Healthy People, Healthy Families, Healthy Communities

Hutt Valley District Health Board 2011/12 ANNUAL PLAN

WITH STATEMENT OF INTENT 2011-14

Whanau Ora Ki Te Awakairangi

Towards a Healthier Hutt Valley

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Annual Plan Approval

The Hutt Valley District Health Board's Annual Plan for the financial year 2011/12 is approved.

Hon Tony Ryall
Minister of Health

Virginia Hope
Chairperson
Hutt Valley District health Board

Letter of Approval from Minister of Health

Office of Hon Tony Ryall
Minister of Health
Minister of State Services

11 JUL 2011

Dr Virginia Hope
Chair
Hutt Valley District Health Board
Private Bag 31 907
LOWER HUTT 5040

Dear Dr Hope

Hutt Valley District Health Board 2011/12 Annual Plan

This letter is to advise you I have approved and signed Hutt Valley District Health Board's (DHB) 2011/12 Annual Plan for three years.

This year has seen significant change to the accountability framework for all DHBs with the introduction of annual Regional Service Plans to replace District Strategic Plans and one Annual Plan that incorporates the Statement of Intent. These changes are designed to help improve the way we plan service delivery by setting a long term direction and clear pathways to get there, through an integrated approach linking the different levels of health care.

I want to thank you for your cooperation as we transition to this new way of thinking and look forward to your continued support as we strive for improved health services for all New Zealanders.

Clinical and financial sustainability

All DHBs are expected to budget and operate within allocated funding and identify specific actions to improve financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery.

I am pleased to see your DHB is planning to breakeven for the three planning years and that your plan notes a focus on identifying actions to ensure you continue to live within your means.

Primary Care

Delivering better, sooner and more convenient services closer to home has been a priority for the Government and DHBs for a number of years. Closer integration of services across primary and secondary care and a greater range of services being delivered in the community should not only reduce pressure on hospitals but also improve the patient experience. It is important that you collaborate with your regional DHB colleagues to develop this integration effectively.

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

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan including more tangible actions and deliverables to show how you will achieve real progress towards providing a better range of services in the community. I expect you to be active in advancing these improvements to the way primary care services are delivered in the community.

Regional Collaboration

Greater regional collaboration is a key aspect of the new accountability arrangements and supports more effective use of clinical and financial resources. Better collaboration amongst DHBs is essential to address priority vulnerable services and has the potential to maximise efficiencies through shared back office functions, as well as IT, workforce support and development and capital investment. As core elements of the National Health Board's work, I look forward to seeing the benefits of collaborative partnership with your fellow DHBs as these important regional initiatives are implemented.

Your Annual Plan incorporates a strong regional flavour. It is evident that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning.

I expect to see delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan and look forward to seeing greater ongoing support for the work of Health Benefits Limited in developing shared back office functions where appropriate. I also thank you for your continued commitment to work with the Health Quality and Safety Commission.

Health of Older People

The prioritisation of investment in services to ensure the health and support needs of older people are met is important. An ongoing programme will be required to manage the impact of our ageing population on health services and support the provision of high quality and sustainable services in this area.

I am pleased to see more detail in your Annual Plan on how you are planning to deliver health services for older people. I am especially interested to follow your progress in relation to addressing the respite care needs of your community and the effective use of recent additional funding for this service.

How you will provide new and expanded services for people with dementia is of importance to me as is your DHB's continued application of the comprehensive clinical assessment tool (interRAI) currently being rolled out nationally.

Clinical Leadership

Clinical leadership is fundamental to improving patient care and has an important role in supporting overall service delivery in a number of ways. Engagement with clinical leaders aids job satisfaction for health care professionals and improves delivery of workforce initiatives. The success of clinical networks is based on clinical input working across regions and nationally to assist with overall service delivery. Clinical leadership also plays an important part in the integration of service delivery closer to home.

I expect to see clinical leadership embedded as a way of working within your DHB and the ways in which you seek engagement with your clinicians continue to expand over coming years.

Health Targets

New Zealanders have high expectations that they will have access to quality health care services when they need them. The Government's Health Targets are selected to drive ongoing improvements in specific priority areas in order to meet the growing expectations of the public.

I appreciate Hutt Valley DHB's efforts to deliver on the Health Targets and your progress in delivering on these. It is good to see that you have identified more specific actions within your Annual Plan that you will take to ensure you achieve your planned performance on the six Health Targets.

Mental Health Ringfence

I am approving your plan with the expectation that your DHB will work closely with the National Health Board to agree and ensure appropriate use of any currently unallocated mental health ringfence funding in line with policy.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service change or service reconfigurations must comply with the requirements of the Operational Policy Framework and you will need to advise the National Health Board of any proposals that may require my approval.

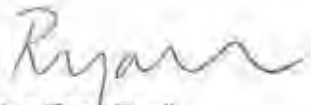
Additionally, my acceptance of your Annual Plan does not indicate support for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependant on both completion of a sound business case, 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 acknowledge that the impacts for DHBs of the earthquakes in Christchurch over the last year are difficult to determine and that these have not been taken into account in producing Annual Plans. The impacts of these events are ongoing for the health sector and will need to be managed beyond what is included in your Annual Plan.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2011/12 Annual Plan.

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

Yours sincerely



Hon Tony Ryall
Minister of Health

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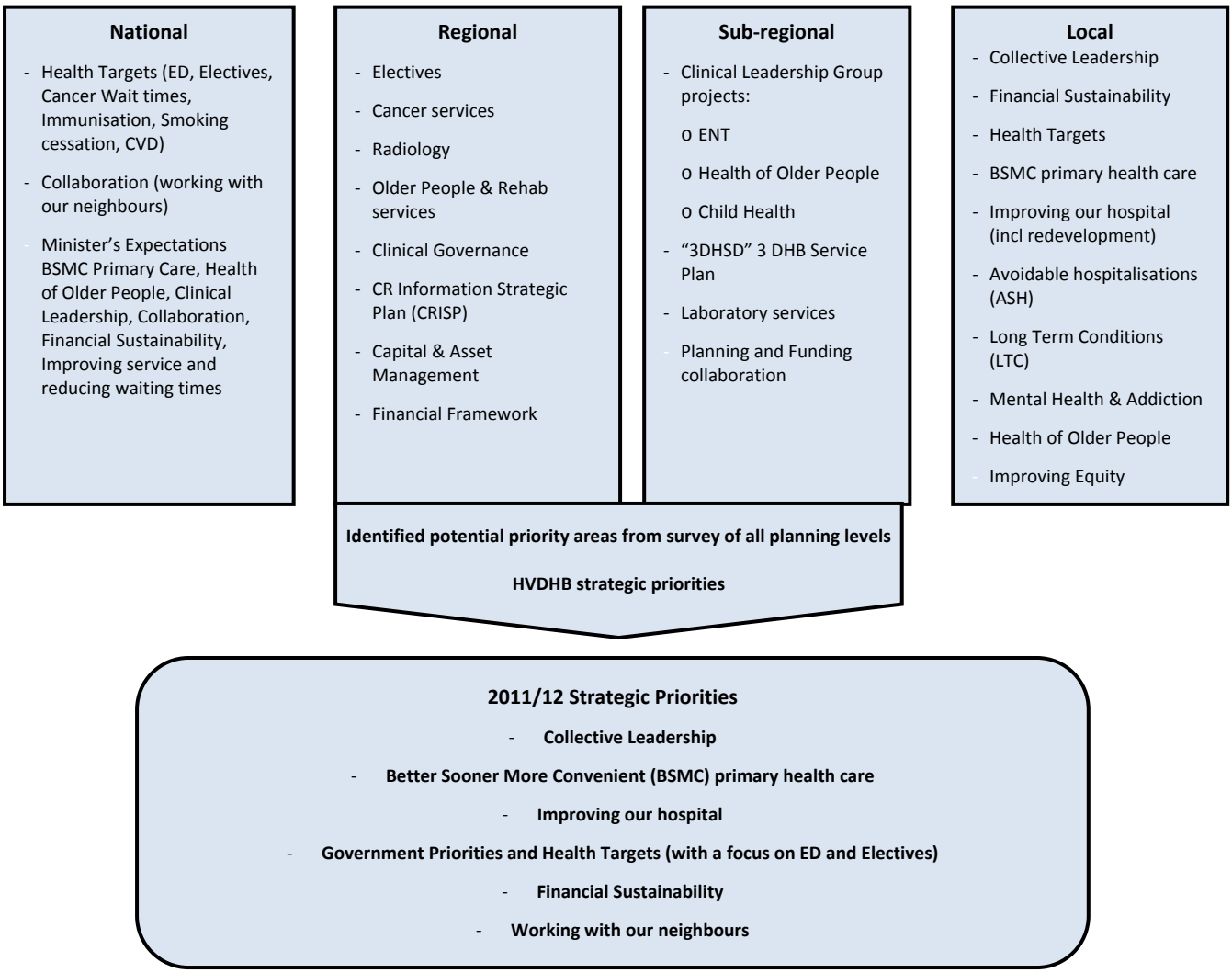
MODULE 1: Introduction

1.1 FOREWORD

This Annual Plan is the basis for our work in the next three years, with a particular focus on 2011/12. It outlines the actions we will take to achieve our vision of 'healthy people, healthy families, healthy communities.' It also sets out how we will deliver on the Governments Health Targets and Priorities in an environment of fiscal constraint.

Our priorities for 2011/12 are Collective Leadership, Better Sooner More Convenient primary health care, Improving our Hospital, Government Priorities and Health Targets, Financial Sustainability, and Working with our neighbours. These priorities continue with the direction of our 2010/11 District Annual Plan, and reflect our continued commitment to improving the health of our population, improving the health journey for people, and managing and controlling costs.

We have arrived at these priorities after taking into account national, regional, sub-regional, and local planning considerations. The relationship between these considerations, and the process of distilling them into our DHB strategic priorities and key actions areas, is shown below:



Our priorities will help us in providing the best possible service to our population:

- Experience has shown us that collectively led initiatives, with clinicians and non-clinical managers working in partnership, are more likely to be acceptable and clinically and financially sustainable.

- Many of the health challenges faced by people in the Hutt Valley relate to how we address the needs and disparities of particular groups in our community, how long term conditions are managed and prevented, and how and when hospital care is accessed. Closer collaboration with the Primary Care sector is necessary to make health and efficiency gains in these areas.

- Integral to our success is collaboration with other DHBs and the wider health sector:

    - The Central Regional Services Plan that has been developed between Hutt Valley, Mid Central, Capital and Coast, Hawke's Bay, Whanganui and Wairarapa DHBs is an important starting point for greater efficiency in service provision, to be secured through collaboration.

    - Sub-regionally, we have a particularly close relationship with Capital and Coast and Wairarapa DHBs. We have joint clinical and administrative appointments in place, and are working closely together to ensure resources are shared and used wisely to provide the best health outcomes across our populations. We are planning collaboratively for the future development of our clinical services.

    - Within the wider health sector, we will work with organisations such as Health Benefits Limited and the Health Safety and Quality Commission to provide high quality services more efficiently and effectively.

- In 2011/12 we will also continue our priority of improving our hospital – a key part of the Hutt Valley's health services. In particular, we are focussed on completing the redevelopment of our Emergency Department and theatres. This is a significant capital investment and we are determined to extract the maximum benefit for our local and regional population, particularly in terms of our ability to meet the national health targets around ED waiting times and elective surgery.

- Delivering on the Government's Health Targets and Priorities will make a real difference to the way people experience health care – for example waiting times at our Emergency Department, and the speed and ease with which elective services can be accessed.

- Financial sustainability means that we are using our public funding efficiently, and gives us a stable platform for planning and delivering services to our population.

Finally, although not specifically stated as strategic priorities, we have an ongoing focus on reducing disparities and inequalities, and on improving the quality of the services we provide and fund.

As the new Chair and CEO of the Hutt Valley DHB, we have been greatly encouraged by the strong relationship between the DHB and its community, and the obvious commitment of all staff of the DHB. We are confident that such relationships and attitudes will continue.

We look forward to another year of 'working together for health and wellbeing' in 2011/12. Working together - with the community, primary care, our NGO providers, our neighbouring

DHBs, and the Government - we will succeed in meeting the inevitable challenges that 2011/12 will bring.

The Hutt Valley District Health Board's Statement of Intent for the financial years 2011-14, which is included within this Plan, has been approved.

Virginia Hope
Chairperson

Graham Dyer
Chief Executive Officer

1.2 CONTEXT

1.2.1 Background

District Health Boards (DHBs) are responsible for providing and/or funding the provision of health and disability services. DHB statutory objectives under the New Zealand Public Health and Disability Act 2000 include:

- Improving, promoting and protecting the health of people and communities
- Promoting the integration of health services, especially primary and secondary health services
- Seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- Promoting effective care or support of those in need of personal health services or disability support

Other statutory objectives include promoting the inclusion and participation in society and independence of people with disabilities, and reducing health disparities by improving health outcomes for Maori and other population groups.

DHBs also demonstrate a sense of social responsibility, foster community participation in health improvement, and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

1.2.2 Health sector context

Hutt Valley DHB is one of twenty DHBs. In meeting its statutory objectives[1], the DHB actively recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection. At a local level, the DHB works in partnership with its Maori Partnership Board to address issues affecting Maori. In addition, the Maori Health Services Development Group provided operational advice to the DHB's executive management team. These relationships assist to ensure Maori participation at all levels of service planning, and service delivery which protects and improves the health status of Maori.

DHBs are strongly influenced by the Minister of Health's expectations and priorities including the Minister's six health targets.

DHBs are also guided by the Ministry of Health which is responsible for developing a Long Term Health Sector Plan. Once released, this plan will provide a high level direction for the health and disability sector over the next twenty years. It is expected to describe the challenges the system faces and future options for models of care and service configuration. The Long Term Health Sector Plan is intended to guide future decisions regarding service configuration and investment at all levels of the system and will support DHBs in their regional and local planning.

At a regional level, Hutt Valley DHB works closely with the other five DHBs in the Central region[2], including through its well-established sub-regional relationship with Wairarapa and Capital & Coast DHBs.

Together, the Central Region DHBs have developed a Regional Services Plan which assists to ensure the clinical and financial sustainability of the region's health services. It focuses on those services that require strengthening if they are to be sustainable, including older adult and rehabilitation services, radiology services and a stronger emphasis on working together to manage delivery of elective services.

[1] Key statutes include the New Zealand Public Health and Disability Act 2000, and the Crown Entities Act 1994.

[2] The other five DHBs in the Central Region are Hawke's Bay, Whanganui, MidCentral, Wairarapa, and Capital & Coast DHBs.

Planning for the needs of our local population is heavily influenced by our regional and sub-regional planning activity, as this will be a key shaper of the location and delivery of services in the Central region over the next five to ten years.

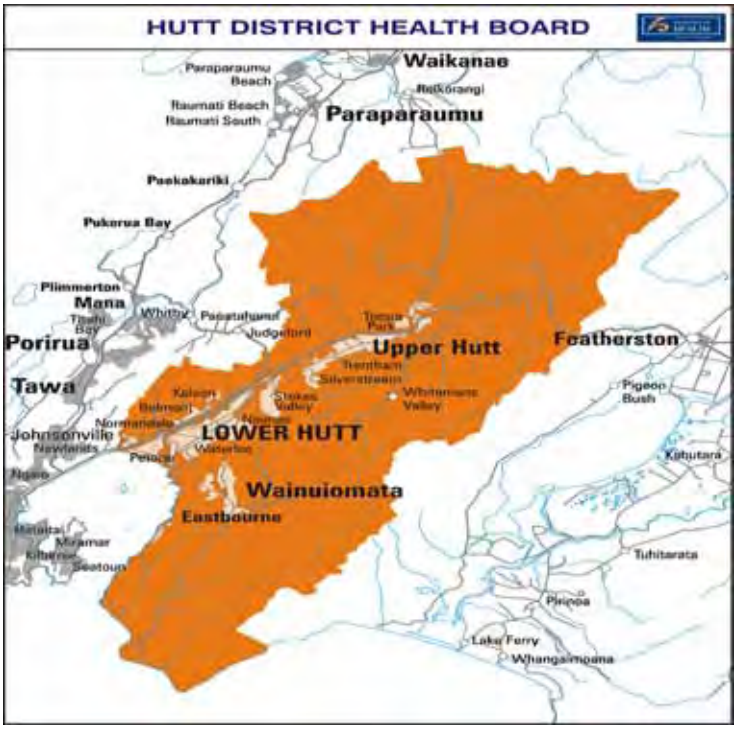
1.3 Population profile

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

1.3.1 Demographics

Hutt Valley DHB is home to 3 percent of the national population. Geographically it is an urban DHB, covering two territorial authorities: Hutt City and Upper Hutt City. Our neighbouring DHBs are Capital & Coast DHB, and Wairarapa DHB.

Hutt Valley DHB district

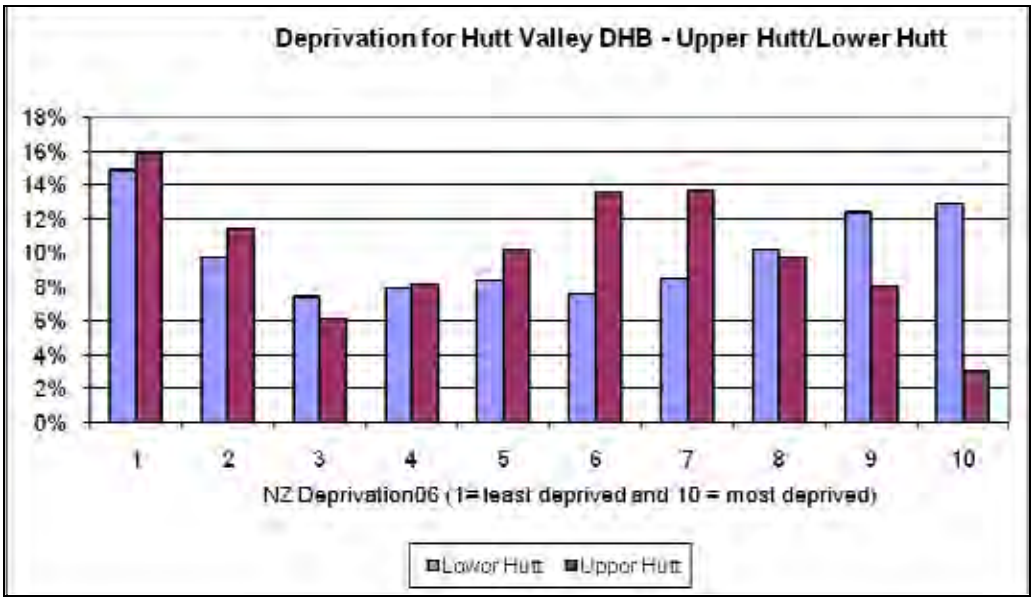


Key features of our population include:

- Our population is currently approximately 144,570[3], projected to increase to around 147,240 by 2026
- Population distribution (age, gender, ethnicity) is similar to the New Zealand population, but with a slightly higher proportion of Maori (17%) and Pacific island people (8%), when compared to the national average
- Our population is currently slightly younger than the national average
- 70% of the population reside in Lower Hutt
- The proportion of people residing in urban areas (98.1%) is higher than the national rate (86%).
- There is variation in the level of deprivation across the Hutt Valley, with 25% of Lower

[3] 2010 NZ Stats Population Projections

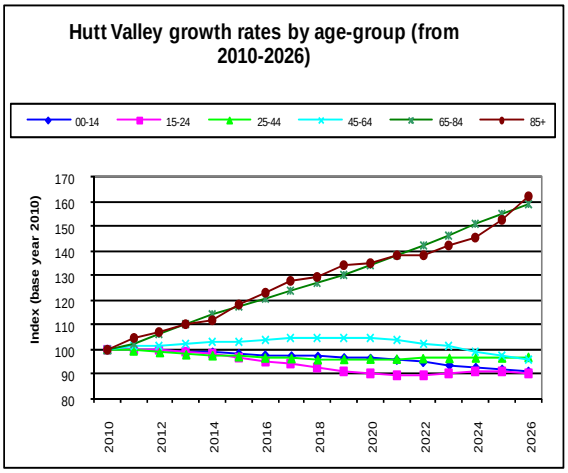
Hutt within Quintile 5, compared with 11% within Upper Hutt (compared to an average of 20%). This is shown by the table below.

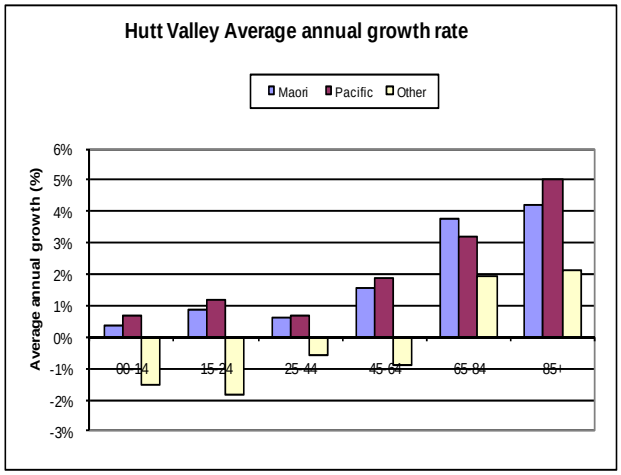


- Maori and Pacific people are over-represented in the most deprived areas.
- Information available from Census data indicates that an estimated 27,000 (17%) Hutt Valley residents have some form of disability and around 16,000 of those people are younger than 65 years. Most disabled people live in the community, with only 13% of older disabled people in residential care and less than 1% of disabled people under the age of 65 in residential care.

Our population demographic is projected to change over time. On the basis of current projections, by 2026:

- We will have more Maori (20%) and Pacific people (10%).
- We will have more people who are older - 19% of our population will be 65 years and over.





1.4 Our Health Profile

The Hutt Valley DHB's health profile is gained through a comprehensive Health Needs Assessment (HNA)[4] that describes our population and their health status. A clear understanding of our population's health status and the conditions and illnesses prevalent in our district helps us focus on the right priorities to meet the needs of our population. Key features include:

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

- Consumption of fruit and vegetables
- Breastfeeding.

Health status
When compared with national figures, our population experiences:

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

Health service utilisation
When compared with national figures, our population has:

- Similar leading causes of hospitalisation, with the exception that asthma is a leading cause of hospitalisation for Maori, Pacific and Asian children aged 0 to 4 years, and diabetes is a leading cause of hospitalisation for Maori and Pacific people 65 years and over
- Significantly higher rates of avoidable hospitalisation, in particular for diabetes, cardiovascular disease – especially ischaemic heart disease, and asthma
- Significantly higher rates for prescriptions in the last 12 months
- Significantly higher rates for emergency department attendances
- Lower number of GPs per 10,000 population.

1.4.1. Maori Health

Our current Maori population is around 25,300 people, which makes up 17.4% of the population in the Hutt Valley. Our Maori population is generally younger than the rest of the population, and experiences higher levels of deprivation than non-Maori. If Maori are to achieve the same level of health as other New Zealanders their health status should be understood in the context of the broader determinants of health, particularly social, cultural and economic status. Strategies to improve Maori health should be effective at improving access to quality health care services for Maori. The Hutt Valley DHB HNA identifies a range of factors where significant disparities exist for Maori. These include:

Health behaviours and risk factors:
When compared with non-Maori in the district, Maori experience:

- Higher prevalence of smoking

[4] Ministry of Health Public Health Intelligence, September 2008 and Central Technical Advisory Services, June 2008 as published on our website www.huttvalleydhb.org.nz

- Lower consumption of vegetables and fruit
- Lower rates of breastfeeding
- Higher rates of hazardous drinking
- Higher prevalence of obesity.

Health status:
When compared with non-Maori in the region, Maori experience:

- Higher rates of death from cancer (especially lung), cardiovascular disease, stroke, and suicide
- Higher prevalence of asthma, diabetes, and depression
- Poorer oral health.

Health service utilisation
When compared with non-Maori in the region, Maori experience:

- Higher rates of avoidable hospital admissions
- Higher rates of hospitalisation of children for dental conditions and asthma
- Greater unmet need for a GP.

1.4.2 - Pacific Health
Hutt Valley has a relatively high Pacific population, and is one of seven District Health Boards (DHBs) with specific responsibility for addressing Pacific Health inequalities. The current Hutt Valley Pacific population is around 11,000 people, or 7.2 percent of total population. By 2031 the Hutt Valley Pacific population is projected to grow to around 14,750, or around 10 percent of the total Hutt Valley population.

The Pacific population in the Hutt Valley is generally younger than the rest of the population and experience higher levels of deprivation than both Maori and non-Maori. Around 60% of the Pacific population in Hutt Valley is Samoan, with the next biggest island groupings being Cook Island Maori and Tokelauan.

Pacific people experience significantly poorer health than other New Zealanders, excluding Maori. In particular, they experience high rates of chronic diseases such as diabetes, and higher rates of avoidable hospitalisations.

Health behaviours and risk factors:
When compared with non Pacific/non Maori people in the region, Pacific people experience:

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

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

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

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

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

1.4.3 Implications

These factors indicate that our existing activities in the following areas need to continue and increase in emphasis:

- Working closely with primary care to address long term conditions and avoidable hospitalisation, and to reinforce education and prevention, particularly amongst people with higher needs
- Continuing our positive engagement with our community providers, including through the cluster of Whanau Ora providers, with a focus on education, prevention and outreach services particularly amongst Maori and Pacific people
- Continuing our emphasis on undertaking actions to better link our hospital with our primary care providers; and
- Positioning ourselves to meet the changed demand for services which will result from an aging population.

1.5 Operating environment

In addition to the health needs and demographic profile of the Hutt Valley population, a range of external and internal factors influence the decisions we make, including how we plan, fund and deliver health services for our population.

New Zealand Economy
The Government has indicated that the rate of growth in health funding is unsustainable, particularly in view of the global financial situation.

Factor	Implications
A decrease in the rate of funding growth	Increasing need for prioritisation of funding to those most in need of health and disability services. Increased efficiencies required within existing services. Increased need for clinical leadership to optimise and prioritise resources A risk of MECA settlements above available funding levels prejudicing DHBs ability to live within their means.

Social Factors

People are taking a more active interest in their health, are better informed about their conditions and are more aware of options for treatment than in the past. At the same time as public expectations grow, the health system is experiencing workforce shortages.

Factor	Implications
The public is becoming better informed about health	Patients have higher expectations of health professionals and health services, including access to the right information, so people can take more responsibility for their own care (self management).
People want services suited to their needs	Services are becoming more patient centred and culturally responsive.
Complexity of satisfying society's growing demands for health services	Greater attention on what services are publicly funded and access criteria to those services.
Growing unemployment	Fewer people can afford to visit their GP, delaying early detection and treatment, increasing ED attendances and admissions to hospital that are potentially avoidable.

Health Services

New technologies and models of care, increased emphasis on quality and safety of services and greater involvement and leadership by clinicians in planning and developing services and clinical pathways is expected to lead to better health outcomes. Changes to the way health services are planned and delivered also includes working more closely with other DHBs at a sub-regional, regional and national level.

Factor	Implications
Increased focus on quality and safety of services	An increased focus on quality and safety of services can lead to better health outcomes. Meeting rising quality and safety standards may impose additional costs on the DHB.
Availability of new technologies	Technological advances expand the health system's ability to diagnose and potentially treat people. Adoption of new technologies has cost implications and creates pressure on prioritisation systems.
Greater focus on planning and delivering services nationally and regionally	Changes to the way services are delivered at a local, regional and national level. Service capacity across DHBs is reorganised to ensure best use of available resources.
Greater involvement by clinicians in decision making	A need to continue to strengthen processes and systems that ensure clinical leadership in planning and delivery of health services.

Physical Environment

Physical factors are also relevant to decision making, where they have a significant effect on the health of people, or on the ability of the DHB to provide services.

Factor	Implications

Factor	Implications
Constrained Emergency Department and Theatre capacity at Hutt Hospital (to be addressed by ED/Theatre redevelopment to be completed on schedule in 2011/12)	Ability to meet Emergency Department Waiting Times Health Target currently affected by constrained capacity. Our ongoing actions to improve the efficiency and effectiveness of some services are constrained ahead of the campus redevelopment (to be completed in 2011/12).
Poor housing	Higher prevalence of respiratory diseases resulting in higher hospitalisations.
Proportion of people residing in urban areas much higher than for NZ	Hospital services are in close proximity to population and may be attended more frequently than in rural areas. Higher levels of attendance are also likely to result from Hutt Hospital services being well regarded, and being well located to serve the Hutt Valley population. DHB does not attract rural adjuster funding.

1.6 Key risks

Achieving our strategic outcomes and Government's priorities and targets requires us to manage a variety of risks. Our key risks and mitigation strategies (at a high level) are:

Risk	Mitigation
Unexpectedly high demand for services, which could compromise financial performance	Identify and take opportunities to manage demand, particularly addressing avoidable hospitalisations and long term conditions.
Unexpectedly high IDF outflows could compromise financial performance	Work closely with neighbouring DHBs to better plan and manage IDF flows
Quality has potential to be prejudiced in financially constrained environment	Actively pursue quality agenda with strong clinical and management leadership.
Wage settlements over National Terms of Settlement	Seek cost avoidance opportunities to offset risk
Industrial action prejudicing performance and patient safety	Deploy surgery management strategies to minimise patient risk
Our Screening unit needs to upgrade their mammography equipment in 2011/12 at a cost of $4.3m. A business case will be submitted to the Ministry of Health. If this is not approved, the ongoing delivery of this service will be at risk.	Early engagement with Ministry of Health/National Health Board
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.	Appropriately manage demand driven costs, in conjunction with clinical leaders.

1.7 Nature and scope of functions

The DHB receives funding from the Government to enable it to fund and provide health and disability services to the people that live in the Hutt Valley.

The funding and provision of services by the DHB is overseen by our governance Board. The Board consists of eleven members and has overall accountability for the operation of Hutt Valley DHB. Seven of the members are elected as part of the three-yearly local body election process. The Board has a well established Maori Partnership Board, three statutory advisory committees[5] and a Finance Risk and Audit Committee to assist it discharge its various responsibilities. Clinical leadership input to Board decision making is provided via contribution to Board papers and regular presentations and participation in Board meetings and discussions.

