Healthy People, Healthy Families, Healthy Communities

Hutt Valley District Health Board 2012/13 ANNUAL PLAN

WITH STATEMENT OF INTENT 2012-15

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 2012/13 is approved.

Hon Tony Ryall
Minister of Health

Virginia Hope
Chairperson
Hutt Valley District Health Board

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

02 JUL 2012

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

Dear Dr Hope

Hutt Valley District Health Board 2012/13 Annual Plan

This letter is to advise you I have approved and signed Hutt Valley District Health Board's (DHB) 2012/13 Annual Plan for three years.

I appreciate the significant work that goes in to preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress as I monitor your achievements over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2012, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to safeguarding and growing our public health services.

Health targets

Government Health Targets are selected to drive on-going improvements in specific priority areas in order to meet the public's growing expectations of accessing quality health care.

I appreciate your DHBs efforts to deliver on the Health Targets and your progress in achieving these. Your plan acknowledges the changes in focus with regard to the cancer, immunisation and tobacco targets and identifies actions to support their achievement. I am satisfied the activities you have identified in your Annual Plan will deliver on these new targets, while building on current achievements for emergency departments, electives as well as cardiovascular disease and diabetes.

Shorter waiting times

The Government has made commitments to New Zealanders to deliver even faster access in a number of key areas including elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services. Thank you for your work to support these commitments. I look forward to seeing your planned results in these priority areas.

Integrated care

I expect all DHBs to increase their focus on service integration, particularly with respect to primary care, ensuring the scope of activity is broadened and the pace significantly stepped up. I look forward to seeing an integrated care approach driving delivery and improved performance, especially in relation to unplanned and urgent care, long term conditions and wrap around services for older people.

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I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan and movement towards more tangible actions 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 and community services are delivered closer to home. The Ministry and NHB will work closely with you during the first quarter to support you to develop a robust implementation work programme for the year.

Living within our means

DHBs are required to budget and operate within allocated funding and identify specific actions to improve year-on-year 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. Improvements through national, regional and sub-regional initiatives are expected to be a key focus for all DHBs.

Approval of your Annual Plan is conditional upon your Board fully supporting the investment required in Health Benefits Limited's Finance, Procurement & Supply Chain detailed business case. This is expected to follow completion of the current business case approval process with DHBs and shareholding Ministers.

I am pleased to see that your DHB is planning to break even for the next three years. I will be watching with keen interest your management of financial performance during 2012/13, given the level of improvement initiatives supporting your planned net results.

Savings from the community pharmaceutical budget

Earlier in the year, I directed DHBs to put the $30 million savings from the community pharmaceutical budget for 2012/13 towards the following initiatives:

- extending zero fees for primary care for children under six to afterhours;
- providing support for child and adolescent mental health services;
- implementing faster cancer treatment initiative;
- supporting smart investment home care for older people;
- providing an increase in aged care residential subsidy for bed day price, and for further improvements in dementia services.

I am interested to follow your progress in implementing these initiatives.

Health of older people

Our aging population poses many challenges to the health system and addressing these challenges is a government priority. DHBs are expected to develop wrap around services for older people and continue to invest in home and community support services, including post hospital discharge support to reduce acute admissions.

I am pleased to see detail in your Annual Plan on how you are planning to deliver health services for older people. I am particularly interested to follow your progress in relation to the provision of organised stroke services, services to reduce acute admissions, improvements in respite care and the development of dementia care pathways.

Regional Integration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities.

Included in these priorities are the achievements of regional workforce, IT and capital objectives that have been set, as well as your on-going support for the work of Health Benefits Limited, the National Health Committee and the Health Quality and Safety Commission. I look forward to seeing tangible benefits provided to patients as a result of these important regional initiatives being implemented.

It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan.

Whānau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services in which DHBs play a key role. I expect your DHB planned actions to deliver on Whānau Ora to reflect the strategic change, confirmed support to selected Whānau Ora collectives; greater involvement of DHB leaders; and activities to improve performance and build mature providers.

Prime Ministers Youth Mental Health Project

The Prime Ministers Youth Mental Health Project cross-agency initiatives aim to prevent youth mental health problems developing and improve access to specialised treatment for those who need it. I would like to thank you for your demonstrated commitment to this government priority, including through your planned actions to build capacity and capability of specialist child and youth mental health and addition services, in order to improve service responsiveness.

Cardiac Services

The focus on improving access to cardiac surgery has resulted in very positive outcomes for patients over recent years. I am pleased to see your commitment to continuing progress in this area, through reducing waiting times and ensuring an appropriate level of access during 2012/13, not only for surgery, but across a wider suite of cardiac services.

The link between regional networks and cardiac providers is very important in this area, and I expect your local contribution to align with regional planning, and for regional collaboration to be strengthened to support delivery, waiting list management, and improved patient pathways.

Diabetes Care

This year each DHB has been asked to develop a Diabetes Care Improvement Package in consultation with primary care partners to better support prompt access to services and increasingly more effective management of people with diabetes.

These packages should enable innovation in service delivery, more focused activity to improve patient care where it is most needed and are to be built with strong evidence based best practice in mind. They should build on the good practice already provided through general practice to enhance and optimise outcomes for patients. I look forward to following the progress of these packages with your primary care partners.

Community Pharmacy Services Agreement

DHBs have undertaken to provide a well executed transition to the new Community Pharmacy Service Agreement. I know you will want to ensure your management confirms this happens locally.

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 NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

My acceptance of your Annual Plan does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent 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 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 2012/13 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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.

My approval of your annual plan is contingent on your commitment to (along with your regional DHB partners) present an agreed joint plan, by 30 September 2012 which will ensure the sub-region has broken even financial result for the 2013/14 and out-years. I expect is that this plan will contain specific actions that are achievable and fit within government policy requirements. I have instructed National Health Board officials to work with you to achieve this.

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 2012/13. It outlines the actions we will take to achieve our vision of 'Healthy People, Healthy Families, Healthy Communities' while living within our means in an environment of fiscal constraint.

Internationally the health sector is faced with growing demand within a population that is ageing and which has greater expectations and access to information. At the same time, the global financial crisis continues to have a significant impact on the funding available to the public health service. Against that backdrop, the NZ health sector has, while at a lower rate than prior years, still had funding increases in the context of a neutral government budget.

For the past few years, there has been a focus for district health boards to break even financially as well as increase and improve delivery of services. Living within our financial means is becoming an increasing challenge. This does however provide us with an opportunity to reconsider how we do many things, in order to contribute to creating a health system that is sustainable for the population of the Hutt Valley.

A sustainable health system for the Hutt Valley will be characterised by strong integration between services and clinicians, co-operation and joint work with our neighbouring DHBs, and a focus on finding more efficient ways of delivering our services, while retaining our focus on improved patient care and better health outcomes.

These characteristics are reflected in our Annual Priorities for 2012/13:

- Integrating health services into a more unified system
- Improving our processes and culture
- Government Priorities and Health Targets
- Financial sustainability
- Working with our neighbours, and
- Prevention and earlier intervention.

We also have an ongoing focus on reducing disparities and inequalities, on improving the quality of the services we provide and fund, and on collective clinical and non-clinical leadership.

Our priorities will help us in providing the best possible service in the following ways:

- Many of the health challenges faced by people in the Hutt Valley relate to how long term conditions are managed and prevented, and how and when hospital care is accessed. An integrated whole of Hutt Valley approach is necessary to make health and efficiency gains in these areas.

- Co-operation with other DHBs and the wider health sector is also integral to our success – we cannot "go it alone":

    - 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. As we move forward we, expect this co-operation to be reflected in increasingly common approaches to accountability and planning approaches and documents.

- 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 2012/13 we will also continue improving our hospital as part of our annual priority of improving our processes. In particular, we are focussed on finding improvements in our hospital processes and culture, which will complement the redevelopment of our Emergency Department and theatres. Improvements in these areas will deliver both efficiencies and a smoother patient journey.

- 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.

- Prevention and earlier intervention is critical to developing a sustainable health service, and to improving the overall health of the Hutt Valley population. This will also assist in addressing inequalities, as Maori and Pacific people in the Hutt Valley have a higher risk of developing long term conditions such as diabetes and Heart disease.

We look forward to another year of 'working together for health and wellbeing' in 2012/13. Working together - with the community, primary care, our NGO providers, our neighbouring DHBs, and the Government – is the way we will succeed in meeting the challenges that 2012/13 and the future will bring.

The Hutt Valley District Health Board's Statement of Intent for the financial years 2012-15, 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 provides 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, and expectations regarding integration of services, and stronger working relationships with our neighbouring DHBs.

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 cancer services, older adult and rehabilitation services, stroke services, radiology services and a stronger emphasis on working together to manage delivery of elective services.

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.

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[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.

1.3 Population profile

Information about the Hutt Valley DHB region's population is set out at Appendix 8.2.

1.4 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 publicly funded 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 are expected to lead to better health outcomes. Changes to the way health services are planned and delivered includes working more closely with other DHBs at sub-regional, regional and national levels, and with our primary care partners.

Factor	Implications
Increased focus on quality and safety of services	An increased focus on quality and safety of services will 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, subregional, 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, prioritisation, 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
Some hospital facilities may in the future require modification to meet earthquake standards	Impact on clinical care during any necessary modifications, to be managed with appropriate planning into 2013/14. Financial implications.
Poor housing	Higher prevalence of housing related conditions e.g. (respiratory, cellulitis) resulting in higher hospitalisations.
The proportion of people residing in urban areas is much higher than average for NZ, and within a relatively confined geographical area.	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.

1.5 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[3] 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.

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

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.

1.5.1 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
- 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 Non Governmental Organisation (NGO) providers (10 local, 6 subregional and 8 regional service providers).

Pursuant to s25 of the New Zealand Public Health and Disability Act 2000 (the Act) Hutt Valley DHB is permitted and empowered 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.

1.5.2 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 burns unit covering a population (Wairoa to Blenheim) of over 1 million people
- Reconstructive surgery for breast, head, and neck cancers for the central region
- Sub-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 sub-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 to Hutt Valley, Wellington, and Wairarapa.
- Regional Screening Services, including breast cancer screening, and regional coordination of cervical screening.

1.6 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.

1.7 Allocation of our funding in 2012/13

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 2012/13 will be $340.3M, up from $336.3M in 2011/12. Of this total, $148.2M will be for services provided by the DHB, $77.6M in payments to other DHBs for services they will provide to Hutt Valley residents, $105.6M on services delivered by other providers, and $3.0M on governance and funding administration costs.

In total, Hutt Valley DHB expects to receive $440.0M in 2012/13 (all sources) to spend on health and disability services for the people of Hutt Valley, including $47.5M in payments from other DHBs for services Hutt Valley DHB will provide for their residents. This represents an increase in overall revenue of 1.5% against our total 2011/12 revenue. How we share this funding amongst our different services providers each year is a critical decision for the DHB.

1.8 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
Service	
Breast screening service - mammography equipment is end of life. Until replaced, equipment is at risk of breakdown, compromising service delivery.	Ensure upgrade progressed in 2012/13, and in the interim, ensure outsource contingency plans are in place.
Service Quality	
Quality has potential to be prejudiced in financially constrained environment	Actively pursue quality agenda with strong clinical and management leadership.
Industrial action could prejudice performance and patient safety	Deploy management strategies to minimise patient risk
Financial Performance	
Savings/efficiency goals will not be met, compromising financial performance	A broad range of opportunities are being developed, to deliver a level of savings over that which is required. This allows for the reality that not all ideas will deliver, or deliver to the level expected.
Unexpected imbalance in IDF flows could compromise financial performance	Work closely with neighbouring DHBs to better plan and manage IDF flows
Wage settlements over National Terms of Settlement	Seek cost avoidance opportunities to offset risk
Unexpectedly high demand for services (especially demand driven services), which could compromise financial performance	Identify and take opportunities to manage demand, particularly addressing avoidable hospitalisations and long term conditions, in conjunction with primary and secondary clinical leaders.

MODULE 2: STRATEGIC DIRECTION

2.1 Our Vision

The Government's overarching policy objective in healthcare is that New Zealanders lead longer, healthier, and more independent lives. Achieving this requires the co-operation 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

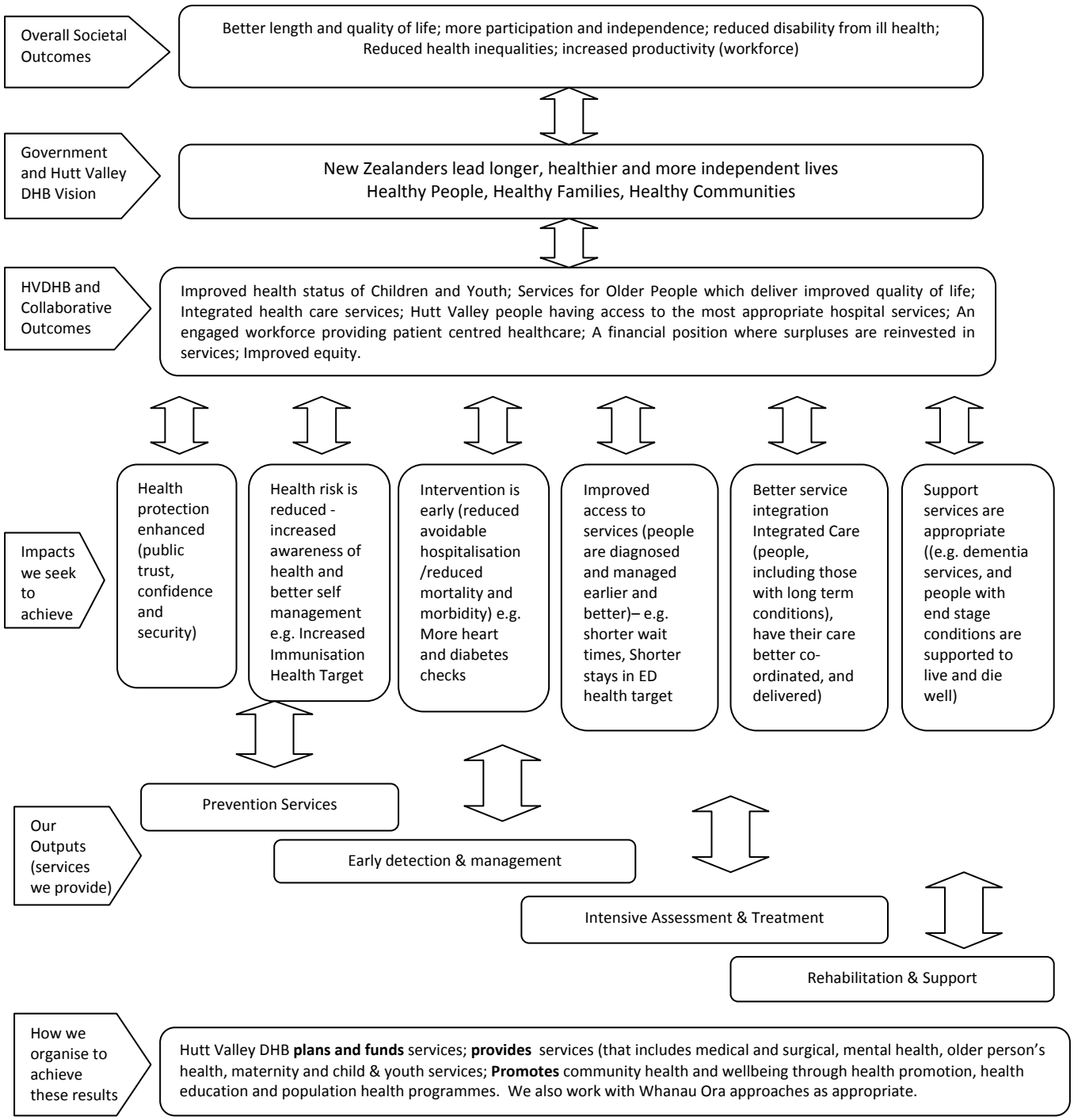
2.2 Strategic Directions

The DHB is developing a set of Strategic Outcomes to guide its work over the next 5 years to deliver on its Vision of Healthy People, Healthy Families, Healthy Communities. Work with our Board to establish these Outcomes will be progressed in 2012/13. At this stage, the Outcomes are likely to reflect:

- Improved health status of children and youth
- Services for older people which deliver improved quality of life
- Integrated health care services
- Hutt Valley people having access to the most appropriate hospital services
- An engaged workforce providing patient centred healthcare
- A financial position where surpluses are reinvested in services
- Improved equity

2.3. 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.[4]



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

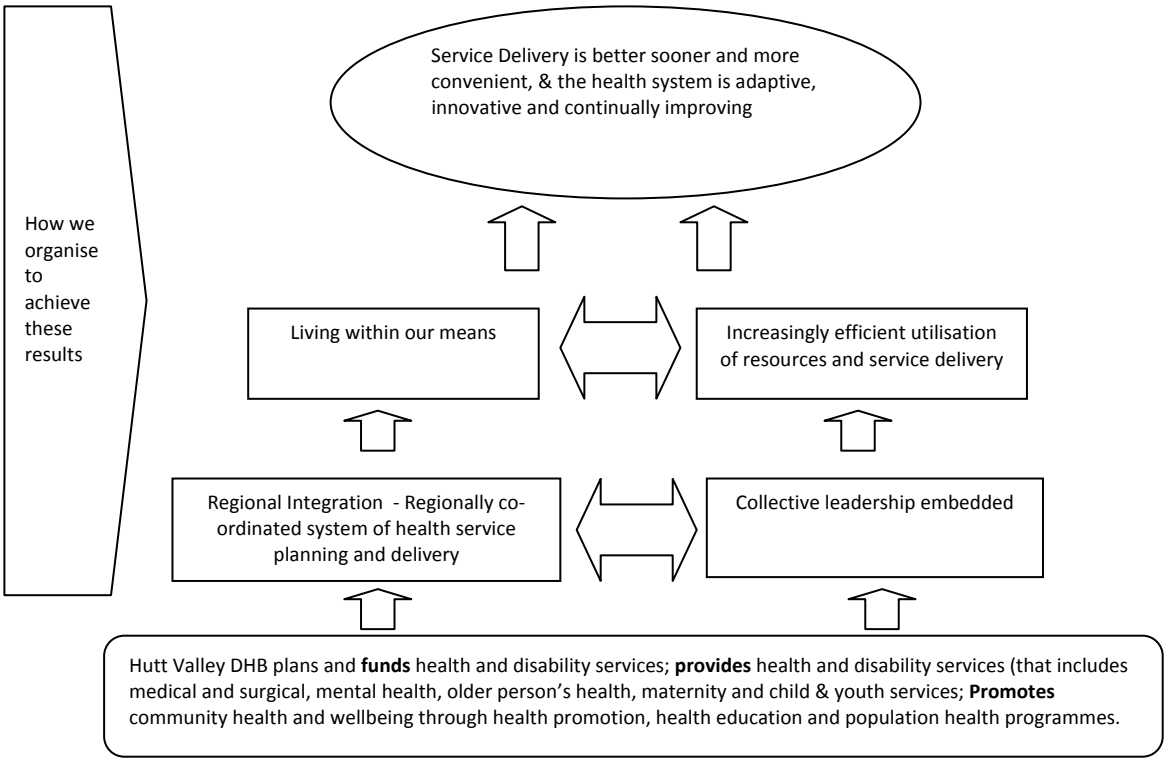
- Outcome - the end result of our activities. Many different things will lead to outcomes – not just what we do.
- Impact (or intermediate outcome) - the contribution made to an outcome by our outputs.
- Output - the things or services we produce.

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 5.

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:



2.4 Annual Priorities

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

Determining our annual priorities for 2012/13 requires us to consider issues at each level of service planning – national, regional, sub regional, and local.

2.4.1 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 close to the 95% target), and Better Help for Smokers to Quit (as one of the top performing DHBs).

In 2012/13 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.

2012/13 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 at least 4,000 discharges per year (compared with the previous average increase of 1,400 per year)
Shorter waits for cancer treatment	Everyone needing radiation or chemotherapy treatment will have this within 4 weeks.
Increased immunisation	95% of 8 mth olds will have completed their scheduled vaccinations (staged, by 2014)
Better help for smokers to quit	95% of hospitalised smokers are provided with advice and help to quit. 90 percent of patients who smoke and are seen by a health practitioner in primary care or public hospitals, are offered brief advice and support to quit smoking.
More heart and diabetes checks	Increase the percent of the eligible adult population who have had a cardiovascular disease (CVD) check with in the last five years to 75%.
Government Priority	**Description**
Integrated Care (including child and youth initiatives)	International evidence shows that integrating primary care with other parts of the health service is vital to better management of long-term conditions, an ageing population and patients in general. This is achieved through better coordinated health and social services and the development of care pathways designed and supported by community and hospital clinicians. DHBs will also work with local primary care networks and the Ministry of Health to provide zero fees after hours GP visits for children under six.
Shorter Waiting Times	People will receive better health services when they have improved access to diagnostic tests, faster cancer treatment, shorter waits for elective surgery, and shorter waits
Health of Older People	Our population continues to age and pose new challenges. DHBs are expected to engage with primary/community care to develop integrated services for older people that support their continued safe, independent living at home, particularly after a hospital discharge. DHBs will also work with the Ministry to implement the Government's commitments relating to dedicated stroke units and dementia.
Regional Integration	Greater integration between regional DHBs is important for both financial and clinical reasons. DHBs need to make significant progress in implementing their Regional Service Plans, and delivering on regional workforce, IT and capital objectives that have been set. We will be monitoring execution against the various dashboards used by the NHB. Boards will need to support and advance the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission.
Whanau Ora Services	A health system that functions well for Whānau Ora is one that requires the health sector to work in a more seamless way with other parts of the social sector and expects improved outcomes and results for New Zealand families
Living within our means	Live within our means "year on year": through improvements in purchasing, productivity, and quality and further reducing administrative overheads

2.4.2 National - Service Planning

Work programme to develop National Services and National Service Improvement programmes was introduced by the National Health Board in 2010 aimed at improving equity of access, quality, consistency and sustainability for vulnerable services, particularly high cost low volume specialist services for example, paediatric and congenital cardiac services. Building on the DHB model, lead DHB providers were selected to be responsible for the provision and development of a national service, most of which were funded from "top slice". DHBs that were recipients of the service were expected to work collaboratively with the national service provider, supporting outreach clinic arrangements to improve access for their populations. National Service Improvement programmes required the commitment of clinicians and managers within DHBs across a designated service pathway to identify areas of opportunity and work together on interventions to improve equity of access, quality, consistency and sustainability nationwide.

A small group of services (set out below) are planned or partially 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.

2.4.3 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 Central Region DHBs have together developed a Regional Services Plan (RSP).The RSP provides an overarching framework for future planning, and sets the region's short and medium term priorities to 2016/17 and beyond. It builds on the Regional Clinical Services Plan (2008) and the 2011/12 Regional Service Plan (RSP).

Better integrated, more convenient and people centred services will provide a better experience for patients. These changes can also potentially decrease the demand for higher cost hospital based care, decrease the average cost per intervention and make better use of our specialist workforce and expensive technologies.

In alignment with our Annual Plans across the region and to provide options for achieving the Governments aims for the health and disability system in a sustainable way, we have identified the following seven strategic foci. These have been developed as follows:

1. **Service Models–** Designing services to meet individual needs which respond to demographic changes; particularly the ageing and increasing diversity of need and poorer health outcomes for Māori and pacific peoples will require new models of care which should drive investment in workforce, capital and information. For example, investment in information systems such as shared electronic records, to enable improved coordination between primary care services.

2. **System/Service Integration –** Supporting health professionals, service providers and DHBS to better coordinate and integrate care, by placing patients and carers at the centre of service delivery, while reducing waste, harm and unjustified variation in the quality of care and service performance.

3. **Building a Workforce of the future -** We need to strengthen innovation, new ways of working and the development of sustainable workforces into the future. We will do this by ensuring workforce development enables sustainable service delivery. The regional focus includes health work force across the continuum of service delivery. The clinical workforce is the key agent in delivering better health care at the frontline and needs to be effectively engaged in designing and implementing change.

4. **Ensuring services are supported by appropriate infrastructure and enablers**

We operate in a challenging environment. The development of regional IT systems will enhance patient care by enabling clinicians from one DHB to have access to medical records from another DHB thus improving patient outcomes by quicker access to medical histories.

5. **Improving quality and safety across regional services**

   We will improve the quality of services as a region. Central DHBs have adopted the Triple Aim which focuses on improving the design and coordination of care through population health management and by understanding how service cost and productivity can impact on the quality of a patient's experience.

6. **Promoting strong corporate and clinical governance -** effective leadership ensures that the region is moving in the same direction and working collaboratively. For example the shift towards a regional planning approach and focus on establishment of a Regional Shared Service Organisation (RSSO).

7. **Increasing productivity whilst living within our means. -** Increasing our focus on proven preventative measures and earlier intervention. Incremental change to improve existing services is necessary, but is unlikely to be sufficient to meet the simultaneous challenges arising from the fiscal position and the changing needs of regions residents. New incentives, financial and non financial may be needed to deliver better performance.

Key Highlights for the 2012/13 Regional Services Plan

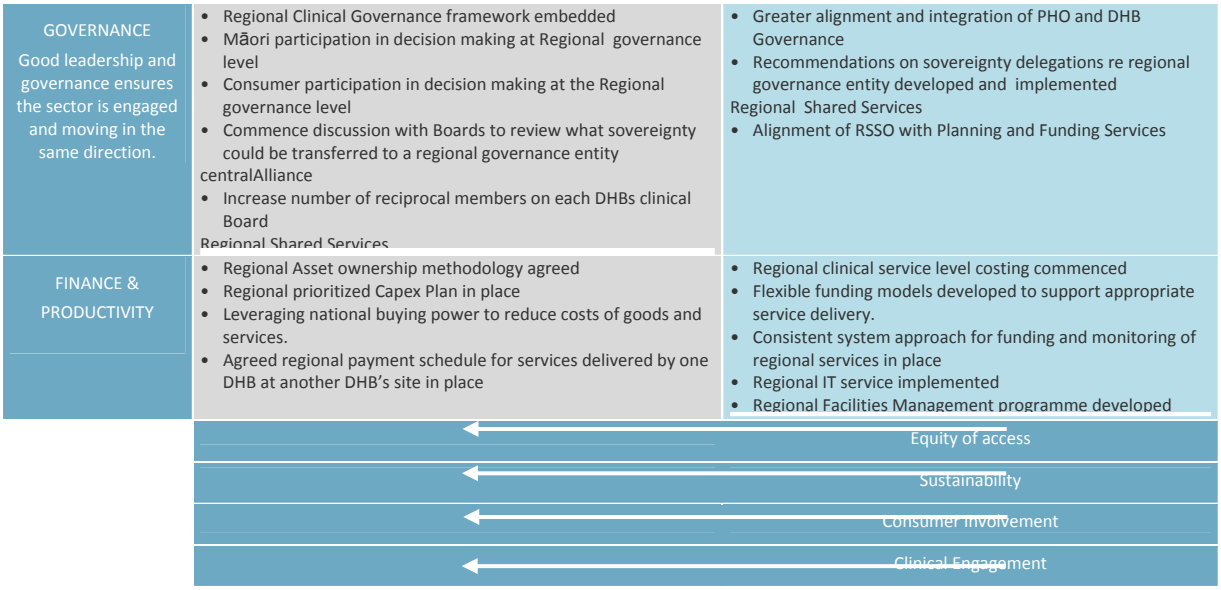
- Detailed action plans have been developed for the following service priority areas - cancer, cardiac, electives, health of older people (including stroke), radiology, and renal
- A continued focus remains on Mental Health and Addiction services, Māori Health, Renal Services, Population Health, sub regional work programmes and Quality and Safety.
- Detailed action plans have been developed for four non clinical service priority areas or key enablers such as development of a regional shared service organisation (identifying its future focus), Central Region Information System, Workforce and Capital Asset Management.
- Detailed action plans have been developed for the sub regional work programmes for the 3DHBs and centralAlliance.
- All action groups and networks continue to be clinically led
- Further alignment and integration of clinical services at both a regional and sub regional level builds on earlier work
- System integration opportunities with primary care partners at a local level and across the Central Region.

A 'whole of system' approach is being led by DHB clinicians and managers to integrate and transform the Central Region health system. The regional, sub-regional and local DHB work programmes for 2012/13 are being aligned as appropriate with the strategic drivers and intentions set out above

The table below summarises the action roadmap of Central Region DHBs over the next five years. The focus is to join up the region's clinicians, clinical systems and pathways to become a more regionally integrated health service. The roadmap has an implementation outcome focus.

