan will be cost neutral in the year incurred
- Administration/management numbers will not exceed the cap established in January 2009, i.e. 388FTEs except by agreement of the Minister of Health.

Demand for Hospital & Associated Services

- Hutt Valley DHB will live within its budget. This may require restructuring costs
- Overall acute demand will be similar to that of 2009/10, thus allowing planned levels of elective procedures to be undertaken
- Elective throughput will be in accordance with the Elective Services Plan
- Interdistrict Inflows and outflows use the volumes and prices provided by the Ministry of Health IDF budget files
- Breast reconstruction surgery is budgeted at $1.4m revenue.

National Policy

- Government policy settings will not vary significantly
- The impact of changes to the income and asset testing regime will be cost neutral, with revenue equating to current costs
- Revenue for capital and operating costs, as detailed in Hutt Valley DHB's business case for Child & Adolescent Oral Health Services, will be provided from national funds
- All changes resulting from implementation of the Ministerial Review Group's recommendations will be at least cost neutral to Hutt Valley DHB
- There will be no new Government health service initiatives

Contracted Providers: Pricing

- There will be no price increases for contracted providers unless required under existing contracts
- Price and volumes increases for pharmaceuticals (community pharmaceuticals and pharmaceutical cancer treatment) have been assumed to be in line with national agreement and PHARMAC budgets
- Private laboratory costs to be met by private patients.

6.2.1 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 settling in this 12 month period. We have assumed that they will be settled within nationally agreed assumptions. 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 budgeted levels is a risk, given the increases in salary movements in this sector over the last 12 months.

6.2.2 Out Years 2011/12 to 2012/13

We have assumed base revenue increases of 3.01% for 2011/12 and 2.92% in 2012/13 years respectively. Both years reflect the impact of service reconfigurations. The impact of the ED/Theatre redevelopment project is reflected in the 2011/12 position. We are budgeting for an ongoing breakeven position from

2011/12.

6.3 Capital Expenditure

Our capital expenditure plans for the three-year planning period are included at Appendix 7. 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.

6.4 Efficiency Initiatives

Details of our living within our means initiatives and performance improvement actions are included in Section 3.

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 no business cases requiring approval at the Ministry of Health at this time.

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 draw down 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 also entering into lease financing for clinical equipment of up to $10m over the next two years.

Appendix 1: Our vision, goals and values

Vision

Whanau Ora ki te Awakairangi

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, early treatment and easy access
Effective, efficient and high quality services
Seamless integration
An inclusive district

Key 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 information and measuring progress
Developing the workforce
Improving our hospital

Appendix 2: DHB Non-financial monitoring framework and performance measures

The Ministry monitors DHB performance on behalf of the Minister. The DHB non-financial monitoring arrangements, form part of the wider accountability requirements, and are a key tool to provide assurance that the DHB delivers in terms of the legislative requirements[9] and in terms of Government priorities. The Ministry of Health has developed a monitoring framework based on four dimensions of DHB performance.

Policy Priorities Dimension

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
HT1	Shorter stays in emergency departments		Total	95%	% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	**95%**	Quarterly
HT2	Improved access to elective surgery		Total	4,896	The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1400 per year)	**4,000**	Quarterly
HT3	Shorter waits for cancer treatment		Total	100%	% of patients in category A, B and C wait less than **four** weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).	**100%**	Quarterly
HT4	Increased Immunisation		Māori	90%	% of two year olds are fully immunised by July 2011	**90%**	Quarterly
			Pacific	90%			
			Total	90%			
HT5	Better help for smokers to quit:	1. Hospitalised smokers	Total	90%	% of hospitalised smokers will be provided with advice and help to quit by July 2011	**90%**	Quarterly
		2. Primary Care	Total	80%	% of patients attending primary care will be provided with advice and help to quit by July 2011	**80%**	Quarterly
HT6	Better diabetes and cardiovascular services	1. Diabetes Management	Māori	56%	Increased percent of people with diabetes have satisfactory or better diabetes management		Quarterly
			Pacific	64%			
			Other	65%			
			Total	64%			
		2. Diabetes Checks	Māori	60%	Increased percent of people with diabetes attend free annual checks		
			Pacific	53%			
			Other	82%			
			Total	75%			
		3. CVD Lipids	Māori	67%	Increased percent of the eligible adult population have had their CVD risk		
			Pacific	70%			