We work within our allocated funding to "improve, promote, and protect" the health of the population within the district and to promote the independence of people with disabilities (as set out in section 23 of the NZPHD Act).

This requires Hutt Valley DHB to consider how best to meet needs and deliver services including:

- prevention services
- early detection and management services
- intensive assessment and treatment services
- rehabilitation and support services

These four service groupings comprise the different output classes used to explain our services in our Statement of Forecast Service Performance (see Module 4).

The scale and scope of services we fund across each of these four output classes is influenced by the outcomes and priorities that the Government and the DHB want to achieve, as well as the Government's service coverage requirements and our assessment of the health needs within our community.

1.7.1 Our Funder Role

Hutt Valley DHB funds a wide range of services through agreements and contracts with multiple providers. Many of the services we fund are provided locally, by our hospital provider arm (see below) and our primary and community providers. Most of the tertiary specialist services are delivered by health providers outside the Hutt Valley, primarily Capital and Coast DHB and are funded through the Inter District Flows (IDF) mechanism.

Through numerous contracts, the Hutt Valley DHB funds and works closely with a wide range of health service providers in the community, including:

- One Primary Health Organisation (previously four) encompassing around 27 different general practices, and Ropata Medical Centre (within the shared cross boundary Cosine PHO)
- Other primary health care providers, including well child service providers, Maori health providers, Pacific health service providers, youth health service providers, palliative care services, pharmacists, laboratories, radiology services, and dentists.

These providers in turn deliver a wide range of services, for example:

- School based youth health services, diabetes outreach services, community dental services, after-hours services subsidy, and additional well child services

[5] Hospital Advisory Committee, Community and Public Health Advisory Committee, Disability Advisory Committee

- Support for a range of infrastructure requirements for primary health care: access to hospital based information systems, GP Registrar programme, practice nurse development, Pacific and Maori scholarship programmes, access coordination services
- Health of Older People services, with contracted providers include 17 aged residential care facilities, (which provide a mix of rest home, hospital, dementia, psycho-geriatric care), day support and respite care services, and three home based support service providers
- Community mental health services via contracts with 15 Non Governmental Organisation (NGO) providers and 18 subregional and regional service providers.

Hutt Valley DHB is permitted and empowered under s25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary or desirable in fulfilling its objectives and/or performing its functions pursuant to the Act.

1.7.2 Our Provider Role - Hutt Hospital

The Hutt Valley DHB's own service provider is the Hutt Hospital. This is often referred to as the DHB's 'provider arm'. It delivers a wide range of services including secondary and tertiary care services and some regional and national services. Examples include:

- Medical services including emergency department, and the medical services that manage patients with chronic illnesses and those that present to the hospital with an acute illness. The services involves both inpatients and outpatients
- Regional plastic surgery/maxillofacial and burn unit covering a population (Wairoa to Blenheim) of over 1 million people
- Reconstructive surgery for breast, head, and neck cancers for the central region
- Regional rheumatology services covering the Hutt, Wellington and Wairarapa
- Otolaryngology (ENT) service, audiology and dermatology services
- Surgical services, including dental, general surgical, ENT, gynaecology, and orthopaedic surgery
- Maternity, child and youth health services
- Mental health services, including the Central Region Eating Disorder Service (CREDS)
- Community dental services encompassing the Hutt Hospital Dental Unit, the Regional School Dental Service and the Central Region Adolescent Oral Health Coordination Service
- Regional Public Health services, including public health leadership, community health, chronic disease prevention and environmental health functions
- Regional Screening Services, including breast cancer screening, and regional coordination of cervical screening.

1.7.3 Our Ownership Interests

Hutt Valley DHB's ownership of assets is limited to Hutt Hospital, and the fixtures, fittings and equipment used in the delivery of services.

1.8 Allocation of our funding in 2011/12

In funding these different services, we must manage our share of the national funding allocation in a financially responsible manner. The DHB's share of this funding is determined by the Population Based Funding Formula (PBFF), based on the number of people living in our district, taking into account different population factors such as age, sex, ethnicity and levels of social deprivation and unmet need.

Hutt Valley DHB's share of PBFF revenue for 2011/12 will be $331.9M. Of this total, $141.3M will be for services provided by the DHB, $75.2M in payments to other DHBs for services they will provide to Hutt Valley residents, $112.3M on services delivered by other providers, and $3.1M on governance and funding administration costs.

In total, Hutt Valley DHB expects to receive $448.4M in 2011/12 (all sources) to spend on health and disability services for the people of Hutt Valley. This represents an increase in funding of 3.8% over our total 2010/11 funding. How we share this funding amongst our different services providers each year is a critical decision for the DHB.

MODULE 2: STRATEGIC DIRECTION

2.1 Our Vision

The Government's overarching policy objectives in healthcare are that New Zealanders lead longer, healthier, and more independent lives.

Achieving this requires the actions of many people and organisations acting across the wider social and physical environment: this includes individuals, families, the actions of many agencies, the DHB, and local and central government.

Hutt Valley DHB's vision in contributing to those objectives is summarised as:

Whanau Ora ki te Awakairangi

Healthy People, Healthy Families, Healthy Communities

Closely related to this vision are our values:

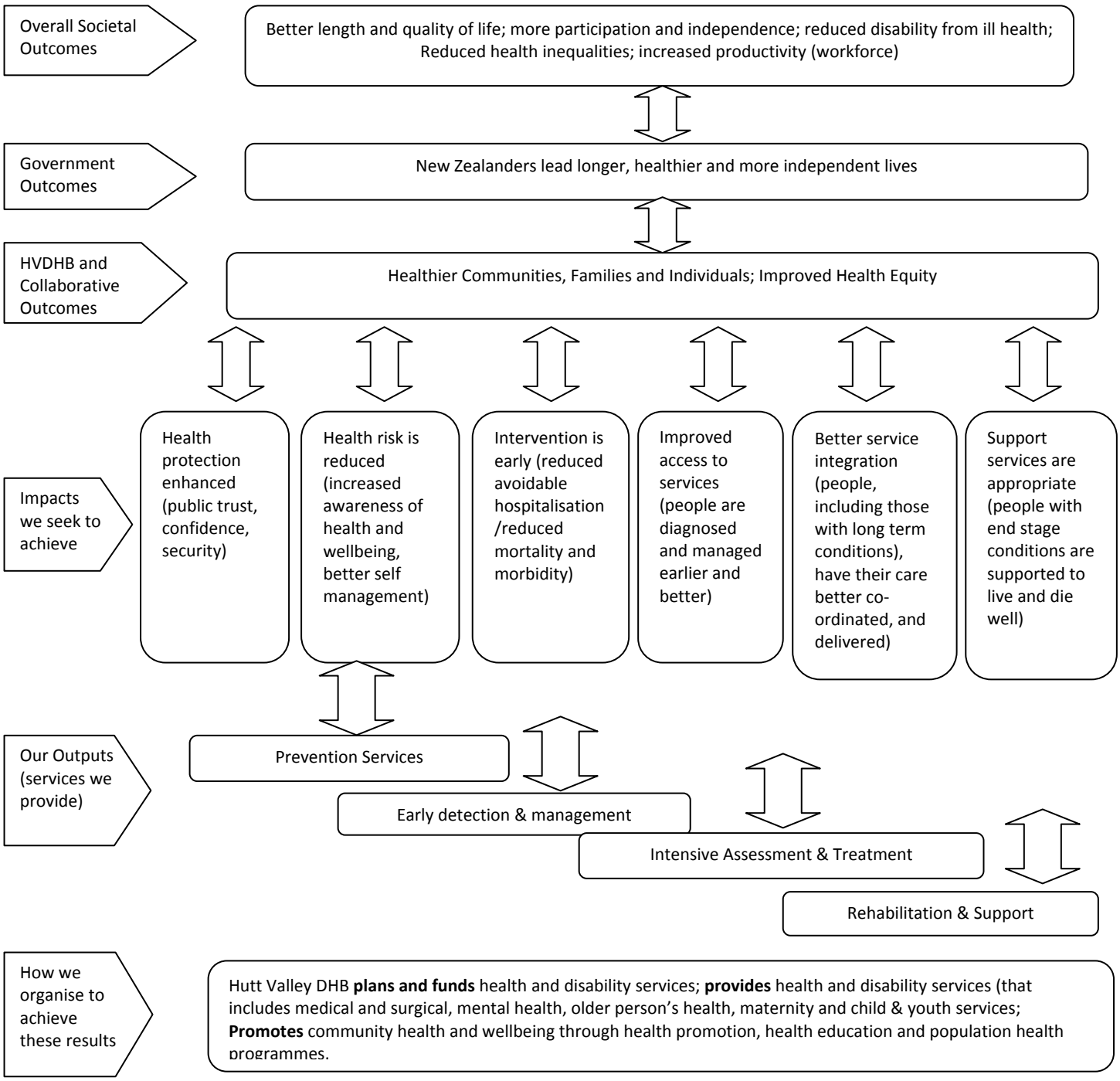
- Can do – leading, innovating, and acting courageously
- Working together with passion, energy, and commitment
- Trust through openness, honesty, respect and integrity
- Striving for excellence

2.2. Planning Framework

Our vision and our values underpin the process of planning our health services. This planning process needs to drive outcomes at local, sub-regional, regional, and national levels. The way in which we contribute to overall health system achievement, and plan in that context, is shown below.[6]

[6] In reading this diagram, the following terms are used:

- Outcome - the end consequences for the community of the activities we (and others in the health system) perform. Many different things will lead to outcomes – not just what we do.
- Impact (or intermediate outcome) - the contribution made to an outcome by our outputs.
- Output - the things or services we produce.

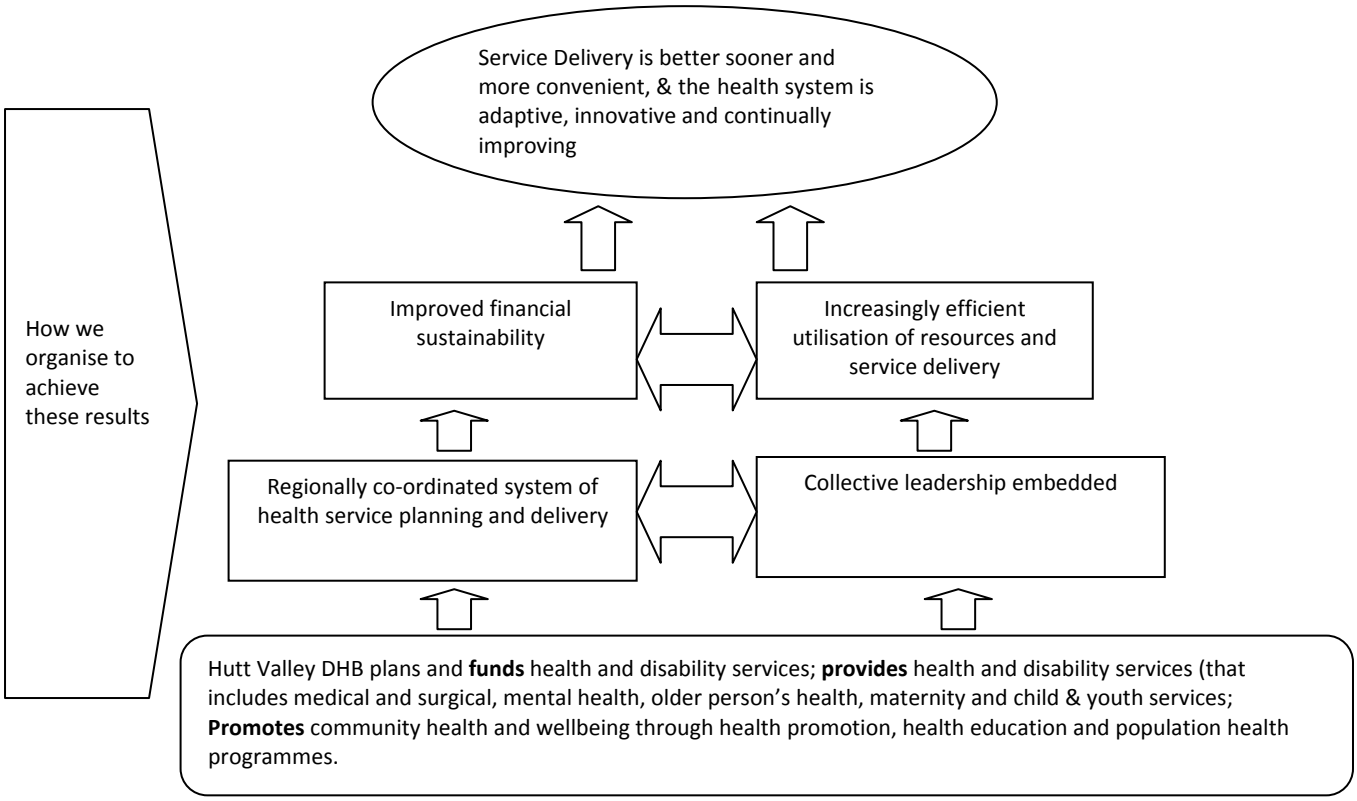


This 'intervention logic' helps us to direct our activities towards to the overall outcomes we want from our health system. Further detail of the output classes and the way they relate to the impacts we seek to achieve is set out in Module 4.

In addition to focussing on *what* we deliver, the Government also requires an increased emphasis on *how* we organise to achieve the results that we are seeking. This is reflected in key Government policy priorities in health –

- Service Delivery is Better Sooner and More Convenient, and
- The Health System is Adaptive Innovative and Continually Improving.

We influence these system operation goals through "How we organise" ourselves, as shown in the diagram below:



2.3 Strategic Priorities

We recognise that the best outcomes will be delivered by identifying and working on a small group of key strategic priorities – drawn from a wider group of priorities related to both 'what' and 'how' we deliver.

In identifying these priorities we have been mindful of the changes to the emphasis of the health system arising from the work of the Ministerial Review Group. In particular there is a strengthened requirement for us to plan, configure and deliver services in a way which improves, promotes and protects the health of the population of the Hutt Valley[7], but which also assists us to contribute to meeting national and regional population needs.

Determining our strategic priorities for 2011/12 requires us to consider issues at each level of service planning – national, regional, sub regional, and local.

2.3.1 National Planning - Government Targets and Priorities

Delivering on Government Health Targets and Priorities is an ongoing strategic priority for Hutt Valley DHB. It is also a priority where we have made significant achievements, for example in Immunisation (where we are ahead of the 90% target), and Better Help for Smokers to Quit (as one of the top performing DHBs).

[7] See also the remainder of the statutory functions and objectives of DHBs – sections 22 and 23 of the New Zealand Public Health and Disability Act

In 2011/12 we will continue our strong focus on all Government Targets and Priorities, with particular emphasis on *Improving Access to Electives* and *Shorter Stays in Emergency Departments*. This reflects the regional work on improving the Central Region's electives performance, and the close relationship between the Emergency Department wait times target and our ED/Theatre redevelopment. These Targets and Priorities are summarised below, and discussed further in Module 3.

2011/12 Health Targets and Priorities

Health Target	Description
Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours
Improved access to elective surgery	The volume of elective surgery will be increased nationally by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within 6 weeks by the end of July 2010 and within four weeks by December 2010.
Increased immunisation	90% of two year olds will be fully immunised by July 2011; and 95% by July 2012.
Better help for smokers to quit	80% of hospitalised smokers are provided with advice and help to quit by July 2010; 90% by July 2011; and 95% by July 2012. Similar target for primary health care will be introduced from July 2010 or earlier through the PHO Performance Programme.
Better diabetes and cardiovascular services	a. Increased percent of the eligible adult population have had their CVD risk assessed in the last five years. b. Increased percent of people with diabetes attend free annual checks. c. Increased percent of people with diabetes have satisfactory or better diabetes management.
Government Priority	**Description**
Clinical leadership	• Strengthening clinical engagement from bedside to boardroom. • Working with our neighbours to further encourage and support clinical networks, with clinicians leading the development and operation of identified priority services and the integration of services closer to home.
Services Closer to Home	Refocus resources towards delivering services in local community and/or integrated settings, closer to patients. Including • Reducing unplanned admissions through working with community and hospital clinicians • Ensuring community and hospital based clinicians are at the forefront of development, supported by management • Developing efficient and effective family health centres • Supporting the Whanau Ora initiative
Health of Older People	• Build better systems – including standardised monitoring and audit (InterRAI) as tools to improve quality across homecare and aged residential care • Focus on improving older people's underlying health and wellbeing – particularly in the areas of mental health (dementia) and preventing disease and injury. • Provide new and expanded services – concentrating on dementia, and primary and community care improvements to avoid hospital admissions • Support family/whanau – in particular provision and access to respite care, day programmes and social supports • Engage in next steps of work on the national aged residential care review
Regional Collaboration	Significant development of regional collaboration including: • Regional Service Plans focussing on a small number of high priorities and vulnerable services

	• Development of shared back-office functions • Regionalisation of IT platforms, support, and workforce development
Financial sustainability	Live within our means "year on year": through Improvements in purchasing, productivity, and quality and further reducing administrative overheads

2.3.2 National - Service Planning

A small group of services (set out below) are planned nationally, as their small size, retention of specialists, or critical mass issues make them vulnerable if they are not funded, planned and managed in a nationally co-ordinated way. These services will continue to be delivered by DHBs, but will be centrally led by the National Health Board.

National Services	
Clinical Genetics	Paediatric Oncology
Paediatric Pathology	Paediatric Gastroenterology
Paediatric Metabolic Services	Neurosurgery
Paediatric Cardiology	Major Trauma
Paediatric Cardiac Surgery	

National Service planning will have a minimal impact on Hutt Valley DHB, because where these services are required for our population, they are already delivered by other providers. The DHB is not intending to provide any specific contribution to national services, other than by a proportionate financial contribution. National Planning does not generate any specific strategic priorities for Hutt Valley DHB.

2.3.3 Regional and Sub Regional Service Planning

Regional

Hutt Valley DHB is part of the Central Region of DHBs. The Central Region covers the Lower North Island, and comprises Capital & Coast DHB, Hutt Valley DHB, Wairarapa DHB MidCentral DHB, Whanganui DHB, and Hawke's Bay DHB. This region serves a population of over 850,000 people.

The key strategic challenges we face as a region in improving the health of our collective population are:

- Ensuring that our services are sustainable
- Meeting increasing expenses within tighter revenue growth
- Managing significant financial investment to upgrade the region's hospitals
- Achieving combined cost efficiencies in the order of $40 million in the 2011/12 year
- Adopting a systematic framework to address changes in the workforce, IT and capital investment.

The Central Region's response to these challenges is set out in its Regional Services Plan (RSP). The RSP seeks to deliver "a regionally co-ordinated system of health service planning and delivery that will lead to ongoing improvements in the sustainability, quality, and accessibility of clinical services". The RSP also explains how the region's response will:

- improve services sustainability
- develop clinical networks for quality and safety
- address new models of care (expert care as safely as possible and as close to the patient's home as possible); and
- optimise operations and utilisation of resources

To begin this work, the Central Region DHBs have agreed on a group of priority areas where work is to be advanced, set out below:

Meeting the Health Targets:
Shorter Waits for Cancer Treatment: All Central Region DHBs have met the target for the first quarter 2010/11. The priority for the region for 2011/12 is to reduce premature death from Cancer by ensuring people with cancer have equitable and timely access, particularly Maori, to radiation treatment, and improving the treatment of priority cancer sites. Aspects of cancer services, such as Medical Oncology, are vulnerable. The emphasis of the plan is to develop sustainable models of specialist service delivery by moving towards a single service, two-site model with closer collaboration between the two current providers – Capital & Coast and MidCentral DHB.
Improved access to elective services: Access to elective services varies across the Central Region, with some populations having far better access than other populations. The aim is to improve access for consumers to elective care, reduce waiting times and avoid further complications caused by delays in treatment. The focus of this plan is to ensure the Central Region DHBs deliver the required levels of service. This includes the ability to deliver elective volumes (meeting the Minister's expectations), provide equitable access to surgical services, the development and implementation of an integrated Central Region production plan, and capacity and distribution modelling to support future development. Clinical Leadership is seen as the key to ensure the success of this approach. There is a need to make the most of existing surgical services across the Central Region through smarter choices about how, where and when we provide elective surgical services. The Central Region has agreed to implement a common waiting list approach during 2012/ 13 (across one or two services) as a building block to developing a sub-regional or regional elective booking system as a single point of entry for patients. In 2011/12, there will be a specific focus on achieving targets for cardiac surgical discharges, monitoring for inequity in access to cardiac interventions particularly for Maori and access to bariatric surgery.
Strengthening Services:
Radiology Services: The focus for 2011/12 is on developing a patient focussed regional radiology service focusing initially on after hour's coverage, and then a fully regionalised service, to reduce service vulnerability across the region and enhance timely access to radiology services. This requires an enhanced IT infrastructure for

Picture Archiving and Communications (PACS) and Radiology Information Services (RIS), and strong clinical governance through the use of evidence based referral guidelines.
Older Adults and Rehabilitation: The key focus area for 2011/12 is the development of regionally coordinated multidisciplinary models of care for older adults that can be locally implemented. This will support older adults with co-morbidities to remain independent for as long as possible, remain out of hospital and have care provided in a culturally appropriate way.
Sub-regional activity
Capital and Coast, Hutt Valley and Wairarapa DHBs: The three Greater Wellington Board Chairs agreed a Statement of Commitment to a closer relationship in early 2010. The sub-regional Clinical Leadership Group has projects for ENT services and Child Health underway. There are also a range of other initiatives being progressed involving two or more of the DHBs.
The Central Alliance: MidCentral and Whanganui DHBs entered into a formal alliance (the Central Alliance) in 2009. The agreement establishes a contractual arrangement for how the two DHBs will identify and implement collaborative initiatives to improve the efficiency and effectiveness of services. Collaboration now exists across much of the two DHBs' activities, with joint appointments to key management and clinical positions, a shared women's health service, common purchasing of hospitality services, common financial management system technology and the devolution of the Central Alliance concept into business-as-usual planning and management.
Key enabling services:
Clinical Leadership and Clinical Governance: The focus of this plan is to improve the quality of care and enhance patient safety by strengthening and aligning clinical leadership and governance systems across the Central Region DHBs. Early actions will be the establishment of a Regional Clinical Board, providing greater support for sole practitioners, implementing regional credentialing to one or two services, and considering opportunities for joint appointments. This will lead to improved quality and safety of services for patients, and sustainability of services through shared appointment opportunities.
Central Region Information Systems Plan: The CRISP supports regional delivery of effective and coordinated care for consumers by building systems that will deliver information to clinicians across the region regardless of their own or their patient's location. It also supports the clinical requirements of the Regional Services Plan's strengthening vulnerable services projects and the existing Regional Clinical Services Plan (RCSP) Programme. Health professionals across the region will be able to share relevant information about patients so that safe and effective care can be provided. Patients will be able to communicate with health professionals when they need to, using a range of communication technologies.
Capital and Asset Management: Future capital and asset management planning will be undertaken within the context of service planning to ensure that expenditure plans will address regional requirements and health needs, coordinate future investments, and maximise the health dollars available to the region.
Shared Support Services (non – clinical): The focus of this plan is to identify the non-clinical support functions where there is unnecessary duplication and cost in the configuration of current services, and where significant benefit will be delivered from shared service arrangements. Benefit may be in the form of cost reduction, improved service, and risk reduction or as a key enabler to service change. This initial plan focuses on Health Benefits Ltd national shared services and on three keys projects in 2011/12 - shared laundry, payroll and recruitment processes.
Transport and accommodation: Major transport improvements will be needed so patients and their families/whānau, and health professionals, can get to community health centres and hospitals. Accommodation needs to be available so people and travelling specialist clinicians have somewhere to stay when they are away from home. These arrangements should be well co-ordinated and made on behalf of patients and their families/whānau. Active participation in national discussions, with a view to determining a regional solution in the context of the national network, is required.

Further details, including our specific actions are set out in the RSP, which can be accessed at *info@centraltas.co.nz*.

Sub–regional

In addition to our work with the wider Central Region, we also have a strong record of working closely with our immediate neighbours, Wairarapa DHB and Capital & Coast DHB. This close relationship has led to significant joint activity, including:

- A joint contract between Hutt Valley DHB and Capital & Coast DHB for community laboratory services.
- Hutt Valley DHB is the lead provider for Regional Screening Services, Plastics, and Regional Public Health Services. It works closely with Wairarapa DHB and Capital & Coast DHB to meet population health needs.
- Hutt Valley DHB provides payroll service to Wairarapa DHB.
- Cross appointments to clinical and other roles (for example, joint Director of Allied Health and Joint Communications Manager across Hutt Valley and Wairarapa DHBs).
- Development and implementation of a Clinical Leadership Group comprising senior clinicians from the three DHBs, leading work on specific service projects, for example in Ear, Nose and Throat, and Child Health.

Key sub-regional work for 2011/12 includes:

- Advancing a Three DHB Health Services Project (3DHSD) to enhance clinical and financial sustainability across sub-regional hospital campuses.
- Advancing key workstreams within a programme of work led by our Clinical Leadership Group. This will include working to improve the ENT, Child Health, and Older People's services available within the sub-region.
- Closer cooperation in providing Urology and Ophthalmology services, Laboratory Services, and General Surgery
- Collective review of appropriate senior clinical and executive positions as they become vacant to determine opportunities for cross DHB appointments.

Increasing our co-operation at this level of planning and service delivery is central to delivering high quality cost effective services to our population, and to the sub-region.

2.3.4 Local Service Planning

At a local (DHB) level, our planning work (including our 2008 Health Needs Assessment[8]) identifies the following key activity areas and issues as important:

- Prevention - Our subregional "Keeping Well" approach is a prevention framework which aims to influence health behaviours and risk factors, including prevalence of smoking, rates of breast-feeding and prevalence of obesity.

- Avoidable Hospitalisation – further developing our ongoing and evolving work with primary care to address higher than average rates of avoidable hospitalisation – including through improved referral pathways for older people, and the burden of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease and chronic mental health disorders.

[8]Public Health Intelligence, Ministry of Health, September 2008

- Addressing inequalities in health status - particularly in respect of long term conditions and risk factors amongst Maori and Pacific people (as demonstrated in our annual *Improving Equity* report).

- Collective Leadership - continuing our progressive strengthening of collective leadership both in our hospital and in our interface with primary care.

- Hospital redevelopment – completion of our redeveloped Emergency Department, new theatres and Medical Assessment and Planning Unit (MAPU) to deliver improved patient experience and hospital efficiency, and continue our ongoing progress towards meeting the health targets for Shorter Stays in ED, and Increased access to Elective Services.

- Financial Sustainability - focus on improving hospital productivity, controlling major costs drivers, and value for money in demand driven services (including in mental health both locally and jointly with Capital and Coast DHB). In all of these areas, involvement of clinical leaders will ensure that patient care is optimised. We will also participate strongly in regional and subregional projects to achieve greater efficiencies in back office functions.

2.4 - Summary of 2011/12 Strategic Priorities

In 2011/12 we will focus on the following six strategic priorities to improve the health of our population:

Strategic Priorities

- Collective Leadership
- Better sooner more convenient (BSMC) primary health care
- Improving our Hospital
- Government Priorities and Health Targets (with a focus on ED and Electives)
- Financial sustainability
- Working with our neighbours

Underpinned by

Patient Centred Quality & Reducing Inequalities

As shown above, underpinning these six priorities are an ongoing focus on patient centred quality, and an emphasis on reducing inequalities. These foci inform everything we do, and are embedded in our culture. It is critical that they are visible and 'front of mind' in all of our planning and activities.

A high level outline identifying the issue which these priorities will address, the anticipated impact, and the DHB's contribution, is set out below. Further details of how we will give effect to our Strategic Priorities are set out in Module 3.

Strategic Priority	DHB Issue	Impact
1. Collective Leadership	The DHB is facing key challenges, with an ageing population, increasing expectations on the quality and safety of clinical services, a continued shift of services to different settings, increasing use of technology and ongoing constraints to funding. Clinical input and leadership in these areas is critical to success. Collective leadership is a key enabler to developing and implementing changes which will improve patient care.	Improved collective leadership leading to: • Safer, better, higher quality and more sustainable services • More effective mechanisms for implementing change
2. Health Targets, in particular Shorter stays in ED and Improved Access to Electives	A. Our performance is below the expectations we have of meeting the Government's ED health target. Long stays in emergency departments (EDs) are linked to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients. B. We need to make the most of existing surgical services across the Central Region through smarter choices about how, where and when we provide elective surgical services. The region is meeting many base health needs but some DHBs are over providing whilst others are under providing. Greater efficiency and consistency is required.	A. Reduced length of stays in EDs. Better clinical outcomes for people using services. B. Elective services will be delivered more efficiently across the region, assisting all DHBs within the region to meet targets and expectations.
3. Better Sooner More Convenient (BSMC) primary health care	Many of the Hutt Valley population's key health issues need to be addressed at both a primary and secondary level. We are increasing our existing collaborative work between primary and secondary care to improve outcomes and improve health equity. Opportunity exists for improved efficiency and better patient experience and outcomes through smarter use of primary care	Consolidating PHOs will create an environment more conducive to service integration, and to improving patient experience. Improved primary/secondary integration will lead to better prevention and management of long term conditions, and reduce health inequalities.
4. Improving our hospital – ED/Theatre redevelopment)	We have made a significant investment in our ED/Theatre redevelopment, and this provides an opportunity to improve ED waiting times, theatre throughput and productivity.	Improved performance against ED target, improved patient experience, better productivity and efficiency of hospital, and enhanced clinical job satisfaction
5. Financial Sustainability	The DHB (and the Central Region) need to work hard to ensure financial security in 2011/12 and future years.	Financial security will allow better opportunities for investment in new or improved services.
6. Working with our neighbours	The DHB needs to work with other DHBs to implement models of care which will deliver better sooner more convenient health care, and improve clinical and financial sustainability of services.	Working with our neighbours creates potential for cost efficiencies and improved service delivery.

2.5 Action Areas

In giving effect to our Strategic Priorities, we have also identified several key Action Areas, where the DHB intends to put specific emphasis at an operational level. These are noted below, including their relationship to our Strategic Priorities.