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

	2012–13	2013-14
SERVICE MODELS AND INTEGRATION Designing new models of care which have a whole of system integrated approach	Integration • Whole of health continuum Integrated care strategy developed for four services • Common integrated clinical pathways including access to diagnostics developed for four services and implemented Electives • Collaborative action initiated to ensure the region meets the new ESPI compliance targets • Regional and sub-regional surgical acute /elective pathway flows are consulted upon and developed • Regional/ sub regional interim booking system in place for four services • Regional elective prioritisation criteria in place for four services • Common referral guidelines and access criteria developed four services • Reduce inequalities in access • DHBs meet health targets • Regional facility and capacity strategy developed Cardiac • Implement scoring tools for Acute Coronary Syndrome (ACS) Radiology • Regional Radiology referral guidelines and access criteria in place. Cancer • Implement national colonoscopy prioritisation tool • Discussion and planning for alignment of the regional cancer services commences • Regional plan developed for implementation of faster cancer	Integration • Whole of system Integrated care strategy implementation commences for agreed next phase • One population and one system approach for service delivery and funding Electives • Regional elective waitlists in place • Regional electives services strategy implemented • Acute/ elective pathways are implemented • Regional electives prioritisation criteria in place for four more services • Commence implementation of 18 week elective pathway in four services Cancer • Regional cancer services fully aligned 3DHB • Further four sub regional services established
WORKFORCE Strengthen innovation, new ways of working and the development of sustainable workforces	• Within 3DHBs and centralAlliance all new Senior Medical Officers (SMO) are collaborative appointees • Regional work force strategy across whole of system developed • Integrated sub regional HR functions implemented • Continue to review roster arrangements for acute services sub regionally and regionally • A single regional Resident Medical Officer Unit consulted on and developed • Regional staff orientation and education programmes developed • Clinical skills passport developed to allow for a more mobile workforce • Commence discussion with workforce and unions re potential flexibility of work locations.	• Further review of roster arrangements for acute services • Regional elective management teams established • Regional training Hub facilitating professional workforce development • A single regional Resident Medical Officer Unit established • A single regional Senior Medical Officer Unit consulted on and developed • Standardised clinical policies and procedures are implemented • Clinical skills passports implemented
INFRASTRUCTURE & ENABLERS Supporting health professionals to better coordinate and integrate care	• 3DHB single planning and funding unit established(if this is the outcome of an appropriate consultation process) • Integrated Regional Decision Support functions established • Strategy developed for a regional IT service • Business case prepared exploring regional laundry options • Investigate options for internal audit and sharing of food services CRISP • Local clinical work stations (CWS) implemented in Central Alliance • Local Patient Administration System (PAS) implemented in Central Alliance • Regional Picture Archiving & Communication System (PACS) developed and implemented • Regional Radiology Information System (RIS) developed • E referrals implemented across 3DHB region E Medicine • E medicine reconciliation commence rolled out	CRISP • Regional clinical work stations (CWS) rolled out to all clinicians in the region • Regional Patient Administration System (PAS) archive rolled out • E referrals implemented across region • Regional Radiology Information System (RIS) implemented E medicine • Implement regional e prescribing • Plan e Medication Management Sub regional • Executive leadership team (including clinical leaders) for each sub regional grouping established
QUALITY & SAFETY Improving the quality of services as a region, reducing waste and harm	• Region works collaboratively on national initiatives e.g. falls, pressure areas, medicine reconciliation, hand hygiene • Regional adverse events framework developed • Adopt principle of zero tolerance for preventable patient harm regionally • Continue to standardise clinical policies and procedures • Regional SMO credentialing of further four services	• Regional framework for consumer involvement developed • Annual Consumer forum established • 3 year Regional Quality Plan developed • Implement regional adverse event management framework



Sub–regional

A Shared Community

The Three District Health Board Health Services Development (3DHB HSD) programme is a collaborative programme between Hutt Valley, Wairarapa and Capital Coast DHBs. The Sub-Regional Clinical Leadership Group (SRCLG) believe that by collaborating we can advance improvements in the quality of patient care, manage risk, improve processes, sustain our workforce and make the best use of our resources to a greater extent that working separately.

A whole of system approach that spans the health continuum will enable the greatest gain to the patient/whanau experience, population health and clinical / financial sustainability. This is consistent with the Triple Aim of improving the patient/ whanau experience and the health of the population whilst ensuring value for money and living within our means.

The 3 DHBs are committed to developing a joint plan by 30 September 2012 to ensure the sub-region has a break even financial result for 2013/14 and out years.

3D - Design and Development Principles

Future service development in the sub region will have the following themes:

1. The programme of work will be clinically led. Managerial support will enable the collaborative approach to be achieved.
2. The level of response for any particular action will be predetermined, e.g.:
    a. National
    b. Regional
    c. Sub regional or
    d. Local responses.
3. Clinical pathways will be developed and implemented that take into account cultural, ethnic, gender and age specific needs.
4. Planning and implementation activity will actively consider how any action will impact on the 7 parameters of clinical quality (safe, responsive, efficient, effective, provided in continuity, equitable access, appropriate).

5. Services will be patient/whanau centred (not provider centred). Service users will be engaged in the development and design of services.
6. The inclusion of services that support peoples self management will be a desired outcome.
7. Clinicians supported by managers will lead the development, design and implementation of services, systems and processes.
8. A whole of health system approach will be taken that is cognisant of non-publicly funded health care provision, that has the community setting as the centre of health care provision and ensures that hospitals focus on what they are best placed to provide.
9. Delivery of services will be within available funding (including an allowance for future investment).
10. The design of services will enable a flexible and mobile workforce to provide care in keeping with the 7 parameters of quality, with the workforce moving to deliver services in the right place, in the right time.

The shared Vision and Principles mean that every decision is made within the context of the sub region. The Table below refers.

3D Vision and Principles

Common functions: • Common models of care • Clear pathways across the health service continuum • Streamlined (reduced waiting and reduced duplication) • CRISP • Shared referral guidelines, and prioritisation, common access criteria	**Integrated Services**[5] • Single service that may be delivered from multiple sites • Services operate across the sub-region with service specific resources • Services have clear deliverables and quality expectations • Potential to review on-call arrangements	**Reconfigured Use of Facilities** As integrated services are developed distinct from facilities the configuration and utilisation of facilities would be considered by each service and as a whole
Integrated HR and workforce support • HR functions • Occupational health services • SMO / RMO units • Nurse resources • Allied health resources • Administration staff • Shared training • Single HRIS	**Integrated Funding** • Purpose designed funding mechanisms (not IDF default) • Has a common planning function with individual Board accountability for funding	**Integrated Quality and Risk frameworks** • One quality and risk management framework • Single credentialing system • Shared policies, procedures (clinical and corporate)
Integrated infrastructure (in addition to CRISP) • One telecommunication function (e.g. 1 switch board) • One shared knowledge management system o website, o intranet, o email	**Integrated planning processes and documents** • One workforce plan • One Capital plan • One common Annual plan • One learning and development strategy	**Integrated NHB accountability frameworks** • Shared health targets • Shared performance assessment targets

Progress to date

A range of joint initiatives, joint appointments and joint agreements have been implemented through the collaborative approach. The more substantive examples are outlined in the table below.

Joint initiatives, agreements and appointments across the 3 DHBs

[5] Integrated services has been used generically in this table. This could mean single function across the 3 DHBs or other such combinations as best enables the vision and principles. This would be determined through employment consultation and clinical engagement.

Joint initiatives	Joint Agreements	Joint Appointments
Payroll Services – HVDHB provides these to WDHB	HR review (3 DHBs)	Director of Allied Health, (HVDHB and WDHB)
Child Health and Gastroenterology Service Review	General surgery agreement (HVDHB and WDHB)	A joint Human Resources GM has been agreed between CCDHB and HVDHB, and the appointment process is underway
Obstetric and Gynaecologist and General Surgery clinics and surgery across HVDHB and WDHB	MOU agreed between the three DHBs for SMO appointments (subject to ASMS consultation). It includes agreement to implement joint SMO credentialing processes, and SMOs working sub regionally with opportunities to do elective lists or clinics within the 3 DHBs	An Allied Health Educator has been appointed between CCDHB and HVDHB, to support the Directors of Allied Health in both organisations
Sub-regional approach to Planning and Funding under consideration		
Joint sonographer service WDHB and HVDHB	Lab project (CCDHB and HVDHB)	Radiology registrar training position and start of shared after hours call (HVDHB and CCDHBs)

An ongoing programme of work will continue in 2012/13. Main aspects are outlined in Module three.

2.4.4 Local Service Planning

At a local (DHB) level, our planning work (including our 2008 Health Needs Assessment[6]) identifies the following key activity areas and issues as important:

- Prevention and Earlier Intervention - Our subregional "Keeping Well" approach is a prevention framework which aims to influence health behaviours and risk factors, including prevalence of smoking, of breast-feeding, of obesity and of child health conditions such as skin infections and gastroenteritis.

- Avoidable Hospitalisations – more aggressively implementing our ongoing and rapidly evolving work with primary care to address higher than average rates of avoidable hospitalisation – including through improved referral pathways for skin conditions, respiratory conditions, gastroenteritis, and dental conditions. Focus areas are also likely to include older people, and the burden of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease, cardiovascular and cardiac conditions, and chronic mental health disorders.

- 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.

- Improving our Hospital – we have completed our new Emergency and Theatre re-development, on time and ahead of budget. Our challenge is now to improve our hospital's culture and processes to be increasingly patient centred and efficient.

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

- Financial Sustainability – an increasing need to more urgently focus on improving hospital productivity, controlling major cost drivers, and value for money in demand driven services (both locally and jointly with Capital and Coast DHB and/or Wairarapa 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.

Although our priorities continue to have a relatively stable direction of travel, it is becoming increasingly clear that we must increase the pace with which we make improvements to the way we work with our primary care and community partners, with our neighbouring DHBs, and within our organisation. We need to best use our available resources to deliver and fund the most appropriate healthcare for the Hutt Valley population, and the other populations we impact on. This "picking up the pace" will be challenging, but if managed well will strongly position Hutt Valley's healthcare services for the future.

2.5 – Summary of 2012/13 Annual Priorities

In 2012/13 we will focus on the following annual priorities to improve the health of our population. Underpinning these six priorities are an ongoing focus on patient centred quality, an emphasis on reducing inequalities, and a commitment to collective leadership. 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.

2012/13 Annual Priorities

- Integrating health services into a more unified system
- Improving our processes and culture
- Government Priorities and Health Targets
- Financial sustainability
- Working with our neighbours
- Prevention and earlier intervention

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

Annual Priority	DHB Issue	Impact	Strategic Outcome
1. Prevention and earlier intervention	Prevention and Earlier Intervention is a way in which the health of individuals and populations can be improved with relatively low cost interventions at an early stage. Conditions can be prevented, and in other cases identified early, giving better potential outcomes for patients at a lower cost to the health system.	Conditions can be prevented, and in other cases identified early, giving better potential outcomes for patients at a lower cost to the health system.	Improved Child Health Status, Improved health status of Older people. Reduced inequalities.
2. Health Targets and Government Priorities	A. Our performance is below the expectations we have of meeting the Government's ED health target. Long	A. Reduced length of stays in EDs. Better clinical outcomes for people using services.	Improved Child Health Status, Improved health

Annual Priority	DHB Issue	Impact	Strategic Outcome
	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.	B. Elective services will be delivered more efficiently across the region, assisting all DHBs within the region to meet targets and expectations.	status of Older people, Integration, Access to appropriate Hospital services.
3. Integrating health services into a more unified system	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	Consolidation of PHOs and establishment of the Primary Secondary Strategy Group (PSSG) have created a foundation for more service integration, and improved patient experiences. Improved primary/secondary integration will lead to better prevention and management of long term conditions, and reduce health inequalities.	Integration, Improved Child Health Status, Improved health status of Older people
4. Improving our processes and culture	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	Access to most appropriate hospital services
5. Financial Sustainability	The DHB (and the Central Region) need to work hard to ensure financial security in 2012/13 and future years.	Financial security will allow better opportunities for investment in new or improved services.	Financial Sustainability
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.	Access to most appropriate hospital services, Financial and Clinical Sustainability

2.6 Action Areas

In giving effect to our Annual Priorities, we have also identified three key Action Areas, where the DHB intends to put specific emphasis at an operational level. These are:

- Avoidable hospitalisations: improving our performance in this area is 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.

- Service Optimisation/Efficiencies programme – a set of activities which will assist us to achieve a break-even result, and position the DHB well for the future. Examples of projects include:
    - Improving hospital discharge processes and reducing unnecessary patient time in hospital
    - Better management of staff leave
    - Implementing a staff management and rostering tool to ensure correct staffing levels and mix
    - Optimising the surgical patient pathway
    - Best practice prescribing
    - Opportunities to increase income

- Working with our neighbours – primarily sub regional initiatives and in particular the 3D project: 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.

The way these Action Areas relate to our Annual Priorities and our Strategic Direction and Outcomes is set out below.

Action Area	Prevention and Earlier Intervention	Integration	Improving our Processes and Culture	Govt Priorities and Health Targets	Working with our neighbours	Financial Sustainability	Reduces inequality / enhances quality	Strategic Outcome
Avoidable hospitalisations: working to improve how the health system in the Hutt Valley addresses relevant conditions	✓	✓	✓	✓		✓	✓ (Equity) ✓ (Quality)	Improved health status of children; Integration Financial Sustainability
Working with our neighbours – primarily sub regional initiatives in particular the 3D project:			✓	✓	✓	✓	✓ (Quality)	Access to the most appropriate hospital services; Financial and Clinical Sustainability
Efficiencies programme – a set of activities which will assist us to achieve a break-even result, and position the DHB well for the future	✓	✓	✓	✓		✓	✓ (Quality)	Improved health status of children; Access to the most appropriate hospital services; Financial Sustainability

2.7 Further Significant DHB Plans

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 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 and 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.

Disability Plan

One of the objectives that all DHBs share is to promote the inclusion and participation in society and independence of people with disabilities.

The Minister of the Crown responsible for disability issues determines a strategy for disability support services to provide the framework for the Government's overall direction of the disability sector in improving disability support services.

The resulting New Zealand Disability Strategy, along with the UN Convention on the Rights of Persons with Disabilities provides the big picture of what New Zealand aims to achieve with disabled people. Our plan seeks to give shape to the intent of the strategy, noting however that funding for Disability Service is administered by the Ministry of Health.

Hutt Valley and Capital and Coast District Health Boards share the advice of a joint Disability Support Advisory Committee. This change recognises the increase in shared initiatives between the DHBs, and the need for neighbouring communities to work together.

For the first time, Hutt Valley and Capital and Coast DHBs are producing a shared disability strategy implementation plan, called *Valued Lives, Full Participation.* A key action in the plan is a commitment to ensure that our electronic patient information systems have the capacity to flag disability so this information is available to all staff as appropriate.

The plan also outlines how we will continue to engage with people with disabilities and value their advice. The Hutt Valley Disability Advisory Group has provided expertise since 2006 to DHB staff, managers and contractors, and we will continue to seek their input.

Following our joint pilot of the Health and Disability Commission Health Passport in 2011, we will go on encouraging members of the community who choose to complete a passport. We will continue to make information on the passport initiative available to DHB staff, so it is a recognised part of interactions with patients. This process provides an opportunity for people with particular care needs to articulate them when they are well, in a form that staff recognise.

2.8 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.

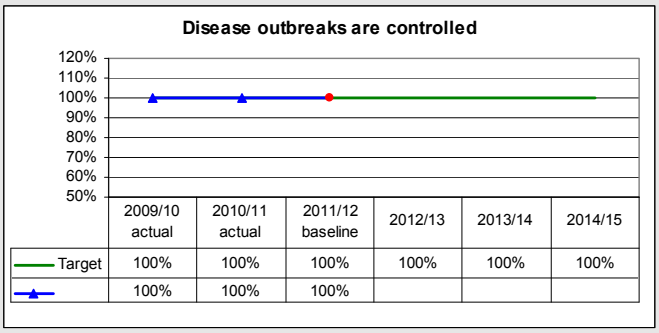
The table includes aspects of performance against Government Performance Requirements (see Module 8), and of delivery on our strategic priorities and against the Impacts we seek to achieve (see section 2.2 above).

Disease outbreaks are controlled

Output Class - Prevention Services

Main Areas of Performance: Health Promotion and Education Services, Statutory and Regulatory Services

- 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.
- **Impact or Strategic Outcome**: Health protection is enhanced; public trust, confidence and security; Improved health status of children

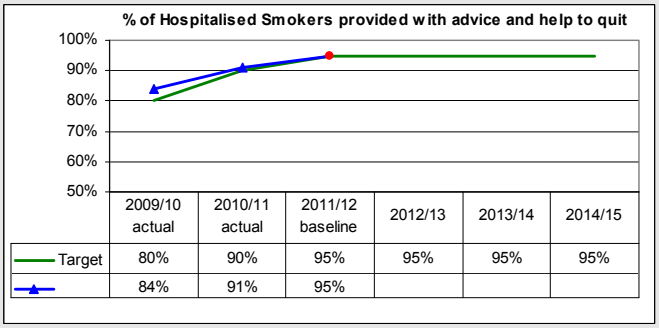


Better help for Smokers to Quit (*Health Target)*

Output Class - Prevention Services

Main Areas of Performance: Health Promotion and Education Services

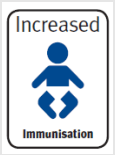
- Ensuring that our population is able to make healthy choices and that we support such choices is key to reaching our goals. Addressing health behaviours and risk factors is what we do when we implement tobacco cessation programmes.
- **Impact or Strategic Outcome***:* Health risk is reduced; people are healthy, able to self manage and live longer; Integration



2011/12 baseline actual as at Q2 2011/12

Percentage of 8 mth olds fully immunised

(Health Target)

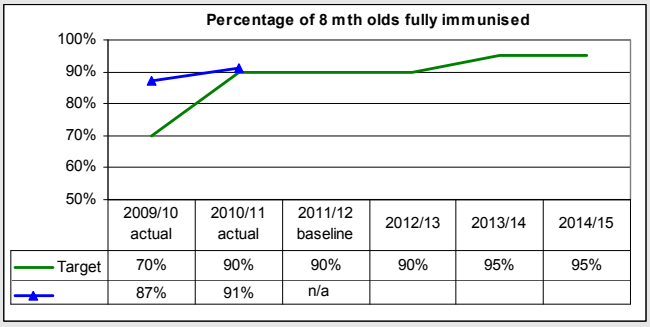


Output Class - Prevention Services

Main Areas of Performance: Immunisation, Well Child, School Health Services

- Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of disease and preventing them from spreading to vulnerable people or population groups
- **Impact or Strategic Outcome***:* Health risk is reduced; people are healthy, able to self manage and live longer; Improved health status of children

Note: data from 2009/10 to 2011/12 relates to percentage of 2 year olds fully immunised. Change of indicator from 2012/13.



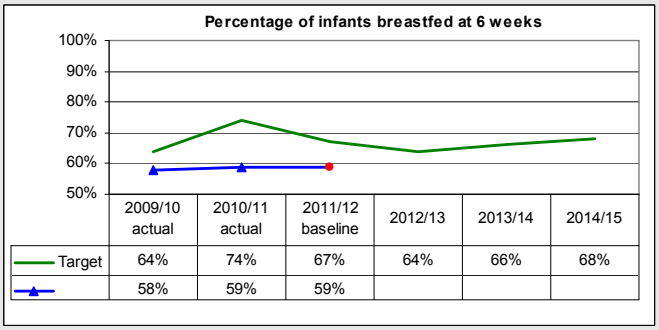
	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	70%	90%	90%	90%	95%	95%
	87%	91%	n/a			

Increased Percentage of infants breastfed at 6 weeks

Output Class - Prevention Services

Main Areas of Performance: Health Promotion and Education Services

- Good nutrition (including breastfeeding), 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.
- **Impact or Strategic Outcome**: Health risk is reduced; people are healthy, able to self manage and live longer; Improved health status of children



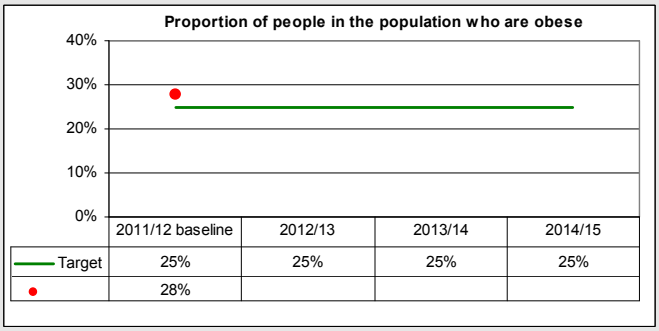
	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	64%	74%	67%	64%	66%	68%
	58%	59%	59%			

A reduction in obesity prevalence amongst the Hutt Valley DHB population

Output Class - Prevention Services

Main Areas of Performance: Health Promotion and Education Services

- 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.
- **Impact or Strategic Outcome**: Health risk is reduced; people are healthy, able to self manage and live longer.



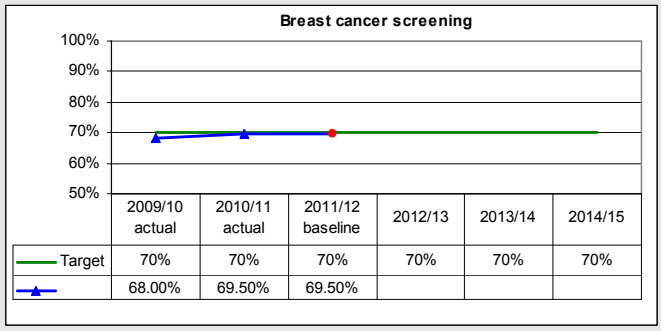
	2011/12 baseline	2012/13	2013/14	2014/15
Target	25%	25%	25%	25%
	28%			

Obesity prevalence is obtained from NZ Census.

Breast cancer screening - percentage of eligible population screened every 2 years[7]

Output Class - Prevention Services
Main Areas of Performance: Population Based Screening Programmes

- Early identification of breast cancer improves the chance that it can be treated successfully.
- **Impact or Strategic Outcome:** Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; lower mortality rates and better health outcomes.

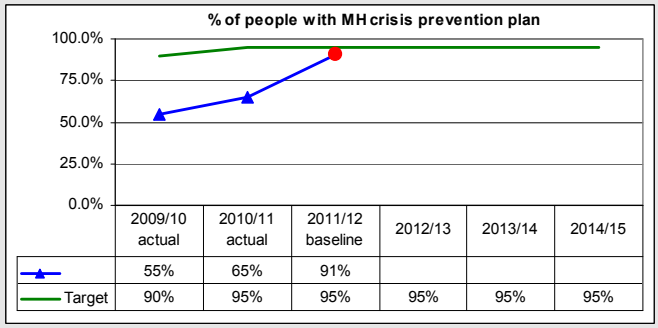


	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	70%	70%	70%	70%	70%	70%
	68.00%	69.50%	69.50%			

Reduced number of people experiencing a mental health crisis - % of people with crisis prevention plan

Output Class - Early Detection & Management Services, Intensive Assessment and Treatment Services, Rehabilitation and Support Services
Main Areas of Performance Mental Health Services – including community and support services

- 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 are minimised. Effective prevention planning can be expected to contribute materially to improved outcomes for clients.
- **Impact or Strategic Outcome:** Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; better health outcomes. A significant number of programmes have been implemented to improve the opportunities for early intervention and planning to reduce relapses. These activities are expected in turn to reduce readmissions. Access to the most appropriate hospital services.



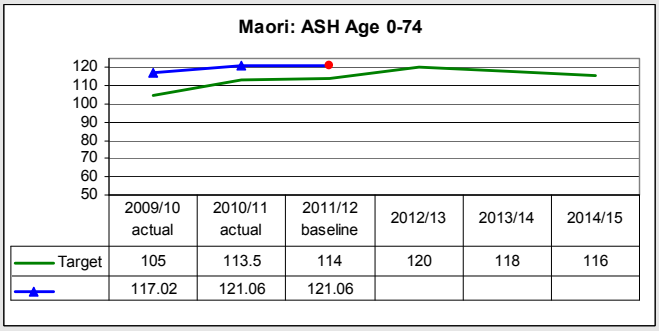
	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
	55%	65%	91%			
Target	90%	95%	95%	95%	95%	95%

2011/12 baseline actual as at Q2 2011/12

Reduced avoidable hospitalisations – rates of ambulatory sensitive hospitalisations

(expressed as ratio of observed to expected for each aged group where 100 is benchmark – lower is better)

Output Class Prevention Services,
Early Detection & Management Services, Intensive Assessment and Treatment Services, Rehabilitation and Support Services
Main Areas of Performance Immunisation, Well Child, School Health Services, Primary Health Care Services, Oral Health Services, Primary & Community Care Programmes, Mental Health Services, Community Nursing Services

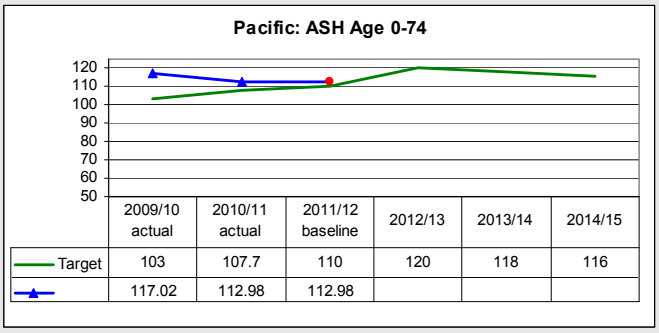


	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	105	113.5	114	120	118	116
	117.02	121.06	121.06			

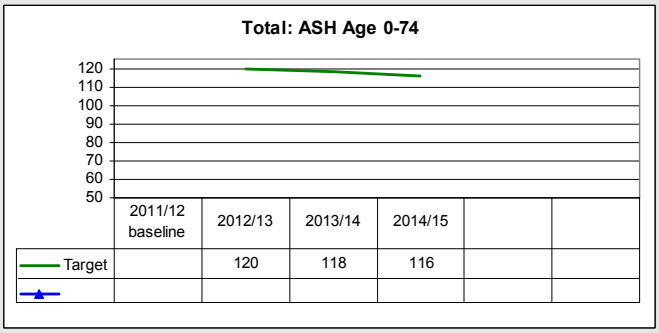
[7] The Ministry of Health sets breast screening coverage target rates based on targets for reduced mortality (breast cancer). For example if 70% of eligible women are screened for breast cancer then we can expect a 30% reduction in mortality amongst the screened population.

- 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 highlights disparities between different population groups.