[9] New Zealand Public Health and Disability Act 2000

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
			Other	78%	assessed in the last five years		
			Total	76%			
PP1	Clinical leadership self assessment		Total	The DHB provides a qualitative report in the form of a self assessment identifying progress achieved; What's worked; what hasn't; Planned actions - for each of the following areas of focus: • whether managers and clinical leaders feel valued and recognised for their leadership capability • whether joint management and clinical relationships are effective • whether strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines • whether there is shared ownership of organisational outcomes across management and clinical leadership, and across disciplines.			Annual
PP2	Implementation of Better, Sooner, More Convenient primary health care		Total	The DHB is to supply a report confirming it has implemented the changes to primary care service delivery models agreed in its DAP **OR** a report identifying why changes to primary care service delivery models agreed in its DAP have not been implemented, with an associated resolution plan.	Those DHBs involved in the development of business cases with successful Expression of Interest providers are required to report on progress of the implementation of those changes as agreed to in their DAP. Those DHBs not involved in the development of business cases are required to report on the implementation of changes to primary health care that deliver on the core elements outlined in Chapter 3 of Better, Sooner, More Convenient and agreed to in its DAP.		Annual
PP3	Local Iwi/Māori engagement and participation in DHB decision making, development of strategies and plans for Māori health gain	Measure 1	Total	100%	% of PHOs with Māori Health Plans (MHPs) that have been agreed to by the DHB		Six-monthly
		Measure 2	Total	100%	% of DHB members that have undertaken Treaty of Waitangi training		
		Measure 3	Total	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 during the reporting period. • Provide a copy of the Memorandum of Understanding (MoU).			
		Measure 4	Total	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	Total	Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) **OR** for newly established PHOs, a report on progress in the development of MHPs (include a list of the names of these PHOs).			
		Measure 6	Total	Describe when Treaty of Waitangi training (including any facilitated by the Ministry) has, or will, take place for Board members.			

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
		Measure 7	Total	Two Key Milestones from your Māori Health Plan: 1. Ensuring Maori women have an LMC 2. Increasing Maori adolescent uptake of dental services	Identify at least two key milestones from your Māori Health Plan to be achieved in 2009/10. 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 during the current year.		
PP4	Improving mainstream effectiveness DHB provider arms pathways of care of Māori	Measure 1	Total	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.			Six-monthly
		Measure 2	Total	Report on an example(s) of actions taken to address issues identified in the reviews.			
PP5	Waiting times for chemotherapy treatment		Total	100%	% of patients wait less than six weeks between first specialist assessment and the start of chemotherapy treatment. Wait times templates are to be supplied each quarter, The templates should display results for each month within the quarter. Qualitative comment on reasons (and management plans) for people with chemotherapy waits longer than 6 weeks is to be supplied in quarterly reports.	**100%**	Quarterly
PP6	Improving the health status of people with severe mental illness	Age 0-19	Māori	4.50%	% of people domiciled in the DHB region, seen per year.		Six-monthly
			Other	2.30%			
			Total	2.30%			
		Age 20-64	Māori	4.80%			
			Other	2.90%			
			Total	2.90%			
		Age 65+	Total	1.47%			
PP7	Improving mental health services using crisis intervention planning		Total	95%	% of long-term clients (in contact for 2 years or more) who have relapse prevention plans.	**90%**	Six-monthly
PP8	DHBs report alcohol and drug service waiting times and waiting lists		Total	Waiting times and waiting lists are to be measured, for one month, every six months, to inform Ministry policy and, to determine the variation and extent of waiting times and waiting lists to determine if targets will be required to be set in the future. DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period. A narrative is also required to: 1. identify the name and location of service(s) with the longest waiting time and waiting list 2. explain variances of more than 10% in waiting times or waiting lists 3. explain/identify targets that the DHB may have for reducing waiting times and or	Service type: Inpatient Detoxification, Specialist Prescribing, Structured Counselling, Day Programmes and Residential Rehabilitation. DHBs will report waiting times by Māori and Other ethnicities.		Six-monthly