Action Areas	Collective Leadership	BSMC primary care	Improving our Hospital	Govt Priorities and Health Targets	Working with our neighbours	Financial Sustainability	Reduces inequalities /enhances quality
Complete our ED/Theatre redevelopment to get the best possible patient pathways and outcomes and productivity gains from our theatre and ED upgrade. This is a significant investment for the DHB and needs to provide significant clinical and efficiency returns.	✓		✓	✓	✓	✓	✓(Quality)
Bedding in our new PHO, Te Awakairangi Health. A strong relationship with our PHO is key to better primary/secondary integration. This includes improving workforce capability and approaches to working with our Maori communities (in particular relationships with Whanau).	✓	✓	✓	✓		✓	✓ (Equity)
Collective Leadership: the operation of: • a Primary/Secondary Strategy Group (created in 2010/11) providing collective leadership across the primary secondary interface; • a Secondary Strategy Group to provide collective leadership across the Hutt Hospital clinical services. Both groups will be central to developing and implementing clinically led initiatives.	✓	✓	✓	✓		✓	✓(Quality)
Long term conditions & avoidable hospitalisations: these areas are key to better addressing our population's health needs, including in particular our high rates for Maori and Pacific people, and require an integrated approach from primary and secondary services.	✓	✓	✓	✓		✓	✓ (Equity) ✓(Quality)
Working with our neighbours – primarily sub regional initiatives: the Wellington/Hutt Valley/Wairarapa subregion is a realistic setting for strong collaborative action, including initiatives generated by the sub regional Clinical Leadership Group, and back office efficiencies.	✓		✓	✓	✓	✓	✓(Quality)
Health of Older People: developing an enhanced local model of integrated care by primary and secondary care health professionals, alongside needs assessment and service co-ordinators and providers. This will align with Hutt Valley DHB actions within subregional Health of Older People Work Plan and the local implementation of InterRAI,	✓	✓		✓	✓		✓ (Equity) ✓(Quality)
Preventative Services: focussing on implementing actions to address child and youth health in one or more communities of need in connection with our subregional "Keeping Well" Strategy, and identifying and implementing actions to improve breastfeeding rates	✓	✓		✓	✓		✓ (Equity)

2.6 Maori Health Plan

The DHB has developed a Maori Health Annual Plan (MHAP), which sets out its intentions toward improving the health of Maori and their whanau, and reducing health inequalities for Maori. The plan can be accessed at www.huttvalleydhb.org.nz.

The MHAP records a set of national priorities, Central Region priorities (see Tu Ora, the draft Regional Maori Health Plan), and district priorities.

Our district priorities have been identified in conjunction with the DHB's Maori Partnership Board and Maori Health Services Development Group. They are: Child Health, Immunisation, Breastfeeding, Long term Conditions, Health of Older People, Smoking, Mental Health & Addictions, Workforce, data quality, and determinants of health. Each of these priority areas has a set of identified action points.

There is strong alignment between the MHAP district priorities and the DHB's strategic priorities and action areas. Examples include our focus on reducing inequalities, the need to address avoidable hospitalisations and long term conditions, and preventative actions such as immunisation, smoking cessation and breastfeeding.

2.7 Key impacts and measures of performance

The functions and operations of the DHB are wide-ranging and complex. To assist with building an overall picture of performance, we have identified a group of key measures for assessing our performance. These measures are set out in the table below, linked to Government Health Targets and Priorities.

The table includes aspects of performance against Government Performance Requirements (see Module 9), and of delivery on our strategic priorities and against the Impacts we seek to achieve (see section 2.2 above).

Alignment of our Strategic Priorities, the Impacts we want, key performance measures, and service delivery outputs (aggregated into Output Classes)

	Government Target/Priority Interface (as applicable)	Impact or Strategic Priority	Key measures[9]	2013/14 Target	2012/13 Target	2011/12 Target	Baseline	Output Class	Main areas of performance
Impacts		***Health protection is enhanced; public trust, confidence and security;*** We cannot achieve our goals if we do not protect the health of the population, such as when we control the spread of infectious diseases, or assure the quality of our water.	Disease outbreaks are controlled	100%	100%	100%	100%	Prevention Services	Health Promotion and Education Services Statutory and Regulatory Services
		***Health risk is reduced; people are healthy, able to self manage and live longer;*** Ensuring that our population is able to make healthy choices and that we support such choices is key to reaching our goals. Addressing health behaviours and risk factors is what we do when we implement tobacco cessation programmes, work to reduce obesity (which is a major factor in long term health conditions) and when we work to	Reduced number of smokers in the population Better help for Smokers to Quit ***(Health Target)***	< 18% 95%	< 18% 95%	< 18%[10] 95%	22.6%[11] 88%[12]	Prevention Services	Health Promotion and Education Services
			Percentage of 2 year olds fully immunised ***(Health Target)***[13]	95% *(reported/ assessed by ethnicity)*	95% *(reported/ assessed by ethnicity)*	95% *(reported/ assessed by ethnicity)*	91%[14]	Prevention Services	Immunisation, Well Child, School Health Services

[9] Some of measures and targets associated with the impacts 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 within our DAP. Other measures are drawn from national survey data – NZ Health Survey and other national data collections as published by the Ministry of Health from time to time.

[10] Less than national average, measured at next census.

[11] Baseline measure is % of Hutt Valley residents aged 15 years and over that were regular smokers as measured by the NZ Census 2006. NZ Health Survey 2006/07 data gives an aged standardised prevalence rate of 18.6%.

[12] Quarter 2 2010/11

	Government Target/Priority Interface (as applicable)	Impact or Strategic Priority	Key measures[9]	2013/14 Target	2012/13 Target	2011/12 Target	Baseline	Output Class	Main areas of performance
		improve our breast-feeding rates. We also contribute to the development of healthy housing policy and long-term local government plans for our community.	Percentage of infants breastfed at 6 weeks[15]	66% *(reported/ assessed by ethnicity)*	65% *(reported/ assessed by ethnicity)*	64%[16] *(reported/ assessed by ethnicity)*	59%[17]	Prevention Services	Health Promotion and Education Services
Impacts			Proportion of people in the population who are obese	< 25%[18] *(reported/ assessed by ethnicity)*	< 25%[19] *(reported/ assessed by ethnicity)*	< 25%[20] *(reported/ assessed by ethnicity)*	27.8%[21]	Prevention Services	Health Promotion and Education Services
		Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; We know that the earlier we identify particular conditions and	Breast cancer screening - percentage of eligible population screened every 2 years[22]	70% *(reported/ assessed by ethnicity)*	70% *(reported/ assessed by ethnicity)*	70% *((reported/ assessed by ethnicity)*	69.5%[23]	Prevention Services	Population Based Screening Programmes

[13] The national immunisation goal is 95% of children fully immunised at two years of age by ethnicity. Immunisation coverage for 2-year olds tells us whether children have received the full series of infant immunisations when they are most vulnerable and also tells us which children are not being reached by our immunisation system.
[14] Baseline measure is Quarter 2 2010/11.
[15] Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy and childhood. The Ministry of Health has identified targets for the proportion of infants exclusively and fully breastfed: 85% at discharge from maternity unit, 74+% at six weeks; 57+% at three months; 27+% at six months.
[16] Subject to final calculation
[17] Baseline measure is first 6 months of 2010/11.
[18] Less than national average.
[19] Less than national average.
[20] Less than national average.
[21] Aged standardised prevalence NZ rate of obesity 15+ years from New Zealand Health Survey 2006/07.
[22] The Ministry of Health sets breast screening coverage target rates based on targets for reduced mortality (breast cancer). For example if 70% of eligible women are screened for breast cancer then we can expect a 30% reduction in mortality amongst the screened population.
[23] Baseline measure is 2009/10

	Government Target/Priority Interface (as applicable)	Impact or Strategic Priority	Key measures[9]	2013/14 Target	2012/13 Target	2011/12 Target	Baseline	Output Class	Main areas of performance
Impacts	***Services Closer to Home*** *– more services delivered in the community*	the earlier we intervene the better the health outcomes can be. A significant number of programmes have been implemented to improve the opportunities for early intervention. These activities are expected in turn to reduce avoidable hospitalisations.	Improved oral health in children – children caries free at 5 years of age[24]	70%	70%	70%[25]	58.3%[26]	Early Detection and Management Services	Oral Health Services
			Reduced number of people experiencing a mental health crisis - % of people with crisis prevention plan[27]	95% *((reported/ assessed by ethnicity)*	95% *(reported/ assessed by ethnicity)*	95% *(reported/ assessed by ethnicity)*	65%[28]	Early Detection & Management Services Intensive Assessment and Treatment Services Rehabilitation and Support Services	Mental Health Services – including community and support
	Services Closer to Home, Clinical Leadership, Health of Older People Shorter stays in Emergency Departments		Reduced avoidable hospitalisations – rates of ambulatory sensitive hospitalisations expressed as ratio of observed to expected for each aged group where 100 is benchmark[29]	Maori 0 – 4 < 129.07 Pacific 0-4 < 145.45 Other 0-4 <139.12 Maori 45-64 <100.00 Pacific 45-64 < 93.17 Other 45-64 < 104 Maori 0-74 < 114 Pacific 0-74 < 110 Other 0-74 < 108.32	Maori 0 – 4 < 129.07 Pacific 0-4 < 145.45 Other 0-4 <139.12 Maori 45-64 <100.00 Pacific 45-64 < 93.17 Other 45-64 < 104 Maori 0-74 < 114 Pacific 0-74 < 110 Other 0-74 < 108.32	Maori 0 – 4 < 129.07 Pacific 0-4 < 145.45 Other 0-4 <139.12 Maori 45-64 <100.00 Pacific 45-64 < 93.17 Other 45-64 < 104 Maori 0-74 < 114 Pacific 0-74 < 110 Other 0-74 < 108.32	Maori 0 – 4 < 141.06[30] Pacific 0-4 < 158.96 Other 0-4 <152.52 Maori 45-64 <103.46 Pacific 45-64 < 93.17 Other 45-64 < 107.1 Maori 0-74 < 121.06 Pacific 0-74 < 112.98 Other 0-74 < 109.41	Prevention Services Early Detection & Management Services Intensive Assessment and Treatment Services Rehabilitation and Support Services	Immunisation, Well Child, School Health Services Primary Health Care Services Oral Health Services Primary & Community Care Programmes Mental Health Services Community Nursing Services

[24] The number of caries free children at 5 years of age for different ethnic groups provides information that allows DHBs to evaluate how health promotion programmes, and services such as the DHB Community Oral Health Service (COHS) and other child oral health providers, are influencing the oral health status of children.
[25] Total, across Maori, Pacific, and Other.
[26] 2010 calendar year
[27] All clients with enduring mental illness should have up to date crisis prevention/resiliency plans (NMHSS criteria 16.4). Crisis prevention/resiliency planning has been shown to be a key component of service delivery that ensures the medium to longer impacts of a serious mental illness to be minimised. Effective prevention planning can be expected to contribute materially to improved outcomes for clients.
[28] Baseline measure in quarter 2 2010/11

	Government Target/Priority Interface (as applicable)	Impact or Strategic Priority	Key measures[9]	2013/14 Target	2012/13 Target	2011/12 Target	Baseline	Output Class	Main areas of performance
	Health of Older People	***Access to services is improved; people with early conditions are treated and managed earlier and illness progression is reduced;*** Working to improve access to services within our community, primary health care, and hospital services ensures that we deliver health equitably, in a way and place that works for our population, and improves their health outcomes. A priority is ensuring increased access to health services for high needs groups, where health inequities clearly indicate issues of access for these population groups.	Improved access to mental health services[31]	0-19 Maori - 2.8% 0-19 Total 2.65% 20-64 Maori – 5.4% 20-64 Total – 3.45%	0-19 Maori - 2.75% 0-19 Total 2.6%[32] 20-64 Maori – 5.35% 20-64 Total – 3.4%	0-19 Maori - 2.7% 0-19 Total 2.55% 20-64 Maori – 5.3% 20-64 Total – 3.35%	0-19 Maori - 2.21% 0-19 Total 2.23% 20-64 Maori – 5.24% 20-64 Total – 3.27%	Early Detection & Management Services Intensive Assessment and Treatment Services Rehabilitation and Support Services	Community Mental Health Services Mental Health Services Community Mental Health Support Services
	Shorter stays in Emergency Departments		Reduced avoidable hospitalisations	See above	See above	See above	See above	See above	See above

[29] Avoidable hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings. Ambulatory sensitive admissions are the largest contributor to avoidable hospitalisations. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors. If there is good access to effective primary health care for all population groups, then it is reasonable to expect that there will be lower levels of ambulatory sensitive hospital admissions. This indicator will highlight disparities between different population groups.

[30] Baseline measures to September 2010

[31] Percentage of population accessing mental health services for different ethnic groups and by age group, compared to the 3% of the population that are estimated to have severe mental health disorders, provides a measure of access and availability of mental health services.

[32] Outyear figures are indicative and subject to target information from Ministry of Health

			Elective Services Standardised Intervention Rate[33]	308 per 10,000 population	308 per 10,000 population	308 per 10,000 population	280 per 10,000 population	Intensive Assessment and Treatment Services	Elective Services
Impacts	***Services Closer to Home*** 	***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;*** Health service delivery has become increasingly specialised with a dividing up of functions, professions, services, and locations. As a result, a patient may receive services in a variety of settings from many different providers, particularly for people with long-term conditions. Taking a more patient centred approach, better	Diabetes management:*)* The number of people with Type I or Type II diabetes on a diabetes register that had an HbA1C[34] <= 8% at their free annual check / the number of people with type I or type II diabetes on the diabetes register (Ministry supplied denominator). Diabetes Annual Reviews.	Maori 60% Pacific 53% Other 82% Total 75% Maori 67.4% Pacific 65.2% Other 77% Total 74%	Maori 60% Pacific 53% Other 82% Total 75% Maori 67.4% Pacific 65.2% Other 77% Total 74%	Maori 60% Pacific 53% Other 82% Total 75% Maori 67.4% Pacific 65.2% Other 77% Total 74%	75%[35] (total) 64% (total)	Early Detection & Management Services	Primary & Community Care Programmes

[33] Standardised intervention rates measure a DHB's delivery of elective services relative for their population, relative to other regions.

		coordinating care pathways, and better supporting health professionals to work across service settings and share information, for the benefit of the patient, are important steps in working towards better service integration.	Cardiovascular disease risk assessment: ***(Health Target)*** the number of people in the eligible population who have had the laboratory blood tests for assessing absolute risk in the last 5 years/ the number of people in the eligible population.	Maori 90% Pacific 90% Other 90% Total 90%	Maori 90% Pacific 90% Other 90% Total 90%	Maori 90% Pacific 90% Other 90% Total 90%	75.9%[36]	Early Detection & Management Services	Primary & Community Care Programmes
	Services Closer to Home 		Reduced avoidable hospitalisations	See above	See above	See above	See above	See above	See above
Strategic Priorities	***Clinical Leadership***	***Collective Leadership***	Improved results in Clinical engagement survey [37] Clinically led initiatives within Hutt Hospital and across primary/secondary interface are developed and implemented.	Improved Results of ASMS In Good Hands Survey Qualitative Reporting	Improved Results of ASMS In Good Hands Survey Qualitative Reporting	Improved Results of ASMS In Good Hands Survey Qualitative Reporting	Results of ASMS In Good Hands 2010 Survey	N/A	N/A

[34] The HbA1c test, also called a glycosylated haemoglobin or HbA1c, gives doctors a view of the patient's blood sugar levels over the prior 120 days - the approximate lifespan of a red blood cell. Results of this blood test can help a doctor understand if a prescribed diabetes treatment plan is working as intended.
[35] Baseline measure Quarter 2 2010/11
[36] Baseline measure Quarter 3 2009/10
[37] ASMS "In Good Hands" Survey

	Regional Collaboration	***Working with our neighbours***	Identifiable improvements in patient care and/or savings from joint activities Inter-DHB working groups involving clinicians and management agree concrete proposals for sustainable service development Additional "joint" services commenced Hutt Valley, Capital & Coast and Wairarapa DHBs develop a draft 3DHSP	Qualitative Reporting	Qualitative Reporting	Qualitative Reporting	N/A	N/A	N/A
	Services Closer to Home ***Health of Older People***	***BSMC primary health care***	Reduced avoidable hospitalisations (see above) DHB/primary care working groups (for example PSSG) involving clinicians and management agree concrete proposals for sustainable service development Improvement in ED and CVD Health Targets	See above Qualitative Reporting See above See above	See above Qualitative Reporting See above See above	See above Qualitative Reporting See above See above	See above N/A See above See above	N/A	N/A
	Living within our means	***Financial sustainability***	Sustained or Improved financial performance over time	Breakeven (or better)	Breakeven	Breakeven	Breakeven	N/A	N/A

MODULE 3: DELIVERING ON PRIORITIES & TARGETS

This section sets out our key activities, actions and outputs to deliver on each of the priorities outlined in the Minister's Letter of Expectations, on Health Targets, and on other priorities identified in Module 2. These are presented in the tables in this Module.

3.1 PRIORITIES AND TARGETS

3.1.1 Government priorities

These are presented in the Minister's Letter of Expectations. The priorities are:

- Clinical Leadership
- Services Closer to Home
- Health of Older People
- Regional Collaboration
- Living within our Means

3.1.2 Health Targets

Health Targets have not changed for 2011/12. They are:

- shorter stays in Emergency Departments
- improved access to elective surgery
- shorter waits for cancer treatment radiotherapy
- increased immunisation
- better help for smokers to quit
- better diabetes and cardiovascular services

Government Priority: Implement the Better, Sooner, More Convenient approach to primary health care/Services Closer to Home.

Comment: Hutt Valley DHB has made significant progress against this priority. Four PHOs have been consolidated into one – Te Awakairangi Health. We have recognised the benefits of shifting some secondary care services to primary care, and over the life of the DHB, have established a number of initiatives in this area including: Primary Care Skin Lesion Programme, Primary Care Sterilisation Services, Community Radiology, and Direct GP referrals for CT Head services. Some hospital clinicians currently run clinics and participate in Multi-Disciplinary Team meetings in primary care settings. This priority is also a Strategic Priority for Hutt Valley DHB in 2011/12, with work to address key population health issues around long term conditions and avoidable hospitalisations requiring continued emphasis from both primary and secondary clinicians and managers.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
Further develop our 'working with' relationship with primary health care through: • participation in a recently established Primary Secondary Strategy Group, a primary/secondary leadership team of primary and secondary clinical leaders and senior managers which provides a forum to enable joint primary and secondary clinical leadership and decision making, planning and implementation. • working closely with the Hutt Valley's new consolidated PHO to ensure that learnings and successes from original PHOs are retained and built on Using these relationships, we will: • in conjunction with PSSG, agree an implementation plan for progressing BSMC policy • implement initiatives to address the high level of avoidable hospitalisations in the Hutt Valley, building on current cellulitis and respiratory projects, including through o working with PSSG by December 2011 to identify options for addressing ASH rates o funding and supporting a nurse-led skin infection project starting by December 2011; o Supporting development of cellulitis guidelines with leadership of PSSG by December 2011. • identify and implement actions to address the burden of long term conditions, including the recommendations of a recent review of diabetes services during 2011/12 • identify and implement actions to improve access to diagnostic procedures for primary care referred patients, including: o undertaking a review of access and funding for community radiology (to be	An efficient and sustainable health system that enhances primary health care's significant role in the design and delivery of health services. A better working relationship will mean more successful identification of issues, and development and implementation of solutions, leading to better patient outcomes. Models of care crossing primary/secondary continuum will be more appropriate Reducing ASH rates, thereby improving health outcomes. Reducing burden of long term conditions Changes in the location of services are expected to result in sooner and more convenient	Proposals from PSSG are adopted Models of care crossing primary/secondary continuum will be agreed by primary and secondary clinicians Clinicians working in our hospital are deployed into community settings. Improvement in ASH rates, and co-ordinated management of long term conditions	New Zealanders living longer, healthier and more independent lives. Service Delivery is better sooner and more convenient, & the health system is adaptive, innovative and continually improving

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
completed by April 2012) o Funding, during 2011/12, a primary care nurse led "Nurse Laboratory Testing" project to develop consistent processes and protocols required to support access to nurse laboratory testing. • progress work to locate services in the "right place" in the primary/secondary continuum, including as appropriate further shifts of secondary care functions into primary and community care settings, including: o Providing dietetic services in the community, including Pomare Health Centre (from 1 July 2011) and extending to one or more additional high needs communities by June 2012. o Shifting responsibility for B4SC from the DHB to the primary sector (contract value $320k), via a direct contract with Plunket (to be entered into in July 2011) in place of the current DHB provided service. o Providing currently hospital based physiotherapy services in Wainuiomata by June 2012 o Expanding multidisciplinary (primary and secondary clinicians) work with vulnerable elderly clients in Hutt Valley– including through a pilot for upskilling aged care RNs by working in Hutt hospital for week during July 2011; and by improving aged care workforce by rotating GP registrars through Older Persons Rehabilitation Service and Stroke clinics during 2011/12 to enhance ability to provide care in community settings. o Work actively with practices undertaking feasibility studies (or considering doing so) for Integrated Family Health Centres in the Hutt Valley, including through encouraging practices to participate in feasibility studies, providing population data, and assisting with business case development o Monitor PHO performance against the PHO Performance Programme and work with PHOs to ensure appropriate performance levels. o Use, as applicable, the Ministry guidance on PHO Cash Reserves, to develop plans for the use of any significant PHO Cash Reserves, by Q4 2011/12. • implement actions to optimise pharmaceutical prescribing, as the Hutt Valley appears to	delivery of services in the community, rather than in hospital settings. This will in turn reduce pressure on relevant hospital services, and result in the upskilling of primary care providers so that primary care will increasingly become the "home" of those services.		

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
have relatively high levels of prescribing for its population o Enrol 1000 patients in the pilot synchronisation service – to improve adherence to medication for people with Long Term Conditions by December 2011 o Work with Pharmac, Ministry of Health (Medicines Control) and Hutt Valley Aged Care GP Peer Group to make acute care medicines available after hours at rest homes, by April 2012; o Discuss with PSSG options to address, and progress recommendations by May 2012. • continue work to expand the primary care workforce and enhance its capability, including development of clinical leadership. This includes: o ongoing access to eduction fund for primary care nurses to upskill at Hutt hospital o administering the primary nurse innovation fund to support innovation projects o Ongoing primary care nursing access to the Hutt Valley DHB Professional Development and Recognition Programme o Continue to provide mentoring and support to people seeking to qualify as nurse practitioners o Hutt Valley DHB Summer Student Programme, which exposes second and third year medical students to primary and secondary practice. o Hutt Valley DHB leading sub-regional HWNZ demonstration site with 15 GP registrars. Hutt Valley DHB employs 6 GPEP1 registrars.			

Government Priority: Clinical Leadership

Comment: Hutt Valley DHB has made significant progress against this priority. The DHB has strongly modelled a collective leadership approach for some time, with our Senior Management Team including our Chief Medical Officer, Primary Care Liaison, Director of Allied Health, and Director of Nursing. We also foster clinical leadership through a wide range of clinical groups covering multiple disciplines. Clinical Heads and Managers jointly develop and signoff service plans and agreements. Clinical leadership is a critical element in the work of our Exceptional Funding Committee. Clinical leadership input to Board decision making is provided via contribution to Board papers and regular presentations and participation in Board meetings and discussions. In the latter part of 2010/11 we have also significantly progressed the introduction of a Primary Secondary Strategy Group (PSSG) and a Hospital Strategy Group. PSSG is increasingly providing direction and leadership within the DHB and in primary care. Our clinicians also lead and influence subregional activities through their involvement in the Clinical Leadership Group (CLG), with the Hutt Valley CMO chairing the Group, and two senior Hutt Valley Clinicians leading the ENT project and the child health project. At a regional level, Hutt Valley DHB provides two members for the Regional Leadership Committee, including allied health leadership.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
At a regional level: The DHB will continue to encourage and support clinicians from Hutt Valley to be actively involved in regional discussions to ensure health service planning and delivery leads to improvement in the sustainability, quality, and accessibility of clinical services. Facilitate a Central Region Training Hub development, governed by CMO/DON/DAH group, emphasising HWNZ priority of PGY1 and 2. ***At a sub-regional level:*** The DHB will encourage and support clinicians from the Hutt Valley to lead discussions on improving services across the sub-region through a Three DHB Health Services Plan (3DHSD). Provide additional analytical and planning support to regional and sub-regional groups to assist development and implementation of proposals. Improving aged care workforce through better education of carers – including through implementing an e-resource to upskill generalist staff in dementia care. ***At a local level:*** Implement and actively support the Primary Secondary Strategy Group (largely made up of senior primary and secondary clinicians)	Improved patient care, with patient journeys across DHBs more streamlined and co-ordinated Postgraduate Training and Education within the region is coordinated to provide the best use of available resource whilst maximising the quality of the product delivered. Improved clinical sustainability of services Development of clinical networks and new models of care that support delivery of services as close as possible to the patient's home Secondary clinicians work with primary care and community clinicians to better manage patients with acute, complex or long term conditions Secondary clinicians increase involvement in strategic hospital management Improved clinical engagement in Hutt Hospital	Inter-DHB working groups involving clinicians and management agree concrete proposals for sustainable service development Clinically led initiatives within Hutt Hospital and across primary/secondary interface are developed and implemented. Models of care crossing primary/secondary continuum will be agreed by primary and secondary clinicians Improved results in Clinical Engagement survey	New Zealanders living longer, healthier and more independent lives. The health system is adaptive innovative and continually improving Increasingly efficient utilisation of resources and service delivery

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
Implement and actively support a Hospital Strategy Group (senior clinical group within hospital) Improving aged care workforce by rotating GP trainees through Older Persons Rehabilitation Service and Stroke clinics			

Government Priority: Regional Collaboration – working with our neighbours

Comment: Hutt Valley DHB has a strong record of working closely with our immediate neighbours – Wairarapa DHB and Capital & Coast DHB. This close relationship has led to significant joint activity, including: a joint contract between Hutt Valley DHB and Capital & Coast DHB for community laboratory services; Hutt Valley DHB being the lead provider for Regional Screening Services and Regional Public Health Services; Hutt Valley DHB providing payroll service to Wairarapa DHB; cross appointments to clinical roles (for example, joint Director of Allied Health across Hutt Valley and Wairarapa DHBs); development and implementation of a Clinical Leadership Group comprising senior clinicians from the three DHBs, leading work on specific service projects, for example in Ear, Nose and Throat, and Child Health

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
At a regional level: Implement Hutt Valley DHB contributions to the Central Regional Service Plan Contribute to implementation of the Central Region Information Services Plan ***At a sub-regional level:*** Provide additional analytical and planning support to CLG to assist development and implementation of proposals Digital mammography - Replace key clinical equipment to ensure service coverage (subject to Ministry funding) Implement back office initiatives (as agreed) The DHB will encourage and support clinicians from the Hutt Valley to lead discussions on improving services across the sub-region including a Three DHB Health Services Project (3DHSD) to enhance clinical and financial sustainability across sub-regional hospital campuses.	Improved clinical and financial sustainability of services A shared information system for all clinicians in the Central Region that will provide access to a single set of clinical records, and a single system. Development of improved models of care centred on patients Sub regional consistency of practice and access	2011/12 actions within RSP delivered 2011/12 actions within CRISP delivered Inter-DHB working groups involving clinicians and management agree concrete proposals for sustainable service development Implementation of CLG proposals across multiple DHBs Identified cost avoidance from joint activities Hutt Valley, Capital & Coast and Wairarapa DHBs develop a 3DHSD proposal	Regionally co-ordinated system of health service planning and delivery Increasingly efficient utilisation of resources and service delivery Service Delivery is Better Sooner and more Convenient

Government Priority: Health of Older People (HOP)

Comment: Since 2004, the DHB has supported more people to stay in their homes – 43% more people between 2004 and 2008. The total number of subsidised clients in residential care also increased, but now represents a smaller proportion of DHB supported people compared with 2004. These increases have required an overall increase in funding of 45% for health services to older people, with Home Based Support (HBSS) receiving 114% more funding, and Aged Residential Care (ARC) receiving 60% more funding. The DHB has also made improvements in other areas including a new Needs Assessment and Service Coordination (NASC) service, more funding for podiatry, better information systems, and closer working relationships between clinicians and providers. But we need to do more, as our population of older people is increasing (an expected increase of 74% by 2021). Many older people want to stay in their own homes, and we want to be better able to support this with access to prevention, respite care, day programmes and social supports, and through improved primary care support. The Hutt Valley has sufficient rest home and hospital level beds for older people, but is likely to need additional dementia and psychogeriatic beds in the next five years. We also need to improve quality across the spectrum of HOP services, through increased workforce development, and improved systems and pathways - supported by appropriate monitoring and audit. The DHB has recently upgraded its InterRAI tool, and will continue to use InterRAI assessments to determine access to home based support services for older people and to aged residential care.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
At a regional level: Work with central government and other central region DHBs on the next steps of the national aged residential care review Continue to promote water fluoridation, which assists in preventing osteoporosis (a risk factor for falls/severity of injury from falls) ***At a sub-regional level:*** Implement the sub regional Capital Coast, Hutt Valley and Wairarapa) HoP workplan as agreed ***At a local level:*** Continue use of the nationally agreed validated assessment process (using InterRAI tools) for older people Implement an enhanced planned respite care service[38] with the sector, including: • ensuring information and education about the range of respite services is made increasingly available to primary care givers of older people; and • implementing a central contact point for planned and	Better alignment of services and models of delivery for the sub-region (including dementia and psychogeriatric care). Standardised assessment reduces duplication and improves integration of care for older people. Increased uptake of respite services, better outcomes for older people and their families/Whanau. Better integration across levels of care and organisations leading to smoother transitions between services and reduced avoidable hospitalisations.	Increased access to services for older population Web based InterRAI being used by co-ordination service and linked into by other services. Increased uptake of allocated respite care packages by family/Whanau. Improvement in ASH rates, and management of long term conditions Reduced hospitalisations for falls (over 75 years of age)	New Zealanders living longer, healthier and more independent lives. In line with *Ageing in Place*, older people and their family/Whanau are supported to maintain wellbeing and independence in their own homes. Older People can access services at the right time, in the right place with the right provider (better sooner more convenient services) The health system is adaptive innovative and continually improving

[38] The DHB has as part of a recent RFP process, consulted on respite care services with various groups, including Advocacy Groups and Family members.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
emergency respite • Investing in dedicated planned respite beds Initiate work with the community, primary and secondary care sectors (including primary and secondary clinicians, NASC and providers) to • better integrate the care management and coordination of services for older people; • develop quality and preventative approaches that reduce injuries and avoidable hospitalisations. Expand dementia services by: • Improving care through better education of carers – including through implementing an e-resource to upskill generalist staff in dementia care • Improving utilisation - working with providers to optimise bed mix to best meet demand for services • Develop baselines and targets beyond bed utilisation			

Government Priority: Living within our means

Comment: Hutt Valley DHB has demonstrated its ability to meet financial targets over recent years, with a focus on controlling hospital cost drivers and managing demand driven services. In all of these areas, increasing involvement of clinical leaders will ensure that patient care and resource use are optimised simultaneously. We will also participate strongly in regional and subregional projects to achieve greater efficiencies in back office functions. Since 2008, we have worked with providers to address value-for-money issues in mental health, to better understand what our population is receiving from the investment in these services. 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 while reducing the investment. In 2011/12, we will continue this approach, both locally and jointly with Capital and Coast DHB, maintaining provision and quality of services within these services. We recognise that our overall expenditure on mental health may be below the identified ring-fence level, but we are confident that service levels and quality will be maintained.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
At a regional level: Review provision of services in the following areas: • laundry services across the region • payroll systems	Effective delivery of services while releasing resources to support	Review of laundry and payroll services complete by December 2011, see RSP for further details	Increasingly efficient utilisation of resources and service delivery New Zealanders living longer,

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Measured by	In support of system outcomes
Improve recruitment, retention processes and professional support services for all staff disciplines ***At a sub-regional level:*** Gain efficiencies in non-clinical support area including finance, laundry, supply, payroll, recruitment, accounts payable, banking Identify and implement actions to drive efficiencies through collaborative service arrangements, for example in ENT ***At a local level:*** Rheumatology and cardiology services - combine wards and enhance outpatient services) to release FTE resource for reallocation for MAPU and day procedures unit. Collective leadership to improve management of demand driven services, e.g. Health of Older People (residential care) and optimising pharmaceutical prescribing.	other services. Improved clinical and financial sustainability of services	Faster and more streamlined recruitment of all staff/ disciplines (for further measures see RSP) Identified cost efficiencies Hutt Valley DHB financial performance at breakeven or better for 2011/12 Demand levels stay within or improve against forecast levels	healthier and more independent lives. The health system is adaptive innovative and continually improving

Health Targets

Health Target: Shorter stays in Emergency Departments.