- Impact or Strategic Outcome: Services Closer to Home, Clinical Leadership, Health of Older People; Health risk is reduced; people are healthy , able to self manage and live longer; Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; better health outcomes. A significant number of programmes have been implemented to improve prevention, access to primary care and the opportunities for early intervention. These activities are expected in turn to reduce avoidable hospitalisations. Improved health status of children; Integration



	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	103	107.7	110	120	118	116
	117.02	112.98	112.98			



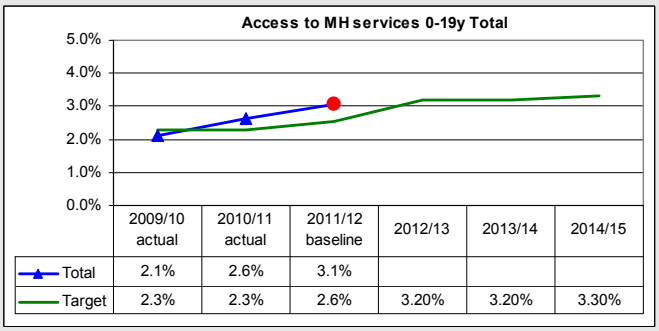
	2011/12 baseline	2012/13	2013/14	2014/15		
Target		120	118	116		

Improved access to mental health services

Output Class Early Detection & Management Services, Intensive Assessment and Treatment Services, Rehabilitation and Support Services

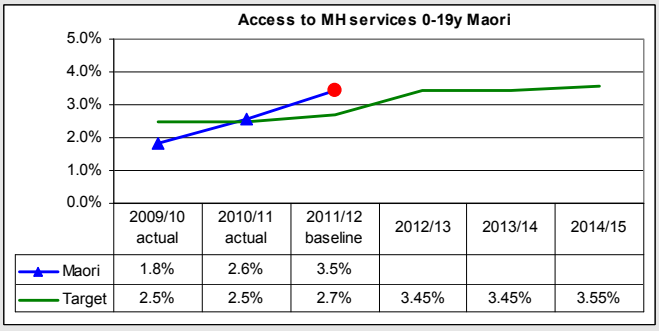
Main Areas of Performance Community Mental Health Services, Mental Health Services, Community Mental Health Support Services

- Percentage of population accessing mental health services for different ethnic groups and by age group, compared to the 3% of the population that are estimated to have severe mental health disorders, provides a measure of access and availability of mental health services.
- Impact or Strategic Outcome: Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; better health outcomes. A significant number of programmes have been implemented to improve access to care and the opportunities for early intervention. Integration



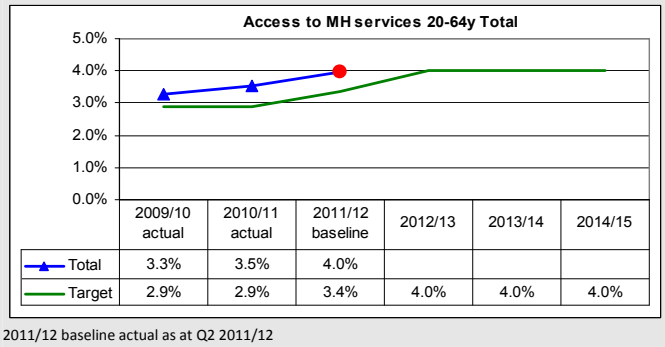
	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Total	2.1%	2.6%	3.1%			
Target	2.3%	2.3%	2.6%	3.20%	3.20%	3.30%

2011/12 baseline actual as at Q2 2011/12



	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Maori	1.8%	2.6%	3.5%			
Target	2.5%	2.5%	2.7%	3.45%	3.45%	3.55%

2011/12 baseline actual as at Q2 2011/12



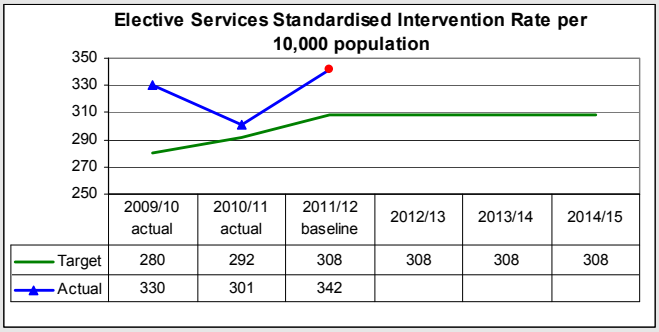
	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Total	3.3%	3.5%	4.0%			
Target	2.9%	2.9%	3.4%	4.0%	4.0%	4.0%

2011/12 baseline actual as at Q2 2011/12

Elective Services Standardised Intervention Rate[8]

Output Class: Intensive Assessment and Treatment Services
Main Areas of Performance Elective Services

- Access to elective surgery is one of the ways we know our hospital services are delivering the services New Zealanders need in an efficient way.
- **Impact or Strategic Outcome**: Improved access to services means people are diagnosed and managed earlier and better, with better outcomes. Access to the most appropriate hospital services

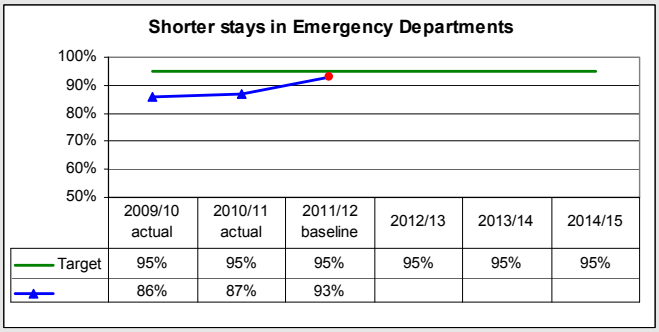


	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	280	292	308	308	308	308
Actual	330	301	342			

Increased % of people attending EDs have wait times of less than 6 hours

Output Class: Intensive Assessment and Treatment Services
Main Areas of Performance Acute Services

- People will receive better health services when they have improved access to diagnostic tests, faster cancer treatment, shorter waits for elective surgery, and shorter waits in Emergency Departments.
- **Impact or Strategic Outcome**: Improved access to and timeliness of services means people are diagnosed and managed earlier and better, with better outcomes. Access to the most appropriate hospital services



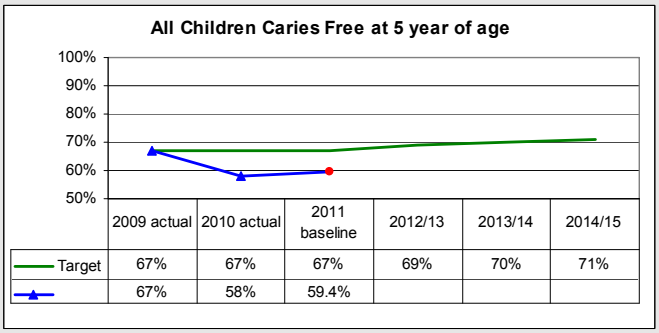
	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	95%	95%	95%	95%	95%	95%
	86%	87%	93%			

2011/12 baseline actual as at Q2 2011/12

Improved oral health in children – children caries free at 5 years of age

Output Class - Early Detection and Management Services
Main Areas of Performance Oral Health Services

- 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 health providers, are influencing the oral health status of children.
- **Impact or Strategic Outcome**: Health risk is reduced; people are healthy , able to self manage and live longer; intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; better health outcomes. These activities are expected in turn to reduce avoidable hospitalisations. Improved health status of children



	2009 actual	2010 actual	2011 baseline	2012/13	2013/14	2014/15
Target	67%	67%	67%	69%	70%	71%
	67%	58%	59.4%			

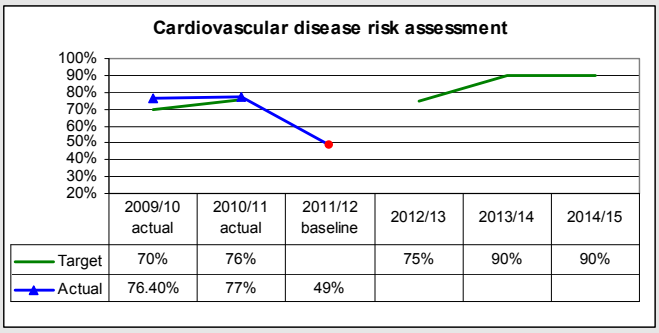
[8] Standardised intervention rates measure a DHB's delivery of elective services relative for their population, relative to other regions.

Cardiovascular disease risk assessment: *(Health Target)*

Output Class - Early Detection & Management Services

Main Areas of Performance: Primary & Community Care Programmes

- Early detection of CVD risk enables improved management of risks, leading to reduced acute hospitalisations, and improved self care.
- **Impact or Strategic Outcome**: Intervention is early; people who are at risk of illness or injury are diagnosed and managed earlier; better health outcomes. A specific programme has been implemented to improve the opportunities for early intervention. These activities are expected in turn to reduce avoidable hospitalisations; Integration



	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	70%	76%		75%	90%	90%
Actual	76.40%	77%	49%			

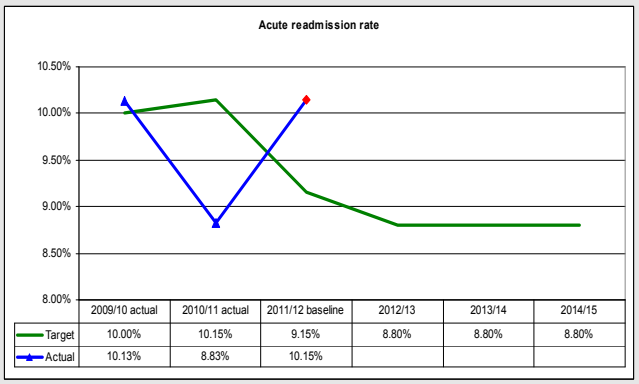
Note: The reduction between 2010/11 and 2011/12 baseline (Q3 22011/12) is due to a change in measurement of this target.

Acute Re-admission rate

Output Class: Intensive Assessment and Treatment Services

Main Areas of Performance Acute Services

- As we work to reduce the length of time people stay in hospital, acute re-admission rates are a helpful indicator in ensuring people received appropriate care.
- **Impact or Strategic Outcome**: This is a *q*uality indicator**. If** acute re-admission rates climb over time, it can suggest that better discharge processes are needed, more community support is required, or lengths of stay may in some cases need to be longer. Access to the most appropriate hospital services



	2009/10 actual	2010/11 actual	2011/12 baseline	2012/13	2013/14	2014/15
Target	10.00%	10.15%	9.15%	8.80%	8.80%	8.80%
Actual	10.13%	8.83%	10.15%			

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. They have been developed with the assistance and guidance of Te Awakairangi Health, the Hutt Valley Primary Secondary Strategy Group, and our Maori Partnership Board.

3.1 PRIORITIES AND TARGETS

DHBs and the Ministry of Health are charged with giving effect to the overarching goal for the health sector of *Better, Sooner and More Convenient* health services for all New Zealanders (BSMC services).

Key principles that are foundational to planning in order to achieve BSMC services are:

- Using a partnership approach to service planning in which (primary/secondary) clinicians and (primary/secondary) managers jointly agree service priorities along with appropriate funding levels.
- Using a whole of system view to determine the most efficient model of service delivery, and to ensure service planning is not done in silos.
- Providing a different model of care that incorporates a range of 'hospital' services to be delivered within community/primary care settings.
- Active engagement of 'front-line' clinical leaders/champions in health services delivery planning across the sector at both local and regional levels.
- Integrating and coordinating clinical services to provide greater accessibility and seamless delivery.
- Strengthening clinical and financial sustainability.
- Making better use of available resources.

Three important policy drivers have been identified through which the health sector may best utilise resources to achieve BSMC services – regional collaboration, integrated care (clinical and systems focused) and continuing to seek better value for money. These terms have the meanings below.

- **Regional collaboration:** DHBs working together more effectively, whether regionally or sub-regionally.

- **Integrated care:** includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services.

- **Value for Money:** is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

3.1.1 Government priorities

Specific areas of focus within the policy settings described above are presented in the Minister's Letter of Expectations. The priorities are:

- Integrated Care, including child and youth initiatives
- Shorter Waiting Times[9]
- Health of Older People
- Regional Integration, including cardiac services
- Whanau Ora Services
- Living within our means

3.1.2 Health Targets

The Government has also required DHBs to work to deliver a set of Health Targets. For 2012/13, these are:

- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment (radiotherapy and chemotherapy)
- Increased immunisation
- Better help for smokers to quit
- More heart and diabetes checks

3.1.3 Local priorities

Local priorities not already included through Government Priorities are:

- Improving our Hospital – processes and culture
- Prevention and Earlier Intervention

[9] Included within the Integrated Care Priority, and the Improved access to elective surgery and Shorter waits for cancer treatment (radiotherapy and chemotherapy) Health Targets.

Government Priorities

Government Priority: Integrated Care / Local Priority: Integrating health services into a more unified system

(Includes aspects of Shorter Waiting Times priority)

Comment: This priority is an Annual and Strategic Priority for Hutt Valley DHB in 2012/13, 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. Hutt Valley DHB has made significant progress against this priority in 2011/12. 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,, 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. The Hutt Valley Primary/Secondary Strategy Group has been leading development of integrated care pathways, and in improving the interface between primary and secondary care. In 2012/13 we will continue and increase our emphasis on working as an integrated system.

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
More connected Planning		.	
Improve alignment in the annual planning processes of the DHB, Te Awakairangi Health and Hutt Valley Primary and Secondary Strategic group (PSSG)	Strategic plans of the DHB and Te Awakairangi are developed collaboratively	Alignment of planning will ensure that issues are identified early and joint development of solutions will result in better implementation of solutions, leading to better patient outcomes	Service Delivery is better sooner and more convenient, & the health system is adaptive, innovative and continually improving New Zealanders living longer, healthier and more independent lives
Work with PSSG, Te Awakairangi PHO, and other appropriate stakeholders to agree relevant work programmes.	Programmes agreed		
CVD - In consultation with Te Awakairangi Health develop a collaborative approach to monitoring progress against agreed CVD PPP targets.	Increase the number of CVD risk assessments undertaken (refer also More Heart and Diabetes Checks Health Target)		
Smoking - RPH Smoke free coordination team will continue to work closely with primary care to increase the number of clinicians receiving ABC training.	An increased number of ABC training sessions are delivered for Primary Care.		
Diabetes – Implementation of the Hutt Valley Diabetes Care Improvement Package from 1 July 2012 - details are included at Appendix 8.8)	Implementation of Diabetes Care Improvement package and monitoring against agreed measures.		

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
Improving Medicines Management Identify and reduce medicine related admissions to hospital • Quantify and identify medicine related admissions to secondary care • Ensure community pharmacies develop medication management plans in consultation with GPs Develop effective patient focused medicines management • Implement synchronisation across all Hutt Valley community pharmacies • Support implementation of national pharmacy contract, for example promoting the service to General Practitioners	Approach to measurement agreed Medication related admissions reduce Medication management plans developed	People will have better managed care, and will need to go to hospital less.	
Improving Access to Diagnostics			
Identify and implement actions to improve access to radiological diagnostic procedures for primary care referred patients, including: ▪ In partnership with PSSG, implementing clinical criteria community radiology trial, reviewing trial, rolling out improved access as appropriate. ▪ Review the 2011/12 primary care nurse led "Nurse Laboratory Testing" project to develop consistent processes and protocols required to support access to nurse laboratory testing, and roll out as appropriate	Trial completed, reviewed, and rolled out as appropriate by March 2013 Project completed, reviewed, and rolled out as appropriate during 2012/13.	Changes in referral criteria to community radiology will mean access is based increasingly on clinical need	
Collect, measure and monitor diagnostics wait-times measures – Note; Coronary angiography procedures are not performed at this DHB and are not planned to be.	75% of accepted referrals for a CT or MRI scan will receive their scan within 6 weeks (42 days) 50% of *urgent* diagnostic colonoscopies will occur within two weeks (14 days) 50% of diagnostic colonoscopies will occur within six weeks (42 days) 50% of surveillance or follow up colonoscopies will occur within twelve weeks (84 days) of the planned date.		

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
Work with PSSG to identify clinically agreed opportunities for improved primary care access to diagnostics.	PSSG considers and provides recommendations by December 2012.		
Improving Patient Pathways, including for identified groups			
Work through PSSG to develop improved integrated prevention/primary/secondary patient pathways, including for people with the following ASH conditions: a. Cellulitis b. Gastroenteritis c. Dental conditions (for children) d. Respiratory	Action plans developed and implemented, ASH rates decrease in out-years Integrated pathways for highest priority area developed and implemented; ASH rates reduced for 0-4 year olds	Models of care crossing primary/secondary continuum will be more appropriate. Greater consistency in patient care management Better management of long term and chronic conditions	
Working through PSSG to improve patient pathways to Elective Surgery	Clinicians identify easier access and communication between GPs, DHB, SMOs and specialist nurses ESPI compliance achieved		
Identifying and implementing an IT solution to provide electronic clinical access to pathways (including agreeing information sharing protocols), and improving electronic access to patient records (including towards a shared electronic patient record).	IT solution agreed with primary care, and implemented	Greater consistency in patient care management	
Identify and implement actions to address the burden of long term conditions, including through: • working with (PSSG) to identify priority projects to improve treatment. This is integrally linked to the unplanned/acute care work, and to actions to address ASH rates. Current work plan includes Medication management; Clinical pathway development; and Shared care opportunities for Chronic Conditions. • Implementing Diabetes care Improvement Package • Review and Roll out (as agreed with primary care) Congestive Heart Failure clinic pilot	Reduction in ASH rates Reduction in Hospital Bed Days for people with long term conditions Projects will be identified and Targets will set by PSSG by end of September 2012	Better management of long term and chronic conditions	
Child and Maternity As a pilot DHB for the Maternity Quality and Safety Programme	Improved quality of Maternity service	Greater consistency in patient care	

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
the DHB will continue implementation of the agreed work Programme	delivery	management	
Continue to ensure GP details are captured in the Maternity Service records, and the DHB NIR administrator and Immunisation coordinator work closely link new mothers with Primary Care if they have not identified a G.P	Number of new mothers and children supported to enrol with Primary Care	Greater consistency in patient care management	
Continued delivery of DHB Funded Pregnancy and Parenting Education Sessions, with a particular emphasis on high needs/risk mums e.g.: teens and Maori. This includes delivery in of programmes in variety of settings including youth centres and marae.	Number of Pregnancy and parenting sessions delivered.	Better informed and prepared new mothers and families.	
We will continue to meet targets of timeliness and appropriateness of referred services for children through the B$SC programme. We will work closely with Capital Coast DHB to improve efficiency of delivery through our shared provider of this service	Achievement of agreed delivery targets for the B$SC programme	Earlier identification and access to services for young children	
Implement agreed changes following the 2012 review of Primary Mental Health Services in the Hutt Valley	Changes in the model of care identified by the review will be implemented during 2012/13.	More comprehensive primary mental health services for the Hutt Valley population delivering more sustainable and equitable access. Increase motivation for self care and seeking help earlier Improve mental health and addictions promotion, prevention, early detection and intervention for all age groups	
Unplanned/acute care			
Implement initiatives to address the high level of avoidable hospitalisations in the Hutt Valley, building on current skin infection and gastroenteritis projects, including by working	Action plans developed and implemented, ASH rates decrease in out-years	People will have better managed care, and will need to go to hospital less.	

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
through PSSG to identify further options for addressing ASH rates especially for respiratory conditions	A reduction in inpatient admissions from 13,370 to 12,968		
PSSG led workstreams to: (a) identify further non ASH related opportunities for reduction in ED attendances, acute inpatient admissions and bed days (b) Identify and implement opportunities to better manage acute demand	Identify volumes open to management in primary/community settings. No increase in acute bed days from 52,672 ED attendances will increase by no more than 3% down from 4%	People will have acute care managed in primary settings where appropriate, and will need to go to hospital less.	
Agreement and achievement of target for the prevention of readmissions for 75+ population (and any other target populations)	Maintaining readmission rate of 11.73% for people under 75 years which is well below the national average		
Negotiate contractual arrangements with primary care, and with guidance from PSSG, implement zero fee after hours GP visits for children under six	Provision of 100% access to free after hours care for under 6 yr olds by 30 June 2013.		
Service Integration Work with the Ministry of Health to identify and implement changes to funding arrangements which will increase funding flexibility to primary care. Work with PSSG to identify opportunities for guidance and leadership on investment and disinvestment decisions.		Changes in the location of services are expected to result in sooner and more convenient 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.	An efficient and sustainable health system that enhances primary health care's significant role in the design and delivery of health services.

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
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: ▪ Evaluate pilots run during 2011/2012 that provided services in the "right place" in the continuum of care of patients. Where appropriate, work with primary care to agree roll out of successful pilots to the wider Hutt Valley. Pilots include: • Congestive Heart Failure clinic pilot • Skin infection nursing innovation • Secondary services delivered in primary mental health clinics • Radiology Referral Criteria ▪ Dietician clinics in practices ▪ Gastroenteritis pathway for paediatrics ▪ Develop a home based treatment team to provide appropriate mental health treatment in Service Users' homes. ▪ As agreed with Primary Care, increase the number of clinics/MDT meetings in the community (for example, respiratory, cardiac) ▪ Assess linkages within our hospital ambulatory care services (for example community health, diabetes, respiratory, Older Persons community team), and identify opportunities for efficiencies or changes to increase delivery in community based settings.	Trials reviewed and findings implemented in agreement with primary care. Improvement in ASH rates, and co-ordinated management of long term conditions Reduction in inpatient bed days and length of stay in mental health inpatient service. Increase in clinics run by DHB employed clinicians within the primary care environment. [10] Assessment completed and opportunities for improvement identified and progressed.	Provide better linkages between chronic care services that will improve the patient's experience; Identify better ways that the DHB can integrate work with or devolve work to the community	
Continue work to expand the primary care workforce and enhance its capability, including development of clinical			

[10] A "clinic" in this case can be either a MDT meeting (GPs, DHB SMOS, primary care nurses and DHB CNSs or allied health) at which a number of patients are discussed or it can be a focused appointment opportunity for primary care patients to be assessed, managed and treated in primary care by secondary clinicians who liaise with primary care for ongoing management.

The actions we'll take this year	Measured by	How they will help	In support of system outcomes
leadership. This includes: ▪ Provide/contribute to educational support for primary care as agreed with primary care ▪ Ongoing access to education fund for primary care nurses to upskill at Hutt hospital ▪ Administering the primary nurse innovation fund to support innovation projects ▪ Ongoing primary care nursing access to the Hutt Valley DHB Professional Development and Recognition Programme ▪ Continue to provide mentoring and support to people seeking to qualify as nurse practitioners ▪ Hutt Valley DHB Summer Student Programme, which exposes second and third year medical students to primary and secondary practice. ▪ Upskill primary care clinicians to increasingly manage conditions currently managed in secondary settings.	Education courses agreed and provided.		

Government Priority: Regional Collaboration / Local Priority – working with our neighbours

Comment: In addition to our work with the wider Central Region, we also work closely with our neighbours – Wairarapa DHB and Capital & Coast DHB. The 3DHB HSD is a collaboration programme between Hutt Valley, Wairarapa and Capital and Coast DHBs. The focus of the programme is to take a whole of system approach that spans the health continuum that will enable the greatest gain to the patient / whanau experience, population health and clinical and financial sustainability consistent with the Triple Aim Approach. As already outlined in module two good progress has already been made. The following table outlines the eight key actions that have been agreed by the SRCLG that will be progressed by the Wairarapa, Hutt Valley and Capital and Coast DHBs as part of our collaborative work programme for 2012/13. These sub regional actions are also reflected in the RSP.

The actions we'll take this year	Timeframe for delivery	How they will help	Measured by	In support of system outcomes
Implement agreed recommendations from the completed service reviews: - ENT - Child Health - Gastroenterology	Quarter 1 Quarter 4 Quarter 3	A single service approach will assist with workforce sustainability challenges, improve equity of access and improve the quality of care (against the 7 quality parameters)	Recommendations are implemented within agreed timeframes and fiscal parameters	Mobile and flexible health workforce Improved quality of care Improved patient / whanau experience
Consult on the development of a 'single service' approach for General Surgery , Orthopaedics , Breast Surgery and Anaesthetics across the 3 DHB's	Quarter 3		'Single service' approaches for the named specialties will be considered by the SRCLG and recommendations forwarded to each Board	
Utilise sub-regional radiology capacity – equipment and staff – to reduce radiology wait lists and improve equity of access to diagnostic services	Quarter 2	Wait times for diagnostic services will reduce and imaging equipment will be utilised to its full potential	Wait times for diagnostic radiology referrals	Improved quality of care Efficient use of infrastructure investment Improved patient / whanau experience
Implement the outcomes of the consultation process on a sub-regional approach to planning and funding functions	Quarter 2	Planning and funding functions support a collaborative sub-regional / whole of system approach to service delivery	Recommendations are implemented within agreed timeframes and fiscal parameters	
Human resource and occupational health and safety policies and practices across the 3 DHB's will be aligned	Quarter 4	This will enable joint appointments / shared staffing arrangements to be more easily implemented		

The actions we'll take this year	Timeframe for delivery	How they will help	Measured by	In support of system outcomes
Complete capacity analysis work for the 4 facilities / 3 DHBs that considers physical, workforce and equipment capacity	Quarter 1	Capacity information, collected in a consistent manner, will aid clinicians in considering 'single service' approaches to improve the utilisation of scarce workforce and capacity resource	Capacity information is utilised by services in considering 'single service' approaches	Improved patient / whanau experience Improved utilisation of scarce resources
Collaborate on the implementation of a Finance Management Information System (FMIS) solution that is consistent with the national FMSS approach	Quarter 4	A consistent FMIS will improve data collection, procurement knowledge and enable shared service delivery as per direction by HBL	Agreement to implement FMIS solution at HVDHB and WDHB	Value for money
An alternative funding approach to IDFs will be developed and piloted as part of a 'single service 'implementation	Quarter 2	Funding arrangements should incentivise providers to deliver services consistent with design principles, the IDF mechanism has been highlighted as a deterrent to a 'single service ' approach	Implementation and evaluation of an alternate funding mechanism	Improved patient / whanau experience Improved quality of care

Government Priority: Health of Older People (HOP)

Comment: 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 will continue to use InterRAI assessments to determine access to home based support services for older people and to aged residential care. In 2012/13 we will further increase our focus on this key population.

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
At a regional and sub regional level:			New Zealanders living longer, healthier and more independent lives. In line with *Ageing in Place*, older
Planning for meeting the future needs of our aging population in conjunction with Wairarapa and Capital and Coast DHBs.	Better integration of services going into aged care. Improved quality of care for elderly receiving services.	Joint actions agreed and implemented	

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
Adopt the Central Region Integrated Framework of Care for Older People, focussing on: ▪ Comprehensive clinical assessment ▪ Improved coordination ▪ Monitoring of outcomes. Participate in national HOP Steering Group work to identify core quality measures for HOP services	The DHB will continue to participate in Central Region HOP benchmarking and will participate in nation wide benchmarking for Older People on core quality measures as identified by the DHB HOP Steering Group.	Benchmarking indicators (including for readmission rates) are confirmed. Benchmarking results are available for analysis.	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
Continue to work with regional and subregional DHBs to align service allocation for long term support.	People moving within the region have consistent service delivery.	Eligibility criteria agreed.	
At a local level:			
Specialist staff providing support and expertise to Aged Residential Care (ARC), Home Based Support Services (HBSS) and primary care will meet regularly (6 weekly). Specialty includes: geriatricians, psychogeriatricians, palliative care, Nurse Practitioners (medical and mental health) & wound care nurses.	Greater integration of specialist services into aged care.	Number of facilities with 3 year certification increases (improved care planning and management will assist with achieving longer certification).	
Increase the number of facilities participating in the Nurse Practitioner education and support initiative from three to nine.		Number of facilities increased to nine; Surveys undertaken pre and post education and support initiatives demonstrate improved knowledge	

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
Trial, with support of PSSG, a Post- Acute care service to support frail older persons who are discharged from MAPU An assessment of the MAPU and ED pilot where rehabilitation support worker and registered nurse provide discharge oversight and ensure home supports needs are assessed sooner. Continue to monitor our readmission rates for over 65's and maintain our low rates against the national average. The DHB is committed to supporting smarter services for older people from its share of the $3 million identified from pharmaceutical savings	Will allow quicker discharge for patients who need community support and will avoid admission for others while social supports are being organised.	Service developed, trialled, and reviewed. Maintain acute re-admissions for over 75s at 11.73%	
Improve integration between hospital community services for older people and community based providers to better co-ordinate care. Specific actions will include: • Co-ordinated contact points for service providers • Discharge summaries provided to community providers • Dementia pathway developed with involvement of hospital specialists, primary care and community based provider through a joint working groups comprised of these groups. • Formalise a dementia pathway in conjunction with Capital & Coast DHB. • Develop education opportunities with Alzheimers NZ for carers and staff working in aged care. • The DHB is committed to the development of dementia pathways form its share of the $2.5 million identified from pharmaceutical savings	Improved quality of care, and sustainability of care provided at home. Improved quality of care – people with dementia will experience improved care from professional and informal carers.	Dementia e-learning tool available across the Region by June 2013 Reduced acute re-admissions for over 75s Dementia pathway implemented by June 2013	
Respite Monitor progress of two dedicated respite beds, with service coordination providing bed management.	Carers will be able to book respite in advance – thereby improving their ability to sustain care giving.	40% occupancy in first 12 months; Carers satisfaction with respite service > 80%.	

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
InterRAI All assessments for long term funded support are undertaken using an interRAI assessment. All clients receiving long term funded support are reviewed using an interRAI assessment. We will work with the interRAI Long Term Care Facility project to support all facilities that opt into the programme in the Hutt Valley. Includes providing Systems Clinician and Lead Practitioner time and expertise.	Standardised and audited assessment –improved matching of need to service allocation. Reduction in duplication of assessment and planning. Improved risk assessment and care planning.	100% of people receiving long term funded support have a Comprehensive Clinical Assessment (using any of the interRAI assessment tools) within the year. 25% of long term residents in the number of facilities set out in the implementation plan have a care plan developed by utilising Comprehensive Clinical Assessment (using any of the interRAI assessment tools).	

Government Priority: Child and Youth Mental Health

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
Build the capacity and capability of specialist infant child and youth mental health and addiction services to improve the responsiveness of CAMHS services to local, sub regional, and regional populations. Build effective accessible specialist and youth AOD services that reduce alcohol-related harm. Continue to strengthen formal links between PHO, NGO and other DHBs who deliver child and youth mental health and addictions services. This includes other agencies such as CYPS, Special Education. Continue to provide services that ensure adolescents / young people have access to timely and youth accessible services from assessment to follow up (such as youth one stop shops, school based services) that are well integrated into local physical and mental health and addictions, and social services.	A health system that functions well for child and youth mental health and addiction services is one that is responsive and addresses inequalities with a particular focus on Māori through: • building resilience • being recovery focused • supporting self management • early intervention • integrated services	Identify progress towards or maintenance of a target for 3% of child and youth population seen by specialist mental health and addiction services. PP6: Improving the health status of people with severe mental illness through improved access. PP8: Shorter waits for non-urgent mental health and addictions services, 80% of people seen within 3 weeks and 95% within 8 weeks.	A more unified and improved health and disability system. People receive better health and disability services. Good health and independence are protected and promoted.