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
				waiting lists			
PP9	Delivery of Te Kokiri: the mental health and addiction action plan		Total	DHBs are to provide a summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan.			Annual
PP10	Oral Health DMFT Score at year 8		Māori	1.2	% of children with decayed, missing or folled permanent teeth at year eight.		Annual
			Pacific	1.2			
			Other	0.7			
			Total	0.9			
PP11	Children caries free at 5 years of aged		Māori	50%	% of children carries free at 5 years of age		Annual
			Pacific	50%			
			Other	75%			
			Total	67%			
PP12	Utilisation of DHB funded dental services by adolescents		Total	70%	% of adolescent utilisation of DHB funded dental services		Annual
PP13	Improving the number of children enrolled in DHB funded dental services	Measure 1	Total	65%	% of children under five enrolled in DHB funded dental services		Annual
		Measure 2	Total	7%	% of preschool and primary enrolled with DHB funded dental services who have not been examined according to there planned recall.		
PP14	Family violence prevention		Total	140/200	combined audit score	**140/200**	Annual

System Integration Dimension

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
SI1	Ambulatory sensitive (avoidable) hospital admissions	1. Age 0-74	Māori	113.5	Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.		Six-monthly
			Pacific	107.7			
			Other	113.5			
		2. Age 0-4	Māori	123.8			
			Pacific	123.2			
			Other	143.7			
		3. Age 45-64	Māori	102			
			Pacific	<89.6			
			Other	110.5			
SI2	Regional service planning		Total	DHBs are to report confirming: • The DHB has progressed the RCSP according to plan submitted to Ministry of Health If the DHB cannot provide the confirmation report outlined above, it is expected that the DHB will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and provided to the Ministry no later than three months after the non-compliance is first reported.			Six-monthly
SI3	Service coverage		Total	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: • analysis of explanatory indicators • media reporting • risk reporting • formal audit outcomes • complaints mechanisms • sector intelligence.			Six-monthly
SI4	Elective services standardised intervention rates	1. Intervention rate	Total	292 per 10,000	Intervention rates not significantly below the expected level. For any procedure where the standardised intervention rate in the 2009/10 financial year or 2010 calendar year is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate **AND**	**At least 292 per 10,000**	Six-monthly
		2. Major joint procedures intervention rate for Hip and Knee	Total	21 per 10,000		**21.0 per 10,000 (10.5 each for knee and hip)**	
		3. Cataract procedures intervention rate	Total	27 per 10,000		**27.0 per 10,000**	

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
		4. Cardiac procedures intervention rate	Total	6.23 per 10,000	2. whether the DHB considers the rate to be appropriate for its population **OR** 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2010/11) that will ensure the target rate is achieved.		
SI5	Agreed Funding for Māori Health and disability initiatives	Measure 1	Total	It is expected that setting expectations in DAPs and monitoring DHB performance against this indicator HKO-04 will ensure increased funding for Māori health and disability initiatives Please complete the following measures in the Template provided: **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.		Annual
		Measure 2	Total				
		Measure 3	Total				
SI6	Risk Reporting		Total	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). If the DHB cannot provide the confirmation report outlined above, it is expected that the DHB will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and provided to the Ministry no later than three months after the non-compliance is first reported.			Six-monthly
SI7	Improving breast-feeding rates	6 Weeks	Māori	74%	% of infants exclusively and fully breastfed at 6 weeks	**74%**	Annual
			Pacific	74%			
			Other	74%			
			Total	74%			
		3 Months	Māori	57%	% of infants exclusively and fully breastfed at 3 months	**57%**	
			Pacific	57%			
			Other	57%			
			Total	57%			
		6 Months	Māori	27%	% of infants exclusively and fully breastfed at 6 months	**27%**	

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
			Pacific	27%			
			Other	27%			
			Total	27%			