Comment: Hutt Valley DHB Hutt Valley DHB is committed providing shorter stays for patients in our Emergency Department (ED). Our target is that 95% all patients will be admitted, discharged, or transferred from the ED within 6 hours. Reduced ED length of stay means better services and procedures further up the line in wards and diagnostic departments. ED performance is therefore a measure of how well the different parts of the hospital work together. Meeting the target in the future will require a combination of changes - to infrastructure, to processes, and to culture. As part of our commitment to ensuring faster and better services for ED patients, Hutt Valley DHB is finalising construction of a new ED with nearly three times the number of treatment spaces as the current department. The new department will be operational during 2011/12. A key process change is the introduction of a Medical Assessment and Planning Unit. An example of cultural development is the recent branding of our emphasis on this Health Target as "Shorter Stays by Better Ways".

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Infrastructure: Complete and transition to our new ED **Process** Open a new 8 bed Medical Assessment and Planning Unit (MAPU) to improve the patient flow between emergency department and the medical ward, by December 2011. Implement changes to models of care, with currently planned actions including: • Co-locate existing acute medical clinics run by senior clinicians with ED • Implement a scheduled date of discharge policy across the hospital • Stream patients to minor injury and illness area • Improve patient flow and care between emergency department and wards and rehabilitation services • Improve process (especially timeliness) for	Create more room to see and assess patients in a timely manner. Facilitates timely assessment, treatment and discharge of a cohort of patients who can be managed in a shorter time frame Will assist patients to be admitted in a more timely manner, reduce bed blocking and allow earlier transfer to rehab services Improve flow between ED and discharge, and provide increased senior medical input into clinical decision making, speeding up processes. Allow more timely transfer of patients to the medical service and allow focus on patients who can be discharged within 24 hours Discharging patients in a more timely manner	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	For each of ED facility of level 3 and above: Numerator: number of patient presentations to the ED with an ED length of stay less than six hours, and Denominator: number of patient presentations to the ED.	New Zealanders living longer, healthier and more independent lives' and the intermediate outcome of 'people receive better health and disability services'. Other outcomes supported by the measure are 'the health and disability system and services are trusted and can be used with confidence' and 'a more unified and improved health and disability system'. It also supports delivery of the Minister of Health's priority of 'Improving hospital productivity. Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in the emergency department therefore improves the health services DHBs are able to provide. It also impacts on the Ministerial priority of improved hospital productivity by ensuring resources are used effectively and efficiently. Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
discharge into the community (facilitated by allied health and the Needs Assessment and Service Coordination agency) **Culture** Continue with our "Shorter Stays by Better ways" branding. Increase focus on expectation of achieving Health Target during registrar induction Closer monitoring (daily, weekly as appropriate) of Target Performance.	will free up beds for ED admissions Avoids prolonged hospital stays waiting for assessment and community care management Increase "buy in" to target, and embed meeting this Target as part of our business as usual,			

Health Target: Improved access to elective surgery Health Target

Comment: Hutt Valley has consistently met its annual Electives Health Target. An innovation which the DHB intends to pilot in 2011/12 is a short stay unit, where, as clinically appropriate, patients are admitted and discharged within 24 hours where the procedure is carried out in a theatre setting. This is intended to improve productivity and to limit unnecessary hospital stays thereby increasing overall capacity as well as providing a better patient experience, which in turn improves overall capacity. The DHB is committed to the effective management of patients who have received a commitment to surgery or FSA within a maximum 6-month waiting time. We will also continue with our work to support increasing referrals for delayed breast reconstruction.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Strengthen our relationships with primary care and with the other service providers within our sub region to provide an appropriate level of surgical procedures. Maintain relationships with private providers Improve preoperative assessment processes	Maximise appropriateness of referrals Maximise public capacity to deliver surgical procedures. Supplement public capacity judiciously	4,946 elective discharges	Elective discharges	New Zealanders living longer, healthier and more independent lives. Maintain and improve access for the Hutt population to surgical procedures in line with national intervention rates.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Improve management of acute surgery Scheduling additional weekend theatre sessions, and utilising private sector capacity. Continue to work with Wairarapa DHB to identify and utilise available theatre capacity Review the theatre rosters to optimise use of theatre time in the new suite Continue communication with Central Region DHBs, clinical networks, media, and General Practice (including through our Primary Secondary Strategy group) regarding access to delayed breast reconstruction surgery.	Minimise cancelled theatre bookings Minimise acute interruptions of elective sessions. Assist to manage wait time s for patients, Meet demand for breast reconstruction services across Central Region.			

Health Target: Shorter waits for cancer treatment radiotherapy

Comment: Hutt Valley DHB works closely with its provider Capital & Coast DHB to deliver radiotherapy services. The relationship has been highly successful, with the Health Target being met in 2010/11. Hutt Valley DHB will work closely with Capital and Coast DHB to identify and address any process issues, including access to procedures within each DHB, which have the potential to delay the treatment start date.

With respect to Health Target, we will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Further improve information systems and collection, supporting prospective demand management allowing flexibility in managing workflow and scheduling. Work with Capital & Coast DHB to streamline	Minimisation of Hutt Valley DHB portion of waiting time.	Everyone needing radiation treatment will have this within four weeks.	The percentage of patients ready for treatment in category A, B and C waiting less than four weeks between first radiation oncology assessment and the start of radiation treatment (Ready for	Delivery against this measure meets the gaols of the national Cancer Control Strategy • Reduce the incidence and impact of cancer • Reduce inequalities with respect to cancer By ensuring everyone needing radiation treatment will

With respect to Health Target, we will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
workflow from Hutt Valley DHB FSA to start of treatment to ensure patients start treatment within four weeks. Work in collaboration with Wellington Blood and Cancer Centre to identify where our portion of the pathway (eg. waiting times for investigations and pre-radiotherapy treatments) contributes to not achieving the target, and put processes in place to minimise the bottlenecks and / or impact of bottlenecks on target achievement.			treatment patients are those who are assessed as able to start their radiation treatment, this excludes patients who require further clinical assessment, other treatment prior to radiotherapy, are not fit to start treatment because of their medical condition or who choose to defer their treatment, and includes category D patients).	have this within four weeks the DHB will impact the Ministerial priority of improved hospital productivity by ensuring resources are used effectively and efficiently. Consistent performance of the DHB against this target, ensuring the timely access to radiation treatment for everyone needing it, will support public trust in the health and disability system and services and that these services can be used with confidence. Through the intermediate outcomes the target contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives.

Health Target: Immunisation

Comment: Immunisation of 2 year old children has been a particular success for Hutt Valley DHB and its provider partners, as we have worked together in a way which has meant the Health Target has been exceeded during 2010/11. This has been recognised with presentation of a certificate from the Minister of Health. We are continuing to work hard with our provider partners to reach an even higher level of performance.

We will undertake the following activities	We expect these actions will support improved performance	To deliver the Health Target	Measured by	In support of system outcomes
Work with two (pilot) GP practices to understand their immunisation processes, and use the information to improve systems and processes across the Hutt Valley. Development of a process to improve services to 'high-high' needs infants, through greater Whanau engagement. Measure immunisation status and reasons for late/ non-vaccination of children attending Paediatric Out-Patients Service and identify solutions to improve	Process and system improvements and better integration across primary care, OIS, paediatric outpatients, and the NIR teams	The national immunisation goal is 95% of children fully immunised at two years of age by ethnicity.	95% of infants vaccinated, reported by ethnicity NIR recorded OIS referrals and outcomes. Individual GP delivery gaps and vaccination timeliness is identified	New Zealanders lead longer, healthier and more independent lives Delivery against this target reduces health risk by: • Immunisation providing individual protection for some diseases • Giving population-wide protection by reducing the incidence of diseases and preventing them spreading to

We will undertake the following activities	We expect these actions will support improved performance	To deliver the Health Target	Measured by	In support of system outcomes
this. Development of improved systems and processes to improve enrolment of new-borns with primary care. Review of Outreach Immunisation Service (OIS) referral/ feedback pathway Pilot of the National Immunisation Register (NIR) as a hub for referrals to OIS for over-due vaccination. Consult with and provide feedback to stakeholders to improve system processes and outcomes				vulnerable people ("herd immunity").

Health Target: Better help for smokers to quit

Comment: Hutt Valley DHB significantly improved its performance against this target over 2009/10, increasing to over 80%. The DHB intends to continue its strong performance in this important preventative service. The Hutt Valley DHB electronic discharge summary (EDS) now has mandatory smoking status to accurately capture and report this data to the Ministry, and nursing planning documentation also carries smoking status information. These are becoming part of an integrated sustainable system for smokefree interventions. DHB staff are working with Primary Care to meet the 2010/11 targets and establish a foundation for achieving it's the 2011/12 targets.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Provide ABC Training and education for smoking cessation monthly to all staff. Junior doctors have ABC smoking cessation on their quarterly training rotation. Provide monthly data on Health Target progress (including ethnicity reporting) to each department/ward. Ensure all forms of subsidised NRT are widely available in the hospital (for patients and staff). Provide ABC training to clinical staff working in primary care, drawing on the approach which has worked successfully in secondary care.	Improved awareness of relevant staff about the need to ensure smoking status information is correct prior to discharge, and the importance of advice to quit. Staff in the wards will be aware of their own performance and progress on this target. NRT will be easy to access. Secondary and primary care clinicians	95% of hospitalised smokers will be provided with advice and help to quit by July 2012. Primary care "better help for smokers to quit" - national goal of 90% of enrolled patients who smoke and are seen in General Practice will be provided with advice and	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit, with ethnicity reporting.	Delivery against this measure supports the RPH outcome of Smokefree Living, which reduces tobacco related morbidity and decreases tobacco related disparity. The measure also supports the ABC Implementation Plan outcome of integrated health systems for smoking cessation. Brief advice from a health professional to smokers is shown to increase the chance of smokers making a quit attempt. Brief advice works by

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Work with new PHO to enhance focus on assisting Maori smokers to quit, and to identify options for DHB support more generally Hutt Valley DHB clinical champion will provide support to, and raise awareness of smokefree activities at senior clinician level. Continue to provide a Primary Care Support Advisor based in Regional Public Health to deliver support and advice to primary care. Liaise with PHO in relation to data collection and reporting (managed by MoH and DHBNZ) and assist PHO in advocating for process and system improvements	will know, support and endorse each other's ABC approach to quitting.	help to quit by July 2012 (reported through the PHO Performance Programme, broken down by ethnicity)		triggering a quit attempt rather than by increasing the chances of success of a quit attempt. Nicotine replacement therapy doubles the chance of a quit attempt becoming effective. Combing NRT with support is shown to be even more effective. By encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and a reduction in the risk of the individuals contracting chronic smoking related diseases. This will promote and protect good health and independence.

Health Target: Better Diabetes and Cardiovascular Services

Comment: Over the past few years, Hutt Valley DHB has made some improvements in addressing long term conditions, with particular progress in diabetes services. However, the Hutt Valley population still has higher than average rates of avoidable hospitalisation, and a significant burden of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease, cardiovascular disease and chronic mental health disorders. The DHB has a longstanding and continuing emphasis (as demonstrated in our annual Improving Equity report) on addressing inequalities which exist in health status and in risk factors amongst Maori and Pacific people, and this will continue to underpin our activities to reach this Health Target.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Review and where agreed, implement the recommendations of the HVDHB Funder Review of Diabetes Services 2010, having particular regard to the unmet need of Maori and Pacific people with diabetes.	Enhanced collaboration and co-ordination between primary and secondary care services, with better information sharing of patient information between primary,	Increase the percent of people with diabetes will attend free annual checks Increase number of people	Increased number and proportion of people with diabetes have attended their free annual diabetes check.	Delivery against this measure supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives' and the intermediate outcome of 'people

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver the Health Target	Measured by	In support of system outcomes
Complete the reconfiguration of PHOs into one entity. Work with the new PHO to develop an appropriate, comprehensive CVD risk assessment focus, with enhanced focus on high risk groups including Maori and Pacific people. Ensure the level of funding to primary care reflects the expected increase in the prevalence of people with diabetes	community and secondary providers Comprehensive, consistent service delivery across the Hutt Valley Practices will work with their patients to • improve management of diabetes • better identify people at risk of CVD and assist them to manage the risks.	with diabetes will have satisfactory or better diabetes management. Increase the percent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years	Proportion of people who have satisfactory or better diabetes management (defined as having an HbA1c of equal to or less than 8%) at the time of their free annual diabetes check. The percentage of Health target for CVD risk assessment achieved	receive better health and disability services'.

Regional, sub regional actions within the Central RSP sponsored by Hutt Valley DHB Chief Executive Officer.
This section is for information only. It does not create accountability on Hutt Valley DHB.

Regional Plans sponsored (solely or jointly) by the Hutt Valley DHB CEO (information only)	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes
Radiology Services The radiology project seeks to standardise on prioritisation criteria, which will then allow a greater level of sharing of radiologist resource through the application of a regional PACS system, implementation of a suitable Radiology Information Service and development of a regional radiology services for after – hour's services. This will address periodic radiologist shortages and inconsistencies in radiologist access. ***Clinical Leadership Programme*** • Advancing key workstreams within a programme of led by our Clinical Leadership Group. This will ir working to improve the ENT, Child Health, and People's services available within the sub-region. • Closer cooperation in providing Urology and Ophthalm services, Laboratory Services, and General Surgery • Collective review of all senior clinical and exe positions as they become vacant to determine opportu for cross DHB appointments. ***Capital Asset Management*** Establish the terms of reference of the regional capital committee to oversee capital investment proposals across the region	A sustainable regional radiology service that is patient focussed, high quality, timely and affordable Sub – regional integration of services where there are real gains to be achieved in access to and delivery of care for consumers Develop a more coordinated and affordable approach to capital asset management across the region	On Central regional implementation plan.	See RSP, Plan 4. See RSP Plan 5 See RSP Plan 9	Delivery against this measure supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives', and the intermediate outcome of 'A more unified and improved health and disability system'. Regional service planning will provide a strategic, medium term context for DHBs to develop their annual plans at the district level, and will foster collaborative approaches to strengthening service viability and improved performance.

DHB local priorities

Our strategic priorities are largely already addressed through the earlier sections covering Government Targets and Priorities (see above) as follows: Collective leadership - the Government Priorities of *Clinical Leadership*, Better Sooner More Convenient primary care - the Government Priority of *Services Closer to Home*, Government Priorities and Health Targets (discussed above); Financial Sustainability - the Government Priority of *Living within our means*, and Working with our neighbours - the Government Priority of *Regional Collaboration).* The remaining priority, Improving our Hospital, is addressed below.

Local priority: Improving our Hospital

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	Aligns with Government Health Target or Priority	Measured by	In support of system outcomes
Operationalise HSG Implementation and active support of a hospital strategy group (senior clinical group within hospital) ***Improve ALOS*** Implement Estimated Date of Discharge on inpatient wards Actively manage discharge planning to support discharge seven days a week. ***Bedding in hospital redevelopment*** Review MAPU Pilot and incorporate learnings into final MAPU Implement theatre/hospital efficiency programmes including TPOT ***Working with our Neighbours*** The DHB will encourage and support clinicians from the Hutt Valley to lead discussions on improving services across the sub-region	Secondary clinicians increase involvement in strategic hospital management Improved clinical engagement in Hutt Hospital Better patient experience and outcomes Improve performance against Shorter Stays in ED Health target Improved theatre efficiency Improved clinical sustainability of service	Clinical Leadership Regional Collaboration Shorter Stays in ED Health Target Improved Access to Electives Services Health Target	Improved results in Clinical engagement survey (ASMS *In Good Hands* Survey) Improved performance against Shorter Stays in ED Health target The average length of stay reflects best practice. Increased theatre productivity Increased patient satisfaction Reduced acute readmission rate	New Zealanders living longer, healthier and more independent lives The health system is adaptive innovative and continually improving Clinical leadership embedded

MODULE 4: FORECAST SERVICE PERFORMANCE

4.1 Output Classes and Statement of Forecast Service Performance

This section of the Annual Plan sets out a summary of our intended outputs for 2011/12.

4.1.1 Output Classes; Relationship to Impacts

For 2010/11 outputs were categorised into four Output Classes[39]. For 2011/12 the descriptions of these have changed slightly to better reflect the nature of service provided. The Output Class categories are:

- Prevention Services
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support

The DHB considers that the outputs and measures below provide a reasonable representation of the full range of services provided by the organisation under each output class.

In our Statement of Forecast Service Performance, we link our outputs to the impacts we want to achieve. It is important to note that linkages will not always be directly quantifiable or separately identifiable. Many factors influence the impacts we seek to contribute to. In addition, many of the impacts will not be seen within a single year, and trend data will be necessary to develop a view as to whether the impacts sought are eventuating.

4.2 Prevention Services[40]

Hutt Valley Prevention Services Environment

Prevention services are delivered through a range of providers within the Hutt Valley district. Regional Public Health is the main provider of public health services for the greater Wellington region. Other providers include the DHB, Primary Healthcare Organisations, private and non-governmental organisations e.g. Maori providers, Sports Trust and local and regional government.

Regional Public Health

Regional Public Health (RPH) is a regional service within Hutt Valley DHB, serving the populations of Capital and Coast, Hutt Valley and Wairarapa DHBs, and working under the shared strategy for population health "Keeping Well". Regional Public Health is responsible for delivering most of the outputs that make up the Prevention Services Output Class Statement of Forecast Service Performance:

- Health Promotion Services and Education Services; working with our communities, local government and government agencies to ensure that the settings in which people live, work, play and learn can support healthy choices.
- Statutory and Regulatory Services; address such issues as sanitation, water quality, promoting water fluoridation, food safety and control of the spread of infectious diseases.
- Immunisation, Well Child, and School Health Services; preventing disease and improving health for families/whanau, children and young people through individual service delivery such as immunisation, new entrant health screening, ear van service and vision and hearing tests in school and preschool settings.

Population Based Screening

The Ministry of Health contracts the Hutt Valley DHB to provide the regional breast cancer screening service (BreastScreen Central) and national cervical screening coordination services (National Cervical Screening Programme).

- BreastScreen Central provides breast cancer screening for women aged 45 to 69 years from fixed and mobile sites throughout the Hutt Valley DHB, Wairarapa DHB and Capital & Coast DHB regions.
- Hutt Valley DHB provides one of the 12 regional National Cervical Screening Programme coordination services throughout New Zealand.

[39] In 2009-10 DHBs trailed the use of new 'aggregate classes' aligned to the Population Continuum of Care.

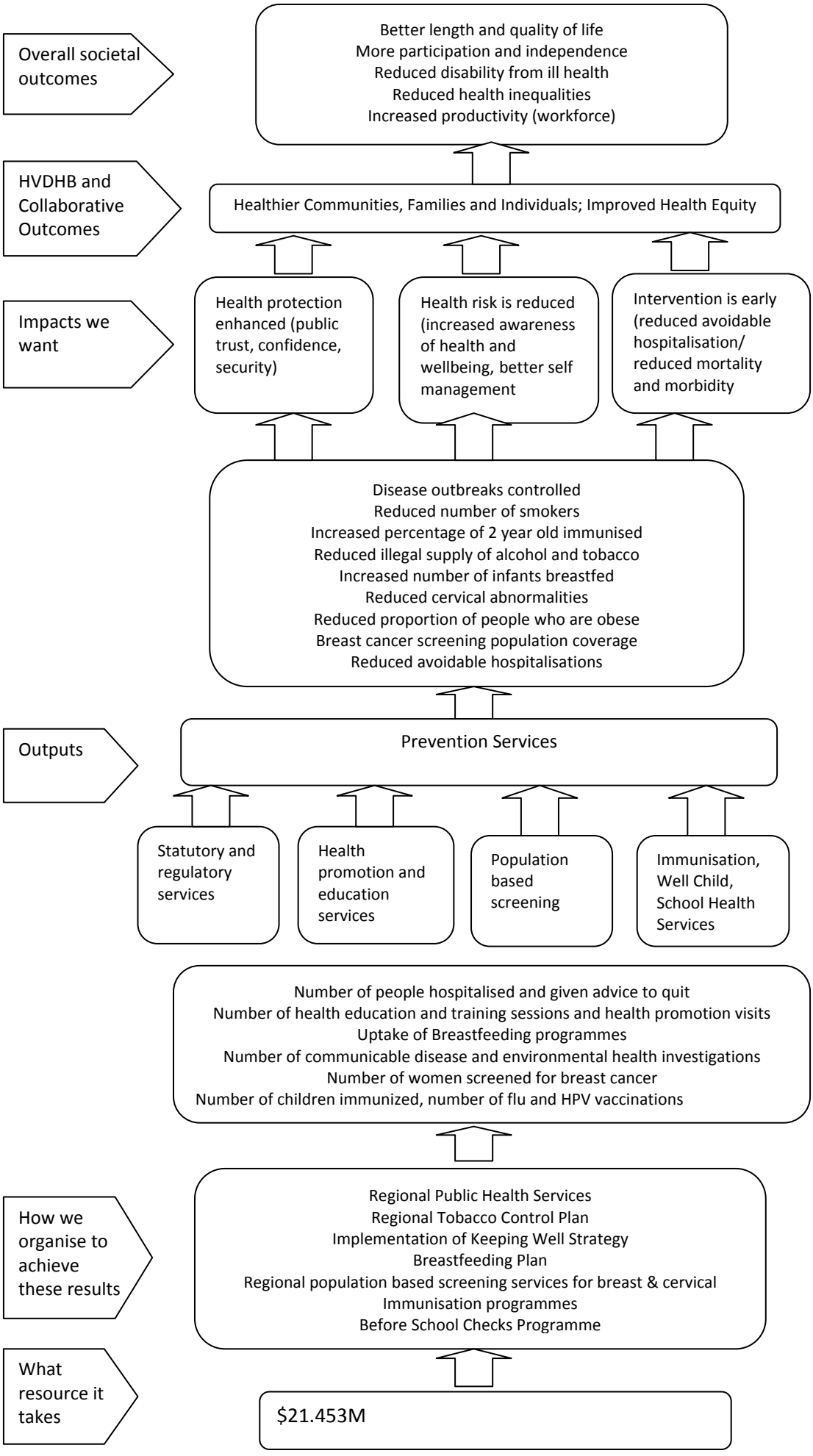
[40] Prevention services are publicly funded services that protect and promote health in the whole population/identifiable sub-populations. They prevent disease and enhance the health status of the population . Public Health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and individual health protection services such as immunisation and screening services.

In 2011/12 we continue to work in key population health areas to:

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

The Outcomes Framework for the Prevention Services Output Class is shown overleaf.

Prevention Services Output Class Intervention Logic



Statement of Forecast Service Performance for Prevention Services Output Class

This section outlines the Prevention Services we intend to deliver to our population. Some of these services are provided directly by Hutt Valley DHB while we fund others through a range of contracts with Primary Health Care providers and other NGOs. The outputs are aggregated into: Health Promotion & Education Services, Statutory & Regulatory Services, Population Based Screening, and Immunisation, Well Child, and School Health Services.

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[41]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[42]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">Output: Health Promotion and Education Services - Includes programmes such as: Healthy Communities, Health Promoting Schools, Nutrition and Physical Activity, Sexual Health, Early Child Health, Injury Prevention, Mental Health awareness, Prevention of Alcohol and other Drug related harm, Tobacco Control, and provided by Regional Public Health, Primary Care, and NGOs. Ensuring that our population is able to make healthy choices and that we support such choices is key to reaching our goals. Addressing health behaviours and risk factors is what we do when we implement tobacco cessation programmes, work to reduce obesity (which is a major factor in long term health conditions) and when we work to improve our breast-feeding rates.</td></tr>
<tr>
<td>Smoking cessation services

Education and training sessions

Health promotion visits

Provide strategic public health input and expert advice to inform policy and public health programming</td>
<td>% of smokers hospitalised and given advice to quit (Hutt Valley DHB population only) – Health Target
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>88%</td><td>95%</td></tr></table>90% of enrolled patients who smoke and are seen in General Practice will be provided with advice and help to quit by July 2012

Number of education and training sessions provided
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>906</td><td>855</td></tr></table>Working groups where input provided
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>64</td><td>64</td></tr></table>Number of schools and early childhood services receiving health promotion visits (Hutt Valley and Capital & Coast DHB populations)</td>
<td>Health risk is reduced:
Reduced number of smokers in the population[44] reduces health risk of cancer and heart disease.
Increased breastfeeding rates support healthy development and reduces risk factors, for example, of obesity</td>
<td>Breastfeeding rates increase (six weeks) Baseline: 58%[45]

Breastfeeding rates increase six months)
Baseline: 36%[46]

Change in percentage of Smokers in Population (assuming Census/Health Survey conducted)
Baseline (male/female)[47]:
Maori: 37% 42%
Pacific: 31% 20%
Other: 18% 16%
Asian: 15% 4%</td>
<td>Better length and quality of life, Healthier Communities, Families, and Individuals, Improved health equity</td>
</tr>
</table>

[41] The baseline for setting of targets and measures varies for different outputs – some baselines are based on latest actual figures, some baselines are based on the last calendar or financial year, and some baseline measures are provided directly by the Ministry of Health. Where measures and targets are new for the 2009/10 year there may be no baseline data.

[42] The main measures of performance (sub-outputs) are largely delivered in accordance with the Ministry of Health Nationwide Service Framework Library Service Specifications, which specify the service coverage, service quality, timeliness and effectiveness requirements. In addition, the Ministry of Health DHB Performance Monitoring Framework may apply and may specify quantity, quality, timeliness and effectiveness requirements. Outputs are also delivered in accordance with wider health sector, professional and organisational standards for quality, timeliness and effectiveness for the specific service area.

Outputs - Main areas of performance	Output Measure(s) (including Baselines[41]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[42]	Impacts	Impact Measures	Outcomes
	Baseline: 138[43] — By July 2012: 138 **Number of opportunities taken to provide strategic public health input and expert advice to inform policy and public health programming** Baseline: 73 — By July 2012: 73			
Output: Population Based Screening Programmes: Provided by Regional Screening Services based at Hutt Valley DHB to Capital & Coast DHB and Wairarapa DHB. Includes breast cancer screening services direct to the public and national cervical screening programme regional coordination services, provided under contract to the Ministry of Health.[48] Breast cancer is an important health concern in New Zealand. International evidence has shown that breast screening delivered through a properly organised programme is efficacious in reducing mortality from breast cancer for women aged 50-69 by 30 percent. It has been estimated that an organised breast screening programme in New Zealand could save approximately 100 lives per year in the first five years, and up to 175 lives per year after twenty years of screening.[49]				
Breast screening services	Breast screening: Baseline: Total 12,462 (72.4%)[50] Maori = 1342 (62.1%) Pacific = 702 (63.2%) — 2011/12: Total = 12,663 Maori = 1,645 Pacific = 837	Health risk is reduced; People live longer, they are healthier and more able to live independently. Reduced impact and mortality from breast cancer due to early detection.	Incidence of breast cancer reduces (regionally or nationally) [51] Breast cancer registration: 510[52]	Better length and quality of life, Healthier Communities, Families, and Individuals,
Output: WellChild, Well School Services Provided by Primary Care, Well Child Providers, and Regional Public Health. School and Pre School Health Services are those services and programmes that are delivered in schools and early childhood centres. The focus of the service is on the identified needs of children and young people (hearing & vision screening, assessment and referral services, case management services, involvement in Strengthening Families, adolescent clinics and self referral clinics, opportunistic immunisation, communicable disease prevention). The evidence suggests that school-based and youth-specific health services are effective in connecting young people into health care; particularly young people from high need populations. The primary objective for providers of School and Preschool Services is to support and assist children, young people to maximise their physical, mental and emotional health potential, thereby establishing a strong foundation for ongoing healthy development.[53] The Before School Check is a nationwide				

[43] Broken down into 23 HVDHB Schools, 28 CCDHB Schools, and 87 Early Childhood Centres
[44] As measured by the NZ Health Survey and NZ Tobacco Survey
[45] 2009/10 actual
[46] 2009/10 actual
[47] 2006/07 15+ years of age daily, standardised per 100000
[48] Regional National Cervical Screening Services do not fit the definition of an output, good or service provided for a third party – these services are enablers or internal capability.
[49] BreastScreen Aotearoa National Policy and Quality Standards, National Screening Unit, Ministry of Health, July 2008. Figures for lives saved are not available at a DHB level.
[50] Based on cohort of 14,360 eligible women between ages 45 and 69
[51] This information will not be collected by the DHB, and utilising this measure is dependant on a national or regional organisation or grouping confirming collection and availability of data.
[52] Total Maori, Pacific, Asian, and Other - 25+ years age standardised per 100,000; 2005-2007
[53] Nationwide Service Framework; Service Specifications; Tier 2 Preschool and School Health, Ministry of Health 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[41]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[42]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">programme offering a free health and development check for four year olds. The B4 School Check aims to identify and address any health, behavioural, social, or developmental concerns which could affect a child's ability to get the most benefit from school, such as a hearing problem or communication difficulty. It is the eighth core contact of the Well Child Tamariki Ora Schedule of services.[54]</td></tr>
<tr><td>Visits to schools by health nurses (No. schools HVDHB = 75 & No. schools C&C DHB = 138)

Before School Checks</td><td>Number of Visits to schools by health nurses
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>C&CDHB
3363
HVDHB
1632</td><td>C&CDHB
3363
HVDHB
1632</td></tr></table>
Number of Before School Checks
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>1406(338 High needs)</td><td>1754 (406 high needs)</td></tr></table></td><td>Early detection and treatment of health and development issues which will impact on a child's learning.