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
Continue to share strategic development planning, training, peer support and supervision with CCDHB. As opportunities arise continue to develop specific training packages with the Werry Centre and participate in relevant programmes the Werry Centre and Te Pou offer through out the year. Participate in regional efforts (through the regional Mental Health and Addictions Network) to improve youth forensic services.			
Improving co-ordination between existing providers delivering brief interventions, group programmes and classes, to enhance efficiency and access. Work with existing youth one-stop-shops and PHOs to identify and implement options to improve integration into primary care			

Government Priority & Local Priority: Financial Sustainability

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. We will also undertake an internal efficiency programme to improve our financial sustainability, while maintaining service coverage and quality.

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
At a national level: Identify Shared Services actions aligned with Health Benefits Limited (HBL) work programmes as agreed ***At a sub-regional level:*** Gain efficiencies in non-clinical support area including finance, 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:*** . Undertake an efficiency optimisation improvement programme including addressing (inter alia): • Improving hospital discharge processes and reducing unnecessary patient time in hospital • Better management of staff leave • Implementing a staff management and rostering tool to ensure correct staffing levels and mix • Optimising the surgical patient pathway • Best practice prescribing For further detail see Paragraph 7.4	Effective delivery of services while releasing resources to support other services. Improved clinical and financial sustainability of services	Progress on delivery of actions aligned with HBL work programmes as agreed and reported on in monthly financial reports. Review of laundry and payroll services complete by December 2011, see RSP for further details Faster and more streamlined recruitment of all staff/ disciplines (for further measures see RSP) Hutt Valley DHB financial performance at breakeven for 2012/13 Demand levels stay within or improve against forecast levels	Increasingly efficient utilisation of resources and service delivery New Zealanders living longer, 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 to providing shorter stays for patients in our Emergency Department (ED). Our target is that 95% of all patients will be admitted, discharged, or transferred from the ED within 6 hours. Reduced ED length of stay arises from 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. Our performance against this target has improved (now regularly in the mid 90%) through a combination of process improvements, close monitoring, and operation of our new ED. Meeting the target in the future will require a continuation of our work on our processes, and also significant work with our primary care partners to identify how as a system the Hutt Valley can care better for acute patients by a greater emphasis on management in primary care (where clinically appropriate).

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Process		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
Continue diagnostic work to identify the main factors impacting on ED Length of Stay, therefore ensuring that the main constraints and bottlenecks are addressed first.	Allows resources to be focused on areas that will make the biggest difference to improving management of acute services.			
Work through PSSG to identify client groups including frequent attendees who would more appropriately be managed in primary care, and potential solutions.	Work to more appropriately manage "demand" for ED services, and assist patients to receive the most appropriate type of care.			

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Implement changes to models of care including: • Develop and formalise an RMO escalation plan to bring extra medical resources to the front door when medical patient presentations/wait times reach a critical point • Strengthen the interface between ED and the Medical service through regular ED/patient flow meetings • Increase the allied health resource and focus on the ED through the regular ED/patient flow meetings • Pilot a Senior nurse role to coordinate the patient flow between ED/MAPU/Medical • Improve process (especially timeliness) for discharge into the community	Improves ability of ED service to meet demand levels "real time". Breakdown of siloed working roles leading to faster and better communication and decision making between clinicians. MDT discussions will highlight areas of bottleneck that require review Coordinate the patient journey and focus on the patient's progress, leading to improved patient flow. Facilitates timely assessment, treatment and discharge of a cohort of patients who can be managed in a shorter time frame, freeing up beds for ED admissions			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.
Culture				
Increase focus on expectation of achieving Health Target during registrar induction Closer monitoring (daily, weekly as appropriate) of Target Performance. Continue to socialise a new way of working (with new rotations of junior doctors and new staff etc) that emphasises the importance of the Target.	Acceptance of the patient's experience as being paramount 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 (Includes aspects of Shorter Waiting Times priority)

Comment: Hutt Valley has consistently met its annual Electives Health Target. The DHB is committed to the effective management of patients who have received a commitment to surgery or FSA within a maximum 5-month waiting time. We will also continue with our work to support increasing referrals for delayed breast reconstruction.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Allocate Electives funding to continue to support our increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care.	Improved access to elective services	4,946 elective discharges	Meeting the health target. Our Elective service standardised intervention rates will meet expectations by June 2013	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.
Strengthen our relationships with service providers within our sub region to provide an appropriate level of surgical procedures, and meet regional targets.	Maximise public capacity to deliver surgical procedures		Meeting the health target during the 2012/13 year	
Patients will be prioritised for treatment on national tools, and treatment will be in accordance with assigned priority.			Increased uptake of national CPAC tools to improve consistency in prioritisation decisions.	
Streamline the patient journey from GP referral to FSA to surgery (where needed) to improve resource utilisation and meet the elective health target and waiting times target	Maximise appropriateness of referrals; Assist to manage wait times for patients; Patient will have timely information about their surgery date		Improved conversion rate from FSA to surgery All patients will wait 5 months or less for first specialist assessment and treatment by June 2013.	
Review our theatre rosters to optimise use of theatre time	Minimise cancelled theatre bookings		Less than 5% of patients will be cancelled on day of surgery; by June 2013 Theatre Utilisation targets met; OS6: % of day surgery; OS7: day of surgery admissions (DOSA) by June 2013	

Health Target: Cancer Services - Shorter waits for cancer treatment (Includes aspects of Shorter Waiting Times priority)

Comment: Hutt Valley DHB works closely with its provider Capital & Coast DHB to deliver radiotherapy and chemotherapy services. The relationship has been highly successful, with the Health Target being met in 2011/12. 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.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Sustain performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources; and investing in workforce and capacity as required. Work with Capital & Coast DHB to streamline workflow from Hutt Valley DHB FSA to: • start of treatment to ensure patients start treatment within four weeks of specialist FSA. • specialist FSA in order to meet Faster Cancer Treatment indicator targets. Identify actions to establish data collection systems to support service improvements along cancer patient pathway. Work with Central Cancer Network in implementing a multi-disciplinary meeting (MDM) conferencing solution to improve access to MDMs by identification of equipment required to enable full participation as a "Host Centre". Development of electronic MDM forms in conjunction with the Central Region Cancer Network and the two regional cancer centres based in Capital Coast and Mid- Central DHBs.	Minimisation of Hutt Valley DHB portion of waiting time.	Everyone needing radiation and chemotherapy 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 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). Report waiting time information for Measure DV1 Improving cancer treatment (establishment of baseline). Number of patients discussed in MDMs increases. Number of workshops 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 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.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Work with Wellington Cancer Society to provide workshops for Maori and Pacific communities to improve knowledge of and timely access to cancer services. Working with CCN on other projects as they develop			Maori and Pacific communities undertaken.	

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 we are on track to meet the Health Target of 95% during 2011/12. The National Health Target has now changed to (by 2014) 95% of 8 mth olds will have completed their scheduled vaccinations. We will continue to work with our primary care and community partners to achieve this new target.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
In collaboration with primary care stakeholders, identify actions to achieve improved immunisation including but not limited to: • develop a system for seamless handover of mother and child as they move through antenatal care, maternity care, birth, Well Child, and primary care • maintain the inclusion of general practitioner details on maternity services booking forms, and actively utilise follow up system where these details are not recorded. • monitor newborn enrolment rates • monitor and evaluate coverage at DHB, PHO and practice level and identify and manage service delivery gaps • identify immunisation status of children going to hospitals and refer for immunisation.	Process and system improvements and better integration across primary care, OIS, paediatric outpatients, and the NIR teams	The national immunisation goal is (by 2014) 95% of 8 mth olds will have completed their scheduled vaccinations.	Achieve 85% rate at eight months for all, Maori, Pacific and Other groups by 30 June 2013; 90% overall by 30 June 2014; and 95% overall by 30 December 2014 Maintain and increase coverage for ethnic and deprivation groups Increase number of children enrolled in a PHO by 8 weeks of age	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 vulnerable people ("herd immunity").

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Maintain an immunisation steering group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit, and which participates in regional and national forums.			Group maintained	
Consult with and provide feedback to stakeholders to improve system processes and outcomes.				
Identify actions to: • improve access to immunisation by developing service delivery models that suit different populations • encourage all child health professionals check the immunisation status of all infants and refer for immunisation at every opportunity • deliver training for immunisation workforce • monitor and review performance of different service delivery models.			Maintain protocols with Well Child/Tamariki Ora and B4SC providers to increase immunisation uptake	

Health Target: Better help for smokers to quit

Comment: Hutt Valley DHB significantly improved its performance against this target over 2011/12, increasing to over 90%. 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 2011/12 targets, and establish a foundation for achieving 2012/13 targets.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Provide ABC Training and education for smoking cessation monthly to appropriate staff. Junior doctors have ABC smoking cessation on their quarterly training rotation.	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 will know, support and endorse each other's ABC approach to quitting.	95% of hospitalised smokers will be provided with advice and help to quit by July 2012. 90 percent of patients who smoke and are seen by a health practitioner in primary care or public hospitals, are offered brief advice and support to quit smoking. Within the target a specialised identified group will include: Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.	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 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
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).				
Hutt Valley DHB clinical champion will provide support to, and raise awareness of smokefree activities at senior clinician level.				

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Continue to provide ABC training to clinical staff working in primary care, drawing on the approach which has worked successfully in secondary care.		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 help to quit by July 2012 (reported through the PHO Performance Programme, broken down by ethnicity)		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.
Liaise with PHO in relation to data collection and reporting (managed by MoH and DHB Shared Services PHO Performance Programme) and assist PHOs (as required) in advocating for process and system improvements				
In agreement with primary care, identify actions to ensure that brief advice and help to quit provided in primary care improves on 2011/12 performance, including ▪ work with the Clinical Services Manager at Kowhai Health/Te Awakairangi Health PHO to identify gaps in ABC service in primary care in the Hutt Valley, including antenatal care; ▪ provide support services around ABC training and tracking systems such as MedTech. ▪ improving the interface between primary and secondary care referrals for smokefree work--particularly the recording of ABC between patients' secondary and primary care records. ▪ Identify options for patients and pregnant women identifying becoming smokefree, with the support of a primary care provider, as a clinical goal. Continue to support these initiatives through the delivery of our Tobacco Contract with the Ministry of Health, with funding allocated equitably to a secondary care advisor and a primary care advisor.				

Health Target: More Heart and Diabetes Checks

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. This will continue to underpin our activities to reach the updated Health Target, with its sharper focus on CVD checks.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
Work with Te Awakairangi Health Trust to identify actions that will improve performance on 2011/12 heart and diabetes checks provided in primary care. We will continue to work closely with both Te Awakairangi Health Trust and Cosine PHO to support them to reach the agreed performance targets for the CVD risk assessment indicator, with agreed incremental improvements over the next three years. The PHO will raise awareness of CVD and diabetes risk factors amongst practices and increase the number of assessments completed amongst the target population Early detection and subsequent management of CVD and diabetes involves follow-up education sessions delivered by practice nurses or GPs. The PHO will facilitate and co ordinate a range of supports to practices including: • CVD assessment training • CVD patient and clinician Resources • Predict Training Advise and practical assistance to set up CVD and diabetes assessment clinics PHO Staff, Outreach Nurses, Community Health Workers and Health promoters will assist by running "Heart check clinics" Providing Lifestyle management advice and supporting the target population to access services such as transport initiative. Implementation of Diabetes Care Improvement package (refer appendix 8.8) with the following areas of focus: • Intensive education at first diagnosis	Enhanced collaboration and co-ordination between primary and secondary care services, with better information sharing of patient information between primary, community and secondary providers Comprehensive, consistent service delivery across the Hutt Valley Apply previous "Get Checked" funding to areas of focus identified in the development of the Diabetes Care Improvement plan Practices will work with their patients to • improve management of diabetes • better identify people at risk of CVD and assist them to manage risks.	Increase the percent of the eligible adult population who have had a cardiovascular disease (CVD) check with in the last five years to 75%.	Percent of the eligible adult population who have had a cardiovascular disease (CVD) check with in the last five years. The eligible population in the Hutt Valley is 32,333 (PPP Data as at June 2011). Diabetes Care Improvement Package. PP20: Submission of quarterly reports re improved management for long term conditions (CVD, diabetes and stroke] Submission of quarterly reports through the PHO Performance Programme	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 receive better health and disability services'.

The actions we'll take this year	How they will help	To deliver the Health Target	Measured by	In support of system outcomes
• Standardised, periodic, clinical review – targeted to High needs groups • Workforce Support including skill development and maintenance for all practitioners • Allied Health services, including podiatry, dietetics and retinal screening We will work with the primary and secondary sector to agree appropriate outputs and measures as part of the implementation of the agreed Diabetes Care Improvement Plan. We will meet quarterly with our Local Diabetes Forum to ensure feedback and input from both a consumer and community perspective.				
Stroke Services: Continue to provide an organised acute stroke service for the DHB population (as recommended in the NZ Clinical Guidelines for Stroke Management) • The DHB will build on the existing dedicated stroke team. The team is developing a plan for 2012/13 which includes early supported discharge, transition to rehabilitation and possible slow stream rehabilitation as well as better services at the hospital front door. • The DHB stroke team is actively working with both the regional and national stroke clinical networks	Reduced acute length of stay for stroke patients An increased percentage of patients discharged to own home Be active members of regional and national stroke clinical networks	Develop community MDT Support early discharge	Stroke services PP20: Submission of quarterly reports re improved management for long term conditions (CVD, diabetes and stroke] ALOS Acute Stroke % patients discharged to own home	All people who have a stroke receive high quality, consistent care to ensure a return to the best possible quality of life.

Local Priorities

Our Annual Priorities are largely already addressed through the earlier sections covering Government Targets and Priorities (see above) The remaining priorities, Improving our Hospital, and Prevention and Earlier Intervention are addressed below.

Local priority: Improving our Hospital - Processes and Culture

The actions we'll take this year	How they will help	Aligns with Government Health Target or Priority	Measured by	In support of system outcomes
Patient Pathways Streamline the patient journey from FSA to surgery to improve resource utilisation and meet the elective health target Introduce the Ubook system improving the ability of patients to book appointments at their convenience	Patients will be established fit for surgery prior to being listed for surgery Patients will not wait longer than 6 months for surgery	Shorter Wait Times More Elective Surgery	Less than 5% of patients will be cancelled on day of surgery ESPI 2 & 5 compliant Improved conversion rate from First Specialist Assessment to surgery	New Zealanders living longer, healthier and more independent lives The health system is adaptive innovative and continually improving
Explore and develop more streamlined clinical pathways for surgical acute patients	Improved timeliness of discharge into the community		3 pathways will be developed Agreed timelines will monitored and targets set Reduction in Acute Average Length of stay	
Operationalise a Hospital Strategy Group Implementation and active support of a hospital strategy group (senior clinical group within hospital) to compliment existing structures.	Secondary clinicians increase involvement in strategic hospital management Improved clinical engagement in Hutt Hospital	Clinical Leadership	Improved results in Clinical engagement survey (ASMS *In Good Hands* Survey)	

The actions we'll take this year	How they will help	Aligns with Government Health Target or Priority	Measured by	In support of system outcomes
Working with our Neighbours Progress the 3D programme. Working together to improve the quality of care, manage risk, improve processes, sustain our collective workforce and make the best uses of our resources to a greater extent than working separately. See "Working with our Neighbours" priority table for further detail.	Improved clinical sustainability of service	Regional co-operation	Senior clinical membership of SRCLG continues. See "Working with our Neighbours" priority table for further detail.	
Improved collaboration with CCDHB – complete feasibility study for a single Laboratory Service across region, recommendations implemented as appropriate	Improved clinical and financial sustainability of service	Regional co-operation, Financial Sustainability	Feasibility study completed, and implemented as appropriate.	
Improve Discharge Planning Optimise discharge processes; including: • Pilot a Post- Acute care response team care service to support Frail older persons who are discharged from MAPU • Complete discharge lounge trial and transition to appropriate location. Use findings of this trial to extend the concept and increase utilisation.	Improve performance against Shorter Stays in ED Health target Improved theatre efficiency Patients will have greater certainty and will spend less time in hospital (where clinically appropriate) Discharging patients in a more timely manner will free up beds for ED and MAPU admissions	Health of Older People Shorter Stays in ED Health Target	Decreased ALOS (OS3) Reduced readmissions (OS8) Improved patient experience Shorter Stays in ED Health Target (Health Target)	

Local priority: Prevention and Earlier Intervention (Includes aspects of Whanau Ora services priority)

Prevention and Earlier Intervention is a way in which the health of individuals and populations can be improved with relatively low cost interventions at an early stage. Conditions can be prevented, and in other cases identified early, giving better potential outcomes for patients at a lower cost to the health system. The DHB has, with its community and primary care partners, achieved well in many aspects of prevention and earlier intervention. This can be seen from the strong performance against the Immunisation, Smoking Cessation, and CVD/Diabetes Health Targets. However, there are areas where we can make further gains.

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
Breast and Cervical Screening Increase equity of coverage for priority women in Breast Screening and Cervical Screening programme by: • Data matching to identify unscreened and under screened women • Ensure ethnicity is recorded accurately on Breast Screening data base and NCSP • Increase smears by reviewing smear taking contracts with a particular emphasis on screening Pacific eligible women • NCSP Data matching - identify eligible women who are overdue by 5 years. Proactively follow-up and offer smears in conjunction with PHO and primary care partners.	Enable equity of coverage to be reached for priority women Maori and Pacific to be achieved as per BSA contract. Enable equity of coverage to be reached for priority women Maori, Pacific and Asian to be achieved as per NCSP contract.	BSA and NCSP coverage reports from NSU show increasing equity of coverage	New Zealanders living longer, healthier and more independent lives.
Oral Health Develop workforce resources that will be used during non-dental healthcare interactions for the 0-5 yrs age group, including: ▪ A workforce resource will be developed as a tool to prompt dental enrolment, screening and the delivery of positive health messages relevant to the child's age. ▪ Service efficiencies will be sought through collaborative arrangements (e.g. LMC/ midwifery, New-Born Hearing Screening; WCTO; NIR and vaccination events) to ensure that all children are, as a minimum, enrolled in the oral health service.	Increased collaboration between child service providers and the Oral Health Service. Improved consistency in the delivery of positive oral heath messages	Number of participating key stakeholders. Increasing the enrolment of infants(0-2 yrs age) to the oral health service by 5 %	
Breastfeeding Increase breastfeeding rates, in particular for Maori and Pacific women; including through:		Increase in breastfeeding rates by 5% for each category by infant age and ethnicity.	

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
▪ Deliver Mum 4 Mum programme - at least 4 training courses through Naku Enei Tamariki Maori Section ▪ Maori and Pacific HVDHB breastfeeding co-ordinators liaise with midwives and LMCs to promote breastfeeding ▪ Identify opportunities for WCTO providers to promote breastfeeding earlier through improved transfer for care between LMCs and WCTO providers.			
Whanau Ora The DHB is committed to further development of the national Te Puni Kokiri led Whanau Ora initiative. Two Whanau Ora Provider Collective business cases are awaiting sign-off via Te Puni Kokiri for their Whanau Ora Programmes in our district, to be launched in 2012/13. Both collectives are made up of local Maori Health provider services and the DHB has entered into Integrated Contract arrangements with both parties to support this. The DHB will: • Attend Regional Leadership Group meetings • Provide, where requested by MoH, advice to MOH regarding local collectives, once collective POAs are signed off. • Contribute to Whanau Ora Collective capability and capacity by engaging in training opportunities, including: o Health Literacy o Mainstream Cultural Responsiveness • Work with DHB Board to facilitate direct engagement between Board and Whanau Ora Collective Governance Groups • Participate in opportunities to support / advise / influence Regional Māori Health Plan and Regional Services Plan development & implementation	Improved provider capability. Improved provider service quality resulting in enhanced outcomes for Service Users. People receive better health and disability services. A more unified and improved health and disability system Improved engagement and interaction between community, primary, and secondary services Opportunities to engage regionally with other Whanau Ora Collectives to share best practice and quality opportunities Opportunities to be work collectively in a way which will benefit transient whanau.	SI5: Delivery of Whānau Ora	
Mental Health In conjunction with CYFS run treatment program helping foster parents manage children/adolescents in their care.		Number of programme sessions for foster parents.	

The actions we'll take this year	How they will help	Measured by	In support of system outcomes
Intersectoral Activity Work more closely with Hutt and Upper Hutt City Council, including: • Improving planning linkages • Undertake joint communications strategies for prevention initiatives • Identify opportunities for co-operation on social determinant related issues, for example alcohol • Link with HCC in regard to the Pomare project and other projects in Hutt City to bring a health focus to urban planning		Opportunities for joint communications identified and implemented. Joint programmes identified and implemented.	
Progress VIP violence prevention programme with a focus on • Systems Development • Training and Education • Evaluation and Reporting			

MODULE 4: STEWARDSHIP

4.1 Managing our business

The basis of our approach to managing our business is to view Hutt Valley DHB as one integrated organisation, although containing a number of different components. This allows us to recognise the strengths and perspectives our different components provide, but assists us to avoid unhelpful silos within the DHB.

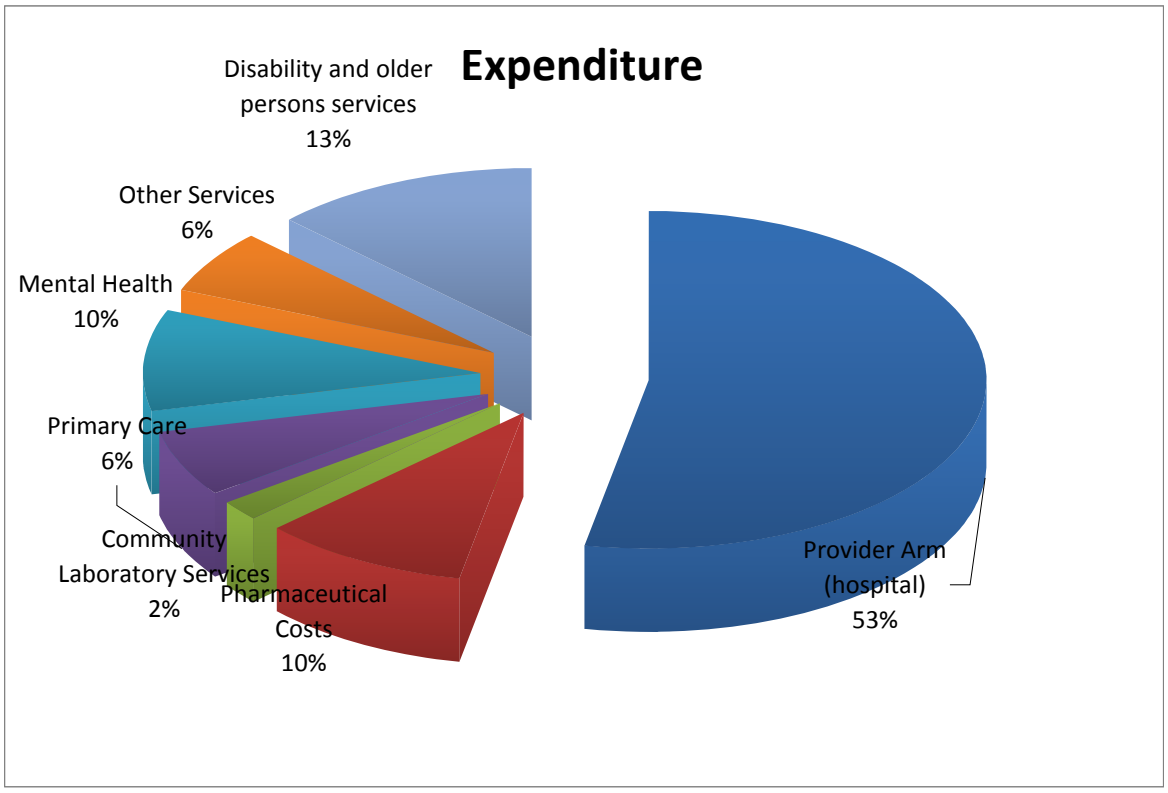
Functionally, there are two main groupings – supported by Governance and corporate services. These two groupings are the DHB's service planning and funding group, and its service provision function. These functions are sometimes referred to as the DHB Funder Arm and Provider Arm.

The Funder Arm funds Prevention, Early Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support Services (these are the way we categorise services we fund or deliver as set out in Module 5). Providers include NGOs, primary care, and Regional Public Health. Our Provider arm delivers Intensive Assessment and Treatment, and Rehabilitation and Support Services.

4.1.1 The Funder Arm

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 administers $405m[11] of service funding, as below:



The DHB Funder Arm ensures value for money as follows:

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

- 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.

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).

The Funder Arm's performance is monitored by the Director of Planning, Funding, and Public Health, the Executive Management Team, and Board (including through the Board's Community and Public Health Advisory Committee).

4.1.2 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:

- $191.8M of land buildings, clinical and other equipment mostly located on the Hospital campus
- $219.9M of revenue mainly provided by the Crown
- 1,818.2 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 Funder Arm, 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 2012/13 the funding is $185.2M**,** with a national pricing programme determining the price of each purchase unit. A further $35.3M largely comes from direct contracts for service with the Ministry of Health, ACC and other DHBs.

There are planned efficiencies of $9.0M 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 $(3.9M) for 2012/13 (to be offset in other activities of the DHB) to ensure an overall 2012/13 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:

- "Shorter Stays through Better Way" project - 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.

- A focus on people with long term conditions as part of our secondary and primary integration work.
- Implementing initiatives 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:

- 3 DHB health services planning with Wairarapa, and Capital Coast DHBs, including:
  - ENT
  - Gastroenterology
  - Child Health
- Central Region Information Services plan (CRISP).

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.

4.1.3 Performance Management

The DHB manages its performance in the following main ways:

- Monitoring achievement of Ministry and Minister targets and measures
- KPIs cascaded from the CEO through senior managers to line managers
- Reporting to the Board and Committees on a local set of priorities and actions, including in against our Annual plan
- Regular financial reporting to the Board and the FRAC Committee
- A set of key hospital operational indicators reported to HAC.
- Regular non-financial performance reporting to CPHAC and to the Board.

The Provider and Funder both have internal reporting measures, compiled by the Funder and reported to Executive Management, Committees, and Boards.

Continuous Improvement Programme

A key aspect of stewardship in 2012/13 will be our work to live within our means, while providing high quality services to the Hutt Valley. This work involves a group of significant projects which are intended to reduce waste, reconfigure systems for greater efficiency, and where appropriate, improve models of care. Examples of the workstreams include:

- Improving hospital discharge processes and reducing unnecessary patient time in hospital
- Better management of staff leave
- Implementing a staff management and rostering tool to ensure correct staffing levels and mix
- Optimising the surgical patient pathway
- Best practice prescribing
- Opportunities to increase income.

This is an aggressive programme of work, which carries risk of delayed or partial non-delivery of programmes and projects. We are working to mitigate this risk by identifying a wider group of projects to deliver efficiencies in excess of the amount required to reach a breakeven position.

4.1.4 Risk Management

Our risk management approach is based on the Australian/New Zealand risk management standard with a strong focus on clinical risk management through clinical leadership and participation in the

identification and minimisation of clinical risks, and through our corporate governance structures to ensure legislative compliance is achieved. Key components of our risk management programme are:

- Policy and reporting framework in line with the Australian/New Zealand risk management standard
- Reporting framework to Finance Risk and Audit Committee (consistent with Capital & Coast DHB)
- Internal financial audit and external audit through certification to ensure compliance
- Service-level risk reports reflecting a bottom-up approach to risk identification, evaluation, treatment and monitoring and review of risk on a regular basis
- Adverse event reporting process covering all clinical, staff and business practices
- Compliance with national serious and sentinel event reporting requirements to the Health Quality and Safety Commission
- Comprehensive complaints and privacy policy and procedures
- Legislative compliance framework.

4.2 Building capability

The DHB is working to develop its capabilities and capacity to meet identified needs for greater clinical leadership, integrated care, and ability to innovate and create novel solutions to challenges. These will be critical attributes during the next five years. This requires work with our systems, our IT, our buildings, and not least, our staff. The main areas of focus will be as follows.

4.2.1 Linked IT (both ICT and clinical technology/communications)

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 2012/13, 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.

4.2.2 Clinical leadership and innovation

We have adapted the leadership and management programme “Xcelr8” in collaboration with Canterbury DHB which provides the opportunity for clinical and management staff to gain new knowledge from other industries, production management principles, quality improvement methodologies, team effectiveness and individual personal development and coaching.

This programme is complemented by opportunities via Ko Awatea at Counties Manukau DHB for staff attending the IHI Executive Management and Improvement Science in Action workshops and professional development programmes. Sponsorship by the Health Quality and Safety Commission has increased our ability to support staff attending these courses which are assisting with growth in leadership, and will increase the organisation's change management and innovation capability.

Other focus areas for improving our capability for innovation and change include senior management learning sets, and working with Regional Training Hubs and HWNZ as programmes are developed.