Ownership Dimension

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
OS1	Staff turnover by major professional group		Total	The DHB provides a qualitative report in the form of a self assessment identifying progress achieved; What's worked; what hasn't; Planned actions - for each of the following areas of focus: Whether •managers and clinical leaders feel valued and recognised for their leadership capability • joint management and clinical relationships are effective • strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines • there is shared ownership of organisational outcomes across management and clinical leadership, and across disciplines.			Quarterly
OS2	Capital expenditure in line with plan	deviation from plan in the YTD	Total	$39.712m	above or below plan as set out in DAP financial templates. Expenditure should not be materially greater than set out in plan.		Quarterly
OS3	Elective and arranged inpatient length of stay	average length of stay for elective and arranged patients with a length of stay of one night or more. The measure is indirectly standardised for DRG cluster and comorbidities.	Total	3.91	DHBs will have individual targets towards shorter length of stay. The suggested benchmark is the average length of stay of the 'fifth-best' DHB in the 2008/09 financial year.		Quarterly
OS4	Acute inpatient length of stay	average length of stay for acute patients with a length of stay of one night or more. The measure is indirectly standardised for DRG cluster and comorbidities.	Total	4.02	DHBs will have individual targets towards shorter length of stay. The suggested benchmark is the average length of stay of the 'fifth-best' DHB in the 2008/09 financial year.		Quarterly
OS5	Theatre productivity	The DHB is expected to reduce the number of theatre sessions that start late, finish early, or are cancelled.	Total		Each quarter, the DHB is required to submit the following data elements for each theatre in each Provider Arm facility: • number of scheduled theatre sessions in the quarter (may be zero if the theatre is not in use) • number of cancelled theatre sessions in the quarter • number theatre sessions that start late (and do not finish early) • number of theatre sessions that finish early (and started on time) • number of theatre sessions that start late and finish early		Quarterly

Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information	National Target	Frequency of reporting
OS6	Elective and arranged day surgery	the rate of day surgery for elective and arranged surgical patients (operating room and non-operating room). The rate is indirectly standardised for DRG.	Total	60%	DHBs will have individual targets towards higher rates of day surgery. The suggested benchmark is the rate of the 'fifth-best' DHB in the 2008/09 financial year.		Quarterly
OS7	Elective and arranged day of surgery admissions	the rate of day of surgery admissions for elective and arranged surgical patients.	Total	90%	of surgery on a day of surgery admission basis (with some room for flexibility). This benchmark is based on Australian experience.	**90%**	Quarterly
OS8	Acute readmissions to hospital	the rate of unplanned acute readmissions within 28 days of original discharge from hospital. The rate is indirectly standardised for a range of factors using regression methods.	Total	10.15%	DHBs will set individual targets for improvement of acute readmission rates. The suggested benchmark is the national average acute readmission rate during 2008/09.		Quarterly
OS9	30 Day mortality	The mortality rate within 30 days of admission for patients in hospital. The rate is indirectly standardised for a range of factors using regression methods.	Total	1.58%	DHB will set individual targets. The suggested benchmark is that DHBs aim to maintain mortality at least at the 2008/09 level for the DHB, or improve it, during the year.		Annual
OS12	National patient satisfaction survey		Total	This measure is a place holder for a patient satisfaction survey or similar tool. Currently there is no detailed measure in this ownership dictionary as a piece of work on the future of the current survey and consideration of alternative models is yet to .take place. A place holder measure is included in the summary tables and diagrams so that the measure is captured in the analysis of reporting burden, but the shape of future surveys and associated measures is yet to be confirmed.			Quarterly
OS10	Improving the quality of data provided to national collection systems	Measure 1 Timeliness of NMDS Data	Total	5%		**>2% and ≤5%**	Quarterly
		Measure 2 NHI Duplications	Total	3%		**>2% and ≤3%**	
		Measure 3 Ethnicity not stated in NHI	Total	4%		**>2% and ≤4%**	
		Measure 4 Start vs specific descriptors in the NMDS	Total	50%		**>50% and ≤59%**	
OS11	Hospital outputs are delivered to plan	The delivery of hospital outputs is measured against planned delivery as stated in the Provider Arm Price Volume Schedule, and expressed as a ratio of (actual/planned).	Total	100%	DHBs are expected to deliver total outputs for the year with a variance of less than three percent from plan overall, and a variance less than five percent in sub-groups of outputs.		Quarterly-for three quarters

Appendix 3: Information Services Strategic Plan

DHB NAME: _____Hutt Valley_____: Prepared: __08 / _Feb__ / _2010__: By: __Tony Cooke (CIO)__