Intervention is early - Reduced avoidable hospitalisations, as earlier identification and treatment of issues will reduce acute attendances</td><td>Reduced ambulatory sensitive (avoidable) hospitalisations (ASH rate), as earlier identification and treatment of issues will reduce acute attendances – Baseline:
Maori 0 – 4 < 140.8
Pacific 0-4 < 160.20
Other 0-4 <155.8
Maori 45-64 <103.6
Pacific 45-64 < 93.9
Other 45-64 < 107.6
Maori 0-74 < 112.9
Pacific 0-74 < 112.9
Other 0-74 < 108.29</td><td>Reduced avoidable hospitalisations – rates of ambulatory sensitive hospitalisations expressed as ratio of observed to expected for each aged group where 100 is benchmark[55]</td></tr>
<tr><td colspan="5">Output: Statutory and Regulatory Services: Includes services provided by Regional Public Health based at Hutt Valley DHB to Capital & Coast DHB and Wairarapa DHB</td></tr>
<tr><td>Investigate communicable disease notifications, including to tuberculosis, meningococcal disease, vaccine-preventable and enteric illness
Environmental health investigations, audits, or incidents including the following Service areas: Food Safety; Drinking Water; Hazardous Substances; Border Health & Emergency Management, Burial and Cremation
Controlled purchase operations carried out on tobacco and alcohol retailers</td><td>Communicable disease notifications investigated
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2633</td><td>2530</td></tr></table>
Number of environmental health investigations
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>1181</td><td>1281</td></tr></table>
Number of controlled purchase operations
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>29</td><td>35</td></tr></table></td><td>Health protection is enhanced; Disease outbreaks are controlled
Health protection is enhanced; Disease/infection outbreaks are controlled
Health risk is reduced; Reduced illegal supply of tobacco and alcohol</td><td>Qualitative reporting on issues identified and severity of outbreaks.</td><td>Healthier Communities</td></tr>
<tr><td colspan="5">Output: Immunisation Services - Provided by Primary Care, Well Child Providers, and Regional Public Health. Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people.[56] .</td></tr>
</table>

[54] Ministry of Health website http://www.moh.govt.nz/b4schoolcheck

[55] Avoidable hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings. Ambulatory sensitive admissions are the largest contributor to avoidable hospitalisations. They provide an indication of access to, and the effectiveness of, primary health care, and management of the interface between the primary and secondary health sectors. If there is good access to effective primary health care, then it is reasonable to expect that there will be lower levels of ambulatory sensitive hospital admissions. This indicator will highlight disparities between different population groups.

[56] Ministry of Health DHB Performance Monitoring Framework 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[41]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[42]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr>
<td>Immunisation services (delivered through general practice, outreach, school and other community settings)</td>
<td>Immunisation: % two year olds fully vaccinated Health Target:
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>91%</td><td>95%</td></tr></table>
Immunisation: Year 7 children vaccinated in schools
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>Hutt Valley DHB 1447</td><td>Hutt Valley DHB 1985</td></tr></table>
Immunisation: Year 8 girls (birth cohort 1998) vaccinated against Human Papillomavirus:
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>Hutt Valley DHB 508</td><td>Hutt Valley DHB 764</td></tr></table>
Immunisation: Over 65 year olds flu vaccinated (CCDHB and HVDHB):
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>Total 13,528
High Needs = 2405 (64%)
Other 11,123 (67%)</td><td>Total 14,154
High Needs 2,497 (64%)
Other 11,656 (69%)</td></tr></table></td>
<td>Health risk is reduced; Intervention is early - Reduced incidence of vaccine preventable diseases among children and older adults –</td>
<td>Reduced or static Notifiable disease rates (MMP) (vaccine preventable)
Baseline (cases)[57]:
Meningococcal Disease > 5
Mumps >5
Pertussis: 53

Reduced Hospital admissions for respiratory conditions of people 65+ -
Baseline: 171 cases[58]

Incidence of cervical cancer reduces (regionally or nationally) [59]
Baseline: N/A</td>
<td>People live longer, they are healthier and more able to live independently.</td>
</tr>
</table>

[57] 2009 reported (ESR Annual Surveillance Report)
[58] 12 months to March 2011 (HVDHB records)
[59] This information will not be collected by the DHB, and utilising this measure is dependant on a national or regional organisation or grouping confirming collection and availability of data.

4.3 Early Detection and Management Services[60]

The Government has identified that ensuring better, sooner, more convenient primary health care is a key priority. In 2011/12 we will develop stronger 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, data) in primary health care to support improved access to services and delivery of more efficient and effective services.

Hutt Valley primary and community health care environment

There is one **Primary Healthcare Organisations** (PHO) in the Hutt Valley, Te Awakairangi Health. This PHO encompass around 27 different practices. There are 74.4 FTE general practitioners (including Registrars and Locums) operating in the Hutt Valley[61]. Over 96% of Hutt Valley population are enrolled with a PHO. In addition, a range of NGOs and private businesses provide primary care services often targeted at specific population groups, or providing particular services in addition to those provided by GPs or Practice Nurses. In addition to national programmes, the Hutt Valley DHB supports a number of local primary health care programmes including: Diabetes outreach services, After-hours services subsidy, and telephone nurse triage service.

The **Community Dental Service** encompasses the Hutt Hospital Dental Unit, the Regional School Dental Service and the Central Region Adolescent Oral Health Coordination Service.

The **Community Pharmacist Service** is provided for our population by 31 Pharmacies in the Hutt Valley. Some prescriptions are filled by pharmacies outside of our district.

The **Community Referred Laboratory Service** is provided under contract by Aotea Pathology for the Hutt Valley and Capital and Coast DHB populations.

The **Community Referred Radiology Service** is provided under contract by Kowhai Health Trust who manages eligible claims for payment for services provided by Pacific Radiology and Hutt Hospital.

The Ministry of Health estimates that those at highest need of mental health services represent around 3% of the population. This equates to 4,200 people in the Hutt Valley. Currently Hutt Valley DHB funds **Mental Health and Addiction Services** provided by the Hutt Hospital, fifteen NGO providers, eighteen sub regional and regional service providers, including a range of regional specialty services primarily delivered by Capital & Coast DHB. The Early Detection and Management Services Output Class specifically refer to **Community Mental Health Services** provided by the Hutt Hospital community mental health team and NGOs. These services include Alcohol and Drug Rehabilitation services, Day services, Maori Health services, and the Central Region Eating Disorder Services. Some of these services are provided on a regional and sub-regional basis.

Key Areas of Focus

Hutt Valley DHB is addressing a number of challenges with regard to Early Detection and Management Services, specifically:

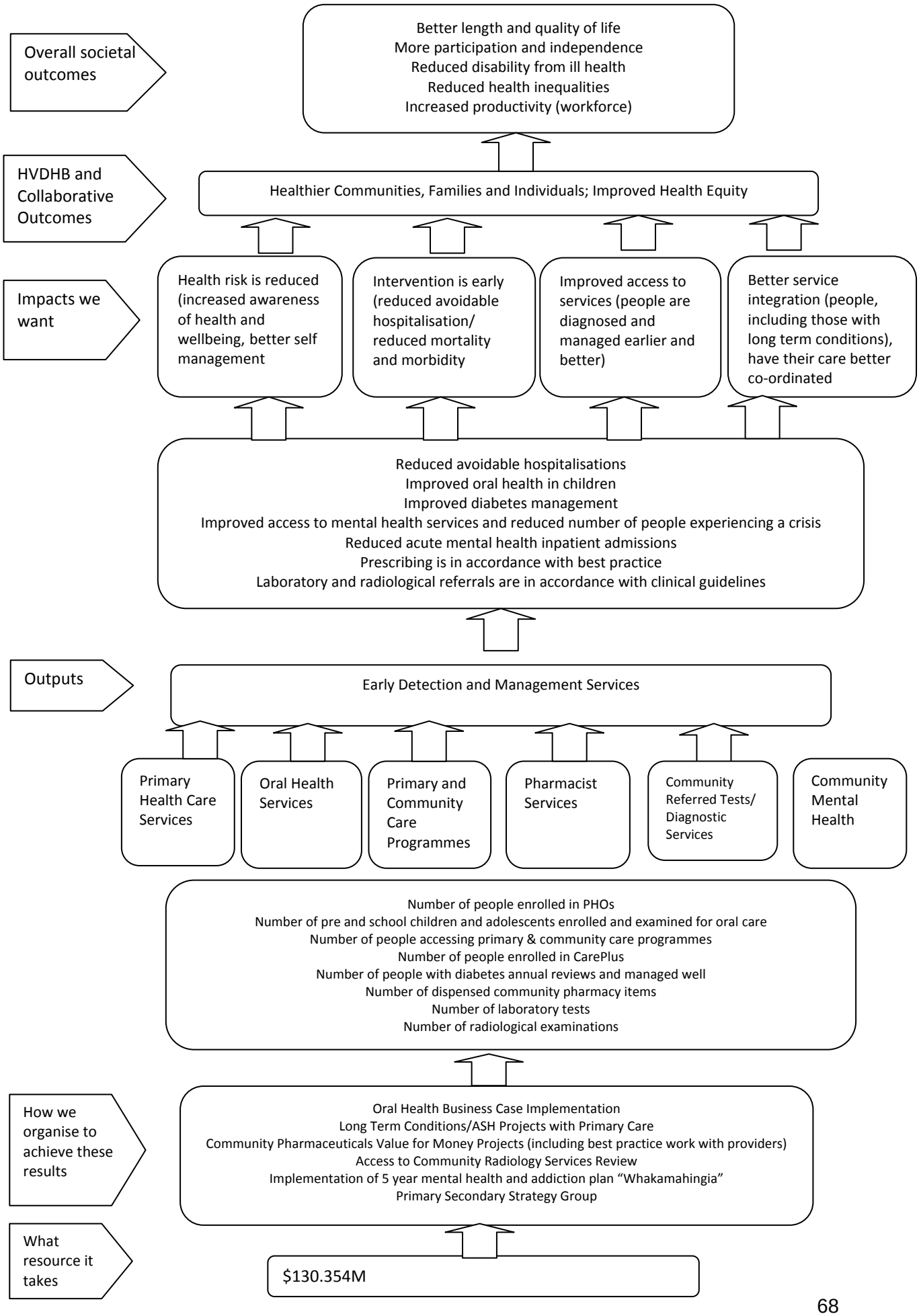
- High rates of avoidable hospital admissions (including in relation to long term conditions) – reflected in our Action Areas (see paragraph 2.5).
- Inequalities in relation to avoidable hospital admissions, annual checks and follow-up management for people with diabetes
- Working together with primary care to improve integration between hospital and primary services
- The need to continue our successes in increasing enrolment for child and adolescent oral health services; reducing disparities in DMFT and caries free figures between Maori, Pacific and other children
- Higher than average expenditure on community pharmaceuticals for our population.

The Outcomes Framework for the Early Detection and Management Services Output Class is set out on the next page.

[60] Early Detection and Management services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. They include general practice, community and Maori and Pacific health services, pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

[61] The numbers of general practitioners fluctuates. Reporting is provided to the DHB on a 6-monthly basis. Data as at January 2010.

Early Detection and Management Services Output Class Intervention Logic



Statement of Forecast Service Performance for Early Detection and Management Services Output Class

This section outlines the Early Detection and Management Services we intend to deliver to our population. Some of these services are provided directly by the Hutt Valley DHB while others are funded through a range of contracts with Primary Health Care Providers and other NGOs. These services include personal health services, mental health services, Maori and Pacific health services and disability support services. The outputs are aggregated into Primary Health Care Services (capitation/first contact), Oral Health Services, Primary and Community Care Programmes, Pharmacist Services, Community Referred Tests/Diagnostic Services.

Statement of Forecast Service Performance – Early Detection and Management Services Output Class.

Outputs - Main areas of performance	Output Measure(s) (including Baselines[62]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[63]	Impacts	Impact Measures	Outcomes
Output: Primary Health Care Services. Primary health care relates to the professional health care received in the community, usually from your GP or practice nurse. Primary health care covers a broad range of health and preventative services, including health education, counselling, disease prevention and screening. A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups. The launch of the Primary Health Care Strategy in 2001, followed by the establishment of Primary Health Organisations (PHOs), set a new direction and vision for primary health care services in New Zealand.[64] Primary Health Care Services are subsidised via a national contract between DHBs and Primary Healthcare Organisations (PHOs) based on the number of people enrolled.				
Primary health care services	**Number of Hutt Valley people enrolled in a Primary Healthcare Organisations** Baseline: 135,365[65] 2011/12: 136,165	Intervention is early, Access to services is improved, Services are better integrated: • Early detection and reduced impact of disease. • Better management of long term conditions in the community. • Reducing growth in demand for acute medical services.	Reduced ASH rate Baseline: See above Reduced rate of non-admitted triage 4 and 5 ED self presentations: Baseline: 39%[66]	People live longer, they are healthier and more able to live independently. .
Primary and Community Care programmes: Provided by Hutt Hospital, Primary Care, and NGOs. Includes CarePlus, Health Promotion, Services to Improve Access, Diabetes Annual Review, CVD Risk Assessment, Cellulitis, Skin Lesions, Sexual Health, Whanau Ora, Primary Mental Health, Podiatry, Dietary, Retinal Screening, Asthma/COPD, care coordination, integrated services, other long term condition programmes. A key priority for implementation of the Primary Health Care Strategy is to reduce barriers for the groups with the greatest need through additional services to improve health and improve access to existing first-contact services. Services to Improve Access (SIA) funding are available for all PHOs for new services or improved access and is additional to the main PHO funding for general practice-type care. [67] PHOs are funded to				

[62] The baseline for setting of targets and measures varies for different outputs – some baselines are based on latest actual figures, some baselines are based on the last calendar or financial year, and some baseline measures are provided directly by the Ministry of Health. Where measures and targets are new for the 2009/10 year there may be no baseline data.

[63] The main measures of performance (sub-outputs) are largely delivered in accordance with the Ministry of Health Nationwide Service Framework Library Service Specifications, which specify the service coverage, service quality, timeliness and effectiveness requirements. In addition, the Ministry of Health DHB Performance Monitoring Framework may apply and may specify quantity, quality, timeliness and effectiveness requirements. Outputs are also delivered in accordance with wider health sector, professional and organisational standards for quality, timeliness and effectiveness for the specific service area.

[64] Ministry of Health http://www.moh.govt.nz/primaryhealthcare

[65] Forecast numbers for Q4 2010/11

[66] 2009/10, % of total presentations to ED (any triage, and any referral source, any discharge status)

[67] Ministry of Health http://www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-sia

[68] Ministry of Health http://www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-healthpromo

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[62]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[63]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">develop health promotion programmes for their enrolled populations.[68] Care Plus is a primary health care initiative targeting people with high health need due to chronic conditions, acute medical or mental health needs, or terminal illness. Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.[69]
The Diabetes Annual Review is funded by the DHB and ensures that Hutt people with diabetes can have a free annual check up with their GP or GP practice nurse. The objectives of the programme are to: screen for the risk factors and complications of diabetes, promote early detection and intervention, agree on an updated treatment plan for each person with diabetes, update the information in the diabetes register used as a basis for clinical audit and planning improvements to diabetes services in the area, and prescribe treatment and refer for specialist or other care if appropriate. [70]</td></tr>
<tr><td>Primary and community care programmes</td><td>Number of people accessing programmes[71]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>22,945</td><td>23,002</td></tr></table>Number of people enrolled in CarePlus:
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2984</td><td>3024</td></tr></table>Number of diabetes annual reviews:
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>4213</td><td>4639</td></tr></table>CVD risk assessment: (Health Target)
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>76%</td><td>90%</td></tr></table></td><td>Early detection and reduced impact of disease; Intervention is early, Access to services is improved -
• Better management of long term conditions in the community.
• Reducing growth in demand for acute and planned medical services.</td><td>Reduced ASH rates
Baseline: see above

Proportion of people who have satisfactory or better diabetes management (defined as having an HbA1c of equal to or less than 8%) at the time of their free annual diabetes check.
Baseline: 75%[72]</td><td>Health risk is reduced; People live longer, they are healthier and more able to live independently.</td></tr>
<tr><td colspan="5">Pharmacist Services: The Hutt Valley DHB funds Community Pharmaceutical Services for community prescribing by GPs and hospital specialists. Pharmacy Services are funded to enable people to have access to Pharmaceuticals and advice services that are responsive to their health needs and priorities. Pharmacy Services are funded as part of an integrated community based health service that: provides people with the best quality and most cost-effective services, within the available funding, based on established professional and quality management standards and codes of practice; provides specialist advice as required to ensure optimal Service User management; ensures people's safety.[73]</td></tr>
<tr><td>Pharmacy Services</td><td>Number of dispensed items
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2,203,000</td><td>2,308,000</td></tr></table></td><td>Access to services is improved, (people's conditions are managed better with hospital attendances reduced) as people receive a wider range and volume of pharmaceuticals, better meeting their health needs</td><td>Reduced ASH rates
Baseline: see above</td><td>People live longer, they are healthier and more able to live independently.</td></tr>
</table>

[69] Ministry of Health http://www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-careplusservice
[70] Ministry of Health http://www.moh.govt.nz/moh.nsf/indexmh/diabetes-getchecked
[71] This data will be limited to those programmes where actual numbers of people attending are able to be readily determined. The total number will include people attending more than one programme.
[72] Q2 2010/11
[73] Nationwide Service Framework; Service Specifications; Community Pharmacy Services, Ministry of Health 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[62]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[63]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">Output: Community Referred Test/Diagnostic Services: The Hutt Valley DHB funds Community Referred Laboratory and Radiology Services requested by GPs and hospital specialists.
Laboratory services are funded for Hutt Valley and Capital & Coast DHB population. Laboratory services provide diagnostic laboratory testing for patients referred by general practitioners, private medical specialists, oral and maxillofacial surgeons, oral surgeons, midwives and certified cervical smear takers. Community laboratory services are funded as part of an integrated community based health service that: Provide patients with the best quality and most cost-effective services based on established professional and quality management standards and codes of practice, provides timely reporting of results to referrers, provides specialist advice as required to ensure optimal patient management, ensures patient and staff safety at all times[74] Diagnostic imaging services provide images of bodily structure and function to aid diagnosis and treatment. Community diagnostic imaging services are funded as part of an integrated community based health service that: Provides patients with quality and cost-effective services based on established professional and quality management standards and codes of practice, encourages best use of resources in the aid of diagnosis in accordance with best clinical practice and the Radiology National Referral Guidelines, provides timely reporting of results to referrers, provides specialist advice as required to ensure optimal patient management, ensures patient and staff safety at all times[75]</td></tr>
<tr><td>Laboratory Tests

Radiological examinations</td><td>Number of laboratory tests
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2,100,807</td><td>2,121,815</td></tr></table>Number of radiological examinations
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>10,400</td><td>10,660</td></tr></table></td><td>Intervention is early, as improved access to diagnostics allows earlier identification of issues.

Access to services is improved, (people’s conditions are managed earlier and better with hospital attendances reduced)</td><td>Reduced ASH rates
Baseline: see above</td><td>People live longer, they are healthier and more able to live independently.</td></tr>
<tr><td colspan="5">Mental Health Community Mental Health Services: The Hutt Valley funds community mental health services provided by Hutt Hospital and NGOs, for the Hutt Valley DHB population, and for other central region DHB populations for specific services and contracts. Specialist mental health and addiction services are delivered to those people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. A focus on early intervention strategies means that services are delivered to people who are at greater risk of developing more severe mental illness or addiction. The aim is for people to have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. Specialist mental health and addiction services are publicly funded for those who are most severely affected by mental illness or addiction.[76] Note that these services are regional and include service provided to non-Hutt Valley residents.</td></tr>
<tr><td>Non-crisis mental health assessment, treatment, monitoring, consult and liaison services.</td><td>Total number of community mental health clients seen[77]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>4,421</td><td>4,421</td></tr></table>Total number of occupied bed days
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>13,851</td><td>13,851</td></tr></table></td><td>Intervention is early, as improved access allows earlier identification of issues; Access to services is improved, (people’s conditions are managed better with hospital attendances reduced) - Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions</td><td>Reduced rate of ED Presentations for Mental Health issues
Baseline: 2%[78]</td><td>People are healthier and more able to live independently</td></tr>
</table>

[74] Nationwide Service Framework; Service Specifications; Community Laboratory Services, Ministry of Health 2010/11
[75] Nationwide Service Framework; Service Specifications; Community Radiology Services, Ministry of Health 2010/11
[76] Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification Ministry of Health 2010/11
[77] Clients see is the total of unique clients seen by each service. A client who uses more than one service will be counted more than once. Output data includes data for clients from other DHBs who used regional services that Hutt Valley DHB is lead DHB for (DHB of service) e.g. AOD residential services etc
[78] 2009/10, % of total presentations to ED (any triage, and any referral source, any discharge status)

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[62]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[63]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">Output: Oral Health Services Include services provided by Hutt Hospital based at Hutt Valley DHB to Capital & Coast DHB. Child Oral Health Service is the provision of a range of dental care to assist the maintenance of a functional natural dentition and to bring about an improvement in oral health status of the population. It includes preventive care, oral health promotion and education, treatment of oral disease and the restoration of tooth tissue. The objective is to achieve a standard of oral health that leads to all children retaining good use of their natural teeth for life.[79]</td></tr>
<tr><td>Enrolment of children in dental services.

Oral examination of preschool children.

Oral examination of adolescents.</td><td>Number of enrolled pre-school and school children (HVDHB and CCDHB populations)[80]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>57,959[81]</td><td>64,416</td></tr></table>Total number of school dental service examinations (Hutt Valley and CCDHB populations)
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>53,395</td><td>59,343</td></tr></table>Number of adolescents examined (Hutt Valley DHB populations)[82]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>6,796
(70.5% of 9,640 cohort)</td><td>7,136
(75% of 9,515 cohort)</td></tr></table></td><td>Intervention is early, as improved access allows earlier identification of issues; Access to services is improved, (people’s conditions are managed better with hospital attendances reduced)

Children are proactively managed so they do not develop caries.

Early caries among children and adolescents is stopped before damage to teeth occurs.</td><td>Increased Percentage of children caries free at age 5:
Baseline: 58.27%[83]

Oral Health DMFT Score at year 8
Baseline: 0.93[84]

Reduced Avoidable Hospital Admissions rate (dental)
Baseline: 140.0[85]</td><td>People live longer; they are healthier and more able to live independently.</td></tr>
</table>

[79] Nationwide Service Framework; Service Specifications; Child Oral Health, Ministry of Health 2010/11
[80] Measured on a calendar year basis
[81] Based on enrolees between aged 0 and 13 years and for subsequent years
[82] The total number of completions and non-completions under the Combined Dental Agreement for adolescent patients plus additional adolescent examinations with other DHB funded dental services (Adolescents are defined as people from Year 9 up to and including age 17 years)/ Eligible population (Ministry denominator)
[83] 2010 calendar year
[84] 2010 calendar year
[85] HVDHB ASH data for 12 months to March 2011

4.4 Intensive Assessment and Treatment Services[86]

Intensive Assessment and Treatment Services encompass all services provided via Hutt Hospital, including:

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

Medical services include emergency department and the medical services that manage patients with chronic illnesses and those that present to the hospital with an acute illness. The services involve both inpatient and outpatient streams.

Hutt Valley DHB provides a regional **Plastic Surgery/Maxillofacial and Burn Unit** covering a population (Wairoa to Blenheim) of over 1 million people. Some of our services are also provided to Canterbury and Otago. We are also the only public hospital in New Zealand providing treatment for vascular birthmarks.

Hutt Valley DHB does not deliver a full **cancer service** and patients are referred to Capital and Coast District Health Board for tertiary cancer treatment services, mainly chemotherapy and radiotherapy services. We are the central region provider of reconstructive surgery for breast and head and neck cancers.

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

The Ministry of Health estimates that those at highest need of mental health services represent around 3% of the population. This equates to 4,200 people in the Hutt Valley. Currently Hutt Valley DHB funds **Mental Health and Addiction Services** provided by the Hutt Hospital, fifteen NGO providers, eighteen sub regional and regional service providers, including a range of regional specialty services primarily delivered by Capital & Coast DHB. The Intensive Assessment and Treatment Services Output Class specifically refers to hospital based **Mental Health Services** provided at the Hutt Hospital and the Infant, Child and Adolescent Family Service.

Hutt Hospital **Maternity Services** have been providing primary maternity care to around 15% of pregnant women in the Hutt Valley.

Key Areas of Focus

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

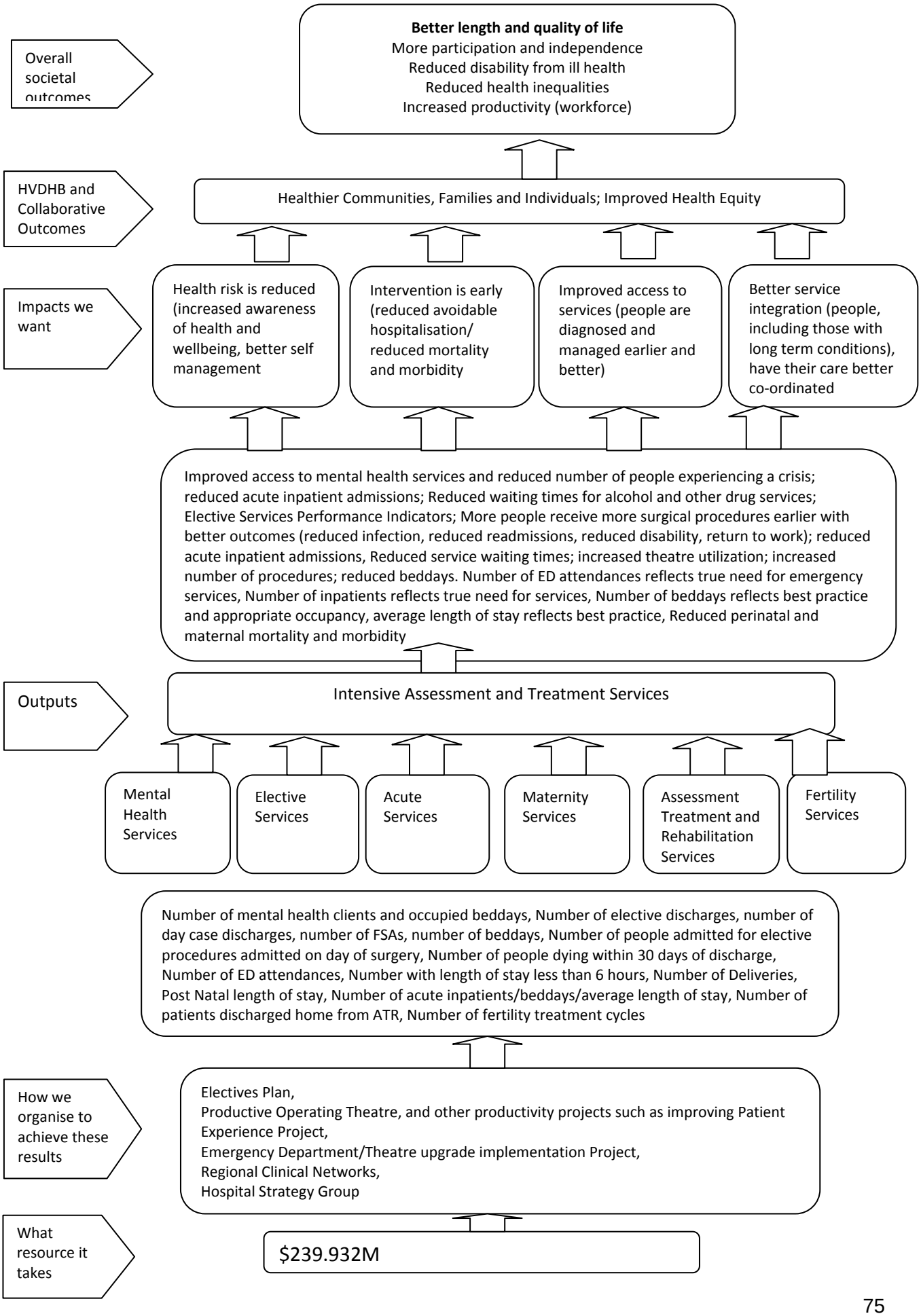
- Improving productivity and releasing more capacity to increase activity, as the new campus development is completed
- Focusing on quality improvements that lead to improvements in efficiency and effectiveness of services
- Working closely with our neighbouring DHBs
- Managing workforce and skill shortages 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

[86] Intensive Assessment and Treatment Services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services, Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services, and Emergency Department services including triage, diagnostic, therapeutic and disposition 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.