4.2.3 Capital and infrastructure development

Our asset management program enables us to continuously update our asset planning. As our ED theatre redevelopment has been completed, our focus now shifts to planning for replacement or rebuilding of two 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
Forecast Capital Expenditure
For the Year Ended 30 June

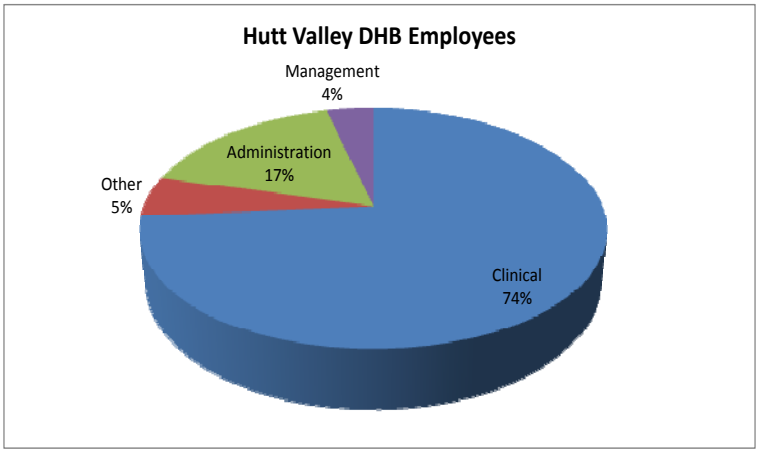
$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Approved / Baseline Expenditure					
Property and Plant	2,192	1,800	1,800	1,800	1,800
Clinical Equipment	1,212	2,000	2,000	2,000	2,000
Computer Equipment	1,186	1,500	1,500	1,500	1,500
Other Equipment	328	200	200	200	200
Motor Vehicles	212	-	-	-	-
Total Baseline	**5,130**	**5,500**	**5,500**	**5,500**	**5,500**
Strategic (Approved)					
Emergency Department & Theatre Development Project	30,715	20,086	7,000	-	-
Child Oral Health	4,081	7,669	2,000	-	-
MRI Replacement	-	-	-	2,250	-
CT Scanner	-	-	-	1,250	-
Financial Management Information System	-	500	1,000	-	-
Total Approved	**34,796**	**28,255**	**10,000**	**3,500**	**-**
All Other Approved Projects	**-**	**-**	**-**	**-**	**-**
All Other Projects	-	-	4,300	-	10,000
Total Capital Expenditure	**39,926**	**33,755**	**19,800**	**9,000**	**15,500**
Financed By:					
Internally Sourced Funding	(2,982)	-	-	-	-
Equity Injections for Deficit Support	-	-	-	-	-
Depreciation	10,079	11,957	14,642	14,698	14,677
Sale of Fixed Assets	9	-	-	-	-
Equity Injections for Capital Expenditure	1,853	4,413	-	-	-
Private Debt	-	3,495	4,300	-	-
CHFA Debt	24,900	22,100	-	-	-
Other (Includes Cash Reserves)	6,067	-	900	-	900
	39,926	**41,965**	**19,842**	**14,698**	**15,577**

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 2012/13 is $19.8m.

4.3 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 8.4.



Our workforce is critical to our success in delivering high quality health and disability services to the population we serve. We are actively strengthening our workforce in a number of ways, as set out in Appendix 8.5. In line with this we are working closely with Capital Coast DHB on the Capital and Coast and Hutt Valley DHB Draft Joint Workforce Plan (appendix 8.6) and are active participants in the Central Region Training Hub (Appendix8.7).

We are committed to developing our workplace in a cohesive way with our close neighbours and wider region to ensure we have a highly skilled and sustainable workforce in place to meet the future needs of our population.

4.4 Quality and Safety

Hutt Valley DHB works to continuously improve 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:

- Medication Safety: Implementation of the paper-based national medication chart, and medicine reconciliation process, and ensure that the appropriate infrastructure is in place to support the implementation of electronic medicine management solutions.
- Quality Accounts: Consider the public reporting of current and planned quality improvement activities through published Quality Accounts.
- Mortality Review: Undertake mortality and morbidity review to identify system quality and safety improvements and change.
- Reportable Events: Adopting the National Reportable Event policy, including reporting of serious and sentinel events to the Commission.
- Infection Prevention and Control: Continued support for development and implementation of:
    - Hand Hygiene: support the national implementation of the Hand Hygiene programme
    - Surgical Site infection surveillance programme: continue to ensure patient harm caused by surgical site infection is reduced by working with the Commission to develop and implement a national SSI programme
    - Central Line Associated Bacteraemia (CLAB): support the national implementation of the CLAB programme
- Improvement Projects: The Commission is focussing on a number of improvement projects. During 2012/13 plans need to reflect support and or implementation of: - Surgical Checklist (to reduce harm associated with surgery)

Our local approach to Quality improvement in 2012/13 include is categorised into three sections:

- 'Whole of System' Approach to Quality Improvement
- Clinical Risk Management – Aiming For Zero Patient Harm
- Infection Prevention & Control – Reducing Hospital Acquired Infections.

Each of these sections includes a set of measurable goals which will improve the Quality of the services we provide. Progress towards these goals will be monitored during the year and escalated to our Executive Management Team as appropriate.

4.5 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.

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.

A significant change to our organisational structure in 2011 was the move to a directorate structure, led by "diamond leadership teams" comprising clinical and non-clinical leaders. The intention of this change is to embed collective leadership in the DHB.

+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.

4.6 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.

4.7 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

4.8 Notification of Subsidiaries; Plans to acquire shares or interests in any company, trusts and/or partnerships

Hutt Valley DHB jointly owns and funds Central Region Technical Advisory Services (TAS) which provides support to the Central region DHBs. TAS supports the effective functioning of DHBs. 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. The DHB has no plans to acquire shares or interests in any company, trusts and/or partnerships except a potential acquisition of redeemable preference shares in CTAS. Any proposal to do so would need to be approved by the Board and the Minister of Health.

4.9 Banking Covenants

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

MODULE 5: FORECAST SERVICE PERFORMANCE

5.1 Output Classes and Statement of Forecast Service Performance

This section of the Annual Plan sets out a summary of our intended outputs (the things we deliver or fund) for 2012/13.

5.1.1 Output Classes; Relationship to Impacts

Our outputs were categorised into four Output Classes[12]. 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. Measures (output and impact) are a combination of volume, timeliness, and quality measures. These are indicated with (v), (t), or (q) as appropriate.

In our Statement of Forecast Service Performance, we link our outputs to the impacts we want to achieve. Linkages will not always be directly quantifiable or separately identifiable. Many factors influence the impacts we seek to contribute to. In addition, many impacts will not be seen within a single year, and trend data will be necessary to understand if impacts sought are occurring.

5.2 Prevention Services[13]

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, 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

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

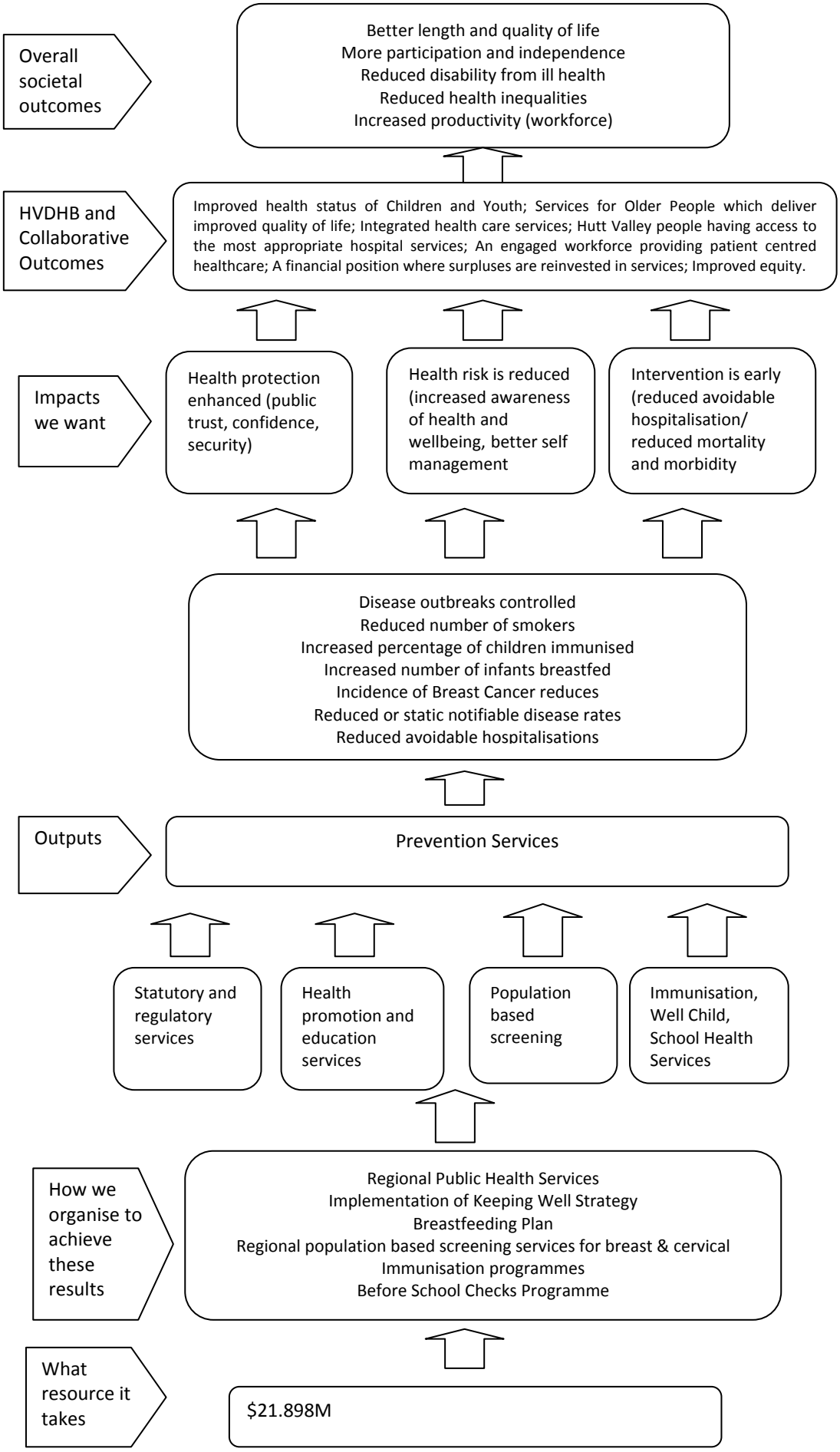
[13] Prevention services are publicly funded services that protect and promote health in the whole population/identifiable sub-populations. They prevent disease and enhance the health status of the population. Public Health services include health promotion to ensure that illness is prevented and unequal 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 2012/13 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
- Reduce avoidable hospitalisations
- 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) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[14]</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 (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>90%</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 2013

Number of education and training sessions provided (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>922</td><td>906</td></tr></table>Number of schools and early childhood services receiving health promotion visits (Hutt Valley and Capital & Coast DHB populations) (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>111</td><td>138</td></tr></table>Number of opportunities taken to provide strategic public health input and expert advice to inform policy and public health programming (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>32</td><td>60</td></tr></table></td><td>Health risk is reduced:
Reduced number of smokers in the population[15] 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: 59% (v,q)[16]

Change in percentage of Smokers in Population (assuming Census/Health Survey conducted) Baseline (male/female)[17](v,q):
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>

[14] 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.

[15] As measured by the NZ Health Survey and NZ Tobacco Survey

[16] This measure, and the following measure are considered quality measures because they, to an extent, represent through changed behaviour how well the outputs were delivered.

[17] 2006/07 15+ years of age daily, standardised per 100000

<table>
<tr><td colspan="5">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.[18] 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.[19]</td></tr>
<tr><td>Breast screening services</td><td>Breast screening (v):
<table><tr><th>Baseline</th><th>2012/13</th></tr><tr><td>Total 11,349[20]
Maori = 1,019
Pacific = 557</td><td>Total = 11,113 (70%)
Maori = 1,183
Pacific = 606</td></tr></table></td><td>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.</td><td>Incidence of breast cancer reduces (regionally or nationally) [21]
Breast cancer registration: 510[22] (v,q)</td><td>Better length and quality of life, Healthier Communities, Families, and Individuals,</td></tr>
<tr><td colspan="5">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 service focuses 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, establishing a strong foundation for ongoing healthy development.[23] The Before School Check is a nationwide programme offering a free health and development check for four year olds. It 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.[24]</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 (v)
<table><tr><th>Baseline</th><th>2012/13</th></tr><tr><td>C&CDHB 3363
HVDHB 1632</td><td>C&CDHB 3363
HVDHB 1632</td></tr></table>
Number of Before School Checks (v)
<table><tr><th>Baseline</th><th>2012/13</th></tr><tr><td>1703</td><td>1778</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 (q)[25] – Baseline:
Maori 0 – 4 < 160.32
Pacific 0-4 < 136.99
Other 0-4 <169.34
Maori 45-64 <111.7
Pacific 45-64 < 103.15
Other 45-64 < 105.2
Maori 0-74 < 134.14
Pacific 0-74 < 117.8
Other 0-74 < 116.79</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[26]</td></tr>
</table>

[18] 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.

[19] 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.

[20] Based on cohort of 15,875 eligible women between ages 50 and 69

[21] 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.

[22] Total Maori, Pacific, Asian, and Other - 25+ years age standardised per 100,000; 2005-2007

[23] Nationwide Service Framework; Service Specifications; Tier 2 Preschool and School Health, Ministry of Health 2010/11

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

[25] ASH rates are considered to also be a measure of quality as they represent how well prevention initiatives and activities in primary and community settings improve health status and accordingly reduce avoidable hospitalisation.

[26] 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.

<table>
<tr><th 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</th></tr>
<tr>
<td>Investigate communicable disease notifications, e.g. tuberculosis, meningococcal disease, vaccine-preventable and enteric illness
Environmental health investigations, audits, or incidents including: 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 (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>2031</td><td>2733</td></tr></table>Number of environmental health investigations (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>1074</td><td>1281</td></tr></table>Number of controlled purchase operations (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>29</td><td>29</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 (q).</td>
<td>Healthier Communities</td>
</tr>
<tr><th 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.[27] .</th></tr>
<tr>
<td>Immunisation services (delivered through general practice, outreach, school and other community settings)</td>
<td>Immunisation: % 8 mth olds fully vaccinated Health Target 95% at end of 2014: (v, t)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>N/A</td><td>90%</td></tr></table>Immunisation: % Year 7 children vaccinated in schools (v, t)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>75%</td><td>75%</td></tr></table>Immunisation: % Year 8 girls (birth cohort 1998) vaccinated against Human Papillomavirus (v,t):
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>63%</td><td>65%</td></tr></table>Immunisation: Over 65 year olds flu vaccinated (CCDHB and HVDHB) (v):
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>11,273</td><td>9791</td></tr></table>(Reduced in 2012/13 as a result of Ropata Medical Centre joining CCDHB Cosine PHO)</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) (v,q)
Baseline (cases)[28]:
Meningococcal Disease > 8
Mumps >3
Pertussis: >35

Reduced Hospital admissions for respiratory conditions of people 65+(q) [29] - Baseline: 171 cases[30]

Incidence of cervical cancer reduces (regionally or nationally) (v,q) [31]
Baseline: N/A</td>
<td>People live longer, they are healthier and more able to live independently.</td>
</tr>
</table>

[27] Ministry of Health DHB Performance Monitoring Framework 2010/11
[28] 2010 reported (ESR Annual Surveillance Report)
[29] See note 25 above
[30] 12 months to March 2011 (HVDHB records)
[31] 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.

5.3 Early Detection and Management Services[32]

The Government has identified that ensuring better, sooner, more convenient primary health care is a key priority. In 2012/13 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, with Cosine PHO operating as a cross boundary PHO contracted to Capital & Coast DHB. Te Awakairangi Health encompass 27 different practices. There are 74.9 FTE general practitioners (including Registrars and Locums) operating in the Hutt Valley[33]. 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, ten local NGO providers, fourteen sub regional and regional NGO 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

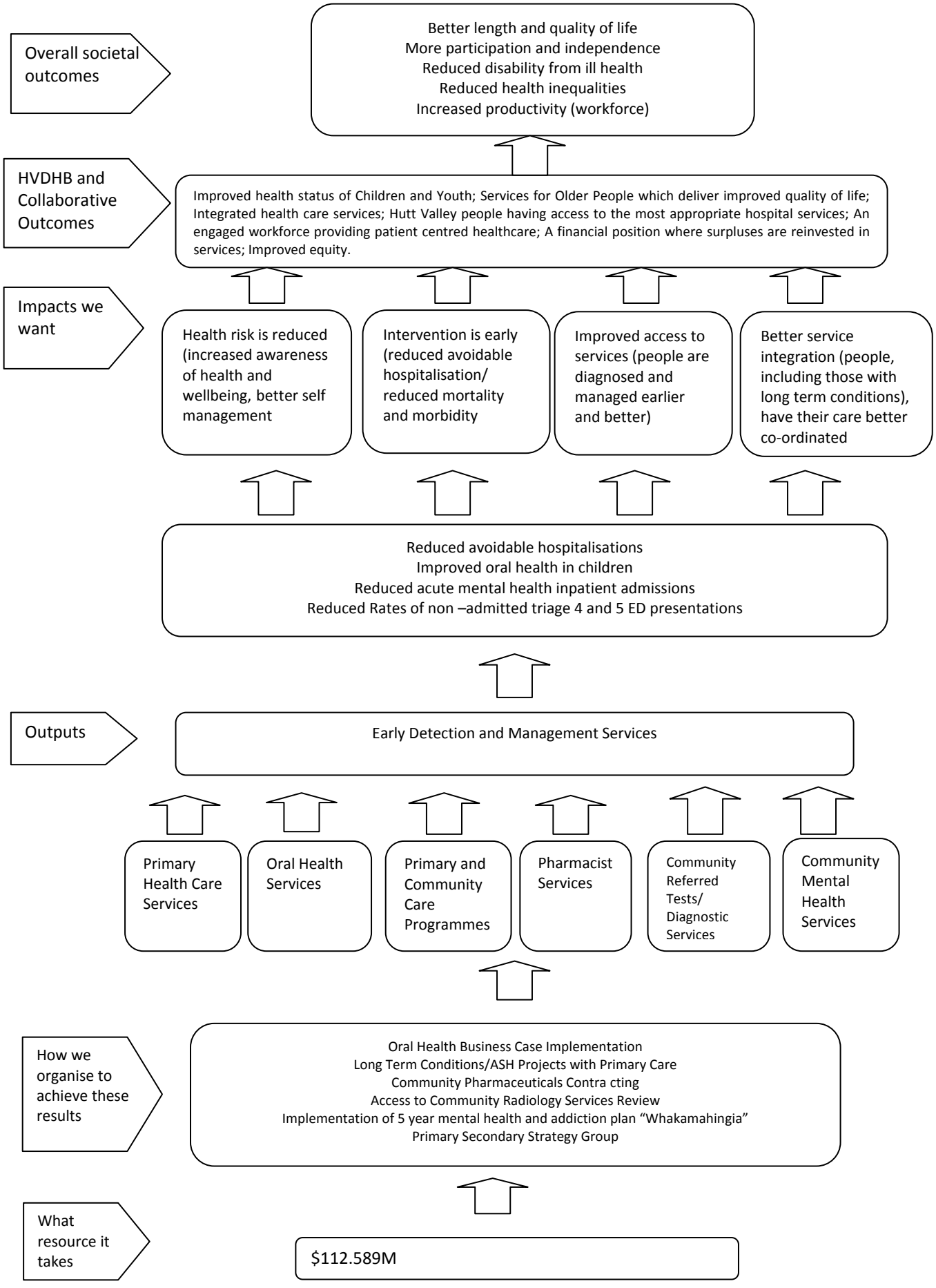
Hutt Valley DHB is addressing a number of challenges with regard to Early Detection and Management Services, specifically:

- 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 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 ethnic groups
- Higher than average expenditure on community pharmaceuticals for our population.

[32] 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.

[33] 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 & 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.

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[34]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">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. [35] PHOs are funded to develop health promotion programmes for their enrolled populations.[36] 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.[37]</td></tr>
<tr><td>Primary and community care programmes</td><td>Number of people accessing programmes (v)[38]
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>23,820</td><td>19,986[39]</td></tr></table>Number of people enrolled in CarePlus (v):
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>2975</td><td>3050</td></tr></table>CVD risk assessment (v): (Health Target)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>25%</td><td>75%</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 (q)[40]
Baseline: see above</td><td>Health risk is reduced; People live longer, they are healthier and more able to live independently.</td></tr>
</table>

[34] 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.

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

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

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

[38] 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.

[39] This figure is reduced as a result of the Get Checked programme now no longer being funded.

[40] See note 25 above.

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.[41]

Pharmacy Services	**Number of dispensed items (v)** Baseline: 2,159,227 2012/13: 2,466,618	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	Reduced ASH rates (q) Baseline: see above	People live longer, they are healthier and more able to live independently.

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.[42] 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 (v)** Baseline: 139,699[43] 2012/13: 140,320	Intervention is early, Services are better integrated: • Early detection and reduced impact of disease. • Better management of long term conditions in the community. • Reducing growth in acute demand	Reduced ASH rate (q) Baseline: See above Reduced rate of non-admitted triage 4 and 5 ED self presentations (q): Baseline: 40%[44]	People live longer, they are healthier and more able to live independently. .

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[45] 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[46]

Laboratory Tests Radiological examinations	**Number of laboratory tests (v)** Baseline: 2,114,711 2012/13: 2,280,000 **Number of radiological examinations (v)** Baseline: 10,660 2012/13: 10,500	Intervention is early, as improved access to diagnostics allows earlier identification of issues. Access to services is improved, (conditions are managed earlier and better with hospital attendances reduced)	Reduced ASH rates (q)[47] Baseline: see above	People live longer, they are healthier and more able to live independently.

[41] Nationwide Service Framework; Service Specifications; Community Pharmacy Services, Ministry of Health 2010/11
[42] Ministry of Health http://www.moh.govt.nz/primaryhealthcare
[43] Forecast numbers for Q4 2010/11
[44] 2009/10, % of total presentations to ED (any triage, and any referral source, any discharge status)
[45] Nationwide Service Framework; Service Specifications; Community Laboratory Services, Ministry of Health 2010/11
[46] Nationwide Service Framework; Service Specifications; Community Radiology Services, Ministry of Health 2010/11
[47] See note 25 above

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.[48] Note that these services are regional and include service provided to non-Hutt Valley residents.

Non-crisis mental health assessment, treatment, monitoring, consult and liaison services.	**Total number of community mental health clients seen (v)[49]** Baseline: 3,900 / 2012/13: 5,000 **Total number of occupied bed days (v)** Baseline: 15,005 / 2012/13: 17,806	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	Reduced rate of ED Presentations for Mental Health issues (q)[50] Baseline: 1.9%[51]	People are healthier and more able to live independently

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.[52]

Enrolment of children in dental services. Oral examination of preschool children. Oral examination of adolescents.	**Number of enrolled pre-school and school children (HVDHB and CCDHB populations)[53](v)** Baseline: 54,044[54] / 2012/13: 58,137 **Total number of school dental service examinations (Hutt Valley and CCDHB populations) (v)** Baseline: 7,621 / 2012/13: 10,461 **Number of adolescents examined (Hutt Valley DHB populations)[55](v)** Baseline: 5,666 (58.8% of 9,640 cohort) / 2012/13: 7,600 (80% of 9,500 cohort)	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.	Increased Percentage of children caries free at age 5: Baseline: 58.27%[56] (q) Oral Health DMFT Score at year 8 (q) Baseline: 1.08[57] Reduced Avoidable Hospital Admissions (dental) (q) Baseline: 395	People live longer; they are healthier and more able to live independently.

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

[49] 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

[50] High quality services will result in reduced acute episodes, reflected in decreased levels of ED attendances.

[51] 2010/11, % of total presentations to ED (any triage, and any referral source, any discharge status)

[52] Nationwide Service Framework; Service Specifications; Child Oral Health, Ministry of Health 2010/11

[53] Measured on a calendar year basis

[54] Based on enrolees between aged 0 and 13 years and for subsequent years

[55] 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)

[56] 2010 calendar year – considered a quality measure as increased % of children caries free demonstrates enrolments and examinations are fit for purpose.

[57] 2010 calendar year - considered a quality measure as decreased DMFT score demonstrates enrolments and examinations are fit for purpose.

5.4 Intensive Assessment and Treatment Services[58]

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
- Children's Health
- Mental health services

Hutt Valley Intensive Assessment and Treatment 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.

[58] 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.

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

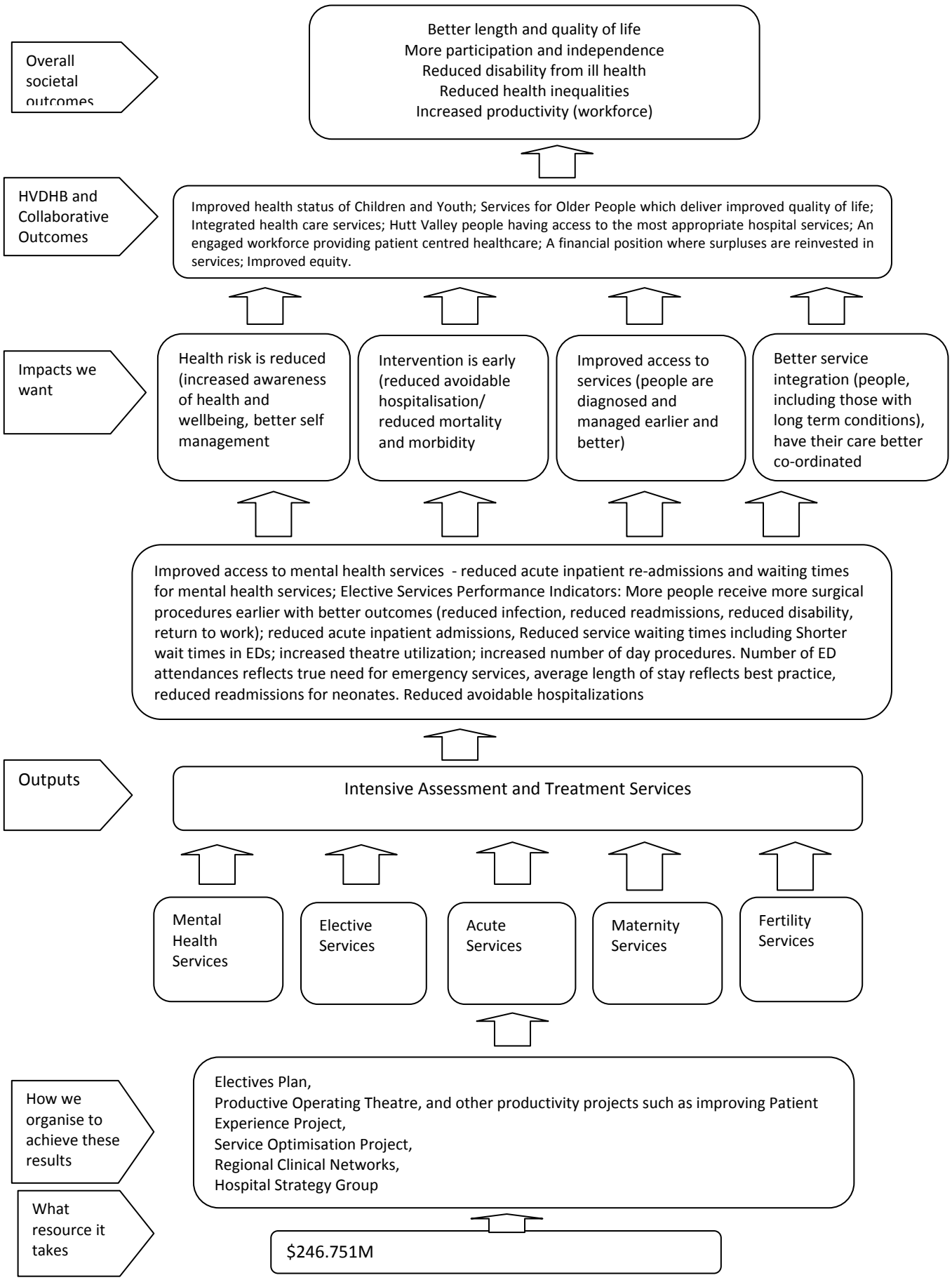
Key Areas of Focus

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
- 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.