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
Infrastructure Upgrade – Network	1	INF-03	Apr-2010	Apr-2011	1	U	L	300	I	Meets requirement for stability and efficiency of operation of all computer systems in the DHB; allows third party vendors to support their equipment remotely eg MRI scanner	Improves network performance, security and resilience; supports ED/Theatre building project; allows better remote access
EMR Enhancements	1	EMR-04	Jan-2010	Jun-2011	5	U	L	300	I	Improves quality of patient care by allowing the clinician to have access to accurate, up-to-date patient information	Upgrade e-referrals system and improve interfaces. Captures more clinical docs electronically. Supports long term care plan templates.
Shared Regional PACS Repository	2	CLN-02	Jun-2010	Apr-2011	7	N	R	200	I	Provides support for radiology as a vulnerable service in the region; improves access to diagnostic tests	Allows off-site storage and reduces need for on-site storage and backup. Eliminates the need to push or retrieve images from other PACS systems in the region
Outpatient Processes	2	PAS-02	Jul-2010	Jun-2011	-	U	L	100	I	Improves patient experience and quality of information; aligns with QIC – Optimising the Patient Journey	Optimises patient attendance at outpatient clinics Improves patient and GP correspondence
Theatre Processes	3	PAS-03	Jan-2011	Jan-2012	-	U	L	100	I	Support new Theatres development; meet reporting requirements for MoH	Support automated theatre booking and clinical workflow; allows more electronic capture and tracking
Video-conferencing	7	INF-04	Apr-2010	Dec-2010	1	N	R	150	I	Supports regional clinical networks and	Allows video-conferencing between

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
										implementation of Regional Clinical Service Plan	users in DHBs using one directory and technology
Single Sign-on	7	INF-05	Jul-2010	Jun-2011	11	N	R	495	I	Supports access for clinicians to systems in other DHBs	Improves clinician access to patient information; reduces need for paper based transfer of clinical information

Key:

Column 2: Project Ranking	**Column 6: HISAC Action Zone**	**Column 7: Project type**	**Column 8: Project significance**	**Column 10: Project Funding Source**
1: Must Do in 2010/2011	1: National Network Strategy	N: New	N: National	I: Internal (in approved DAP)
2: Should Do in 2010/2011 - Probable Do in 2011/2012	2: NHI Promotion	U: Upgrade	R: Regional	M: MoH New Funding
3: Nice to Do in 2010/2011 - Should Do in 2011/2012	3: HPI Implementation	R: Replacement	L: Local	P: Third Party
4: Non-urgent-Requested by Clinicians	4: ePharmacy			N: Not yet determined
5: Non-urgent-Requested by Board/Staff	5: eLabs			
6: Non-urgent-Requested by Ministry	6: Discharge Summaries			
7: Early Warning-upcoming work-probable future Rank 1	7: Clinical Care and Disease Management'			
8: Early Warning-upcoming work-probable future Rank 2	8: Electronic Referrals			
9: Early Warning-upcoming work-probable future Rank 3	9: National Outpatient Collection			
	10: National Primary Care Collection			
	11: National Systems Access			
	12: Anchoring Framework			

Appendix 4: Forecast Financial Statements

Financial Performance

Hutt Valley District Health Board
Statement of Forecast Comprehensive Income
For the Year Ended 30 June

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Revenue	396,956	421,474	435,514	445,302	452,819
Interest Revenue	715	414	576	575	473
Total Revenue	**397,671**	**421,888**	**436,090**	**445,877**	**453,292**
Expenditure					
Provider Expenditure	(206,521)	(214,620)	(222,700)	(223,706)	(223,104)
Operating Expenditure	(185,655)	(197,146)	(199,879)	(202,363)	(206,966)
Depreciation	(7,748)	(8,867)	(9,887)	(11,383)	(12,762)
Interest Expense	(1,251)	(1,256)	(1,506)	(3,329)	(5,207)
Capital Charge	(5,483)	(4,609)	(5,100)	(5,096)	(5,252)
Total Expenditure	**(406,658)**	**(426,498)**	**(439,072)**	**(445,877)**	**(453,291)**
Net Surplus/(Deficit) for the Period	**(8,987)**	**(4,610)**	**(2,982)**	**-**	**1**
Other Comprehensive Income					
Gain/(Loss) on Sale of Assets	(9)	(2)	-	-	-
Revaluation of Land and Buildings	-	7,000	-	-	-
Other Comprehensive Income	**(9)**	**6,998**	**-**	**-**	**-**
Total Comprehensive Income for the Period	**(8,996)**	**2,388**	**(2,982)**	**-**	**1**