The Outcomes Framework for the Intensive Assessment and Treatment Services Output Class is set out on the next page:

Intensive Assessment and Treatment Services Output Class Intervention Logic



Statement of Forecast Service Performance for Intensive Assessment and Treatment Services Output Class

This section outlines the Intensive Assessment and Treatment Services we intend to deliver to our population. Some of these services are provided directly by the Hutt Valley DHB while others are funded through contracts with NGOs (in particular some Mental Health services). The outputs are aggregated into Mental Health Services, Elective Services, Acute Services, Maternity Services, and Assessment, Treatment and Rehabilitation Services.

Statement of Forecast Service Performance – Intensive Assessment and Treatment Services Output Class

Outputs - Main areas of performance	Output Measure(s) (including Baselines[87]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[88]	Impacts	Impact Measures	Outcomes
Mental Health Services: Include services provided at Hutt Hospital and in the community, including by contracted providers. Also includes services provided regionally, and to other DHB populations. Specialist mental health and addiction services are delivered to those people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. The aim is for people to have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. Specialist mental health and addiction services are publicly funded for those who are most severely affected by mental illness or addiction.[89] Service users need easy and well-recognised access to services that are: focused on wellness and recovery, high quality, built on an evidence base of what works best, provided in the least restrictive environment.[90]				

[87] The baseline for setting of targets and measures varies for different outputs – some baselines are based on latest actual figures, some baselines are based on the last calendar or financial year, and some baseline measures are provided directly by the Ministry of Health. Where measures and targets are new for the 2009/10 year there may be no baseline data.

[88] The main measures of performance (sub-outputs) are largely delivered in accordance with the Ministry of Health Nationwide Service Framework Library Service Specifications, which specify the service coverage, service quality, timeliness and effectiveness requirements. In addition, the Ministry of Health DHB Performance Monitoring Framework may apply and may specify quantity, quality, timeliness and effectiveness requirements. Outputs are also delivered in accordance with wider health sector, professional and organisational standards for quality, timeliness and effectiveness for the specific service area.

[89] Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification Ministry of Health 2010/11

[90] Ministry of Health Performance Monitoring Framework, 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[87]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[88]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td>Intensive mental health assessment and treatment services.</td><td>Total number of clients seen[91]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2,308</td><td>2,308</td></tr></table>Total number of occupied bed days
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>7,235</td><td>6,935</td></tr></table>95 % of people have up to date crisis prevention plans[92][93]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>65%</td><td>95%</td></tr></table></td><td>Improved access to services (people are managed earlier and better)
• Reduce the impact of crisis or acute episodes of unwellness.
• Fewer people remain in a specialist mental health service for long periods and have better mental and physical health outcomes.</td><td>Reduced readmission rates to adult inpatient mental health services.
Baseline: 21%[94]

Reduced Average Length of Stay for inpatient mental health services.
Baseline: 13.4 days[95]

No more than 30 days waiting time for Alcohol and Drug Services
Baseline <30</td><td>People are healthier and more able to live independently</td></tr>
<tr><td colspan="5">Elective (Inpatient and Outpatient) Services Elective Services: Includes: Services provided by Hutt Hospital for the Hutt Valley population (provider and population view as measured by Health Targets); Services provided by other DHBs for the Hutt Valley population (population view as measured by Health Targets); and Services provided by Hutt Hospital for other DHB populations (provider and other DHB population view as measured by their Health Targets)The Minister has set an expectation that the national annual increase in elective surgical discharges will improve. The growth in elective surgical discharges will increase access and should achieve genuine reductions in waiting times for patients. Eight Elective Services Performance Indicators have been specified as measures of performance for elective services – measuring quality, timeliness and effectiveness [96]</td></tr>
<tr><td>Elective services</td><td>Elective services provided by Hutt Hospital and by other DHBs for the Hutt Valley population – 4946 discharges Health Target

First specialist assessments (medical & surgical); provided by Hutt hospital and by other DHBs for the Hutt Valley population
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>16,174</td><td>18,614</td></tr></table>Elective Services; provided by Hutt Hospital for the Hutt Valley and other DHB populations</td><td>Improved access to services (people are managed better)</td><td>Day of surgery admission rate[98]
Baseline 77%

Minimise outpatient DNAs
Baseline: 11,010[99]

Patients given a commitment to treatment but not treated within six months
Baseline >5%[100]

Less than 2% of patients will wait longer than 6 months for first specialist assessment (FSA)
Baseline 2%</td><td>People live longer, they are healthier and more able to live independently.</td></tr>
</table>

[91] Clients seen is the total of unique clients seen by each service. A client who uses more than one service will be counted more than once. Output data includes data for clients from other DHBs who used regional services that Hutt Valley DHB is lead DHB for (DHB of service) e.g. AOD residential services etc

[92] Crisis prevention/resiliency planning has been shown to be a key component of service delivery that allows the medium to longer impacts of a serious mental illness to be minimised. Effective prevention planning can be expected to contribute materially to improved outcomes for services. Accordingly, all clients with enduring serious mental illness are expected to have an up-to-date crisis prevention plan. Crisis prevention plan identifies the needs and early warning signs for the services user and their families. The plan identifies what the service users can do for themselves and what the service will do to support the service users.

[93] Ministry of Health Performance Monitoring Framework, 2010/11

[94] 2009/10

[95] 2009/10

[96] http://www.moh.govt.nz/moh.nsf/Files/espijan10/$file/January%202010%20ESPI1.pdf

Outputs - Main areas of performance	Output Measure(s) (including Baselines[87]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[88]	Impacts	Impact Measures	Outcomes
	<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>6,635 (CWD)</td><td>6,722 (CWD)</td></tr></table> **First specialist assessments (medical & surgical)**; provided by Hutt hospital for the Hutt Valley and other DHB populations <table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>15,030</td><td>15,721</td></tr></table> **Percentage of day case discharges;**[97] <table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>57%</td><td>62%</td></tr></table>		30 Day mortality;[101] Baseline 1.53%[102]	
Output: Maternity Services: Includes services provided at Hutt Hospital and in the community. The Maternity Service provides care, from twenty weeks gestation to six weeks following a delivery. The vision is that each woman, and her whanau and family, will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice. Pregnancy and childbirth are a normal life-stage for most women. Additional care will be available to those women who require it.[103]				

[97] One important way in which DHBs can increase hospital throughput is through increasing the proportion of surgery carried out on a day surgery basis. For planned admissions (arranged and elective) it should be possible to improve the management of surgery in order to improve day surgery rates. In addition to the efficiency gains available through day surgery, experience from the United Kingdom has established that patient feedback around day surgery is positive, and day surgery therefore represents a quality experience from the patient perspective.

[98] One important way in which DHBs can improve attainable bed days and increase hospital throughput is through increasing the proportion of surgery carried out on the same day the patient is admitted. The usual term for surgery received on the same day as patient admission is 'day of surgery admission' (DOSA). For planned admissions (arranged and elective) it should be possible to improve the management of surgery in order to improve DOSA rates. The number of patients for which a pre-operative in-hospital overnight stay is clinically necessitated is relatively small.[98]

[99] 2009/10

[100] Performance target for 2010/11 - target was achieved

[101] Mortality rates are a well-established measure of clinical outcomes for hospital patients, due to the fact that mortality is an explicit and readily available measure related to the safety and efficacy of treatment. Overseas experience shows that systemic changes to the way care is offered to patients can lead to measurable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia, and hospital-acquired infections in patients.[101]

[102] Below national average

[103] Nationwide Service Framework; Service Specifications; Maternity Services Tier One Service Specification, Ministry of Health 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[87]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[88]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td>Maternity services</td><td>Number of deliveries
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2,200</td><td>2,200</td></tr></table>Post natal length of stay - Extending postnatal stays for women who choose to stay in a birthing facility longer allows women to establish breastfeeding and gain the confidence to return home. [104]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>2.22</td><td>2.45</td></tr></table>Neo-natal length of stay
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>12</td><td>12</td></tr></table></td><td>Access to services is improved as length of stay better reflects best practice, Women are more confident to return home with their baby as a result of having longer direct access to care and support,</td><td>Reduced readmissions for neonates.
Baseline: 10%[105]</td><td>People are healthier and more able to live independently; Better quality of life, Healthy Families,</td></tr>
<tr><td colspan="5">Acute Services Include services provided by Hutt Hospital for the Hutt Valley population and also for people from other DHB areas. Includes ED - This service is a 24-hour, clinically integrated service that is part of a secure pathway from pre-hospital to definitive care. A hospital Emergency Department treats patients with injury, illness, or obstetric complications. Access to this service must be universal irrespective of an individual’s ability to pay. Key roles for the Emergency Department include: assessment and initial management for medical, surgical and psychiatric emergencies, assessment and initial management for serious injury, assessment and initial management for obstetric emergencies, access to the service may be initiated by an emergency ambulance callout, a primary care provider, a mental health crisis team, or an individual presenting at an emergency department. The service contributes to the regional system for emergency care and operate in synergy with pre-hospital care, ambulance services, and specialised referral services.[106]</td></tr>
</table>

[104] Government priorities, District Annual Plan 2009/10

[105] Readmitted within 28 days of discharge as a neonate; Averaged rate 2007/08 to 2009/10

[106] Nationwide Service Framework; Service Specifications; Emergency Department Services Tier One Service Specification, Ministry of Health 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[87]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[88]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td>Acute services</td><td>Number of Emergency Department (ED) attendances;.[107]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>40,331</td><td>43,640</td></tr></table>Number of inpatients[108]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>13,792</td><td>13,889</td></tr></table>Average length of stay (days): [109]
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>4.04</td><td>4.00</td></tr></table>Reducing Acute Readmission rate[110]:
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>10.15</td><td>9.15</td></tr></table></td><td>Improved access to services; Better Service integration
Decreased ambulatory sensitive (“avoidable”) hospital admissions (ASH) through effective primary care and ED intervention
Reduction of presentations better managed in primary care settings</td><td>Improving number of ED attendances with an ED length of stay less than 6 hours – 95%[111]
Baseline: 88%

Reduced ASH rate
Baseline: see above

Reduced number of non-admitted triage 4 and 5 ED self presentations
Baseline: See above</td><td>People live longer, they are healthier and more able to live independently</td></tr>
<tr><td colspan="5">Fertility Treatment: Includes services provided under contract by Fertility Associates for the populations of the Central Region. The Assisted Reproductive Technology Service (Fertility Treatment) provides a range of specialist treatment services for people experiencing infertility and people with familial genetic disorders.[112]</td></tr>
<tr><td>Fertility services</td><td>Number of fertility cycles
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>280</td><td>280</td></tr></table></td><td>Improved access to services People continue to have appropriate access to fertility services</td><td>N/A – Delivery of service improves access.</td><td>Better quality of life</td></tr>
</table>

[107] Nationwide Service Framework; Service Specifications; Emergency Department Services Tier One Service Specification, Ministry of Health 2010/11

[108] Specialist medical and surgical inpatient services provide services to people whose condition is of such severity or complexity that it is beyond the capacity and technical support of the referring service.[108]

[109] Reductions in the length of stay for inpatients (where clinically appropriate) allow more patients to be treated in hospitals without additional capital investment in hospital beds. This capacity to treat more patients contributes to goals such as decongestion of **emergency** departments, or increases in elective surgery. As well as the improvement in throughput, shortened hospital length of stay for patients reduces risks of nosocomial infections and allows patients to return home. In some cases it may also reflect lowered rates of patient complications, or improvements in the time clinical staff are able to give to direct patient treatment. Treating increasing numbers of patients as day cases or outpatients, or moving less complex services into primary care setting, could increase inpatient length of stay. For this reason, it is important to consider ALOS in conjunction with other measures of hospital (and system) performance, such as day surgery rates and ambulatory sensitive hospitalisations.[109]

[110] Hospital unplanned acute readmission rates are a well-established measure of quality of care, efficiency, and appropriateness of discharge for hospital patients, particularly as a counter-measure to average length of stay. International experience is that shorter lengths of stay are correlated with higher rates of acute readmissions. Unplanned acute readmissions may imply a possible failure in patient management such as discharge too early, or inadequate support at home.[110]

[111] Emergency Department (ED) length of stay is an important measure of service quality in DHBs, because: EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery (and any time spent waiting) is by definition important for patients, long stays in emergency departments are linked to overcrowding of the ED, the medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay, overcrowding can also lead to compromised standards of privacy and dignity for patients, for instance, through the use of corridor trolleys to house patients.[111]

[112] Nationwide Service Framework; Service Specifications; Assisted Reproductive Technology Services Tier Two Service Specification, Ministry of Health 2010/11

4.5 Rehabilitation and Support Services[113]

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.

Hutt Valley Rehabilitation and Support Services

Health of older people services
The population of older people (65 years and over) in the Hutt Valley is 15,940 (2006 census) or 11.3% of our total population compared with 12.2% for New Zealand. The Hutt Valley 65 plus population is projected to increase by 74% between 2006 and 2026. Contracted providers include 16 aged residential care facilities- which provide a mix of rest home, hospital, dementia, psycho-geriatric, day support and respite care services. Three home based support providers cover the Hutt Valley area. Hutt hospital provides a specialist multidisciplinary rehabilitation service for people over the age of 65.

Palliative care services
Palliative care is care provided to terminally ill people to assist them to make the most of their life that remains and to ensure that patients die comfortably. Specialist palliative care is provided by Te Omanga Hospice to people in the community, at residential aged care facilities and at Te Omanga Hospice's inpatient facility. Te Omanga Hospice also has a doctor and nurse based at Hutt hospital. General practitioners and practice nurses provide generalist palliative care, including care provided to residents at aged care facilities.

Disability
The DHB seeks to improve accessibility and responsiveness of services to people with disabilities. Although funding for Disability Support Services remains with the Ministry of Health, the DHB is able to bring a disability perspective to policy and process development. An example of this is the "Health Passport" Pilot, where people with disabilities will be able to more easily record and communicate treatment requirements. In 2011/12 the DHB intends to review its current Disability Strategy with a view to developing measures connected to physical access, service information in appropriate formats, and appropriate communication channels.

Other support services
We provide a range of services to support older people maintain their health and to recover from illness or injury. These include physiotherapy, occupational health and dietetic services. We provide community nursing and social work services and also have NGO providers delivering mental health services in the community.

In recent times the suitability of assessment and reviews of community services has been an issue. We acknowledge these concerns and will address them through improved communication, needs assessment and service coordination processes and greater integration across health services.

In 2011/12, 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 through improved use of the InterRAI tool and working collaboratively with the NGO sector and 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, and other system improvements e.g. incident recording, audit and monitoring.

Our work with Capital & Coast DHB will support these initiatives, reducing duplication of effort and enhancing integration across services. It will also support sub regional planning of future services for our ageing population.

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In 2011/12 we will support primary care to improve its capability to provide generalist palliative care services in collaboration with specialist palliative care services.

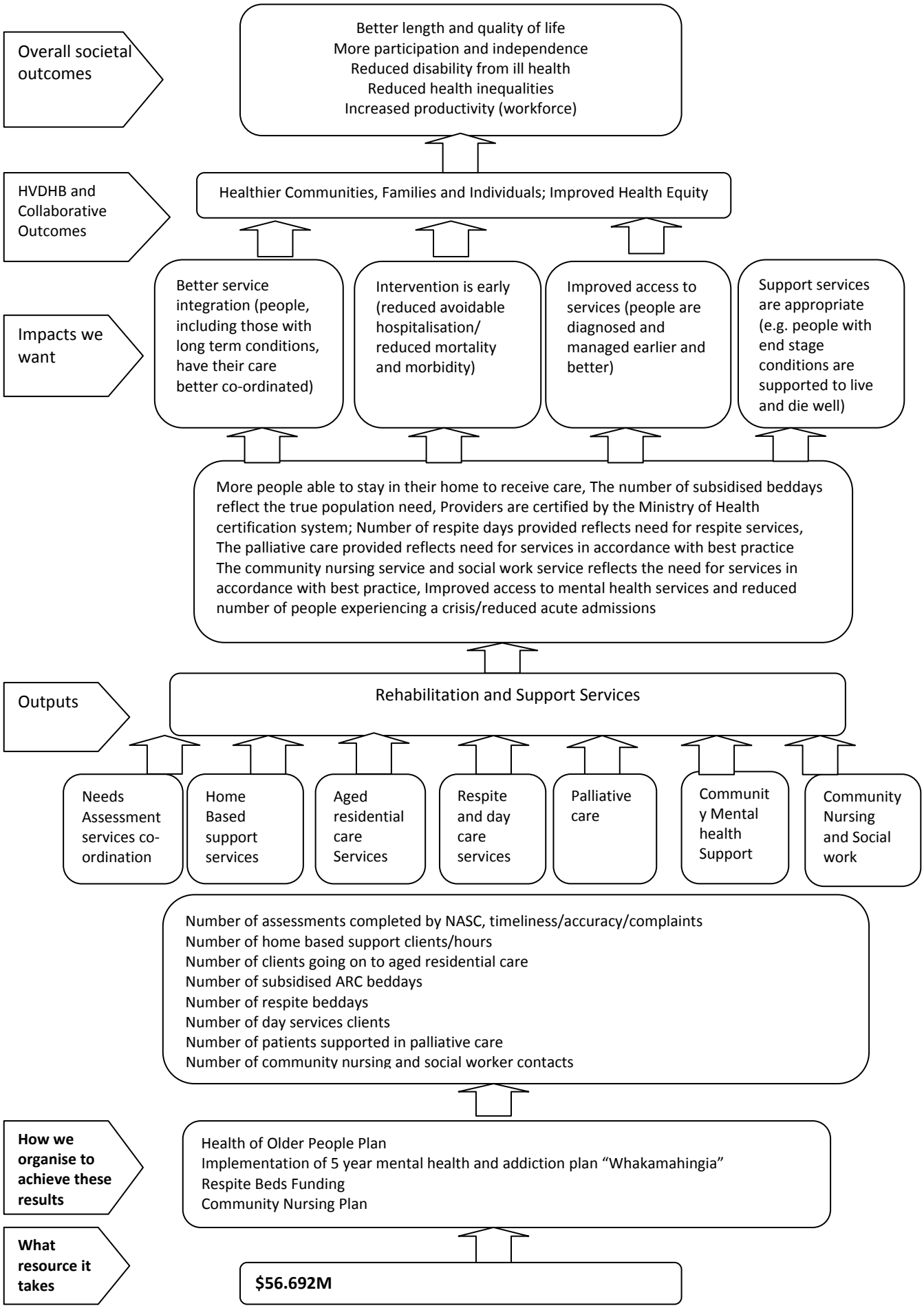
Key Areas of Focus

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
- Improving access to appropriate care for those with dementia and psychogeriatric needs
- 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

The Outcomes Framework for the Rehabilitation and Support Services Output Class is shown overleaf.

Rehabilitation and Support Services Output Class Intervention Logic



Statement of Forecast Service Performance for Rehabilitation and Support Services Output Class

This section outlines the Rehabilitation and Support Services we intend to deliver to our population. Some of these services are provided directly by the Hutt Valley DHB while others are funded through contracts with NGOs. The outputs are aggregated into Needs Assessment Services Coordination, Home Based Support Services, Aged Residential Care Services, Respite & Day Care Services, and Palliative Care.

Statement of Forecast Service Performance – Rehabilitation and Support Services Output Class

Outputs - Main areas of performance	Output Measure(s) (including Baselines[114]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[115]	Impacts	Impact Measures	Outcomes
Needs Assessment Services Coordination: A needs assessment is a process of determining the current abilities; resources, goals and needs of a client and identifying which of those needs are the most important to maximize independence and participation in society. Service co-ordination is the process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the client. Service co-ordination will also determine which of those needs can be met by government funding and other services, and will explore all options and linkages for addressing prioritised needs and goals.				
Needs assessment and service co-ordination.	Number of total assessments (including new, reviews and reassessments) Baseline: 2,522 / 2011/12: 2,683 Number of client complaints Baseline: 14 / 2011/12: <10 % of new assessments completed within agreed timeframes Baseline: 90% / 2011/12: 95%	Improved access to services, Better service integration – improved care co-ordination: • Older people referred for a comprehensive support needs assessment will receive timely assessments. • Access for support needs assessment will be equitable.	Improved average waiting time from receipt of referral to assessment Baseline: 6 days Improved % of new assessments completed within agreed timeframes Baseline: 90%	People are healthier and more able to live independently, Better quality of life
Home Based Support Includes contracted services provided for the Hutt Valley population. The purpose of the Home Support Services is to promote and maintain independence of people who are experiencing difficulty caring for themselves because of an illness or chronic medical condition, or as a result of hospitalisation. This service enables clients to remain in their own home or other private accommodation in the community or return to their home as soon as practical, by providing services that support and sustain activities necessary for daily living in a way which promotes the client's independence and quality of life. By providing assistance with essential activities of daily living Home Support services enable people requiring assistance with activities of daily living to remain safely in their own home for as long as possible.				
Home based support services.	Number of home based support unique clients:	Improved access to services, Better service integration – improved care	Percentage of people aged 65 and over living in home (not in full time ARC)	People are healthier and more able to live

[114] The baseline for setting of targets and measures varies for different outputs – some baselines are based on latest actual figures, some baselines are based on the last calendar or financial year, and some baseline measures are provided directly by the Ministry of Health. Where measures and targets are new for the 2009/10 year there may be no baseline data.

[115] The main measures of performance (sub-outputs) are largely delivered in accordance with the Ministry of Health Nationwide Service Framework Library Service Specifications, which specify the service coverage, service quality, timeliness and effectiveness requirements. In addition, the Ministry of Health DHB Performance Monitoring Framework may apply and may specify quantity, quality, timeliness and effectiveness requirements. Outputs are also delivered in accordance with wider health sector, professional and organisational standards for quality, timeliness and effectiveness for the specific service area.

Outputs - Main areas of performance	Output Measure(s) (including Baselines[114]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[115]	Impacts	Impact Measures	Outcomes
	Baseline: 1,931 — 2011/12: 1,960 Number of home based support hours Baseline: 220,990 — 2011/12: 224,850	Co-ordination, Older people with complex needs able to remain living in their home for longer.	Baseline: 92.9% Reduced percentage of people 75 yrs and older hospitalised for falls domiciled in the DHB region, per year. Baseline: 4.7%	independently
Aged Residential Care Bed Services: includes contracted services provided by Hutt Hospital for the Hutt Valley population and also for people from other DHB areas. Aged Residential Services will: be relevant to the health, support and care needs of each Subsidised Resident, recognising their cultural and/or spiritual values, individual preferences and chosen lifestyles; Provide a homelike and safe environment for each Subsidised Resident; Facilitate and assist the Subsidised Resident's social, spiritual, cultural and recreational needs; Provide the opportunity for each Subsidised Resident wherever possible, or the Subsidised Resident's representative, to be involved in decisions affecting the Subsidised Resident's life; and Acknowledge the significance of each Subsidised Resident's family/whanau and chosen support networks. [116]				
Residential care services	Total number of subsidised aged residential care bed days: Baseline: 301,380 — 2011/12: 301,700 Number of providers audited (actual number depends on Ministry of Health certification timetable and length of certification of providers) Baseline: 4 — 2011/12: 4 Number of residential/Aged dementia bed days Baseline: 31,934[117] — 2011/12: 32,000	Improved access to services, Support Services are Appropriate - Confidence in quality of service provision and quality improvement systems	All providers required to hold certification are certified for three years (excluding new providers who are initially certified for one year). Baseline: 100% Reduced number of care quality complaints to DHB Baseline: 6	Better quality of life, more participation and independence
Output: Respite and Day Care Services: Day Care services are community-based services which assist people with age-related support needs to remain in their own home, and provide support for their carers. The service provides activities, assistance, support and social interaction. It is expected that Day Care services will be part of a comprehensive package of care for people who have been needs assessed and whose support needs are able to be met in the community. Close links will be maintained between Day Care Services, service co-ordinators and Assessment, Treatment and Rehabilitation Units. Residential respite care services are designed to provide a short break for the informal carers of older people, by providing temporary support for the older people in a residential setting. These services can enable older people to stay at home for longer and can improve the health and well-being of their carers.[118]				

[116] National Contract for Aged Residential Care Services, Nationwide Service Framework, Ministry of Health, 2010/11
[117] 2010/11 forecast
[118] Nationwide Service Framework; Service Specifications; Day Care Services and Respite Care Services Tier Two Service Specifications, Ministry of Health 2010/11

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[114]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[115]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td>Respite care services</td><td>Number of respite days
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>1899[119]</td><td>3100[120]</td></tr></table>
Respite beds utilised
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>5.2</td><td>8.5</td></tr></table>
Number of day service clients
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>181</td><td>200</td></tr></table></td><td>Improved access to services, Support Services are Appropriate.</td><td>Increased utilisation of respite services
Baseline: 1899 respite days</td><td>Better quality of life, more participation and independence</td></tr>
<tr><td colspan="5">Palliative Care: Includes contracted services provided in the community. Palliative care is the active care of people with advanced, progressive disease which is no longer responsive to curative treatment, and whose death is likely within 12 months. It is a holistic programme of care, provided by a multi-disciplinary team, and is aimed at improving the quality of life for people who are dying and their families/whānau. [121]</td></tr>
<tr><td>Palliative care services</td><td>Number of patients receiving specialist palliative care
<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>599</td><td>609</td></tr></table></td><td>Support services are appropriate (people with end stage conditions are increasingly supported to die well)</td><td>N/A[122]</td><td>Better quality of life</td></tr>
<tr><td colspan="5">Community Nursing Services: Includes services provided in the community by Hutt Hospital. This service supports clients remaining in their own community by providing nursing services in the client's own home, or on an ambulatory basis. The service provides care for those clients whose level of need is such that they require professional nursing services delivered by nurses or under the immediate direction of nurses. Services include generalist nursing and specialist nursing including complex wound care, IV therapy and eternal therapy, continence, stomal, palliative and home oxygen. The purpose of the service is to: Prevent avoidable admission to, or enable early discharge from, hospital, Minimise the impact of a personal health problem, Provide support to people with long term or chronic personal health problems or conditions, Promote self care and independence, Provide terminal/palliative care in the community where such services are not covered by other service specifications funded by the MOH.[123]</td></tr>
<tr><td>Community Nursing Services</td><td>Total number of contacts</td><td>Support services are appropriate

Access to services is improved - The</td><td>Reduced Avoidable hospitalisation rate (cellulitis, respiratory)
Baseline[125]:</td><td>Better length and quality of life; reduced disability from ill health</td></tr>
</table>

[119] 2009/10 actual

[120] This increase represents an additional increase on the 730 additional days agreed between the Ministry and Hutt Valley DHB

[121] Nationwide Service Framework; Service Specifications; Palliative Care Services Tier Two Service Specifications, Ministry of Health 2010/11

[122] Palliative care is provided to patients with life limiting illnesses that no longer respond to curative treatment. It helps to free patients from suffering and assists the terminally ill to make the most of their life that remains and ensures that patients die comfortably, with dignity and in their own home if that is their wish. Specialist palliative care providers also support family and close friends during the patient's illness and in bereavement.

[123] Nationwide Service Framework; Service Specifications; Specialist Community Nursing Services Tier Two Service Specifications, Ministry of Health 2010/11

Outputs - Main areas of performance	Output Measure(s) (including Baselines[114]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[115]	Impacts	Impact Measures	Outcomes
	Baseline: 30,794 / 2011/12: 30,733[124]	care provided reflects the need for services which, in accordance with best practice, allow people to remain in their homes/communities for longer. Intervention is early - Prevent avoidable admission to, or enable early discharge from, hospital	Cellulitis 0-74 – 133.3 Respiratory 0-74 136.6	
Social Work Services: Includes services provided in the community by Hutt Hospital. This service supports clients remaining in their own community by providing non medical, professional health care services in the client's own home, or in residential care, or on an ambulatory basis in (non-medical) outpatient or community-based clinics. The service is aimed at those clients whose level of need is such that they require health and disability services delivered by social workers. A person may be referred, by a medical practitioner, Needs Assessment and Service Co-ordination (NASC) service (people who have a disability) or other health professional appropriate to the need of the client.[126]				
Social Work Services:	Total number of contacts Baseline: 2,147 / 2011/12: 2,042[127]	Access to services is improved Support services are appropriate	N/A	Better quality of life, more participation and independence
Community Mental Health Support Services: Includes contracted services provided in the community. Specialist mental health and addiction services are delivered to those people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. A focus on early intervention strategies means that services are delivered to people who are at greater risk of developing more severe mental illness or addiction. The aim is for people to have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. Specialist mental health and addiction services are publicly funded for those who are most severely affected by mental illness or addiction.[128] Note that this if a regional service and that delivery is also to non – Hutt Valley residents.				
Community Mental Health Support Services	Total number of clients seen Baseline: 485 / 2011/12: 485 Total number of occupied bed days Baseline: 14,704 / 2011/12: 14,704	Access to services is improved; Intervention is early; Support services are appropriate Reduced number of people experiencing a mental health crisis,	Reduced acute mental health inpatient admissions Baseline: 543[129] Reduced acute mental health inpatient re-admissions Baseline: 21%[130]	Better quality of life, more participation and independence

[124] Change due to more accurate data collection rather than change in services delivered
[125] MoH data 12 months to March 2011
[126] Nationwide Service Framework; Service Specifications; Specialist Allied Health Services Tier Two Service Specifications, Ministry of Health 2010/11
[127] Change due to more accurate data collection, rather than services delivered
[128] Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification, Ministry of Health 2010/11
[129] 2009/10
[130] 2009/10

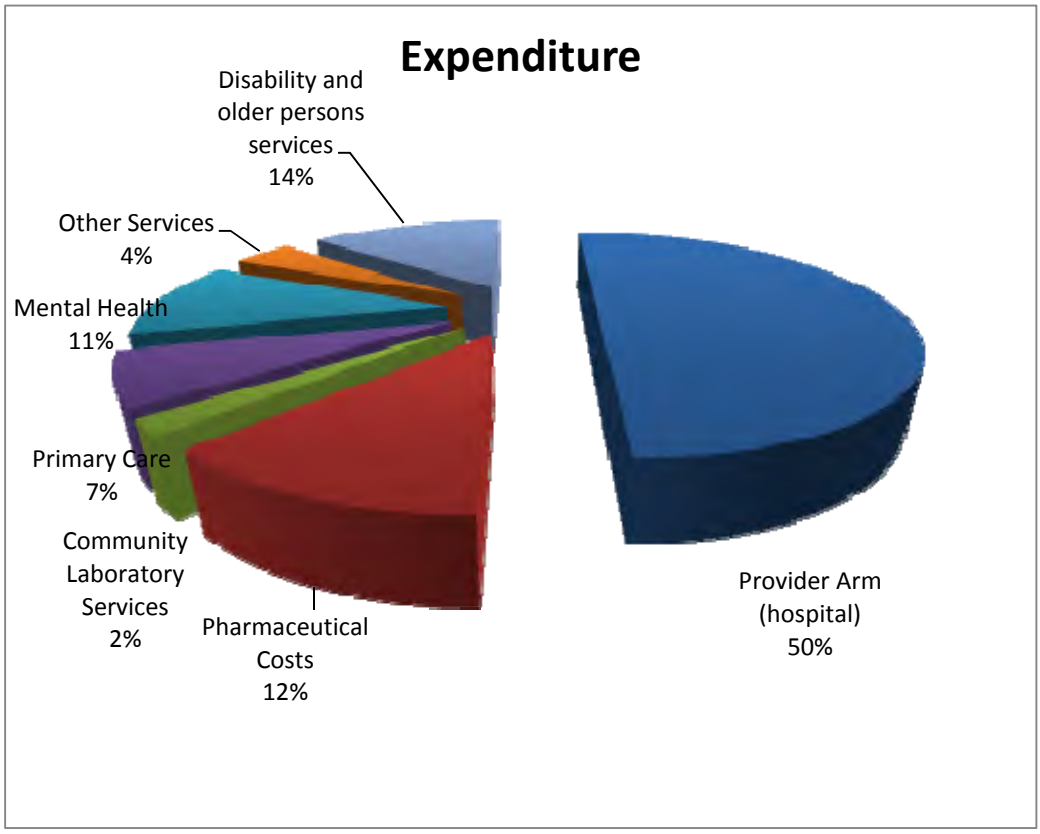
MODULE 5: STEWARDSHIP

5.1 STEWARDSHIP

5.1.1 Ownership Interest - Funder

Hutt Valley DHB's Funder Arm funds a range of providers in the wider health sector. For further details see paragraph 1.7.1.