<table>
<tr><th>Outputs - Main areas of performance</th><th>Output Measure(s) (including Baselines[59]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[60]</th><th>Impacts</th><th>Impact Measures</th><th>Outcomes</th></tr>
<tr><td colspan="5">Mental Health Services: Include services provided at Hutt Hospital and in the community, including by contracted providers. It 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.[61] Service users need easy and well-recognised access to services that are focused on wellness and recovery, built on strong evidence and provided in the least restrictive environment.[62]</td></tr>
<tr><td>Intensive mental health assessment and treatment services.</td><td>Total number of clients seen (v)[63]
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>2,527</td><td>2,500</td></tr></table>Total number of occupied bed days (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>8,072</td><td>6,935</td></tr></table>95 % of people have up to date crisis prevention plans (v,q)[64][65]
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>92%</td><td>95%</td></tr></table>No more than 30 days waiting time for Alcohol and Drug Services (t)
Baseline <30</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(q).[66]
Baseline: 23%

Reduced Average Length of Stay for inpatient mental health services.(t)
Baseline: 18.45 days</td><td>People are healthier and more able to live independently</td></tr>
</table>

[59] The baseline for setting of targets and measures varies for different outputs – unless otherwise specified, the baseline is 2010/11 Actual.

[60] 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.

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

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

[63] 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

[64] 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.

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

[66] Readmission rates are a measure of quality, as they reflect appropriate discharge timing and processes.

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). 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 quality, timeliness and effectiveness [67]

Elective services	**Elective services** provided by Hutt Hospital and by other DHBs for the Hutt Valley population – 4946 discharges ***Health Target(v)*** **First specialist assessments (medical & surgical)**; provided at any public hospital for the Hutt Valley population(v) Baseline: 19,436 — 2012/13: 18,614 **Elective Services*;*** provided by Hutt Hospital for the Hutt Valley and other DHB populations (v) Baseline: 6,627 (CWD) — 2012/13: 6,722 (CWD) **First specialist assessments (medical & surgical)**; provided by Hutt hospital for the Hutt Valley and other DHB populations (v) Baseline: 15,907 — 2012/13: 15,721 **Percentage of day case discharges;[68](t,q)** Baseline: 58% — 2012/13: 60%	Improved access to services (people are managed better)	Day of surgery admission rate[69](v,t) Baseline 88.4% Minimise outpatient DNAs (t) Baseline: 11,010 Patients given a commitment to treatment but not treated within six months (t) Baseline <5% Less than 2% of patients will wait longer than 6 months for first specialist assessment (FSA) (t) Baseline 2% 30 Day mortality (q)[70] Baseline 1.43%	People live longer, they are healthier and more able to live independently.

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.[71]

Fertility services	**Number of fertility cycles (v)** Baseline: 307 — 2012/13: 244[72]	Improved access to services People continue to have appropriate access to fertility services	N/A – Delivery of service improves access.	Better quality of life

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

[68] 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.

[69] 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.[69]

[70] 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.[70]

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

[72] Minimum contract requirement of 1st and 2nd IVF cycles, with actual result depending on demand for services in any year.

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. .

Acute services	**Number of Emergency Department (ED) attendances; (v)**.[73] Baseline: 2012/13 42,453: 43,320 **Number of inpatients (v)**[74] Baseline: 2012/13 13,370: 12,968 **Average length of stay (days) (t):** [75] Baseline: 2012/13 4.03: 4.01 Reducing Acute Readmission rate (q)[76]: Baseline: 2012/13 9.19%: TBC	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	Improving number of ED attendances with an ED length of stay less than 6 hours – 95%[77](t,q) Baseline: 86% Reduced ASH rate (q) Baseline: see above	People live longer, they are healthier and more able to live independently

Output: Maternity Services: Includes services 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 access to 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.[78]

Maternity services	**Number of deliveries (v)** Baseline: 2012/13 2,017: 2,000 **Average Post natal length of stay** (t) (Days) Baseline: 2012/13 1.9: 1.9 **Average Neo-natal length of stay** (days) (t) Baseline: 2012/13 9.4: 9.0	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,	Reduced readmissions for neonates (v,q). Baseline: 14.34%	People are healthier and more able to live independently; Better quality of life, Healthy Families,

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

[74] 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.[74]

[75] Reductions in the length of stay for inpatients (where clinically appropriate) allow more patients to be treated in hospitals without additional capital investment. 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 improves quality through reduced risks of infections. 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 performance, such as day surgery rates and ambulatory sensitive hospitalisations.[75]

[76] 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. Unplanned acute readmissions may imply a possible failure in patient management such as discharge too early, or inadequate support at home.[76]

[77] 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 waiting time) is 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.[77]

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

5.5 Rehabilitation and Support Services

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

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.

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.

In 2012/13 we will support primary care to improve its capability to provide generalist palliative care services in collaboration with specialist palliative care services.

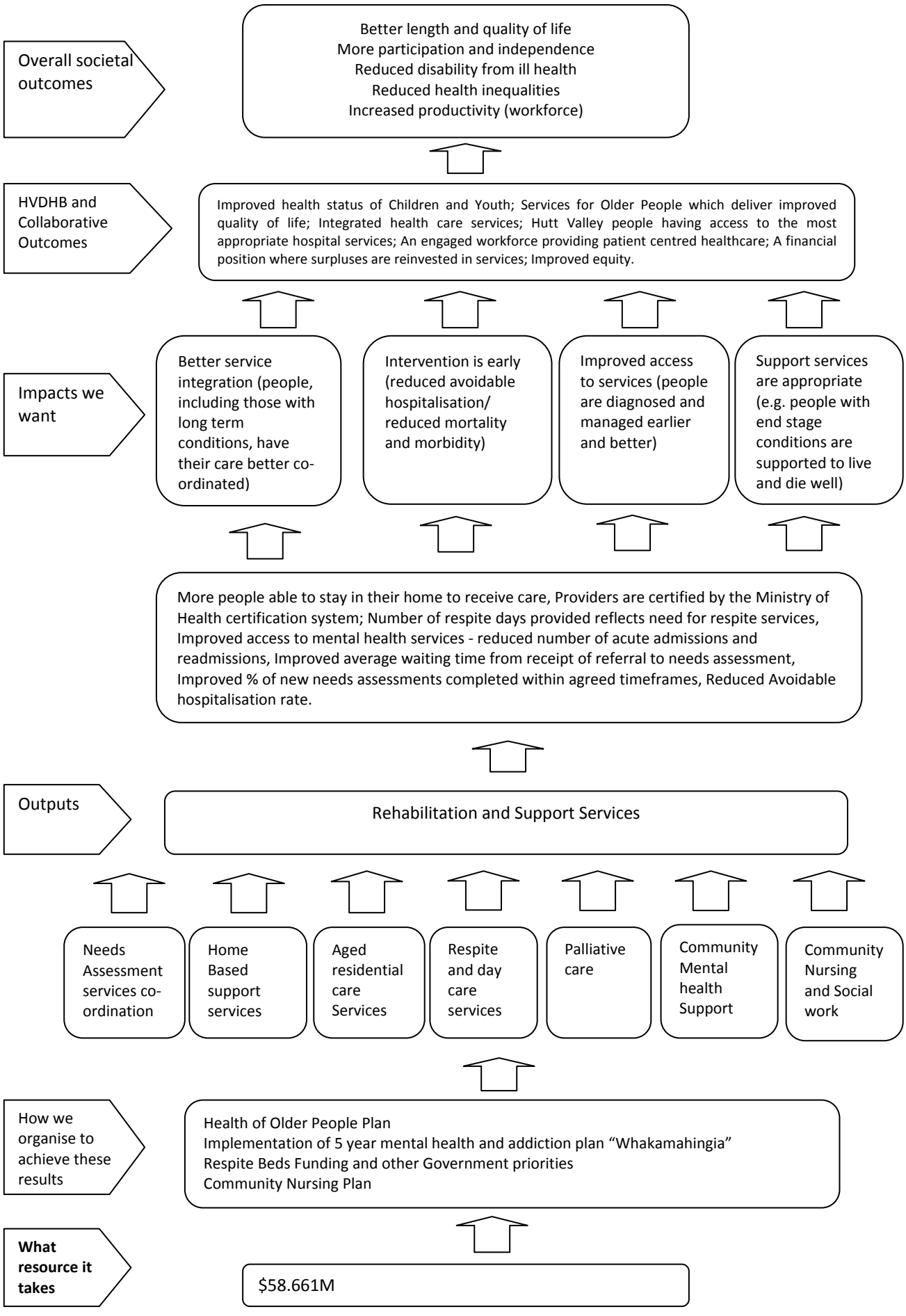
Key Areas of Focus
Hutt Valley DHB has the same leading causes of hospitalisation and mortality for older people as those nationally and many of the challenges facing the provision of health of older people services

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 to provide increasingly "wrap around" services.
- Developing and implementing a dementia pathway.

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 - Rehabilitation & 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[79]) - main measures of performance (includes quantity, quality, timeliness, and effectiveness of outputs)[80]	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) (v) Baseline: 3,576 — 2012/13: 3,600 Number of client complaints to DHB (q) Baseline: 0 — 2012/13: <5 % of new assessments completed within agreed timeframes (t) Baseline: 90% — 2012/13: 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 (t) Baseline: 6 days Improved % of new assessments completed within agreed timeframes (q) 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 (v): Baseline: 1,870 — 2012/13: 1920 Number of home based support hours (v)	Improved access to services, Better service integration – improved care Co-ordination, Older people with complex needs able to remain	Percentage of people aged 65 and over living in home (not in full time ARC) (v,q)[81] Baseline: 93.02%	People are healthier and more able to live independently

[79] 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.

[80] 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.

[81] High quality home based support services will assist people to remain in living arrangements other than in full time Aged Residential Care.

	<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>220,276</td><td>224,850</td></tr></table>	living in their home for longer.		

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. [82]				
Residential care services	Total number of subsidised aged residential care bed days (v): <table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>305,201</td><td>310,250</td></tr></table> Number of providers audited (actual number depends on Ministry of Health certification timetable and length of certification) (v) <table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>8</td><td>12</td></tr></table> No. of residential/Aged dementia bed days (v) <table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>32,574</td><td>33,580</td></tr></table>	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).(v,q)[83] Baseline: 100% Reduced number of care quality complaints to DHB (q) 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. [84]				
Respite care services	Number of respite days (v) <table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>1588</td><td>3100[85]</td></tr></table> Respite beds utilised (v) <table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>5.2</td><td>8.5 [TBC]</td></tr></table> Number of day service clients (v) <table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>188</td><td>200</td></tr></table>	Improved access to services, Support Services are Appropriate.	Increased utilisation of respite services (q)[86] Baseline: 1588 respite days	Better quality of life, more participation and independence

[82] National Contract for Aged Residential Care Services, Nationwide Service Framework, Ministry of Health, 2010/11
[83] Certification for 3 years represents a high level of confidence from the Ministry of Health in the quality of the services provided.
[84] Nationwide Service Framework; Service Specifications; Day Care Services and Respite Care Services Tier Two Service Specifications, Ministry of Health 2010/11
[85] This increase represents an additional increase on the 730 additional days agreed between the Ministry and Hutt Valley DHB
[86] Utilisation of respite beds is a measure of quality, as high utilisation suggests the services meets the needs of clients and their families.

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. [87]

Palliative care services	Number of patients receiving specialist palliative care (v) Baseline: 388 2012/13: 466	Support services are appropriate (people with end stage conditions are increasingly supported to die well)	N/A[88]	Better quality of life

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.[89]

Community Nursing Services	Total number of contacts (v) Baseline: 34,759 2012/13: 38,650	Support services are appropriate Access to services is improved - 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	Reduced Avoidable hospitalisation rate (cellulitis, respiratory) (q) Baseline[90]: Cellulitis 0-74 – 133.3 Respiratory 0-74 136.6	Better length and quality of life; reduced disability from ill health

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.[91]

Social Work Services:	Total number of contacts (v) Baseline: 1,547 2012/13: 1,900[TBC][92]	Access to services is improved Support services are appropriate	N/A	Better quality of life, more participation and independence

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

[88] 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.

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

[90] MoH data 12 months to March 2011

[91] Nationwide Service Framework; Service Specifications; Specialist Allied Health Services Tier Two Service Specifications, Ministry of Health 2010/11

[92] Change due to more accurate data collection, rather than services delivered

<table>
<tr><td colspan="5">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.[93] Note that this if a regional service.</td></tr>
<tr><td>Community Mental Health Support Services</td><td>Total number of clients seen (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>392</td><td>500</td></tr></table>
Total number of occupied bed days (v)
<table><tr><td>Baseline</td><td>2012/13</td></tr><tr><td>12,894</td><td>12,720</td></tr></table></td><td>Access to services is improved; Intervention is early; Support services are appropriate

Reduced number of people experiencing a mental health crisis,</td><td>Reduced acute mental health inpatient admissions (v,q)
Baseline: 461[94]

Reduced acute mental health inpatient re-admissions (v,q)[95]
Baseline: 23%</td><td>Better quality of life, more participation and independence</td></tr>
</table>

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

[94] 2009/10. High quality services will result in reduced acute episodes, reflected in reduced hospital admissions.

[95] Readmission rates are a measure of quality, as they reflect appropriate discharge timing and processes.

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 2012/13 year, except as below

Change	Description of the Change	Benefits of the change	Link lower funding path?	Change due to Local Regional, or National reasons?
Pharmacist Services	Proposal to look at an alternative way of funding community pharmacist services and enhanced services for people with Long Term Conditions assessed as needing additional support. Current pharmaceutical dispensing costs are financially unsustainable with 5-7% year on year increase Current workforce poorly integrated with primary care. Little motivation in funding arrangements to focus on health outcomes and management of chronic conditions.	• Support *Better, Sooner, more Convenient* care. • Improve health outcomes for people with Long-Term Conditions. • Reduce health inequalities. • Contain dispensing costs. • Improve workforce utilisation and community pharmacists working at the top of their scope of practice.	Yes	National initiative to improve community pharmacist services. National commitment to review pharmacist services as part of current national Agreement

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.

MODULE 7: FINANCIAL PERFORMANCE

7.1 Managing Financial Resources

In summary, our financial position for 2012/13 is breakeven with a forecast breakeven position in out years.

7.2 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).

7.2.1 Summary of Operating Budget

Our operating forecast for 2012/13 and for the outyears is for breakeven.

Key Financial Information is in the following table

Hutt Valley District Health Board
Key Financial Information
For the Year Ended 30 June

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Revenue	420,343	433,427	439,909	447,477	455,180
Expenditure	(423,208)	(433,394)	(439,909)	(447,474)	(455,177)
Gain/(Loss) on Sale of Assets	(9)	(33)	-	(3)	(3)
Net Surplus / (Deficit)	(2,874)	-	-	-	-
Total Fixed Assets	168,880	190,678	191,836	186,138	186,961
Net Assets	64,090	68,296	68,089	67,882	67,675
Term Borrowings	(61,054)	(86,874)	(91,399)	(91,624)	(91,849)

7.2.3 Funding Advice

Funding advice was received in December 2011 that included additional funding for 2012/13. The additional funding consists of a 1.49% increase for relieving cost pressures, and an increase of 0.99% for demographic funding.

7.2.3 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	Statement of Forecast Service Performance Expenditure 2012/13 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 ('000s)	Total Budgeted Expenditure ('000s)
Prevention	21,898	-	21,898
Early Detection & Management	100,375	12,214	112,589
Intensive Assessment & Treatment	186,214	60,537	246,751
Rehabilitation & Support	53,797	4,864	58,661
TOTALS	**362,284**	**77,615**	**439,899**

7.3 Assumptions

The key assumptions have been included in our preparation of the forecast financial statements for 2012/15. 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 $19.8 million is planned for 2012/13.
- The ED theatre redevelopment included the build programme will be completed during 2011/12, however in 2012/13 some residual payments on this project are expected to be paid together with the part of the project relating to refurbishment.
- We have assumed a replacement of our financial management system during 2012/13 at a total cost of $1.5m over two years. Our current system will not be supported from 30/6/12. We are working on options with HBL and healthAlliance.
- The last revaluation occurred in June 2011, which produced a movement that was not of sufficient size to warrant a taking up in the accounts. A desktop evaluation to be undertaken in June 2012 is not expected to show a material movement.
- A new ownership investment in an associated business is included in this Plan, relating to ownership of assets from the CRISP project.
- 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 3.20% and 3.18% in 2012/13, and 2013/14.
- Revenue increase from population based funding and demographic changes have been included at 2.47% in 2012/13, 1.73% in 2013/14 and 1.70% in 2014/15.
- No change in capital charge rate of 8%.
- Additional compliance costs e.g. Archives Act changes may be met out of retained earnings.
- There will be no changes to intervention rates and inter-district flows, with no significant impact on

net costs.

- The Statement of Financial Performance does not include the full value of our contract with Aotea Pathology Ltd. Hutt DHB is the lead DHB for this contract but the share of the contract relating to Capital Coast DHB has been treated as an agency relationship.
- No material costs have been included for a pandemic or other natural disaster.
- The national procurement and our own internal procurement programme will deliver $1.8m 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 changed in March 20012, i.e. 376 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 2011, 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 $0.8M revenue.

National Policy

- Government policy settings and 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.

7.3.1 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.

- Health Targets and Performance Measures – where these attract financial consequences, we have assumed they will be met. Not all measures are within our sole control.

7.3.2 OutYears 2013/14 to 2014/15

We have assumed base revenue increases of 1.72% for 2013/14 and 1.70% in 2014/15 years respectively. Both years reflect the impact of service reconfigurations.

7.4 Efficiency Initiatives

The DHB needs to achieve $9m of savings in 2012/13 to reach a break even financial result. It has decided to approach this requirement by improving its configuration and service delivery to improve future sustainability. The goal is to reach the savings target in a way which delivers better services, not simply cheaper, applying a "Triple Aim" approach.

A program of work for delivering the required savings has been created. This consists of a significant number of projects and initiatives being a combination of "business as usual" improvements, evolutionary improvements, and transformational changes to models of care.

We have incorporated into these plans efficiency initiatives of $9.0M in 2012/13 and $0.8M in 2013/14. These include:

- Improving hospital discharge processes and reducing unnecessary patient time in hospital (both admissions and length of stay through, for example, reducing ambulatory sensitive hospitalisation rates)
- Better management of staff leave
- Implementing a staff management and rostering tool to ensure correct staffing levels and mix as part of a strengthened Ops Centre (acting as a central operational "brain" for the hospital)
- Optimising the surgical patient pathway
- Best practice prescribing
- Procurement and Waste Reduction Initiatives
- Exploring revenue opportunities from our facilities, for example fundraising and licensing opportunities.
- "Lean Thinking" processes

Rapid and successful progress in these projects requires appropriate resource. Accordingly, dedicated experienced resource is required, either by re-prioritising and releasing internal resource or buying in external resource.

7.5 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 2012 we will have drawn down the full amount. We will utilise finance leases of $4.3m in 2012/13 for the digital mammography programme. An assumption has been made that the loan due for repayment in April 2013 will be rolled over.

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
	10	Jun 11	5.45	4.24%	Dec 15
	11	Dec 11	6.00	3.71%	Dec 18
	12	Feb 12	6.00	2.915%	Apr 14
To be drawn	13	Apr 12	6.00		
To be drawn	14	Jun 12	4.10		
Total CHFA Loans			**79.00**		

Financial Tables

Financial Performance

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Revenue					
Revenue	210,127	216,689	219,528	225,987	232,178
Interest Revenue	459	351	372	382	388
Total Revenue	**210,586**	**217,040**	**219,900**	**226,369**	**232,566**
Expenditure					
Operating Expenditure	(197,865)	(200,091)	(199,791)	(205,570)	(211,701)
Depreciation	(10,079)	(11,955)	(14,642)	(15,451)	(15,963)
Interest Expense	(1,243)	(3,273)	(4,407)	(4,383)	(4,387)
Capital Charge	(4,987)	(4,808)	(5,568)	(5,537)	(5,541)
Internal Allocations	543	528	600	608	608
Total Expenditure	**(213,631)**	**(219,599)**	**(223,808)**	**(230,333)**	**(236,984)**
Net Surplus/(Deficit)	**(3,045)**	**(2,559)**	**(3,908)**	**(3,964)**	**(4,418)**
Gain/(Loss) on Sale of Assets	(9)	(33)	-	(3)	(3)
Net Surplus/(Deficit)	**(3,054)**	**(2,592)**	**(3,908)**	**(3,967)**	**(4,421)**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**(3,054)**	**(2,592)**	**(3,908)**	**(3,967)**	**(4,421)**
Expenditure Breakdown:					
Personnel Costs	(148,097)	(152,098)	(152,592)	(157,290)	(161,792)
Outsourced Services	(6,292)	(5,171)	(5,360)	(6,683)	(8,286)
Clinical Supplies	(27,000)	(27,868)	(27,803)	(27,640)	(27,571)
Infrastructure and Non-Clinical Supplies	(32,784)	(34,990)	(38,653)	(39,328)	(39,943)
Internal Allocations	543	528	600	608	608
Total Expenditure	**(213,630)**	**(219,599)**	**(223,808)**	**(230,333)**	**(236,984)**

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Revenue					
Revenue	3,171	3,220	3,138	3,181	3,230
Interest Revenue	-	-	-	-	-
Total Revenue	**3,171**	**3,220**	**3,138**	**3,181**	**3,230**
Expenditure					
Operating Expenditure	(2,625)	(2,430)	(2,538)	(2,571)	(2,611)
Depreciation	-	(2)	-	(2)	(2)
Internal Allocations	(543)	(528)	(600)	(608)	(617)
Total Expenditure	**(3,168)**	**(2,960)**	**(3,138)**	**(3,181)**	**(3,230)**
Net Surplus/(Deficit)	**3**	**260**	**-**	**-**	**-**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**3**	**260**	**-**	**-**	**-**
Expenditure Breakdown:					
Personnel Costs	(1,389)	(1,631)	(1,675)	(1,695)	(1,721)
Outsourced Services	(378)	(357)	(336)	(344)	(349)
Clinical Supplies	-	(1)	-	-	-
Infrastructure and Non-Clinical Supplies	(858)	(443)	(527)	(534)	(543)
Internal Allocations	(543)	(528)	(600)	(608)	(617)
Total Expenditure	**(3,168)**	**(2,960)**	**(3,138)**	**(3,181)**	**(3,230)**

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Revenue					
Revenue	381,626	398,248	405,093	412,147	419,304
Total Revenue	**381,626**	**398,248**	**405,093**	**412,147**	**419,304**
Expenditure					
Provider Expenditure	(381,449)	(395,916)	(401,185)	(408,180)	(414,883)
Total Expenditure	**(381,449)**	**(395,916)**	**(401,185)**	**(408,180)**	**(414,883)**
Net Surplus/(Deficit)	**177**	**2,332**	**3,908**	**3,967**	**4,421**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**177**	**2,332**	**3,908**	**3,967**	**4,421**
Expenditure Breakdown:					
Personal Health	(289,211)	(299,996)	(304,652)	(310,591)	(316,275)
Mental Health	(39,866)	(39,853)	(39,935)	(40,704)	(41,429)
DSS	(47,949)	(51,543)	(52,038)	(52,269)	(52,509)
Public Health	(66)	(207)	(276)	(291)	(299)
Maori Health	(1,200)	(1,220)	(1,272)	(1,272)	(1,272)
Internal Allocations	(3,157)	(3,097)	(3,012)	(3,053)	(3,099)
Total Expenditure	**(381,449)**	**(395,916)**	**(401,185)**	**(408,180)**	**(414,883)**

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Revenue					
Revenue	419,884	433,076	439,537	447,095	454,792
Interest Revenue	459	351	372	382	388
Total Revenue	**420,343**	**433,427**	**439,909**	**447,477**	**455,180**
Expenditure					
Provider Expenditure	(206,410)	(210,835)	(212,963)	(213,960)	(214,972)
Operating Expenditure	(200,489)	(202,521)	(202,329)	(208,141)	(214,312)
Depreciation	(10,079)	(11,957)	(14,642)	(15,453)	(15,965)
Interest Expense	(1,243)	(3,273)	(4,407)	(4,383)	(4,387)
Capital Charge	(4,987)	(4,808)	(5,568)	(5,537)	(5,541)
Total Expenditure	**(423,208)**	**(433,394)**	**(439,909)**	**(447,474)**	**(455,177)**
Net Surplus/(Deficit)	**(2,865)**	**33**	**-**	**3**	**3**
Gain/(Loss) on Sale of Assets	(9)	(33)	-	(3)	(3)
Net Surplus/(Deficit)	**(2,874)**	**-**	**-**	**-**	**-**
Comprehensive Income - Gain/(Loss)					
Property Revaluations	-	-	-	-	-
Foreign Currency Translation Reserve	-	-	-	-	-
Cashflow Hedge Reserve	-	-	-	-	-
Asset for Sale Financial Assets Reserve	-	-	-	-	-
Total Comprehensive Income	**(2,874)**	**-**	**-**	**-**	**-**

Movements in Equity

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Crown Equity	40,204	44,410	44,203	43,996	43,789
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings at Beginning of Period	(23,609)	(26,482)	(26,482)	(26,482)	(26,482)
Total Comprehensive Income for the Period	(2,873)	-	-	-	-
Closing Equity	**64,090**	**68,296**	**68,089**	**67,882**	**67,675**

Financial Position

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Public Equity					
Equity	40,204	44,410	44,203	43,996	43,789
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings	(26,482)	(26,482)	(26,482)	(26,482)	(26,482)
Total Equity	**64,090**	**68,296**	**68,089**	**67,882**	**67,675**
Represented by:					
Current Assets					
Bank in Funds	4,122	5,124	214	2,719	3,735
Receivables and Prepayments	16,112	16,172	15,305	15,290	15,570
Inventories	1,264	1,274	1,289	1,284	1,294
Total Current Assets	**21,498**	**22,570**	**16,808**	**19,293**	**20,599**
Current Liabilities					
Bank Overdraft	-	-	(2,700)	-	-
Payables and Provisions	(65,234)	(58,078)	(47,323)	(46,792)	(48,903)
Short Term Borrowings	-	-	-	-	-
Total Current Liabilities	**(65,234)**	**(58,078)**	**(50,023)**	**(46,792)**	**(48,903)**
Net Working Capital	**(43,736)**	**(35,508)**	**(33,215)**	**(27,499)**	**(28,304)**
Non Current Assets					
Property, Plant and Equipment	168,880	190,678	191,836	186,138	186,961
Trust Funds	902	952	992	1,047	1,092
Investment in Associates	-	-	867	867	867
Total Non Current Assets	**169,782**	**191,630**	**193,695**	**188,052**	**188,920**
Non Current Liabilities					
Borrowings and Provisions	(61,054)	(86,874)	(91,399)	(91,624)	(91,849)
Trust Funds	(902)	(952)	(992)	(1,047)	(1,092)
Total Non Current Liabilities	**(61,956)**	**(87,826)**	**(92,391)**	**(92,671)**	**(92,941)**
Net Assets	**64,090**	**68,296**	**68,089**	**67,882**	**67,675**

Cash Flow

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Operating Cash Flows					
Cash Receipts	430,807	433,026	440,424	447,125	454,522
Payments to Providers and Suppliers	(266,508)	(266,601)	(264,762)	(263,013)	(265,159)
Payments to Employees	(148,749)	(153,772)	(153,960)	(160,165)	(163,103)
Interest Paid	(2,090)	(3,273)	(4,407)	(4,383)	(4,387)
Capital Charge Paid	(4,927)	(4,808)	(5,568)	(5,537)	(5,541)
Net Operating Cash Flows	**8,533**	**4,572**	**11,727**	**14,027**	**16,332**
Investing Cash Flows					
Cash Received from Sale of Fixed Assets	17	33	-	3	3
Cash Paid for Purchase of Fixed Assets	(39,926)	(33,755)	(23,800)	(9,000)	(15,500)
Interest Received	459	351	372	382	388
Net Investing Cash Flows	**(39,450)**	**(33,371)**	**(23,428)**	**(8,615)**	**(15,109)**
Financing Cash Flows					
Equity Injections	1,646	4,206	(207)	(207)	(207)
Additional Loans Drawn	24,900	25,595	4,300	-	-
Loans Repaid	-	-	-	-	-
Net Financing Cash Flows	**26,546**	**29,801**	**4,093**	**(207)**	**(207)**
Net Cash Flows	**(4,371)**	**1,002**	**(7,608)**	**5,205**	**1,016**
Opening Cash Balance	8,493	4,122	5,124	(2,484)	2,721
Closing Cash Balance	**4,122**	**5,124**	**(2,484)**	**2,721**	**3,737**
Represented by:					
Bank in Funds	4,122	5,124	214	2,719	3,735
Bank Overdraft	-	-	(2,700)	-	-
Total Cash On Hand	**4,122**	**5,124**	**(2,486)**	**2,719**	**3,735**