Financial Performance

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Revenue	190,872	205,291	210,526	216,651	223,122
Interest Revenue	715	414	576	575	473
Total Revenue	**191,587**	**205,705**	**211,102**	**217,226**	**223,595**
Operating Expenditure	(183,114)	(194,647)	(197,167)	(199,821)	(204,424)
Depreciation	(7,744)	(8,865)	(9,887)	(11,381)	(12,760)
Interest Expense	(1,251)	(1,256)	(1,506)	(3,329)	(5,207)
Capital Charge	(5,483)	(4,609)	(5,100)	(5,096)	(5,252)
Internal Allocations	551	548	564	561	561
Total Expenditure	**(197,041)**	**(208,829)**	**(213,096)**	**(219,066)**	**(227,082)**
Net Surplus/(Deficit)	**(5,454)**	**(3,124)**	**(1,994)**	**(1,840)**	**(3,487)**
Gain/(Loss) on Sale of Assets	(9)	(2)	-	-	-
Net Surplus/(Deficit)	**(5,463)**	**(3,126)**	**(1,994)**	**(1,840)**	**(3,487)**
Expenditure Breakdown:					
Personnel Costs	(134,819)	(145,631)	(147,424)	(150,436)	(156,016)
Outsourced Services	(8,531)	(6,453)	(4,977)	(4,850)	(4,870)
Clinical Supplies	(23,985)	(26,251)	(26,976)	(27,422)	(27,743)
Infrastructure and Non-Clinical Supplies	(30,257)	(31,042)	(34,283)	(36,919)	(39,014)
Internal Allocations	551	548	564	561	561
Total Expenditure	**(197,041)**	**(208,829)**	**(213,096)**	**(219,066)**	**(227,082)**

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Revenue	359,422	383,237	393,744	404,175	415,108
Total Revenue	**359,422**	**383,237**	**393,744**	**404,175**	**415,108**
Expenditure					
Provider Expenditure	(362,988)	(384,723)	(394,732)	(402,335)	(411,620)
Total Expenditure	**(362,988)**	**(384,723)**	**(394,732)**	**(402,335)**	**(411,620)**
Net Surplus/(Deficit)	**(3,566)**	**(1,486)**	**(988)**	**1,840**	**3,488**
Expenditure Breakdown:					
Personal Health	(272,722)	(292,404)	(301,057)	(307,036)	(314,511)
Mental Health	(40,165)	(40,280)	(39,958)	(41,144)	(42,355)
DSS	(44,759)	(46,348)	(47,861)	(48,466)	(49,064)
Public Health	(128)	(421)	(456)	(457)	(458)
Maori Health	(2,202)	(2,340)	(2,244)	(2,245)	(2,245)
Internal Allocations	(3,012)	(2,930)	(3,156)	(2,987)	(2,987)
Total Expenditure	**(362,988)**	**(384,723)**	**(394,732)**	**(402,335)**	**(411,620)**

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Revenue	3,129	3,049	3,276	3,105	3,105
Interest Revenue	-	-	-	-	-
Total Revenue	**3,129**	**3,049**	**3,276**	**3,105**	**3,105**
Expenditure					
Operating Expenditure	(2,541)	(2,499)	(2,712)	(2,542)	(2,542)
Depreciation	(4)	(2)	-	(2)	(2)
Internal Allocations	(551)	(548)	(564)	(561)	(561)
Total Expenditure	**(3,096)**	**(3,049)**	**(3,276)**	**(3,105)**	**(3,105)**
Net Surplus/(Deficit)	**33**	**-**	**-**	**-**	**-**
Expenditure Breakdown:					
Personnel Costs	(1,660)	(1,610)	(1,632)	(1,632)	(1,632)
Outsourced Services	(333)	(375)	(384)	(373)	(373)
Clinical Supplies	(1)	(1)	-	(1)	(1)
Infrastructure and Non-Clinical Supplies	(551)	(515)	(696)	(538)	(538)
Internal Allocations	(551)	(548)	(564)	(561)	(561)
Total Expenditure	**(3,096)**	**(3,049)**	**(3,276)**	**(3,105)**	**(3,105)**