The Funder Arm has 18 Full Time Equivalent employees, with an internal operating budget of $3.2m working on Funder related activities. It administers $448m[131] of service funding, as below:



The DHB Funder Arm ensures value for money as follows:

- Hospital Services: through the development and operation of a Memorandum of Agreement (MoA).
- Other provider services: by closely monitoring performance against agreed contracts, and reviewing as appropriate whether contracts provide good value for money in terms of health outcomes, and alignment with policy and priorities.
- Through an increasing focus on demand, especially in aged residential care (ARC) services where the Hutt Valley has high utilisation of ARC hospital level beds, and the community pharmaceuticals programme, with the appointment of a clinical facilitator to work with clinicians to achieve the programme's aims.

[131] Hutt Valley DHB funds $332m of this amount, with the balance sourced from other DHBs and other sources (for example Ministry of Health)

The Funder Arm ensures quality through standard contract management processes, including negotiation, performance monitoring and management, and audits and reviews (ad hoc and regular).

The key risk to the Funder Arm's performance is demand driven expenditure, in particular in Health of Older People and Community Pharmaceuticals, and increased demand for hospital services (as shown by increased expenditure on IDF Outflows).

5.1.2 Ownership Interests - Provider

The Hutt Valley DHB's provider arm, which provides secondary and tertiary care services and some regional and national services, is based at Hutt Hospital. The services it provides are described at paragraph 1.7.2.

The resources required to deliver these services include:

- $195.3m of land buildings, clinical and other equipment mostly located on the Hospital campus
- $219m of revenue mainly provided by the Crown
- 1,856 full time equivalent staff members

The performance of the Provider Arm against Government Targets, Annual Planning obligations, and financial performance is monitored by the Chief Operating Officer, the Executive Management Team and Board (including through the Board's Hospital Advisory Committee).

Base funding for the Provider Arm is agreed through the MoA. In 2011/12 the funding is $181.3m**,** with a national pricing programme determining the price of each purchase unit. A further $37.7m largely comes from direct contracts for service with the Ministry of Health, ACC and other DHB's.

There is planned cost avoidance of $1.3m assumed in these budgets. These efficiencies come from a range of efficiency programmes within the Provider Arm. We are estimating a deficit for the Provider Arm of $(0.6m) for 2011/12 (to be offset in other activities of the DHB) to ensure a 2011/12 breakeven position.

Our hospital services have implemented changes in recent years resulting in improved productivity and increased capacity to provide more services to increasing numbers of patients. We are continuing this approach with our *Improving the Patient Experience Programme*, which includes:

- "Shorter Stays through Better Way" project is a hospital wide approach to decrease wait times in our emergency department.
- Increasing access to elective surgery by increasing day surgery and day of surgery admission rates and standardising pre-operative assessment.
- Improving GP access to diagnostics.
- A focus on people with long term conditions as part of our secondary and primary integration work.
- Implementing the Productive Operating Theatre (TPOT) to improve theatre efficiency)
- Continuing our procurement savings program

The DHB is also actively participating in a number of regional and sub regional programmes of work which will improve patient outcomes and provide better value for money. Some of these currently under way are

- ENT
- 3 DHB health services planning with Wairarapa, and Capital Coast DHBs
- Central Region Information Services plan

Health Benefits Limited is a national shared services agency tasked with removing waste from the health system. The impact of this is largely unknown at this stage and has not been factored into our financial plans.

5.1.3 Notification of any subsidiaries

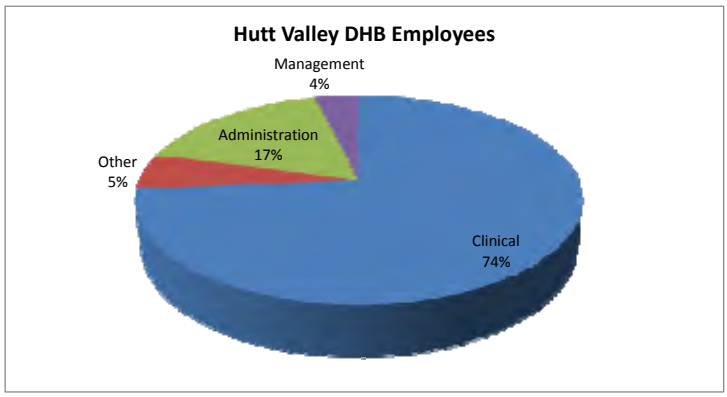
Hutt Valley DHB jointly owns and funds Central Region Technical Advisory Service (TAS), which provides support to the Central Region DHBs. TAS supports the effective functioning of District Health Boards. TAS operates as an expert advisory service that combines information management and analytical capabilities with health service experience and project management skills to provide health service and advice to DHBs.

5.2 Organisational Health

Hutt Valley DHB has a strong and vibrant culture. It is widely regarded as a good employer, with a values based culture, and a strong and transparent relationship with its community.

5.2.1 Human Resources

The composition of Hutt Valley DHB employees is shown below. The "Other" category includes Support Staff, Orderlies, and Cleaners. Administration includes both clinical and non-clinical administration. A copy of our organisational structure is provided at Appendix 9.3.



5.2.2 Workforce Development

Our quality and effectiveness relies on our workforce. Through supporting flexibility and innovation, providing leadership and skill development opportunities, and being a 'good employer' the 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:

- Our zero-tolerance of all forms of harassment and bullying.
- Equitable training and development opportunities for employees.
- The management and disclosure of adverse events to ensure a safe quality working environment.

The Government has also acted at a national level to address workforce issues in order to support the policy imperative of Better, Sooner and More Convenient health services. Health Workforce New Zealand (HWNZ) and Health Benefits Limited (HBL) have been established to support DHBs to reduce unnecessary expenditure, and to increase the focus on and engagement of clinical staff within DHBs.

Accordingly, much of the organisational development activity at Hutt Valley DHB in the 2011/12 year will derive from our work with these organisations, ensuring that systems and processes introduced are both in accordance with the Minister's expectations and standardised across the DHB sector. Some the overriding imperatives expected of our DHB in 2011/12 include:

- Strengthening clinical involvement and engagement to improve health workforce job satisfaction and patient care
- Leadership skills development for clinicians
- Establishing clinical networks within and across regions
- Training in the Whanau Ora models of healthcare
- Regional/national collaboration in workforce development initiatives
- Improved collaboration between primary and secondary care
- Supporting community and hospital-based doctors, nurses, pharmacists and other allied health professionals to refocus their resources towards delivering services in local community settings

In addition to regionally and nationally developed training, local training will include:

- support for managers to: manage change well, apply the new performance appraisal system to best effect, build and rebuild teams, resolve conflict and ensure dignity is preserved for all staff in the workplace in accordance with our zero tolerance for harassment and bullying.
- a DHB leadership Journal Club after its inaugural session in 2010. There has been very good interest shown in this forum particularly by clinicians
- our existing innovative scholarship programmes

5.2.3 Recruitment

HBL has developed a national recruitment system and process, including one national job board including underlying candidate tracking and application management processes. The

DHB will adopt this, which will significantly reduce the costs of securing new staff by reducing advertising costs and standardising agency contracts with reduced fees.

We will develop an increased settlement support package for overseas clinicians to ease their transition to the country and, in accordance with proven trends, extend their tenure in New Zealand and with the DHB.

5.2.4 Staff retention and engagement

HWNZ has taken the lead in the national staff retention and engagement. It is currently developing and/or implementing several programmes, for example:

- A mentoring programme for junior doctors
- High quality training programmes and enhanced career development opportunities to maximise staff potential
- An effective medicine apprenticeship model that combines rewarding learning opportunities with supported exposure to service, leading to safe and skilled practitioners
- Attractive career pathways that will aid recruitment, retention and the return of NZ-trained clinicians
- Career planning for nurses, pharmacists and allied health professionals via new scopes of practice and the introduction of individual career planning and a national mentoring service

Locally we will monitor staff engagement and work to establish ourselves as an employer of choice within our sector.

5.3 Building capability and capacity

The main area of capability the DHB needs to develop over the next three to five years is clinical leadership. Further information is set out 5.2.2 and 5.2.4.

5.3.1 Capital and infrastructure development

Our asset management program enables us to continuously update our asset planning. Once our ED theatre redevelopment (see below) is completed our focus will shift to planning on replacement or rebuilding of 2 earthquake prone buildings on our campus (in accordance with our *Integrated Campus Plan)*. The other major piece of work underway at present is the implementation of the oral health business case.

A three year view of capital is set out below:

Capex

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Baseline Expenditure					
Property and Plant	224	1,800	1,800	1,800	1,800
Clinical Equipment	2,618	2,000	2,000	2,000	2,000
Computer Equipment	1,039	1,500	1,500	1,500	1,500
Other Equipment	142	200	200	200	200
Motor Vehicles	237	-	-	-	-
Total Baseline Expenditure	**4,260**	**5,500**	**5,500**	**5,500**	**5,500**
Strategic Expenditure					
Emergency Department & Theatre Development Project	18,190	27,774	24,106	-	-
Child Oral Health	312	6,008	4,735	-	-
MRI Replacement	-	-	-	-	2,250
CT Scanner	-	-	-	-	1,250
Financial Management Information System	-	-	-	1,200	-
Emergency Department & Theatre Development Project Eqpt	-	-	8,700	-	-
Total Strategic Expenditure	**18,502**	**33,782**	**37,541**	**1,200**	**3,500**
All Other Approved Projects	**-**	**1,200**	**-**	**-**	**-**
Total Capital Expenditure	**22,762**	**40,482**	**43,041**	**6,700**	**9,000**
Financed By:					
Net Surplus / (Deficit)	(4,536)	(2,975)	-	-	-
Equity Injections - Deficit Support	8,687	-	-	-	-
Depreciation Expense	8,595	9,974	11,615	12,756	13,976
Sale of Fixed Assets	1,338	-	-	-	-
Other - Includes Cash Reserves	8,494	4,999	2,462	3,092	3,512
Equity Injections for Capital Expenditure	2,265	4,767	3,303	-	-
Private Debt	-	2,500	7,500	-	-
CHFA Debt	13,000	24,900	22,100	-	-
Total Financing	**37,843**	**44,165**	**46,980**	**15,848**	**17,488**

We have not identified any significant assets that are surplus to long-term health service delivery needs, including land. When disposing of land, Hutt Valley DHB will abide by the appropriate statutes and be guided by appropriate business principles. Hutt Valley DHB will not dispose of any land without first consulting with the Minister of Health. We will also comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any process relating to the Crown's good governance obligations in relation to Maori sites of significance.

Our capital spend for 2011/12 is $43.0m, of which only $5.5m is discretionary. The remainder is committed funds for the ED/theatre redevelopment, and the oral health project.

Emergency Department/Theatre Project

Ministerial approval of the $82 million expansion of Hutt Hospital in June 2008 was a significant step in this crucial development. The addition of four more operating theatres, a new emergency department sized to be able to cope with 40,000-plus attendances (allowing for future growth) 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 in the third quarter of 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 July 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.

Oral health project

In October 2009 our Oral Health Business Case for the re-development of the School Dental Service was approved and fully funded by the Ministry. The capital funding allows for the purchase of several new dental examination vans and community clinics across the Wellington region. As Hutt Valley provides this service for Capital & Coast DHB we are also responsible for their capital injection.

We are confident this project will achieve the associated savings and efficiencies outlined in our business case. In our business case we outlined a move to reduce the number of arrears and increase productivity. This work is being achieved in parallel to the building of new clinics. Over the past three years we have consolidated these changes reducing our arrears position from 37% in 2007 to 6% in 2010; improved service delivery for over 17,000 children.

These changes to arrears and productivity make us confident we will have the capacity and capability to deliver this project safely and efficiently. Our focus is now broadening to increased enrolment of pre-schoolers and improved adolescent utilisation.

5.3.2 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 a continued requirement to invest in core IT infrastructure and staff skills.

Collaboration between the DHBs in the Central region will continue towards the delivery of the Central Region Information Services Plan (CRISP). CRISP will eventually deliver a shared system to all clinicians in the Central Region that will provide access to a single set of clinical records, and a single system. This Plan is also aligned with, and will support, the other regional initiatives and National Health IT Board programmes (subject to ordinary business case processes).

In 2011/12, the CRISP programme is expected to be delivering a regional archive solution that will be used by all regional DHBs to archive and restore digital radiography images

Improvements to the local IT infrastructure will also continue and will provide enhanced performance, reliability and availability of critical systems.

5.3.3 Quality and Safety

Hutt Valley DHB has a strong and positive culture of continuously improving the quality and safety of the services we provide. Our values of "can do", innovating, working together and striving for excellence are fundamental to achieving our quality goals.

Our quality goals are underpinned by an emphasis on patient centred care, openness and transparency, learning from error or harm and ensuring that the contribution of staff from all levels of the DHB for quality improvement and innovation is truly valued.

Hutt Valley DHB continues to actively support and participate in national quality and patient safety initiatives and will continue to support the priorities of the Health and Safety Quality Commission including the development of a medicines reconciliation process; the introduction of a nationally standardised medication chart; a focus on reducing hospital-acquired infections; and the introduction of a programme to improve consumer participation.

In line with our strategic priorities the focus for quality in 2011/12 will be:

Strategic Priority	Quality Goals
Collective leadership	Ensure membership of our Patient Safety Leadership Group reflects our clinical workforce. Ensure quality and patient safety initiatives are clinically led with a focus on patient-centred care delivery.
Meeting health targets and government priorities	We have made achievement of health targets a quality issues - the primary driver of achieving the health targets is to improve health outcomes for our community eg: Smoking target and ED Wait target are key quality improvement initiatives.
Primary care consolidation, integration and service location	Increase our capabilities to support primary care quality initiatives, education and support eg: develop a quality network. Further develop quality programmes to achieve consolidation and integration initiatives.
Improving hospital services	Strengthen our collective leadership and consumer participation of our "Improving the Patient Experience Programme". Promote lean thinking tools and techniques through the Productive Ward, Productive Operating Theatre and Productive Hospital programmes.
Working with our neighbours	Achieve consistency of reporting at a Board level, sharing of quality resources including training opportunities and integrating similar quality improvement and innovation initiatives. Achieve shared clinical governance at sub-regional level through shared committees and advisory roles eg: some combining of clinical committees and shared membership on patient safety and clinical governance committees.
Financial sustainability	Focus on quality improvement and innovation that improve service delivery and increase productivity. Improve our capabilities for utilising clinical information to aid decision making

5.4 Consultation with Minister of Health

The DHB will consult with the Minister of Health/Ministry of Health in relation to:

- proposed service changes
- acquisition of shares or other interests

- entry into joint ventures and/or collaborative or co-operative agreements or arrangement (where required under s24/28 of the New Zealand Public Health and Disability Act 2000)
- capital expenditure if required by policy and/or legislation
- otherwise as required by legislation, regulation, or contract.

5.5 External Reporting

Hutt Valley DHB provides regular reporting to the Minister and Ministry of Health as outlined below.

Reporting to the Minister of Health

Reporting	Frequency
Information Requests	Ad Hoc
Financial Reporting	Monthly
National Data Collections	Monthly
Risk Reporting	Quarterly
Health Target reporting	Quarterly
Crown Funding Agreement non-financial reporting	Quarterly
Indicators of DHB Performance	Quarterly
Annual Report & audited statements	Annually

5.6 Plans to acquire shares or interests in any company, trusts and/or partnerships

The DHB has no plans to acquire shares or interests in any company, trusts and/or partnerships. Any proposal to do so would need to be approved by the Board and the Minister of Health.

5.7 Banking Covenants

Hutt Valley DHB has no banking covenants with which it is required to comply.

MODULE 6: SERVICE CONFIGURATION

6.1 SERVICE COVERAGE, SERVICE CHANGE, AND SERVICE ISSUES

Service coverage and Service Change

Hutt Valley DHB expects to meet Government service coverage expectations.

As at the date of this Plan, no approvals for service change have been sought by Hutt Valley DHB for implementation in the 2011/12 year.

Service Issues

Hutt Valley DHB is responsible for delivering Screening Services to the women of the Hutt Valley, Capital Coast and Wairarapa. We operate sites at the Hutt Valley Campus, Kenepuru, a mobile caravan and at sites operated by our outsource provider Pacific Radiology. We have an urgent need to convert the old analog mammography equipment to new digital equipment in 2011. The capital cost of doing this is estimated at $4.3m and an injection of funding (both capital and operational) will be sought from the Ministry of Health. If the funding is not available the ongoing delivery of this service will be at risk.

MODULE 7: PRODUCTION PLANNING

7.1 PRODUCTION PLANNING

Summary description of Production Plan

Summarised Outputs (DHB of Service)	Hutt Valley			
	2010/11 Output Plan		% growth	% growth weights
	2010/11 Forecast	2011/12 Planned		
Case-weighted inpatient discharges				
Maternity	**2,650**	**2,830**	**6.80%**	**0.55%**
Medical	**6,643**	**6,438**	**-3.08%**	**-0.62%**
Medical electives	490	494	*0.74%*	*0.01%*
Medical acute	6,153	5,945	*-3.38%*	*-0.63%*
Medical other	-	-	*0.00%*	*0.00%*
Surgical	**11,823**	**11,750**	**-0.62%**	**-0.22%**
Surgical electives	*6,196*	*6,229*	*0.54%*	*0.10%*
Surgical acute	*5,578*	*5,520*	*-1.03%*	*-0.18%*
Surgical other	*49*	-	*-100.00%*	*-0.15%*
Total case-weighted inpatient discharges				
Total	21,116	21,018	-0.46%	-0.30%
Outpatient services (expressed as events)				
ED	32,893	31,734	-3.52%	-0.20%
Medical first	5,227	5,316	1.71%	0.02%
Medical follow up	16,011	16,019	0.05%	0.01%
Oncology	-	-	0.00%	0.00%
Renal	-	-	0.00%	0.00%
Scope	2,519	2,456	-2.50%	-0.05%
Surgical first	10,000	10,405	4.06%	0.08%
Surgical follow up	20,893	21,033	0.67%	0.02%
Other services (expressed as events)				
Maternity	10,711	10,787	0.71%	0.07%
Medical	7,795	8,972	15.10%	0.10%
Surgical	8,698	7,415	-14.74%	-0.10%
Health of Older People	14,602	17,903	22.61%	0.58%
Miscellaneous	178,113	176,436	-0.94%	0.00%
All non-inpatient services (expressed as case-weighted outputs)				
Total	11,811	11,986	1.48%	0.53%
Total volume growth	**32,927**	**33,004**		**0.23%**

Notes:
Summarised Outputs (DHB of Service)

The information used to build this table has been drawn from volume data in the 2011/12 Production Plan, across forecast (2010/11), and planned (2011/12) years. The scope of services counted has been limited to those purchase unit codes that meet two criteria: a national price must exist; and the unit of measure must be output (not input or programme) based. The list of relevant purchase unit codes, and their grouping in this table, is available on request.

The most important results in the table are those in the 'Total volume growth' line, which gives the percentage change in outputs across planned growth from 2010/11 to 2011/12.

The percentage growth weight column contains the weighted contribution to output growth, relative to each service. The weights are based on volume weighted to the national case-mix price.

Inpatients

- Medical inpatients are planned to be lower due to a real decrease in acute inpatients. The introduction of our Medical Assessment & Planning Unit, our increasing work with primary care in connection with avoidable hospitalisations, improved GP access in the Hutt Valley and stabilisation of primary care after hour's services are all expected to assist with improving our acute volumes. This improvement means less acute cases.

- On a case weight or cost weight basis, the new way of counting procedures (WIESNZ11) means a drop in the average CWD per case. There is however an increase in the number of people being treated.

Outpatients

- There is an expected drop in the number of IDF inflow attendances at our ED (that is, less people from other districts) and a reduction in the number of IDF inflows for Scopes, in each case as set out in the National Health Board's published IDF files.

Overall Growth

When acute outputs are excluded, volume growth increases from 0.23% to in excess of 1%.

MODULE 8: FINANCIAL PERFORMANCE

8.1 Managing Financial Resources

In summary, our financial position for 2011/12 is breakeven with a forecast breakeven position in out years.

8.2 Budgeted Financial Statements

The full set of financial statements for Hutt Valley DHB for the planning period are set out below. The forecast financial statements in this plan have been prepared in accordance with New Zealand International Financial Reporting Standards (NZIFRS).

8.2.1 Summary of Operating Budget

Our operating forecast for 2011/12 and for the outyears is for breakeven.

Key Financial Information is in the following table

Hutt Valley District Health Board
Key Financial Information

$m	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Revenue	423	432	448	463	478
Expenditure	(428)	(435)	(448)	(463)	(478)
Net Surplus / (Deficit)	(5)	(3)	-	-	-
Total Fixed Assets	135	163	195	189	187
Net Assets	65	67	70	70	70
Term Borrowings	(32)	(59)	(87)	(87)	(87)

8.2.3 Funding Advice

Funding advice was received in December 2010 that included additional funding for 2011/12. The additional funding consists of a 1.72% increase for relieving cost pressures. Our share of the demographic funding was 1.99%.

8.2.3 Output Class Expenditure

A summary of statement of forecast service performance expenditure for outputs produced by Hutt Valley DHB by Output Class (Module 4) is provided in the table below. Also shown is the inter-district outflow expenditure for outputs produced by other DHBs for the Hutt Valley DHB population. These outputs are not included in the statement of forecast service performance as they are not produced by the Hutt Valley DHB and will be accounted for in other DHB Annual Plans/SOIs. Full forecast financial statements are set out below.

Output Class Expenditure

Output Class	Statement of Forecast Service Performance Expenditure 2011/12 for outputs produced by Hutt Valley DHB ('000s)	Inter-district Out-Flows Expenditure for outputs produced by other DHBs for the Hutt Valley DHB population ('000's)	Total Budgeted Expenditure ('000's)
Prevention Services	21,453	-	21,453

Early Detection and Management Services	121,362	8,992	130,354
Intensive Assessment and Treatment Services	179,347	60,585	239,932
Rehabilitation and Support Services	51,087	5,605	56,692
TOTAL	373,249	75,182	448,431

8.3 Assumptions

The key assumptions have been included in our preparation of the forecast financial statements for 2011/14. Our Statement of Accounting Policies is included at Appendix 9.3

General Assumptions

- No external deficit funding will be required during the planning period.
- Capital expenditure of up to $43.0 million is planned for 2011/12.
- Build programme for the ED theatre redevelopment will continue during 2011/12. Interest incurred on funds borrowed will be capitalised against the project until the project is commissioned. The new build part of the project is planned for commissioning in October 2011 with the refurbishment planned for July 2012.
- We have assumed a replacement of our financial management system at the end of 2011/12 at a cost of $1.2m. Our current system will not be supported from that date. We are working on options with HBL and Capital & Coast DHB.
- The last full revaluation occurred on 30 June 2004 with a further full evaluation in June 2010. This produced a movement that was not of sufficient size to warrant a taking up in the accounts. A further desktop evaluation to be undertaken in 2011 is not expected to show a material movement.
- 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 MoA rules with the Funder Arm. Any new or additional costs will be offset by equivalent cost reductions elsewhere in Hutt Valley DHB.
- Interest rates are assumed to rise only minimally over the period.
- 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 3.22%, 3.20% and 3.18% in 2011/12, 2012/13 and 2014/15 respectively.
- Revenue increase from population based funding and demographic changes have been included 3.71% in 2011/12, 3.58% in 2012/13 and 3.46% in 2013/14.
- No change in capital charge rate of 8%.
- Additional compliance costs eg 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.
- No material costs have been included for a pandemic or other natural disaster.
- The national procurement and our own internal procurement programme will deliver $0.5m of bottom line savings to this DHB.
- No allowance has been made for costs related to implementing the RSP. It is

anticipated that any costs will be covered by savings identified to fund RSP projects.

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. 388 FTEs, 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 the last twelve months activity to December 2010, this allows planned levels of elective procedures to be undertaken.
- Elective throughput will be in accordance with the Elective Services Plan.
- Inter-district Inflows and outflows use the volumes and prices provided by the Ministry of Health IDF budget files.
- Breast reconstruction surgery is budgeted at $1.5m revenue.

National Policy

- Government policy settings will not vary significantly.
- The impact of any 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

- The budgets assume that contracted providers will receive a small price increase each year.
- 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 until November 2011.

8.3.1 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.

The key risks associated with the assumptions we have made in our budgeted expenditure 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.

- 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.

8.3.2 OutYears 2012/13 to 2013/14

We have assumed base revenue increases of 3.58% for 2012/13 and 3.46% in 2013/14 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.

8.4 Efficiency Initiatives

We have incorporated into these plans efficiency initiatives of $2.3M in 2011/12 and $1.2m in 2013/14.

8.5 Debt and Equity

Under the ED theatre business case we planned to draw down $60m in debt to fund the project. At the end of June 2011 we will have drawn down $37.9m, the remaining $22.1m will be drawn down in 2011/12. We also will be arranging finance leases of $7.5m in 2011/12 to fund clinical equipment purchases related to the build program.