Capex

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

$000s	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Approved / Baseline Expenditure					
Property and Plant	2,192	1,800	1,800	1,800	1,800
Clinical Equipment	1,212	2,000	2,000	2,000	2,000
Computer Equipment	1,186	1,500	1,500	1,500	1,500
Other Equipment	328	200	200	200	200
Motor Vehicles	212	-	-	-	-
Total Baseline	**5,130**	**5,500**	**5,500**	**5,500**	**5,500**
Strategic (Approved)					
Emergency Department & Theatre Development Project	30,715	20,086	7,000	-	-
Child Oral Health	4,081	7,669	2,000	-	-
MRI Replacement	-	-	-	2,250	-
CT Scanner	-	-	-	1,250	-
Financial Management Information System	-	500	1,000	-	-
Total Approved	**34,796**	**28,255**	**10,000**	**3,500**	**-**
All Other Approved Projects	**-**	**-**	**-**	**-**	**-**
All Other Projects	-	-	4,300	-	10,000
Total Capital Expenditure	**39,926**	**33,755**	**19,800**	**9,000**	**15,500**
Financed By:					
Internally Sourced Funding	(2,982)	-	-	-	-
Equity Injections for Deficit Support	-	-	-	-	-
Depreciation	10,079	11,957	14,642	14,698	14,677
Sale of Fixed Assets	9	-	-	-	-
Equity Injections for Capital Expenditure	1,853	4,413	-	-	-
Private Debt	-	3,495	4,300	-	-
CHFA Debt	24,900	22,100	-	-	-
Other (Includes Cash Reserves)	6,067	-	900	-	900
	39,926	**41,965**	**19,842**	**14,698**	**15,577**

FTEs

DHB Provider
FTEs by Class
For the Year Ended 30 June

	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Medical	231.8	232.6	232.6	232.6	232.6
Nursing	699.2	702.6	689.8	689.8	689.8
Allied Health	396.0	448.4	444.9	444.9	444.9
Non-Allied Health	128.7	128.6	129.8	129.8	129.8
Management/Clerical	337.9	330.9	321.0	321.0	321.0
Total FTEs	**1,793.5**	**1,843.0**	**1,818.2**	**1,818.2**	**1,818.2**

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

	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Medical	0.7	-	0.3	0.3	0.3
Nursing	0.0	-	-	-	-
Allied Health	-	-	-	-	-
Non-Allied Health	-	-	-	-	-
Management/Clerical	14.4	18.2	18.4	18.4	18.4
Total FTEs	**15.2**	**18.2**	**18.7**	**18.7**	**18.7**

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

	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Medical	232.5	232.6	232.9	232.9	232.9
Nursing	699.2	702.6	689.8	689.8	689.8
Allied Health	396.0	448.4	444.9	444.9	444.9
Non-Allied Health	128.7	128.6	129.8	129.8	129.8
Management/Clerical	352.4	349.2	339.4	339.4	339.4
Total FTEs	**1,808.7**	**1,861.2**	**1,836.8**	**1,836.8**	**1,836.8**

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

$000s	2010\11 Audited Actual	2011\12 Forecast	2012\13 Plan	2013\14 Plan	2014\15 Plan
Revenue					
Revenue	23,051	21,552	21,290	21,681	22,083
Interest Revenue	-	-	-	-	-
Total Revenue	**23,051**	**21,552**	**21,290**	**21,681**	**22,083**
Expenditure					
Operating Expenditure	(19,457)	(18,014)	(17,551)	(17,976)	(18,398)
Depreciation	(359)	(275)	(717)	(714)	(700)
Interest Expense	-	(62)	(284)	(283)	(283)
Capital Charge	-	(228)	(238)	(238)	(238)
Internal Allocations	(2,911)	(2,457)	(3,108)	(2,633)	(2,634)
Total Expenditure	**(22,727)**	**(21,037)**	**(21,898)**	**(21,844)**	**(22,253)**
Net Surplus / (Deficit)	**323**	**515**	**(608)**	**(163)**	**(170)**
Gain / (Loss) on Sale of Assets	-	-	-	-	-
Net Surplus / (Deficit)	**323**	**515**	**(608)**	**(163)**	**(170)**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**323**	**515**	**(608)**	**(163)**	**(170)**
Expenditure Breakdown:					
Personnel Costs	(13,078)	(12,939)	(13,076)	(13,447)	(13,804)
Outsourced Services	(1,091)	(811)	(865)	(865)	(867)
Clinical Supplies	(2,005)	(1,725)	(2,014)	(1,982)	(1,947)
Infrastructure and Non-Clinical Supplies	(1,404)	(1,500)	(1,637)	(1,709)	(1,771)
IDF Outflows	(74)	-	-	-	-
External Contract Payments	(2,163)	(1,605)	(1,634)	(1,651)	(1,673)
Internal Allocations	(2,911)	(2,457)	(2,672)	(2,190)	(2,191)
Total Expenditure	**(22,727)**	**(21,037)**	**(21,898)**	**(21,844)**	**(22,253)**

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

$000s	2010\11 Audited Actual	2011\12 Forecast	2012\13 Plan	2013\14 Plan	2014\15 Plan
Revenue					
Revenue	109,590	113,965	116,410	117,313	118,353
Interest Revenue	-	-	-	-	-
Total Revenue	**109,590**	**113,965**	**116,410**	**117,313**	**118,353**
Expenditure					
Operating Expenditure	(104,482)	(106,003)	(108,012)	(109,146)	(110,241)
Depreciation	(162)	(575)	(952)	(940)	(919)
Interest Expense	-	(41)	(41)	(41)	(41)
Capital Charge	(213)	(406)	(983)	(978)	(979)
Internal Allocations	(2,992)	(2,256)	(2,601)	(2,124)	(2,128)
Total Expenditure	**(107,849)**	**(109,281)**	**(112,589)**	**(113,229)**	**(114,308)**
Net Surplus / (Deficit)	**1,740**	**4,684**	**3,821**	**4,084**	**4,045**
Gain / (Loss) on Sale of Assets	(1)	(11)	-	(3)	(3)
Net Surplus / (Deficit)	**1,740**	**4,673**	**3,821**	**4,081**	**4,042**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**1,740**	**4,673**	**3,821**	**4,081**	**4,042**
Expenditure Breakdown:					
Personnel Costs	(11,956)	(10,814)	(11,476)	(11,826)	(12,166)
Outsourced Services	(433)	(351)	(319)	(321)	(324)
Clinical Supplies	(814)	(1,321)	(1,183)	(1,176)	(1,163)
Infrastructure and Non-Clinical Supplies	(2,305)	(2,429)	(2,961)	(2,943)	(3,392)
IDF Outflows	(7,250)	(11,985)	(12,214)	(12,146)	(12,076)
External Contract Payments	(82,099)	(80,125)	(81,835)	(82,693)	(83,059)
Internal Allocations	(2,992)	(2,256)	(2,601)	(2,124)	(2,128)
Total Expenditure	**(107,849)**	**(109,281)**	**(112,589)**	**(113,229)**	**(114,308)**

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

$000s	2010\11 Audited Actual	2011\12 Forecast	2012\13 Plan	2013\14 Plan	2014\15 Plan
Revenue					
Revenue	230,759	240,668	243,808	249,616	255,312
Interest Revenue	459	351	372	382	388
Total Revenue	**231,218**	**241,019**	**244,180**	**249,998**	**255,700**
Expenditure					
Operating Expenditure	(227,794)	(232,814)	(231,995)	(237,052)	(242,496)
Depreciation	(9,552)	(11,098)	(12,965)	(13,791)	(14,339)
Interest Expense	(1,243)	(3,167)	(4,079)	(4,057)	(4,061)
Capital Charge	(4,774)	(4,165)	(4,339)	(4,314)	(4,316)
Internal Allocations	6,649	5,259	6,628	5,793	5,800
Total Expenditure	**(236,715)**	**(245,986)**	**(246,751)**	**(253,421)**	**(259,412)**
Net Surplus / (Deficit)	**(5,497)**	**(4,967)**	**(2,571)**	**(3,423)**	**(3,712)**
Gain / (Loss) on Sale of Assets	(8)	(22)	-	-	-
Net Surplus / (Deficit)	**(5,505)**	**(4,989)**	**(2,571)**	**(3,423)**	**(3,712)**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**(5,505)**	**(4,989)**	**(2,571)**	**(3,423)**	**(3,712)**
Expenditure Breakdown:					
Personnel Costs	(121,119)	(126,409)	(126,149)	(129,993)	(133,679)
Outsourced Services	(5,052)	(4,277)	(4,430)	(5,747)	(7,351)
Clinical Supplies	(22,935)	(23,551)	(23,665)	(23,530)	(23,486)
Infrastructure and Non-Clinical Supplies	(29,749)	(31,356)	(34,354)	(35,064)	(35,700)
IDF Outflows	(60,031)	(61,268)	(60,537)	(60,592)	(60,648)
External Contract Payments	(4,478)	(4,384)	(4,244)	(4,288)	(4,348)
Internal Allocations	6,649	5,259	6,628	5,793	5,800
Total Expenditure	**(236,715)**	**(245,986)**	**(246,751)**	**(253,421)**	**(259,412)**

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

$000s	2010\11 Audited Actual	2011\12 Forecast	2012\13 Plan	2013\14 Plan	2014\15 Plan
Revenue					
Revenue	56,486	56,891	58,019	58,485	59,044
Interest Revenue	-	-	-	-	-
Total Revenue	**56,486**	**56,891**	**58,019**	**58,485**	**59,044**
Expenditure					
Operating Expenditure	(55,167)	(56,526)	(57,724)	(57,926)	(58,149)
Depreciation	(6)	(8)	(8)	(8)	(7)
Interest Expense	-	(2)	(2)	(2)	(2)
Capital Charge	-	(8)	(8)	(8)	(8)
Internal Allocations	(745)	(546)	(919)	(1,036)	(1,038)
Total Expenditure	**(55,918)**	**(57,090)**	**(58,661)**	**(58,980)**	**(59,204)**
Net Surplus / (Deficit)	**568**	**(199)**	**(642)**	**(495)**	**(160)**
Gain / (Loss) on Sale of Assets	-	-	-	-	-
Net Surplus / (Deficit)	**568**	**(199)**	**(642)**	**(495)**	**(160)**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**568**	**(199)**	**(642)**	**(495)**	**(160)**
Expenditure Breakdown:					
Personnel Costs	(3,334)	(3,580)	(3,656)	(3,770)	(3,875)
Outsourced Services	(93)	(90)	(87)	(88)	(89)
Clinical Supplies	(1,236)	(1,273)	(1,351)	(1,344)	(1,345)
Infrastructure and Non-Clinical Supplies	(197)	(134)	(149)	(149)	(149)
IDF Outflows	(5,886)	(4,752)	(4,864)	(4,877)	(4,890)
External Contract Payments	(44,427)	(46,543)	(47,635)	(47,716)	(47,818)
Internal Allocations	(745)	(718)	(919)	(1,036)	(1,038)
Total Expenditure	**(55,918)**	**(57,090)**	**(58,661)**	**(58,980)**	**(59,204)**

MODULE 8: APPENDICES

8.1 MONITORING FRAMEWORK PERFORMANCE MEASURES

Dimensions of DHB Performance Measures (Non financial)

2012/13 Performance Measures

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation set)

Policy Priorities Dimension

Performance Measure and description	2012/13 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 provides a qualitative report as follows: 1. Those DHBs with BSMC Alliance are required to submit jointly agreed • Year Two Implementation Plans by 31 December 2011 or earlier. • Quarterly reports outlining progress against the key deliverables in the jointly agreed Year Two Implementation Plans including resolution plans for any areas of slippage against deliverables • Quarterly reports on the operation and expenditure of the Flexible Funding Pool, including how pool funding has been jointly prioritised to deliver services. 2. All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures: • Description of how all necessary clinicians and managers (primary/community and secondary) will be involved ongoing in the process of development, delivery and review • Activities to integrate community pharmacy • Activities to expand and integrate nursing services • Evidence of health needs analysis of population by localities • Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long term conditions i.e. CVD/Diabetes) including: o Identification of and achievement against targets for the number of people that are expected to be appropriately managed in a primary/community setting instead of secondary care o Identification of and achievement against targets for growth reduction in ED attendance, acute inpatient admissions and bed days o Identification of and achievement against a target for the prevention of readmissions for the 75+ population (and any other target populations) o Identification of, and achievement against new service activity in quantified patient terms • Identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model • Progress against the above infrastructure and revenue stream milestones • Identification of and progress against the activities to ensure free after-hours services to children under six years of age. Additional reporting deliverable required for Quarter 4: Each DHB must provide a report with the following information: • each PHO's working capital requirements • each PHO's total cash balance and total income in advance at the end of the financial year	qualitative deliverable required Set Q1 3% 11.87% Set Q1 qualitative deliverable required	NA	Quarterly

• the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level, and • a copy of the relevant PHO's forecast expenditure plans.					
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 Māori, Pacific , and in total • adults aged 20-64, specified for each of the three categories Māori, Other, and in total • older people aged 65+, specified for each of the three categories Māori, Other, and in total.	**Age 0-19**	Total	3.2%	N/A	Six- Monthly
		Maori	3.45%		
	Age 20-64	Total	4%		
		Maori	6.9%		
	Age 65+	Total	NA%		
PP7 Improving mental health services using relapse prevention 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+)**	Total	95%	**95%**	Six-Monthly
		Māori	95%	**95%**	
	Child & Youth	Total	95%	**95%**	
		Māori	95%	**95%**	

PP8 Shorter waits for non-urgent mental health and addiction services

80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks. *DHBs will be required to meet this target within three years. DHBs will need to set and agree with the Ministry individualised targets (based on data provided by the Ministry) stepped over the three years to ensure the target is met.*

Rolling annual waiting time data will be provided by the Ministry sourced from PRIMHD

A narrative is required to:
1. identify what processes have been put in place to reduce waiting times
2. explain variances of more than 10% waiting times target

Note: The Midland region DHBs will include, as requested, their Child and Youth NGO Mental Health services as part of this performance measure.

%

Mental Health Provider Arm

	<= 3 weeks	<=8 weeks
Age	**Proposed target (%)**	**Proposed target (%)**
0-19	65%	80%
20-64	65%	80%
65+	65%	80%
Total	65%	80%

Addictions (Provider Arm and NGO)

	<= 3 weeks	<=8 weeks
Age	**Proposed target (%)**	**Proposed target (%)**
0-19	65%	80%
20-64	65%	80%
65+	65%	80%
Total	65%	80%

Six-Monthly

PP10 Oral Health DMFT Score at year 8 Transitional measure (not included in performance dashboard reports)				
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).	Total population	0.81 year 1 year 2	NA	Annual
	Maori	0.81	NA	Annual
	Pacific	0.81	NA	Annual
PP11 Children caries free at 5 years of age Transitional measure (not included in performance dashboard reports)				
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).	Total population	69.85%	NA	Annual
	Maori	69.85%	NA	Annual
	Pacific	69.85%	NA	Annual
PP12 Utilisation of DHB funded dental services by adolescents **Transitional measure (not included in performance dashboard reports)**				
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, Māori 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 Population	80% Yr 1 85% Yr 2	**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 Māori oral health providers).	Children Enrolled **0-4 years**	73% Yr 1 75% Yr 2	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 Māori 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**	8% Yr 1 5% Yr 2		

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		Supply of quantitative data required.	NA	Annual
PP18 Improving community support to maintain the independence of older people				
Numerator: The number of people aged 65 and older who have received long-term home-support services in the last three months who have had a Comprehensive Clinical Assessment and a completed care plan. Denominator: The number of people aged 65 and older who have received long-term home-support services in the last three months.		95%	95%+	Quarterly
PP 20 improved management for long term conditions (CVD, diabetes and Stroke)				
Part 1, Focus area 1: Cardiovascular disease DHBs supply a quarterly narrative report that comments on data supplied by the Ministry, and DHB performance in relation to the number of people diagnosed with ischemic heart disease and on lipid lowering medications, with a view to establishing a formal performance baseline for application in 2013/14.		No quantitative target Progress to be demonstrated via qualitative deliverable .	NA	Quarterly
Part 1, Focus area 2: Stroke services DHBs are to provide a quarterly narrative report on stroke services delivered including plans and actions to improve services.				
Part 1, Focus area 3: Maintain or Improve access to Diabetes Annual Reviews Numerator - Count of enrolled people in the PHO with a record of a Diabetes Annual Review during the reporting period Denominator - The number of enrolled people in the PHO who would be expected to have diagnosed diabetes, using the Diabetes Prevalence Estimate Data Source: PHO Performance Programme Indicators Definitions 1 July 2011 version5.3 Sept11		75%		
Part 2, Focus area 1. Progress in delivery of Diabetes care improvements Provide a quarterly progress report on delivery of actions and volumes agreed for each Improvement area identified in the Annual Plan.		Qualitative deliverable.		
Part 2, Focus area 2 Local Diabetes Team Service (or an equivalent service).. Provide the annual report from the local diabetes team to the Ministry as outlined in the Service Specification for Specialist Medical and Surgical Services – Diabetes Service – Local Diabetes Team Service (or an equivalent service).				Annual
Part 2, Focus area 3. Diabetes Management Numerator: (Data source: DHB to provide). The number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64% at their free annual check during the reporting period. Denominator: (Data source: DHB to provide. Note that this is the numerator from the Diabetes Free Annual Check indicator). The number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period.	Total	73%		Quarterly
	Maori	73%		
	Pacific	73%		

PP 21 Ensure Immunisation coverage for two year olds					
Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan. The Ministry will provide summary data for the quarter on the nationwide service framework library web site NSFL homepage: http://www.nsfl.health.govt.nz/.			95%	95%	Quarterly

System Integration Dimension

Performance Measure and description			2012/13 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 Māori 45-64 year olds.	**Age 0-74**	Total	120	NA	Six-Monthly
		Māori	120		
		Pacific	120		
	Age 0-4	Total	152		
		Māori	152		
		Pacific	152		
	Age 45-64	Total	108		
		Māori	108		
		Pacific	108		
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 Progress to be demonstrated via qualitative deliverable.	NA	Quarterly
SI3 Ensuing delivery of Service coverage					
Exception report - 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 exception based qualitative deliverable required.	NA	Six-Monthly

SI4 Elective services standardised intervention rates				
Data sourced from National Minimum Dataset. Exception report - For any procedure where the standardised intervention rate in the 2011/12 financial 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 (2012/13) that will ensure the target rate is achieved	**Major joint replacement procedures**	21 per 10,000	21.0 per 10,000	Annual quarter1
	Cataract Procedures	27 per 10,000	27.0 per 10,000	
Cardiac Procedures Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter 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 (2012/13) that will ensure the target rate is achieved.		6.0 per 10,000	For cardiac surgery a target intervention rate of between 6.2 and 6.5 per 10,000	Quarterly
		11.9 per 10,000	For percutaneous revascularization a target rate of at least 11.9 per 10,000	
		32.3 per 10,000	For coronary angiography services a target rate of at least 32.3 per 10,000	

SI5 Delivery of Whānau Ora			
The DHB provides a qualitative report identifying progress within the year that shows the DHB's active engagement with existing and emerging Whānau Ora Provider Collectives, steps towards improving service delivery within these providers, and supporting the building of mature providers. This will include a summary of the following – how the DHB is: • Contributing to the strategic change for Whānau Ora in the district • Contributing information about Whānau Ora within the district at appropriate forums, including nationally. • Investing in Whānau Ora Provider Collectives through deliberate activities • Involving the DHB's governors and management in the Whānau Ora activity in the district • Demonstrating meaningful activity moving towards improved service delivery and building mature providers.	No quantitative target qualitative deliverable required.	NA	Annual

SI7 Improving breast-feeding rates					
DHBs are expected to set DHB-specific breastfeeding targets with a focus on Māori, 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 Māori 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.	**6 weeks**	Total	64%	**74%**	Annual
		Māori	64%		
		Pacific	64%		
	3 Months	Total	52%	**57%**	
		Māori	52%		
		Pacific	52%		
	6 Months	Total	22%	**27%**	
		Māori	22%		
		Pacific	22%		

Ownership Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OS3 inpatient length of stay			
Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter 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 (2012/13) that will ensure the target rate is achieved.	3.81 Days	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	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
OS6 Elective and arranged day surgery			
Data sourced from National Minimum Dataset. Exception report - 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.	60%	59.2% 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. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	93%	DHBs will be supplied with comparative data on performance relative to other DHBs. For DHBs with a final 2010/11 result that is below 95 percent, their suggested target is 95 percent. For DHBs with a final 2010/11 result that is above 95 percent, their suggested target will be to maintain current levels.	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. Readmissions are aggregated by DHB of service. Where an acute readmission occurs within a different DHB to that of the previous inpatient discharge (ie, the first admission), and the previous discharge DHB of Service is consistent with the previous discharge Agency Code, the readmission will be allocated against the DHB of the initial inpatient discharge. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	To be agreed with Ministry of Health during Quarter 1 2012/13	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly
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)	less than or equal to 6.00%	Greater than 3.00% and less than or equal to 6.00%	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	less than or equal to 2%	Greater than 0.50% and less than or equal to 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	Greater than or equal to 55.00%	Greater than or equal to 55.00% and less than 65.00%	
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.	Less than or equal to 5.00% late	Greater than 2.00% and less than or equal to 5.00% late	
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	Greater than 97.00%	Greater than or equal to 97.00% and less than 99.50%	
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	Greater than or equal to 98.0%	Greater than or equal to 98.0% and less than 99.5%	

Developmental – Establishment of baseline (no target/performance expectation is set)

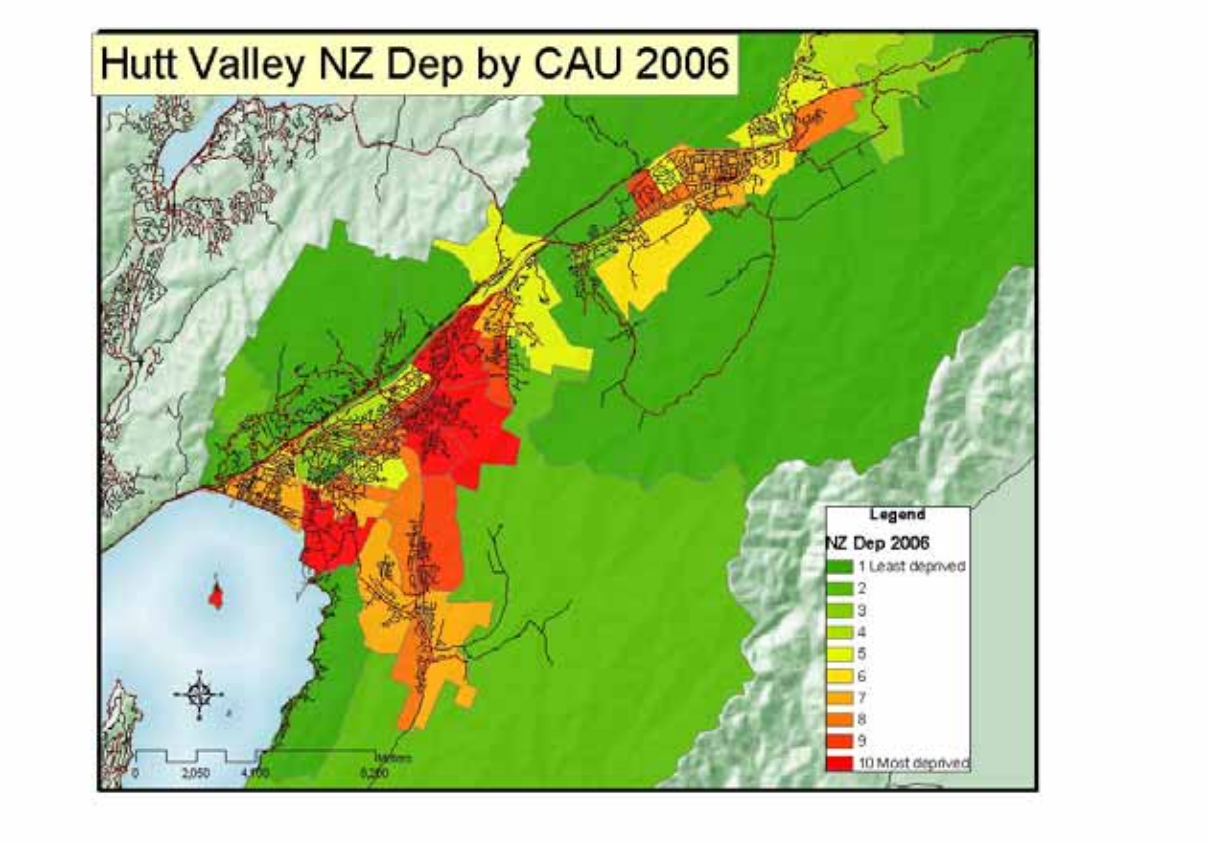
Performance Measure and description		Frequency
DV1: Faster cancer treatment		
Detailed information will be provided in the Ministry of Health's data definitions for the Faster cancer treatment indicators. Please refer to this document for information on the definitions, data collection and exceptions. This information will be available on the NSFL by March 2012.	data is provided to establish baseline	Quarterly

Performance Measure and description		Frequency
DV2: Improving waiting times for diagnostic services		
• Elective coronary angiogram to be reported to the National Booking Reporting System (NBRS) in accordance with NBRS data dictionary reporting requirements. • CT, MRI and colonoscopy reporting templates to be submitted to the National Health Board within 20 days of the end of the previous month. The reporting template will be located on the NSFL website with other Performance Measure documents.	data is provided to establish baseline	Monthly

Appendix 8.2 – Hutt Valley Population and Health Profile

Demographics

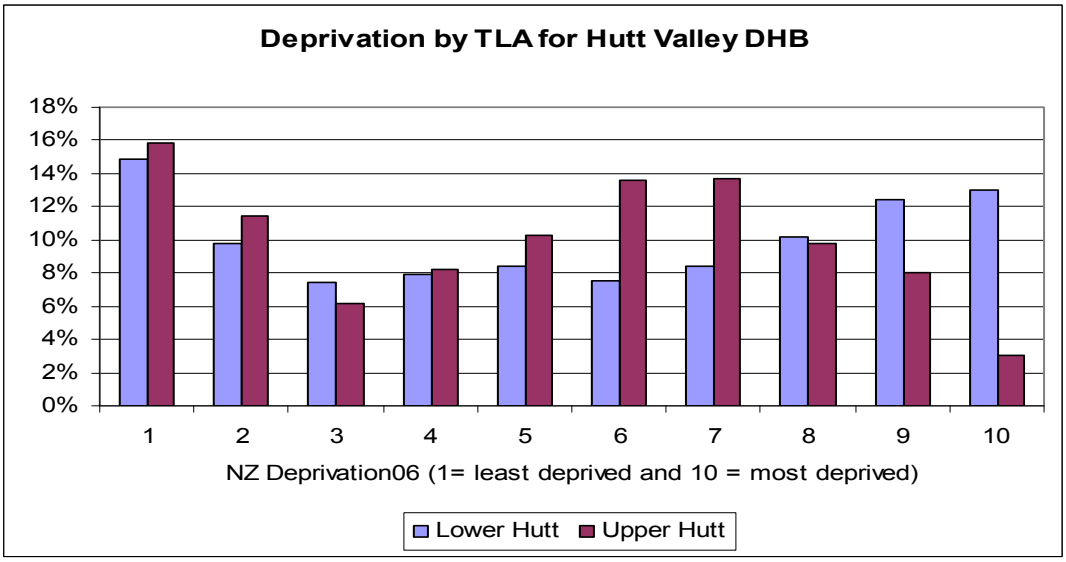
Hutt Valley DHB is home to 3 percent of the national population. Geographically it is an urban DHB, covering two territorial authorities: Hutt City and Upper Hutt City. Our neighbouring DHBs are Capital & Coast DHB, and Wairarapa DHB.



Key features of our population include:

- Our population is currently approximately 144,865[96], projected to increase to around 146,805 by 2026
- Population distribution (age, gender, ethnicity) is similar to the New Zealand population, but with a slightly higher proportion of Maori (17.6%) and Pacific 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 Hutt within Quintile 5, compared with 11% within Upper Hutt (compared to an average of 20%). This is shown by the table below.