Movements in Equity

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Opening Equity as at 1 July	68,311	59,108	64,702	69,132	72,228
Total Comprehensive Income for the Period	(8,996)	2,388	(2,982)	-	1
Contributions from the Crown	-	3,413	7,619	3,303	-
Repayments to the Crown	(207)	(207)	(207)	(207)	(207)
Closing Equity as at 30 June	**59,108**	**64,702**	**69,132**	**72,228**	**72,022**

Financial Position

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Public Equity					
Equity	27,779	30,985	38,397	41,493	41,286
Revaluation Reserves	50,368	57,368	57,368	57,368	57,368
Retained Earnings	(19,039)	(23,651)	(26,633)	(26,633)	(26,632)
Total Equity	**59,108**	**64,702**	**69,132**	**72,228**	**72,022**
Represented by:					
Current Assets					
Bank in Funds	6,225	6	6	6	6
Receivables and Prepayments	12,165	12,658	11,849	13,698	13,546
Inventories	1,202	1,240	1,240	1,240	1,240
Total Current Assets	**19,592**	**13,904**	**13,095**	**14,944**	**14,792**
Current Liabilities					
Bank Overdraft	-	(2,929)	(3,311)	(5,276)	(5,930)
Payables and Provisions	(59,047)	(55,297)	(62,338)	(61,870)	(69,750)
Short Term Borrowings	-	-	-	-	-
Total Current Liabilities	**(59,047)**	**(58,226)**	**(65,649)**	**(67,146)**	**(75,680)**
Net Working Capital	**(39,455)**	**(44,322)**	**(52,554)**	**(52,202)**	**(60,888)**
Non Current Assets					
Property, Plant and Equipment	119,693	149,623	192,184	209,664	222,069
Trust Funds	665	798	798	750	750
Total Non Current Assets	**120,358**	**150,421**	**192,982**	**210,414**	**222,819**
Non Current Liabilities					
Borrowings and Provisions	(21,130)	(40,599)	(70,499)	(85,234)	(89,159)
Trust Funds	(665)	(798)	(798)	(750)	(750)
Total Non Current Liabilities	**(21,795)**	**(41,397)**	**(71,297)**	**(85,984)**	**(89,909)**
Net Assets	**59,108**	**64,702**	**69,132**	**72,228**	**72,022**

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Operating Cash Flows					
Cash Receipts	414,673	357,735	372,854	378,927	387,361
Payments to Providers and Suppliers	(267,419)	(204,838)	(207,184)	(213,707)	(206,693)
Payments to Employees	(132,540)	(147,543)	(147,806)	(151,458)	(156,573)
Interest Paid	(1,238)	(1,256)	(1,506)	(3,329)	(5,207)
Capital Charge Paid	(5,646)	(5,586)	(5,100)	(5,096)	(5,252)
Net Operating Cash Flows	**7,830**	**(1,488)**	**11,258**	**5,337**	**13,636**
Investing Cash Flows					
Cash Received from Sale of Fixed Assets	-	-	-	-	-
Cash Paid for Purchase of Fixed Assets	(10,599)	(32,980)	(44,528)	(27,523)	(16,406)
Interest Received	715	414	576	575	473
Net Investing Cash Flows	**(9,884)**	**(32,566)**	**(43,952)**	**(26,948)**	**(15,933)**
Financing Cash Flows					
Equity Injections	(207)	3,206	7,412	3,096	(207)
Additional Loans Drawn	-	21,700	24,900	16,550	3,850
Loans Repaid	-	-	-	-	(2,000)
Other Non-Current Liability Movement	-	-	-	-	-
Net Financing Cash Flows	**(207)**	**24,906**	**32,312**	**19,646**	**1,643**
Net Cash Flows	**(2,261)**	**(9,148)**	**(382)**	**(1,965)**	**(654)**
Opening Cash Balance	8,486	6,225	(2,923)	(3,305)	(5,270)
Closing Cash Balance	**6,225**	**(2,923)**	**(3,305)**	**(5,270)**	**(5,924)**
Represented by:					
Bank in Funds	6,225	6	6	6	6
Bank Overdraft	-	(2,929)	(3,311)	(5,276)	(5,930)
Total Cash On Hand	**6,225**	**(2,923)**	**(3,305)**	**(5,270)**	**(5,924)**