CHFA Borrowing

	Loan	Drawn Down	$m	Interest Rate	Repayable
Original Loan	1	Dec-07	19.00	6.535%	Dec-19
ED Theatre Business Case	2	Oct-09	4.50	5.49%	Apr-14
	3	Oct-09	4.50	5.97%	Dec-18
	4	Feb-10	2.00	4.88%	Apr-13
	5	Feb-10	2.00	5.52%	Apr-16
	6	Jan-11	5.00	5.02%	Apr-16
	7	Jan-11	5.00	5.685%	Mar-19
	8	Mar-11	4.00	4.50%	Apr-15
	9	May-11	5.45	5.09%	Dec-18
- To be drawn June 2010			5.45		
- To be drawn 2011/12			22.10		
Total CHFA Loans			**79.00**		

Financial Tables

Financial Performance

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Revenue					
Revenue	423,017	431,482	448,030	463,006	477,989
Interest Revenue	345	449	400	400	406
Total Revenue	**423,362**	**431,931**	**448,430**	**463,406**	**478,395**
Expenditure					
Provider Expenditure	(216,584)	(220,979)	(225,632)	(231,649)	(238,971)
Operating Expenditure	(196,554)	(197,410)	(203,180)	(209,703)	(216,092)
Depreciation	(8,595)	(9,974)	(11,142)	(12,756)	(13,976)
Interest Expense	(1,259)	(1,250)	(3,228)	(3,730)	(3,730)
Capital Charge	(4,532)	(5,293)	(5,248)	(5,568)	(5,626)
Total Expenditure	**(427,524)**	**(434,906)**	**(448,430)**	**(463,406)**	**(478,395)**
Net Surplus/(Deficit)	**(4,162)**	**(2,975)**	**-**	**-**	**-**
Gain/(Loss) on Sale of Assets	(376)	-	-	-	-
Net Surplus/(Deficit)	**(4,538)**	**(2,975)**	**-**	**-**	**-**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**(4,538)**	**(2,975)**	**-**	**-**	**-**

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Revenue					
Revenue	384,881	394,335	410,558	424,882	439,198
Total Revenue	**384,881**	**394,335**	**410,558**	**424,882**	**439,198**
Expenditure					
Provider Expenditure	(385,805)	(394,398)	(410,002)	(424,753)	(439,083)
Total Expenditure	**(385,805)**	**(394,398)**	**(410,002)**	**(424,753)**	**(439,083)**
Net Surplus/(Deficit)	**(924)**	**(63)**	**556**	**129**	**115**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**(924)**	**(63)**	**556**	**129**	**115**
Expenditure Breakdown:					
Personal Health	(294,361)	(302,800)	(314,720)	(326,768)	(338,313)
Mental Health	(39,764)	(39,836)	(41,441)	(43,096)	(44,424)
DSS	(45,911)	(47,279)	(49,479)	(50,440)	(51,803)
Public Health	(420)	(66)	(42)	(46)	(47)
Maori Health	(2,379)	(1,260)	(1,224)	(1,241)	(1,262)
Internal Allocations	(2,970)	(3,157)	(3,096)	(3,162)	(3,234)
Total Expenditure	**(385,805)**	**(394,398)**	**(410,002)**	**(424,753)**	**(439,083)**

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Revenue					
Revenue	204,270	207,396	218,626	227,948	235,551
Interest Revenue	345	449	400	400	406
Total Revenue	**204,615**	**207,845**	**219,026**	**228,348**	**235,957**
Expenditure					
Operating Expenditure	(194,229)	(194,712)	(200,491)	(206,958)	(213,281)
Depreciation	(8,592)	(9,971)	(11,142)	(12,753)	(13,973)
Interest Expense	(1,259)	(1,250)	(3,228)	(3,730)	(3,730)
Capital Charge	(4,532)	(5,293)	(5,248)	(5,568)	(5,626)
Internal Allocations	546	549	527	532	538
Total Expenditure	**(208,066)**	**(210,677)**	**(219,582)**	**(228,477)**	**(236,072)**
Net Surplus/(Deficit)	**(3,451)**	**(2,832)**	**(556)**	**(129)**	**(115)**
Gain/(Loss) on Sale of Assets	(376)	-	-	-	-
Net Surplus/(Deficit)	**(3,827)**	**(2,832)**	**(556)**	**(129)**	**(115)**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**(3,827)**	**(2,832)**	**(556)**	**(129)**	**(115)**
Expenditure Breakdown:					
Personnel Costs	(144,201)	(147,177)	(152,858)	(157,719)	(162,381)
Outsourced Services	(6,560)	(4,977)	(4,602)	(4,753)	(4,905)
Clinical Supplies	(26,475)	(26,832)	(28,101)	(29,537)	(30,683)
Infrastructure and Non-Clinical Supplies	(31,376)	(32,240)	(34,548)	(37,000)	(38,641)
Internal Allocations	546	549	527	532	538
Total Expenditure	**(208,066)**	**(210,677)**	**(219,582)**	**(228,477)**	**(236,072)**

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Revenue					
Revenue	3,089	3,169	3,216	3,280	3,352
Interest Revenue	-	-	-	-	-
Total Revenue	**3,089**	**3,169**	**3,216**	**3,280**	**3,352**
Expenditure					
Operating Expenditure	(2,325)	(2,698)	(2,689)	(2,745)	(2,811)
Depreciation	(3)	(3)	-	(3)	(3)
Internal Allocations	(546)	(549)	(527)	(532)	(538)
Total Expenditure	**(2,874)**	**(3,250)**	**(3,216)**	**(3,280)**	**(3,352)**
Net Surplus/(Deficit)	**215**	**(81)**	**-**	**-**	**-**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**215**	**(81)**	**-**	**-**	**-**
Expenditure Breakdown:					
Personnel Costs	(1,539)	(1,550)	(1,689)	(1,721)	(1,755)
Outsourced Services	(350)	(376)	(356)	(365)	(375)
Clinical Supplies	(1)	(1)	-	(1)	(1)
Infrastructure and Non-Clinical Supplies	(438)	(774)	(644)	(661)	(683)
Internal Allocations	(546)	(549)	(527)	(532)	(538)
Total Expenditure	**(2,874)**	**(3,250)**	**(3,216)**	**(3,280)**	**(3,352)**

Movements in Equity

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Crown Equity	38,524	43,084	46,180	45,973	45,766
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings at Beginning of Period	(19,037)	(23,575)	(26,550)	(26,550)	(26,550)
Total Comprehensive Income for the Period	(4,538)	(2,975)	-	-	-
Closing Equity	**65,317**	**66,902**	**69,998**	**69,791**	**69,584**

Financial Position

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Public Equity					
Equity	38,524	43,084	46,180	45,973	45,766
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings	(23,575)	(26,550)	(26,550)	(26,550)	(26,550)
Total Equity	**65,317**	**66,902**	**69,998**	**69,791**	**69,584**
Represented by:					
Current Assets					
Bank in Funds	8,494	4,999	2,462	3,092	3,512
Receivables and Prepayments	12,827	12,325	10,915	15,501	17,011
Inventories	1,355	1,240	1,240	1,250	1,265
Total Current Assets	**22,676**	**18,564**	**14,617**	**19,843**	**21,788**
Current Liabilities					
Bank Overdraft	-	-	-	-	-
Payables and Provisions	(57,028)	(53,752)	(50,823)	(49,625)	(49,301)
Short Term Borrowings	-	-	-	-	-
Total Current Liabilities	**(57,028)**	**(53,752)**	**(50,823)**	**(49,625)**	**(49,301)**
Net Working Capital	**(34,352)**	**(35,188)**	**(36,206)**	**(29,782)**	**(27,513)**
Non Current Assets					
Property, Plant and Equipment	135,381	163,389	195,288	189,232	186,756
Trust Funds	778	895	900	900	910
Total Non Current Assets	**136,159**	**164,284**	**196,188**	**190,132**	**187,666**
Non Current Liabilities					
Borrowings and Provisions	(35,712)	(61,299)	(89,084)	(89,659)	(89,659)
Trust Funds	(778)	(895)	(900)	(900)	(910)
Total Non Current Liabilities	**(36,490)**	**(62,194)**	**(89,984)**	**(90,559)**	**(90,569)**
Net Assets	**65,317**	**66,902**	**69,998**	**69,791**	**69,584**

Cash Flow

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Operating Cash Flows					
Cash Receipts	422,184	432,456	453,084	464,553	481,108
Payments to Providers and Suppliers	(268,949)	(264,385)	(276,185)	(281,082)	(289,673)
Payments to Employees	(146,542)	(151,608)	(155,143)	(159,904)	(165,720)
Interest Paid	(1,581)	(6,593)	(8,812)	(10,578)	(10,578)
Capital Charge Paid	(5,510)	(5,292)	(5,532)	(5,852)	(5,910)
Net Operating Cash Flows	**(398)**	**4,578**	**7,412**	**7,137**	**9,227**
Investing Cash Flows					
Cash Received from Sale of Fixed Assets	1,338	-	-	-	-
Cash Paid for Purchase of Fixed Assets	(22,762)	(40,482)	(43,041)	(6,700)	(9,000)
Interest Received	346	449	396	400	400
Net Investing Cash Flows	**(21,078)**	**(40,033)**	**(42,645)**	**(6,300)**	**(8,600)**
Financing Cash Flows					
Equity Injections	10,745	4,560	3,096	(207)	(207)
Loans - Private Sector	-	2,500	7,500	-	-
Loans - CHFA	13,000	24,900	22,100	-	-
Loans Repaid	-	-	-	-	-
Net Financing Cash Flows	**23,745**	**31,960**	**32,696**	**(207)**	**(207)**
Net Cash Flows	**2,269**	**(3,495)**	**(2,537)**	**630**	**420**
Opening Cash Balance	6,225	8,494	4,999	2,462	3,092
Closing Cash Balance	**8,494**	**4,999**	**2,462**	**3,092**	**3,512**
Represented by:					
Bank in Funds	8,494	4,999	2,462	3,092	3,512
Bank Overdraft	-	-	-	-	-
Total Cash On Hand	**8,494**	**4,999**	**2,462**	**3,092**	**3,512**

Capex

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

$000s	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Baseline Expenditure					
Property and Plant	224	1,800	1,800	1,800	1,800
Clinical Equipment	2,618	2,000	2,000	2,000	2,000
Computer Equipment	1,039	1,500	1,500	1,500	1,500
Other Equipment	142	200	200	200	200
Motor Vehicles	237	-	-	-	-
Total Baseline Expenditure	**4,260**	**5,500**	**5,500**	**5,500**	**5,500**
Strategic Expenditure					
Emergency Department & Theatre Development Project	18,190	27,774	24,106	-	-
Child Oral Health	312	6,008	4,735	-	-
MRI Replacement	-	-	-	-	2,250
CT Scanner	-	-	-	-	1,250
Financial Management Information System	-	-	-	1,200	-
Emergency Department & Theatre Development Project Eqpt	-	-	8,700	-	-
Total Strategic Expenditure	**18,502**	**33,782**	**37,541**	**1,200**	**3,500**
All Other Approved Projects	**-**	**1,200**	**-**	**-**	**-**
Total Capital Expenditure	**22,762**	**40,482**	**43,041**	**6,700**	**9,000**
Financed By:					
Net Surplus / (Deficit)	(4,536)	(2,975)	-	-	-
Equity Injections - Deficit Support	8,687	-	-	-	-
Depreciation Expense	8,595	9,974	11,615	12,756	13,976
Sale of Fixed Assets	1,338	-	-	-	-
Other - Includes Cash Reserves	8,494	4,999	2,462	3,092	3,512
Equity Injections for Capital Expenditure	2,265	4,767	3,303	-	-
Private Debt	-	2,500	7,500	-	-
CHFA Debt	13,000	24,900	22,100	-	-
Total Financing	**37,843**	**44,165**	**46,980**	**15,848**	**17,488**

FTEs

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

	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Medical	217	232	237	231	231
Nursing	685	689	707	714	714
Allied Health	383	405	449	448	448
Non-Allied Health	125	128	129	129	129
Management/Clerical	364	355	353	348	348
Total FTEs	**1,773**	**1,808**	**1,874**	**1,870**	**1,870**

Financial Performance by Output Class

Prevention Services
Statement of Forecast Financial Performance
For the Year Ended 30 June

$000s	2009\10 Audited Actual	2010\11 Forecast	2011\12 Plan	2012\13 Plan	2013\14 Plan
Revenue					
Revenue	24,655	21,118	21,577	22,086	22,550
Interest Revenue	-	-	-	-	-
Total Revenue	**24,655**	**21,118**	**21,577**	**22,086**	**22,550**
Expenditure					
Operating Expenditure	(19,981)	(17,968)	(18,160)	(18,677)	(19,179)
Depreciation	(390)	(358)	(305)	(340)	(369)
Interest Expense	-	-	-	-	-
Capital Charge	-	(142)	-	-	-
Internal Allocations	(3,572)	(2,939)	(2,988)	(2,722)	(2,758)
Total Expenditure	**(23,943)**	**(21,407)**	**(21,453)**	**(21,739)**	**(22,306)**
Net Surplus / (Deficit)	**712**	**(289)**	**124**	**347**	**244**
Gain / (Loss) on Sale of Assets	(2)	-	-	-	-
Net Surplus / (Deficit)	**710**	**(289)**	**124**	**347**	**244**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**710**	**(289)**	**124**	**347**	**244**
Expenditure Breakdown:					
Personnel Costs	(13,817)	(13,413)	(13,553)	(13,932)	(14,296)
Outsourced Services	(1,017)	(911)	(828)	(856)	(883)
Clinical Supplies	(2,239)	(1,564)	(1,901)	(1,980)	(2,049)
Infrastructure and Non-Clinical Supplies	(1,597)	(1,498)	(1,176)	(1,225)	(1,278)
IDF Outflows	-	-	-	-	-
External Contract Payments	(1,701)	(1,082)	(1,007)	(1,024)	(1,042)
Internal Allocations	(3,572)	(2,939)	(2,988)	(2,722)	(2,758)
Total Expenditure	**(23,943)**	**(21,407)**	**(21,453)**	**(21,739)**	**(22,306)**

Early Detection & Management Services
Statement of Forecast Financial Performance
For the Year Ended 30 June

$000s	2009\10 Audited Actual	2010\11 Forecast	2011\12 Plan	2012\13 Plan	2013\14 Plan
Revenue					
Revenue	123,792	127,660	131,397	135,540	140,828
Interest Revenue	-	-	-	-	-
Total Revenue	**123,792**	**127,660**	**131,397**	**135,540**	**140,828**
Expenditure					
Operating Expenditure	(119,024)	(122,614)	(126,347)	(130,056)	(135,141)
Depreciation	(157)	(219)	(528)	(633)	(686)
Interest Expense	-	-	-	-	-
Capital Charge	-	(257)	(480)	(509)	(514)
Internal Allocations	(3,134)	(3,478)	(2,999)	(2,743)	(2,766)
Total Expenditure	**(122,315)**	**(126,568)**	**(130,354)**	**(133,941)**	**(139,107)**
Net Surplus / (Deficit)	**1,477**	**1,092**	**1,043**	**1,599**	**1,721**
Gain / (Loss) on Sale of Assets	(4)	-	-	-	-
Net Surplus / (Deficit)	**1,473**	**1,092**	**1,043**	**1,599**	**1,721**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**1,473**	**1,092**	**1,043**	**1,599**	**1,721**
Expenditure Breakdown:					
Personnel Costs	(13,070)	(13,282)	(14,164)	(14,581)	(14,991)
Outsourced Services	(456)	(575)	(631)	(651)	(671)
Clinical Supplies	(639)	(710)	(1,118)	(1,237)	(1,302)
Infrastructure and Non-Clinical Supplies	(1,154)	(2,034)	(2,503)	(2,589)	(2,655)
IDF Outflows	(6,552)	(9,333)	(8,992)	(9,396)	(9,815)
External Contract Payments	(97,310)	(97,156)	(99,947)	(102,744)	(106,906)
Internal Allocations	(3,134)	(3,478)	(2,999)	(2,743)	(2,766)
Total Expenditure	**(122,315)**	**(126,568)**	**(130,354)**	**(133,941)**	**(139,107)**

Intensive Assessment & Treatment Services
Statement of Forecast Financial Performance
For the Year Ended 30 June

$000s	2009\10 Audited Actual	2010\11 Forecast	2011\12 Plan	2012\13 Plan	2013\14 Plan
Revenue					
Revenue	217,228	226,854	238,587	247,556	255,603
Interest Revenue	345	449	400	400	406
Total Revenue	**217,573**	**227,303**	**238,987**	**247,956**	**256,009**
Expenditure					
Operating Expenditure	(219,560)	(223,512)	(228,337)	(235,820)	(243,159)
Depreciation	(8,044)	(9,391)	(10,302)	(11,762)	(12,882)
Interest Expense	(1,259)	(1,249)	(3,230)	(3,730)	(3,730)
Capital Charge	(4,532)	(4,894)	(4,768)	(5,059)	(5,112)
Internal Allocations	7,316	7,176	6,705	6,044	6,115
Total Expenditure	**(226,079)**	**(231,870)**	**(239,932)**	**(250,327)**	**(258,768)**
Net Surplus / (Deficit)	**(8,506)**	**(4,567)**	**(945)**	**(2,371)**	**(2,759)**
Gain / (Loss) on Sale of Assets	(370)	-	-	-	-
Net Surplus / (Deficit)	**(8,876)**	**(4,567)**	**(945)**	**(2,371)**	**(2,759)**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**(8,876)**	**(4,567)**	**(945)**	**(2,371)**	**(2,759)**
Expenditure Breakdown:					
Personnel Costs	(115,395)	(118,546)	(123,196)	(127,212)	(131,058)
Outsourced Services	(5,357)	(3,777)	(3,405)	(3,520)	(3,633)
Clinical Supplies	(22,246)	(23,268)	(23,716)	(24,914)	(25,876)
Infrastructure and Non-Clinical Supplies	(29,017)	(29,298)	(31,394)	(33,688)	(35,213)
IDF Outflows	(57,054)	(59,682)	(60,585)	(62,622)	(64,728)
External Contract Payments	(4,326)	(4,475)	(4,341)	(4,415)	(4,375)
Internal Allocations	7,316	7,176	6,705	6,044	6,115
Total Expenditure	**(226,079)**	**(231,870)**	**(239,932)**	**(250,327)**	**(258,768)**

Rehabilitation & Support Services
Statement of Forecast Financial Performance
For the Year Ended 30 June

$000s	2009\10 Audited Actual	2010\11 Forecast	2011\12 Plan	2012\13 Plan	2013\14 Plan
Revenue					
Revenue	57,343	55,850	56,467	57,813	58,985
Interest Revenue	-	-	-	-	-
Total Revenue	**57,343**	**55,850**	**56,467**	**57,813**	**58,985**
Expenditure					
Operating Expenditure	(54,573)	(54,310)	(55,969)	(56,804)	(57,599)
Depreciation	(5)	(5)	(5)	(6)	(6)
Interest Expense	-	-	-	-	-
Capital Charge	-	-	-	-	-
Internal Allocations	(609)	(759)	(718)	(579)	(590)
Total Expenditure	**(55,187)**	**(55,074)**	**(56,692)**	**(57,389)**	**(58,195)**
Net Surplus / (Deficit)	**2,156**	**776**	**(225)**	**424**	**790**
Gain / (Loss) on Sale of Assets	-	-	-	-	-
Net Surplus / (Deficit)	**2,156**	**776**	**(225)**	**424**	**790**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**2,156**	**776**	**(225)**	**424**	**790**
Expenditure Breakdown:					
Personnel Costs	(3,458)	(3,501)	(3,624)	(3,713)	(3,794)
Outsourced Services	(82)	(92)	(89)	(92)	(94)
Clinical Supplies	(1,266)	(1,292)	(1,355)	(1,401)	(1,447)
Infrastructure and Non-Clinical Supplies	(130)	(179)	(157)	(162)	(167)
IDF Outflows	(5,335)	(5,189)	(5,605)	(5,773)	(5,947)
External Contract Payments	(44,307)	(44,062)	(45,144)	(45,669)	(46,156)
Internal Allocations	(609)	(759)	(718)	(579)	(590)
Total Expenditure	**(55,187)**	**(55,074)**	**(56,692)**	**(57,389)**	**(58,195)**

MODULE 9: APPENDICES

9.1 MONITORING FRAMEWORK PERFORMANCE MEASURES

Dimensions of DHB Performance Measures (Non financial)

Policy Priorities Dimension

Performance Measure and description	2011/12 Target	National Target	Frequency
PP1 Clinical leadership self assessment			
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: ● Contributing to regional clinical leadership through networks ● Investing in the development of clinical leaders ● Involving the wider health sector (Including primary and community care) in clinical inputs ● Demonstrating clinical influence in service planning ● Investing in professional development ● Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care			
The DHB is to supply a progress report on the implementation of changes to primary health care services that deliver on the core elements of Better, Sooner, More Convenient primary health care. In particular progress must be described regarding: 1. the shifting of services from secondary care to primary care settings; 2. the development of Integrated Family Health Centres; and 3. any specific reporting requirements that may be identified in the Minister's Letter of Expectations (to be confirmed). **AND (as applicable)** 1. Those DHBs involved in Better, Sooner, More Convenient (BSMC) primary health care business case(s) are required to supply a progress report on the implementation of the business case(s) it is involved in. The BSMC Monitoring Framework includes indicators at three levels: 2. Those DHBs involved in Better, Sooner, More Convenient primary health care business case(s) are required to supply a progress report on the operation and expenditure of the flexible funding pool, including how pool funding has been prioritised to deliver services to meet the four high-level objectives. Where problems are identified, resolution plans are to be described.	No quantitative target qualitative deliverable required.	NA	Quarterly
PP3 Local Iwi/Maori engagement and participation in DHB decision making, development of strategies and plans for Maori health gain			
Measure 1 - PHO Maori Health Plans Percentage of PHOs with MHPs that have been agreed to by the DHB.	100%	**100%**	Six-Monthly
Measure 2 - PHO Maori Health Plans 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).	No quantitative target qualitative deliverable required.	NA	
Measure 3 - DHB – Iwi/Maori relationships Provide a report demonstrating: • Achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Maori 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 MoU.			
Measure 4 - DHB – Iwi/Maori relationships Report on how (mechanisms and frequency of engagement) local Iwi/Maori 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 - DHB Maori Health Plan Provide a report by exception on national level priorities that have not been achieved in the DHB Maori Health Plan. The report will say why the priority has not been achieved, what the DHB will do to rectify it, and by when.			
PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Maori			
Measure 1 Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Maori.	No quantitative target qualitative deliverable required.	NA	Six-Monthly
Measure 2 Report on examples of actions taken to address the issues identified in the reviews. The report should identify:• what issues/ opportunities were brought to your attention as a result of the reviews of pathways of care that you identified in Measure one• the follow up actions you intend to take/ are taking as a result of the issues and opportunities that you identified above.The report should include timeframes for implementing the actions you identify.			

Performance Measure and description			2011/12 Target	National Target	Frequency
PP5 Waiting times for chemotherapy treatment					
Provide a report confirming the DHB has reviewed the monthly wait time templates produced by either the relevant Cancer Centre(s) or its own DHB where treatment commenced at that DHB for the quarter. Where the monthly wait time data identifies: • any patients domiciled in the DHB waiting more than four weeks, due to capacity issues, and/or • wait time standards were not met, for patients in priority categories A and B DHBs must provide a report outlining the resolution path.			100% at four weeks	**100% at four weeks**	Quarterly
PP6 Improving the health status of people with severe mental illness					
The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • child and youth aged 0-19, specified for each of the three categories Maori, Other, and in total • adults aged 20-64, specified for each of the three categories Maori, Other, and in total • older people aged 65+, specified for each of the three categories Maori, Other, and in total.	**Age 0-19**	Maori	2.70%	NA	Six-Monthly
		Other	2.50%		
		Total	2.55%		
	Age 20-64	Maori	5.30%		
		Other	3.00%		
		Total	3.35%		
	Age 65+	Total	N/A		
PP7 Improving mental health services using crisis intervention planning					
Provide a report on: 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.	**Adult (20+)**	Maori	95%	**95%**	Six-Monthly
		Non Maori	95%	**95%**	
	Child & Youth	Maori	95%	**95%**	
		Non Maori	95%	**95%**	
PP8 DHBs report alcohol and drug service waiting times and waiting lists					
Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. Reporting will be on the longest waiting time in days, plus the number of people on the waiting list for treatment at the end of the month, i.e. volume and time. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period.			No quantitative target. Supply of quantitative data required.	NA	Six-Monthly
PP9 Delivery of Te Kokiri: the mental health and addiction action plan					
DHBs are to provide a summary report on progress made towards implementation of Te Kōkiri: the Mental Health and Addiction Action Plan. A template for this report can be found on the nationwide service framework library web site NSFL homepage: http://nsfl.health.govt.nz.			No quantitative target qualitative deliverable required.	NA	Annual
PP10 Oral Health DMFT Score at year 8					
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and (ii) children who are caries-free (decay-free).		Maori	1.05	NA	Annual
		Pacific	1.2		
		Other	0.7		
		Total	0.9		
	Total	***Fluoridated***	N/A		
		Non Fluoridated	N/A		

Performance Measure and description			2011/12 Target	National Target	Frequency
PP11 Children caries free at 5 years of age					
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – • Decayed (d), • Missing (due to caries, m), and • Filled (f).		Maori	63%	NA	Annual
		Pacific	50%		
		Other	77%		
		Total	70%		
	Total	***Fluoridated***	N/A		
		Non-Fluoridated	N/A		
PP12 Utilisation of DHB funded dental services by adolescents					
In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: (i) the unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Maori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator.		Total	75%	**85%**	Annual
PP13 Improving the number of children enrolled in DHB funded dental services					
Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Maori oral health providers).		Children Enrolled **0-4 years**	8039	NA	Annual
Measure 2 - In the year to which the reporting relates:(i) the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Maori oral health providers); and(ii) the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.		Children not examined **0-12 years**	5%		
PP14 Family violence prevention					
Confirmation report based on audit scores for partner abuse and child abuse and neglect programme components. (Data source: Provided to DHBs by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit.)			140/200	**140/200**	Annual
PP15 Improving the safety of elderly: Reducing hospitalisation for falls					
The number of people 75 yrs and older hospitalised for falls domiciled in the DHB region, per year.			4.7%	NA	Six-Monthly
PP16 Workforce - Career Planning					
The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories: ● Medical staff ● Nursing ● Allied technical ● Maori Health ● Pacific ● Pharmacy ● Clinical rehabilitation ● Other			No quantitative target. Supply of quantitative data required.	NA	Annual

System Integration Dimension

Performance Measure and description			2011/12 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions					
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 Maori 45-64 year olds.	**Age 0-74**	Maori	114	NA	Six-Monthly
		Pacific	110		
		Other	108.32		
	Age 0-4	Maori	129.07		
		Pacific	145.45		
		Other	139.12		
	Age 45-64	Maori	100		
		Pacific	93.17		
		Other	104		
SI2 Regional service planning					
A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan. For each action the progress report will identify: • the nominated lead DHB/person/position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action. If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.			No quantitative target qualitative deliverable required.	NA	Quarterly
SI3 Service coverage					
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.			No quantitative target qualitative deliverable required.	NA	Six-Monthly
SI4 Elective services standardised intervention rates					
For any procedure where the standardised intervention rate in the 2011/12 financial year or 2011 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** 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 (2011/12) that will ensure the target rate is achieved.	**Intervention rate**		308 per 10,000	**308 per 10,000**	Six-Monthly
	Major joint replacement procedures		21 per 10,000	**21 per 10,000**	
	Hip		10.5 per 10,000	**10.5 per 10,000**	
	Knee		10.5 per 10,000	**10.5 per 10,000**	
	Cataract Procedures		27 per 10,000	**27 per 10,000**	
	Cardiac procedures		6.5 per 10,000	**6.5 per 10,000**	
SI5 Expenditure on services provided by Maori Health providers					
Measure 1 DHB to report actual expenditure (GST exclusive) on Maori providers by General Ledger (GL) code.			No quantitative target. Supply of quantitative data required.	NA	Annual
Measure 2 DHBs to report actual reported expenditure for Maori providers in comparison to estimated expenditure for Maori providers in their Annual Plan for the same reporting period, with explanation of variances.					

Performance Measure and description			2011/12 Target	National Target	Frequency
SI7 Improving breast-feeding rates					
DHBs are expected to set DHB-specific breastfeeding targets with a focus on Maori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Maori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers. The DHB will need to work actively with providers and contract holders to achieve these targets. Breastfeeding targets for "total" remain subject to final calculation.	**6 weeks**	Maori	62%	**74% -**	Annual
		Pacific	67%		
		Other	65%		
		Total	64%		
	3 Months	Maori	46%	**57%**	
		Pacific	55%		
		Other	44%		
		Total	52%		
	6 Months	Maori	18%	**27%**	
		Pacific	25%		
		Other	17%		
		Total	22%		

Ownership Dimension

Performance Measure and description	2011/12 Target	National Target	Frequency
OS3 Elective and arranged inpatient length of stay			
The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The DHB's 'actual' ALOS, and the nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nation-wide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents, and summing the result across all discharge groups.	3.65 Days	NA	Quarterly
OS4 Acute inpatient length of stay			
The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The DHB 'actual' ALOS, and nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nationwide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents for the DHB, and summing the result across all discharge groups.	4.00 Days	NA	Quarterly
OS5 Theatre Utilisation			
Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • Actual theatre utilisation, • resourced theatre minutes, • actual minutes used as a percentage of resourced utilisation The expectation is that DHBs will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: a. For DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended b. For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	85%	**85%**	Quarterly

Performance Measure and description	2011/12 Target	National Target	Frequency
OS6 Elective and arranged day surgery			
The standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs.	62%	**62% Standardised**	Quarterly
OS7 Elective and arranged day of surgery admissions			
The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage.	90%	**90% Standardised**	Quarterly
OS8 Acute readmissions to hospital			
The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB.	9.15%	NA	Quarterly
OS9 30 Day mortality			
The measure is for a standardised mortality rate, in order to improve the comparability of the measure across the sector. The standardised mortality rate is the ratio of the 'actual' to 'expected' mortality rates, multiplied by the nationwide mortality rate, expressed as a percentage. The DHB's 'actual' mortality rate, and the nationwide mortality rate, are both defined as the number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including daycases. The 'expected' mortality rate is derived using regression methods from the DRG and patient population characteristics of the DHB.	1.42%	NA	Annual
OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns)	<6%	**<6%**	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter	<2%	**<2%**	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	>55%	**>55%**	
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter.	<5%	**<5%**	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	>97%	**>97%**	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarterDenominator: Total number of PRIMHD records submitted by the DHB in the quarter	>98%	**>98%**	

Appendix 9.2 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 Public Finance Act 1989 and the Crown Entities Act 2004.

The primary objective of HVDHB is to deliver health and disability services and mental health services in a variety of ways to the community rather than making a financial return. Accordingly, HVDHB is a public benefit entity as defined under NZIAS 1.

Basis of Preparation
Statement of Compliance
The forecast financial statements have been prepared in accordance with the Crown Entities Act 2004, which includes the requirement to comply 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.

Functional and Presentation Currency
The forecast financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand dollars.

Measurement Base
The forecast financial statements have been prepared on the historical cost basis modified by the revaluation of land and buildings.

Significant 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 HVDHB's Board in its 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 forecast 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 statement of forecast comprehensive income in the period in which they are incurred except to the extent they are directly attributable to the acquisition or construction of a qualifying asset in which case they are capitalised as part of the cost of that asset. Qualifying assets are capital projects spanning more than one year and require long-term funding.

Interest paid on borrowings from Crown Health Financing Agency directly attributable to the Theatre and Emergency Department building project has been capitalised to the project in accordance with IAS 23. This policy will apply until such time as the developments are ready for use.

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 forecast comprehensive income 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 and are measured at its fair value.

Goods and Services Tax

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

The net amount of GST recoverable from or payable to the Inland Revenue Department is included as part of receivables or payables in the statement of financial position.

Employee Entitlements

Short-term Employee 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.

A liability and an expense are recognised for bonuses where the DHB has a contractual obligation or where there is a past practice that has crated a constructive obligation.

Long-term Employee Entitlements

Entitlements that are payable beyond 12 months, such as long service, retirement leave, continuing medical education and sabbatical 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 comprehensive income 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. The scheme is therefore accounted for as a defined contribution scheme.

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. If there is a material difference then the off-cycle asset classes are carried at depreciated historical cost. Additions between revaluations are recorded at cost.

Accounting for revaluations:
HVDHB accounts for revaluations of land and buildings 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 comprehensive income. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the statement of comprehensive income 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.

Work in progress is recognised at cost less impairment and is not depreciated.

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 comprehensive income is calculated as the difference between the net disposal proceeds 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 forecast comprehensive income 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 (or valuation) 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.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

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 comprehensive income. 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.

Creditors and other Payables

Creditors and other payables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method.

Trust and Bequest Funds

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

Cost of Services (Statement of Objectives and Service Performance)

The cost of services 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 of Property, Plant, Equipment and Intangible Assets

Intangible assets that have an indefinite useful life, or are not yet available for use, are tested annually for impairment.

Property, plant and equipment and intangible assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and the value in use.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the surplus or deficit.

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 for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Provisions are not recognised for future operating losses.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as a finance cost.

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 250% of the standard levy.

Appendix 9.3 Organisational Chart