Capex

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

$000s	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Approved / Baseline Expenditure					
Property and Plant	5,892	1,800	3,000	1,800	1,800
Clinical Equipment	1,502	2,000	2,000	2,000	2,000
Computer Equipment	3,029	1,500	1,500	1,500	1,500
Other Equipment	177	200	200	200	200
Motor Vehicles	-	-	-	-	-
Total Baseline	**10,599**	**5,500**	**6,700**	**5,500**	**5,500**
Strategic (Approved)					
Emergency Department & Theatre Development Project	-	14,691	30,212	22,023	10,906
Child Oral Health	-	3,413	3,619	3,303	-
All Other	-	9,376	2,875	256	357
Total Approved	**-**	**27,480**	**36,706**	**25,582**	**11,263**
Projects Requiring MOH Approval					
Digital Mammography - National Project under auspices of Ministry	-	-	4,000	-	-
Total Capital Expenditure	**10,599**	**32,980**	**47,406**	**31,082**	**16,763**
Financed By:					
Depreciation	7,748	8,867	9,887	11,229	12,413
Internally Sourced Funding	2,851	-	-	-	-
Capital Injections	-	3,413	7,619	3,303	-
Private Debt	-	5,000	5,000	1,000	500
CHFA Debt	-	15,700	24,900	15,550	3,850
	10,599	**32,980**	**47,406**	**31,082**	**16,763**

FTEs

DHB Provider
FTEs by Class
For the Year Ended 30 June

	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Medical	213	218	224	223	225
Nursing	713	701	699	712	739
Allied Health	392	392	413	401	399
Non-Allied Health	106	126	127	127	127
Management/Clerical	347	350	355	322	312
Total FTEs	**1,770**	**1,787**	**1,818**	**1,785**	**1,801**

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

	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Medical	-	-	-	-	-
Nursing	-	-	-	-	-
Allied Health	-	-	-	-	-
Non-Allied Health	-	-	-	-	-
Management/Clerical	18	17	17	17	17
Total FTEs	**18**	**17**	**17**	**17**	**17**

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

	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Medical	213	218	224	223	225
Nursing	713	701	699	712	739
Allied Health	392	392	413	401	399
Non-Allied Health	106	126	127	127	127
Management/Clerical	365	366	372	340	329
Total FTEs	**1,788**	**1,803**	**1,835**	**1,803**	**1,819**

Appendix 5: 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 presented in these consolidated financial statements.

In preparing these financial statements in accordance with NZ IFRS, HVDHB has applied the mandatory exceptions and certain optional exemptions from full application of NZ IFRS.

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

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

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

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

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

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

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

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

Leases
Finance Leases
Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset are transferred to HVDHB, are classified as finance leases. The assets acquired by way of finance leases are stated at an amount equal to the lower of the present value of the minimum lease payments (at the inception of the lease), less accumulated depreciation and impairment losses; and their fair value. The 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.

New Standards Adopted and Interpretations Not Yet Adopted
Certain new standards, amendments and interpretations to existing standards have been published that are not yet effective for the year ended 30 June 2009, and have not been applied in preparing these consolidated financial statements. The adoption of the following standards is not expected to have a material impact on the DHB's financial statements.

NZIAS 1, Presentation of Financial Statements (revised 2007). The revised standard gives HVDHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). HVDHB is yet to decide whether it will prepare a single statement of comprehensive income or a separate statement followed by a statement of comprehensive income.

NZIAS 2, Inventory for distribution – (effective annual periods beginning on or after 1 July 2009)
NZIAS 39, Classification of financial instruments – (unlikely to be applicable to HVDHB).