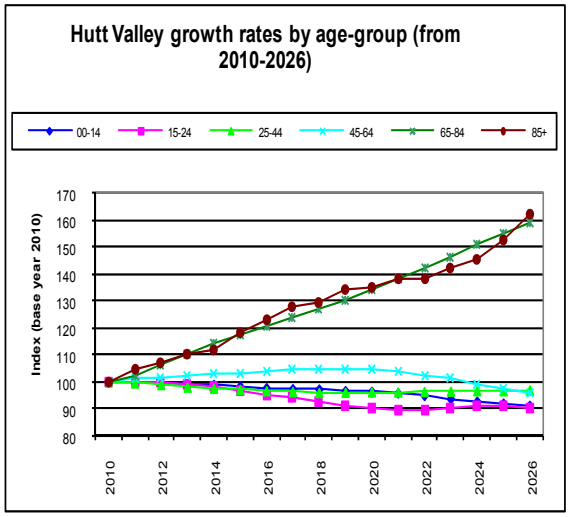
[96] 2011 NZ Stats Population Projections

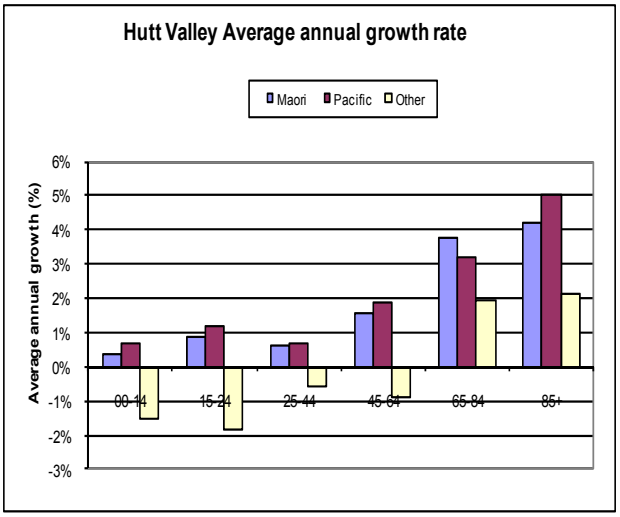


- Maori and Pacific people are over-represented in the most deprived areas.
- Information available from Census data indicates that an estimated 27,000 (17%) Hutt Valley residents have some form of disability and around 16,000 of those people are younger than 65 years. Most disabled people live in the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





Our Health Profile

The Hutt Valley DHB's health profile is gained through a comprehensive Health Needs Assessment (HNA)[97] 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. The following information is drawn from

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

the 2008 HNA and is being revised during 2012. 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.

Maori Health
Our current Maori population is around 25,585 people, which makes up 17.6% 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 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
- 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.

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 12,085 people, or 8.3 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
- Poorer access to oral health checks, diabetes checks, breast and cervical cancer screening

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 Maori and Pacific and 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.

Appendix 8.3 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 the 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 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 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 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 created 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 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	5.3% - 50%
Motor vehicles	5.5 – 12.5 years	8% - 18%
Computer equipment	3 – 5.5 years	18% - 33%
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 Statements (Statement of Objectives and Service Performance)

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

Cost Allocations

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

Cost drivers for allocation of indirect costs

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

Statement of Cash Flows

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

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

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

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

Impairment 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.

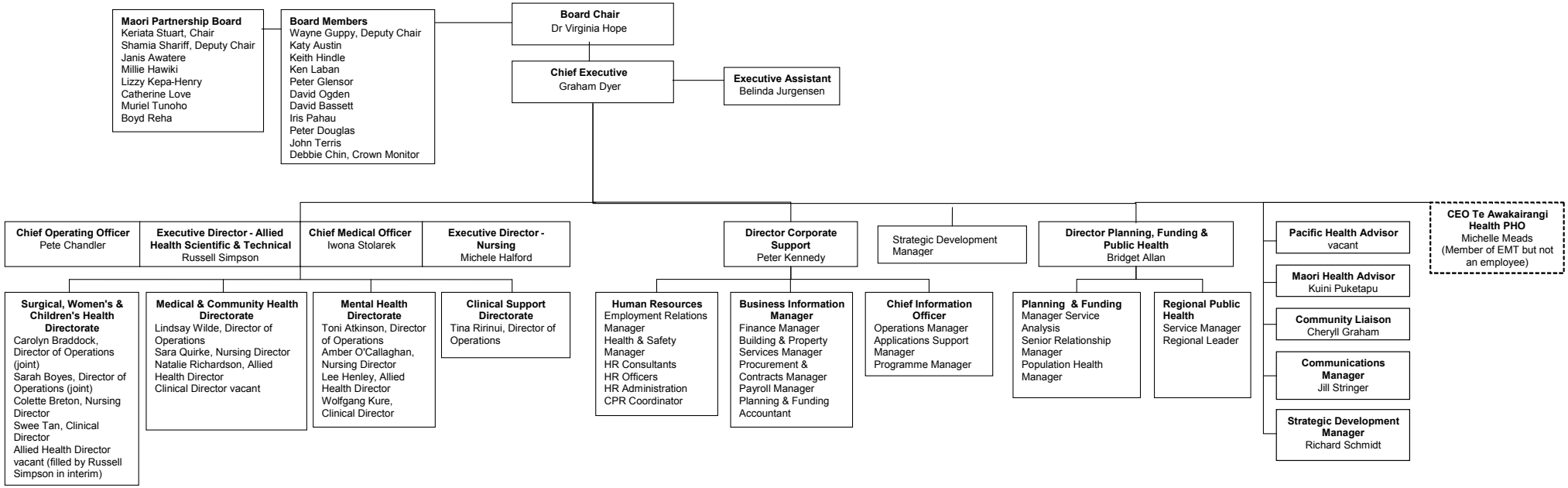
Financial instruments reflected in the statement of financial position include cash and bank balances, receivables, trade creditors and borrowings. These instruments are, generally, carried at their estimated fair value. For example, receivables are carried net of the estimated doubtful receivables. 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 8.4 Organisational Chart



Appendix 8.5 Workforce Strategy - STRENGTHENING OUR WORKFORCE

Ensuring that we have an appropriately skilled and engaged workforce is a key outcome for the DHB. The capability and attitude of our workforce is a key enabler to high quality services. However, as the single biggest employer in the Hutt Valley, the job satisfaction and engagement of the health workforce in the Hutt Valley has a far wider impact.

Our approach to workforce development sits within the wider context of national work led by Health Workforce NZ (HWNZ), and sub-regional and regional directions for developing and maintaining a sustainable health workforce within the changing health environment across the whole of system.

Nationally

The Government has acted at a national level to address workforce issues. HWNZ has been established to support DHBs to implement a range of initiatives designed to recruit, retain and develop the workforce in all specialties and in all areas - ensuring the NZ has the right mix and numbers of people to provide world class health care. Accordingly, some aspects of development activity at Hutt Valley DHB in the 2012/13 year will derive from our work with these organisations, ensuring that systems and processes introduced are standardised across the DHB sector.

Regionally

The Regional Services Plan reflects the expectation of Health Workforce New Zealand and focuses on Regional Training Hubs, the regional implementation of the National Services Reviews, Clinical Leadership and career planning.

The training hub will play a critical role in the coordination of clinical placements to support specialist training programmes. We will contribute to the design and function of the Central Region Training Hub via the Hub Governance Group and Hub Working Group

With regard to national services reviews, we will participate with our regional and sub regional colleagues to implement the recommendations as appropriate.

Sub-regionally

Our focus sub-regionally is led by the Subregional Clinical Leadership Group (SRCLG), a multi professional clinical group that spans primary to tertiary and includes leads from medical, nursing, and allied health. All are involved in the design and implementation of subregional services and developing strategies that promote a flexible and mobile workforce. As part of this approach, there will be emphasis on supporting clinicians in more isolated rural settings. Support for such developments is likely to include integrated quality frameworks, shared pathways and models of care, shared staff support units and approaches, and shared training and educational opportunities.

Locally

The DHB also plans to strengthen its workforce in relation to the following:

- Culture – an increased focus on performance and alignment with organisational objectives, and a more consistent approach to waste. Counter-Fraud training will also be undertaken to reinforce our expectations about the use of public funds.
- Capability, capacity, and change management
    - investing in leaders and future leaders through Canterbury DHB created Xcelr8 programme and to the IHI Improvement Science in Action workshop. The IHI course is sponsored by HQSC. These courses will assist with growth in leadership, and will increase the organisation's change management and innovation capability

- Project and programme management upskilling with internal champions
- Working with our skill mix to ensure more people are working to the maximum of their potential - for example, reducing examples of nurses performing administration tasks.
- Senior management involvement in learning sets.

- Cost containment – a set of initiatives including:
  - Improved leave management,
  - More appropriate rostering,

Non DHB workforce

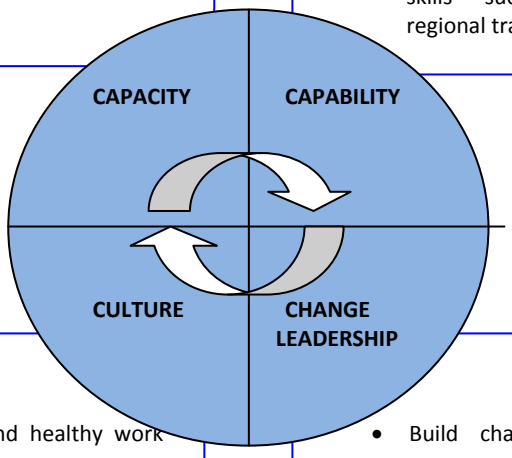
In addition to the DHB's workforce, we are also active in working with our partners in the primary and community sector to identify and provide training opportunities. Examples include:

- Development and Recognition Programme
- Continue to provide support to people seeking to qualify as nurse practitioners
- Hutt Valley DHB Summer Student Programme, which exposes second and third year medical students to primary and secondary practice.
- Upskill primary care clinicians to increasingly manage conditions currently managed in secondary settings.
- Develop education opportunities with Alzheimers NZ for staff working in aged care.

Our overall approach to workforce, as it focuses on capacity, capability, culture, and change leadership, can be depicted and summarised as below:

- Focus on ensuring we have the appropriate skill mix employed within services
- Work with our subregional partners to ensure we have sustainable workforces
- Continue to develop clinical pathways through our Primary Secondary innovative ways to utilise community focused workforces through our Primary-Secondary Strategy Group.

- Ensure staff have access to appropriate training and orientation for the role – utilising the career plan or individual Performance & Development tool to improve fitness for purpose.
- Provide access to annual appraisal for all staff
- Work with our primary and community partners to jointly identify and deliver training and upskilling opportunities
- Better identification and utilisation of existing skills – such as project management and sub-regional training skills



- Creation of a safe, supportive and healthy work environment
- Systematic approach to equality and diversity
- Develop an increasingly innovative approach to our work, including to career planning
- An approach which emphasises collective leadership as a partnership between clinical and non clinical staff.
- Well managed leave and appropriate rostering
- Counter-fraud training
- Actively manage wage expectations

- Build change leadership competency into management training, for example through Xcelr8, IHI, and locally delivered courses
- Embedding of partnership and knowledge sharing via regional training hubs
- Continue to foster partnership approach to relationships with unions
- Participation of clinicians in service design
- Increasing opportunities for strong primary/secondary relationships as a catalyst for changing models of care

Appendix 8.6

CCDHB and HVDHB Draft Joint Workforce Plan

Workforce

CCDHB and Hutt valley are collaborating in the area of Human resources and workforce development. The two DHBs have agreed to the appointment of a joint General Manager Human Resources (GMHR) to ensure that our workforce plans and organisational requirements are aligned. The new GMHR will take responsibility for the completion of a Workforce Plan which will outline priorities, provide specific objectives, detailed activity, and timelines to support the goals listed below. This will be completed by the end of June 2012. This plan will factor in the requirements of HWNZ, the 3DHB subregional plans and the workforce sections of the Regional Services Plan (RSP).

Workforce Plans - Service, Directorate, HHS and Subregional		
Activity	**Intention**	**Measured by:**
Develop base line workforce plans for each directorate which reflect service need, workforce requirements. Work with subregion and region where appropriate to align plans. Follow Health Workforce New Zealand (HWNZ) and Government (AoG) expectations re workforce plans. Plans will take into account the RSP and the 3DHB plan, and any planned or potential changes to the way the DHB delivers services Explore alternate models of care and scopes of practice. Review success of other DHB's activity in this area. Active participation in the Central Region Training Hubs planning and initiative development.	Know our workforce. Align supply and demand. Improve planning and recruitment cycles, minimising business interruptions and reduce costs. HWNZ priorities are actively supported. Targeted training and development is delivered in a cost effective and efficient manner. Advancing management and leadership capability, and succession planning processes. Identity opportunities where extended scopes of practice could improve service delivery (by Directorate service planning and wider Integrated Collaborative Care activity). Develop targeted and organisation wide mechanisms to maintain and further develop an engaged and motivated workforce. Regional participation in the development of an innovation information portal as detailed in the RSP (30 November 2012).	Forecasted workforce planning aligned to service, directorate and regional plans where relevant (refer workforce plan) Targeted recruitment and retention activities to support vulnerable disciplines and sub specialities (refer workforce plan) Manage by establishment process implemented Leadership development programme in place and achieving outcomes A minimum of three PGY1 and 2 training is standardised across the region (by 30 June 2013) Career Planning process, career guidance, and resources are implemented as per HWNZ requirements and as detailed in the RSP (31 July 2012). Improved flow of career planning information for the RMO population across the subregion. Extended GPEP training (GP vocational training) is supported across the sub-region. Learning and Development strategy is implemented Strategic Objectives for Learning, Development and Research are progressed against milestones.

		One example of progress towards opportunity for an extended scope of practice (participation towards the implementation of at least 3 innovative clinical placements/role across the region as detailed in the RSP (30 June 2013)).

Recruitment and Retention		
Activity	**Intention**	**Measured by:**
Explore opportunities for joint appointments across the region as vacancies arise in line with the RSP and sub regional work programme Enhance recruitment and candidate management tools and functions Collaborate with sub region to improve recruitment processes. Senior clinical and non clinical vacancies are reviewed to assess value of a joint appointment approach or region /subregional approach. Improved recruitment and retention data collection Increasing access to training and development activities across the subregion and wider region.	Recruitment practice is efficient, timely and internally aligned Recruitment system managed end to end candidate management process and supports recruitment managers System costs are minimised Recruitment costs are minimised Training costs are minimised and resources maximised Recruitment practice across the subregion is aligned and supported by consistent systems and processes. Joint appointments are made where there is service delivery value added. Clinical and non clinical Consistent contractual approach to contractors and locums Take a collaborative approach with subregion/regional DHB's on recruitment processes.	Systems, polices and procedures are aligned across the sub region (region). Evidence of joint appointments where value added is demonstrated Regular recruitment and retention reporting

Leadership Capability Development		
Workforce Development Activity	**Intention**	**Measured by:**
hance leadership development framework so that it supports the development of leaders across all levels of the organisation and provides a career progression path to ensure it is aligned to the needs of the organisation and achieving desired outcomes Leadership training and development programme(s) are reviewed and refreshed regularly to ensure they match the needs of the leaders in the organisation.	All leaders in HVDHB have the skills and competencies to provide appropriate leadership for their level Operational and Clinical leaders work in partnership Emerging leaders are identified, supported and mentored Succession planning for leadership roles is in place. Staff are provided with the tools, systems and processes and opportunities to develop their leadership capabilities	Leadership framework is in place Leadership roles are filled by our own staff Evidence of collaborative operational and clinical leadership and decision making.

Staff Engagement		
Activity	**Intention**	**Measured by:**
Undertake biannual staff engagement survey Implement specific staff engagement activities, at a Team, Service Directorate and/or organisational level as indicated. Develop activities to support 'positive workplace culture'	Staff Engagement strategy implemented 2012, including development of steering group to support the strategy and staff engagement activity. Align systems, processes and policies to support improved staff engagement Introduce organisational development strategies, and/or training and development opportunities in response to survey results or other metrics/information.	Biannual survey , commencing February 2013 Evidence of organisational communication of results Organisational changes and /or targeted activity programmes to address results of survey and other metrics/information. Improvement in results from survey and metrics over time

Learning and Development (L&D)		
Activity	**Intention**	**Measured by:**
Further develop the learning and development culture by implementing the L&D strategy, ensuring appropriate tools and resources are in place and improve systems and processes to support L&D Work collaboratively with other DHB's, HWNZ, Training Hubs and other agencies as outlined in RSP, 3DHB and other key plans and strategies. Key Learning and Development staff participate in the Central Region Training Hub and HBL activity. Key staff from Skills and Simulation involved in national strategy development for regional/ national approach to Skills and SIM	A Three year Learning and Development Strategy developed and launched in 2012. The strategy will ensure that HVDHB becomes a learning organisation. The strategy is operationalised through Learning and Development Strategic objectives. These will begin to be implemented in 2012/13 Maximise use of expertise, resources and systems through collaboration with other DHB's and stakeholders in the sub regional, region and national activity.	Presence of Learning and Development strategy (ref strategy). Achievement of four high level objectives delivered through detailed plan (refer plan) include 1 Develop Learning and Development Culture at HVDHB 2 Embed Service Excellence Framework 3 Enhance Research culture at HVDHB 4 Strong relationships exist with other DHB's, health sector agencies, tertiary providers and other key stakeholders Learning Management system is in place and aligned across the sub region as detailed in the RSP (by 31 May 2013). MOU is in place for the region re Skills and Simulations as detailed in the RSP (31 March 2013)

Appendix 8.7

Central Region Training Hub

Health Workforce New Zealand (HWNZ) tasked District Health Boards (DHBs) with creating Regional Training Hubs to support post graduate training and education. Working collaboratively will allow each DHB to contribute to the success of the region's workforce development without sacrificing its own autonomy. It will allow the experience, strengths, lessons learnt and best practice identified in one DHB to be shared throughout the entire region.

The Central Region Training Hub will ensure that post graduate training and education within the region is coordinated to provide the best use of available resource whilst maximising the quality of the product delivered.

In November 2011, the Central Region Training Hub Working Group was established. The programme of work is led within the region by lead CEO, Graham Dyer and Clinical Lead Dr Grant Pidgeon. From July 2012 a Regional Programme Director of Training will be employed to drive the programme of work in collaboration with the working group.

The focus for the Central Region Training Hub services plan for 2012/13 is:

- To improve clinical workforce development across the Central Region by including medical, nursing, midwifery and allied health training, as well as promoting inter-disciplinary training and education where appropriate and integrated primary and secondary health.
- To strengthen recruitment, retention and skills development of the clinical workforce by creating a Central Region framework to facilitate DHBs to coordinate and promote training and education across the region.
- To improve operational efficiencies and effectiveness through collaboration and technology.

Table 1: Central Region Training Hub

Outcome	Impacts	Outputs	Measurement
Ensure training has a clear purpose and provides benefit to the trainee and wider health sector and is manageable.	Improved career guidance and support for post graduate trainees.	Career plans are in place and career planning tools and resources available.	• 100% of all trainees in receipt of HWNZ funding have a career plan and in place and access to career guidance and resources by 31st July 2012. • Implementation of a minimum of 3 regional innovative clinical placements/new roles of practice by 30th June 2013.

Outcome	Impacts	Outputs	Measurement
To improve clinical workforce development across the Central Region.	Innovative scopes of practice.	Identify and implement innovative new clinical placements Stock take of innovation within the region.	A Central Region portal for innovation information sharing by 30th November 2012.
To improve operational efficiencies and effectiveness through regional collaboration and technology.	Improved communication and information of regional innovation activity.	Establishment of a Central Region portal for information sharing on clinical innovations.	A report of recommendations for a Central Region learning management system by 31st May 2013.
	Improved shared regional learning and access to online learning modules.	Stock take of regional e-learning platforms and tools and development of recommendations for the region.	A minimum of three PGY1/2 programmes regionally are standardised and training procedures implemented 30 June 2013.
Programmes are standardised and made available to other professional groups and hubs	Improved regionally standardised medical post graduate year 1 & 2 training.	A stock take of PGY1 and 2 raining within the region.	
	Reduced duplication and better use of available resource	Develop regional training programmes.	
	Develop regional skills and simulation training.	Stock take and needs analysis of skills and simulation training within the region.	A memorandum of understanding is implemented in the region for regional skills and simulation training by 31st March 2013

Appendix 8.8

HVDHB Diabetes Care Improvement Plan - Draft

This document sets out Hutt Valley DHB's plan for improved diabetes services to replace the former "Get Checked" annual review in accordance with the planning advice received from the Ministry of Health (MoH). It describes the planning process, key findings, the proposed package of services, the funding model and measurement and monitoring.

Planning Process

A steering group was established comprising 3 general practitioners, 2 primary care nurses, a provider of community based diabetes outreach services, a specialist diabetes physician, a clinical nurse manager diabetes, a PHO chief executive and 3 Planning and Funding staff members. This group was supplemented by two consumer representatives and a podiatrist later in the planning process. The full list of members is included in Appendix 1.

The process followed by the group was:

- Review of background information, including key findings of a diabetes service review which was completed during 2010/11
- Development of key service requirements for diabetes services
- Development of options for service improvement and costings
- Development of recommendations for the Primary Secondary Services Group (PSSG)

Diabetes Prevalence

The estimates of diabetes prevalence in the Hutt Valley are provided by the Ministry of Health (MoH). They were updated, based on new methodology as of December 2010. The table below shows the break-down by NZ Deprivation Index and ethnicity[98].

NZ Deprivation Quintile	Maori	Pacific	Other	Total
1	0.9%	0.5%	13.0%	14%
2	0.5%	0.4%	6.8%	8%
3	1.6%	1.0%	14.0%	17%
4	5.6%	4.9%	25.5%	36%
5	5.4%	6.7%	13.4%	26%
Total	13.9%	13.4%	72.7%	100%

Based on the 2011/12 MoH estimate the population numbers are as follows:

NZ Deprivation Quintile	Maori	Pacific	Other	Total
1	53	29	763	845
2	29	23	399	452
3	94	59	822	975
4	329	288	1,497	2,114
5	317	393	787	1,497
Total	816	787	4,268	5,871

[98] Information supplied by Ministry of health March 2012.

Projections of diabetes prevalence beyond 2011/12 have not been provided by the Ministry at this stage.

Review Findings
A review of diabetes services in the Hutt Valley was completed during 2010/11. The key findings were:

- Uptake of the diabetes Get Checked programme is about 73% in the total population. However uptake amongst Maori and Pacific Peoples was lower.
- The percentage of annual reviews with satisfactory or better management appears to have been generally stable at 68-72%.
- Stakeholders raised the following issues around the current Get Checked programme:
    - The effectiveness of annual reviews is currently evaluated by means of satisfactory or better diabetes management (based on HbA1c). However, this 'snapshot' of glycaemic control is a limited measure as it is based on the pool of current patients rather than following a cohort of patients over a longer period.
    - Counting/seeking out those eligible for annual review who do not attend is limited due to inconsistencies in READ coding.
    - Secondary diabetes services may do the equivalent of an annual review when seeing patients in hospital, but this does not necessarily get fed back into primary care.
    - The demand for community podiatry has grown dramatically, from less than 500 sessions in 2004/2005 to 4950 sessions in 2009/10. These figures are predominantly made up by referrals to community podiatry (for maintenance) from hospital podiatry.
- Stakeholders identified a need to clarify the relationship between primary and secondary services. The following issues were raised:
    - There are currently no criteria for entry to or exit from secondary care services
    - For services, e.g. insulin initiation and basic management, to be provided by primary care practitioners there needs to be a skill development and maintenance programme, as well as adequate resourcing. This can be an issue, particularly in smaller practices.
    - There is a risk that some patients may get lost between exit from secondary care services and re-entry into primary care.
- Outreach services for Pacific and Maori are currently underutilised.

Principles
The principles underpinning the proposed service package are:

- Quality and appropriateness
- Self management
- Continuity of Care
- Equity of Access
- Universal minimum coverage
- Targeted to high needs
- Skilled and educated and supported workforce
- Practitioners working across the seamless spectrum
- Culturally competent workforce
- Evidence based practice

Proposed Service Package
The package of support will have the following key elements:

- Intensive education at first diagnosis
- Standardized, periodic, clinical review

- Workforce support
- Allied health services

Education at first diagnosis

All newly diagnosed patients will receive intensive education in a time frame consistent with their clinical needs. A practice nurse who qualifies or is working towards qualifiaction[99] as a generalist diabetes nurse (as described in the National Diabetes Nurse Knowledge and Skills Framework (NDNKSF)[100] will

- assess the person's needs
- prepare an individual education plan
- deliver the elements of the programme, engaging other disciplines where required
- evaluate and document the programme's effectiveness at an individual patient level
- recommend any further follow-up education required

Standardised, periodic, clinical review

General practices/PHOs will be expected to have a diabetes care improvement plan for their practice that covers the following key elements:

- operate a patient management system with a recall system to ensure that every person with diabetes is offered a systematic clinical review at least annually or more frequently based on clinical need
- ensure each patient has an individual care plan documented in their clinical record – this may be a simple plan of action recorded at each visit. More complex and shared care patients will require a more comprehensive document that is available to the care team and the patient
- treat patients in accordance with national clinical guidelines, ensuring that care is co-ordinated where multi-disciplinary input is required
- provide further education in self-management where required
- provide follow-up services to patients who do not attend review appointments, including accessing available outreach services where appropriate
- refer to secondary care in accordance with local guidelines
- participate in shared care with the specialist diabetes service for high risk patients or when the practitioner is being mentored
- input patient or practice level data to data collection systems

Workforce support

The DHB specialist diabetes service and the PHO will be expected to:

- work with general practices to identify their needs for skill development
- plan and deliver an education programme to meet the needs, utilising the NDNKSF
- evaluate the effectiveness of the education programme at regular intervals and document this
- participate in shared care with primary practitioners for high risk patients
- provide mentorship to primary care nurses and general practitioners
- work in a manner that promotes integration between primary and secondary services and capacity building

[99] A period of two years will be allowed for practice nurses to complete the learning required and achieve recognition under the framework.

[100] Under this framework a generalist diabetes nurse will be providing regular care to people with diabetes and will have completed additional training to a level slightly more than the current Diabetes Action education programme. Higher levels on the framework include specialty diabetes nurses and specialist diabetes nurses: clinical nurse specialists/diabetes nurse leaders.

General practices will be expected to ensure that their team has appropriate training in diabetes management.

Allied health

The following services will be available for people who meet the referral criteria:

- retinal screening
- podiatry – community and specialised
- dietetics – community and specialised

Funding

The current funding supporting the diabetes Get Checked programme is set out below:

Service	Unit	Price	$
General Practice/PHO			
Diabetes annual review	Client	$45.50	$213,850
Diabetes Action Patient Education Sessions	Session	$31.11	$52,889
			$266,739
Allied Health			
Community Diabetes Dietician	Bulk	$66,140.12	$66,140
Dietetics - paediatric Diabetes	Attendances	$122.89	$43,995
Podiatry - Hospital*	Attendances	$149.12	$485,833
Retinal screening	Attendances	$47.08	$140,999
Diabetes Podiatry Sessions - community	Session	$44.44	$244,420
			$981,387
Specialist Diabetes Services (excluding Allied Health)			
Specialist Outreach Services	Bulk	$271,875.13	$271,875
			$271,875
PHO Admin and training support and specified outreach			
Diabetes Training Provision - PHO	Bulk	$6,900.00	$6,900
Admin/Reporting - PHO	Bulk	$35,933.00	$35,933
Outreach diabetes service	Bulk	$64,058.17	$64,058
Admin & reporting get checked	Bulk	$30,713	$30,713
Database	Bulk	$10,000	$10,000
			$147,604
Grand total			**$1,667,605**

* Some of this service is provided for people with conditions other than diabetes

Clinical reviews and education sessions in general practice

The available funding for clinical reviews will be set at $200,000 per annum and targeted to the high needs group of Maori, Pacific and NZ Deprivation Quintile 5 – Other, as well as those with high clinical risk[101] (estimated to be 10% of the population with diabetes). The remainder will be available for increased education sessions for all who require them. No co-payments will be allowed for the targeted groups. The funding will be a bulk payment to each practice based on their enrolled population with diabetes – the payment will incorporate the clinical review and patient education elements as outlined below.

Available funding for clinical reviews	$200,000

[101] High clinical risk is defined in Guidance on the management of type 2 diabetes (2011), New Zealand Guidelines Group and the New Zealand Primary Care Handbook 2012.

Target population	2,487
$ per person per annum	$80.42
Available funding for education	$66,739
Current education sessions	1,700
New education sessions	2,145
Increase in education sessions	445
% increase	26%

The PHO will continue to be funded for administrative support, reporting and database management and practice nurse training. The outreach diabetes service will continue to be funded at current levels.

Workforce support

In year 1 these services will be funded through the Specialised Diabetes Services and the PHO funding identified in the available funding table above. In out-years it is expected that the Specialised Diabetes Service will increase its focus as a highly specialised service that

- treats patients requiring hospitalisation for their diabetes
- manages complex patients in collaboration with primary care
- supports primary care to manage the majority of patients

For example, increased specialist physician hours could be made available by reducing specialist follow-up outpatient attendances to more closely align with the national FSA/follow-up ratio. This could be supported by availability of guidelines for referral into and out of the specialist diabetes service. If the FSA/FU ratio was able to be reduced from the current 1:5.5 to 1:3 (the national ratio is 1:2.5) this would free up clinical hours equivalent to a clinic per week. This resource could be allocated to providing more specialist community based clinics. Similarly the nurse-led clinics could be reviewed and guidelines developed for referral into this service.

Allied health

In year 1 these services will be funded as shown in the available funding table above. In out-years demand pressure will be managed by targeting services to the highest need groups. For example if a $10 surcharge was introduced for community podiatry services an additional 542 sessions could be funded – an increase of 10%.

Outputs and Measures

The following table shows the indicators that will be required for reporting and monitoring purposes:

Indicator	Definition
% of practices with a diabetes care improvement plan in place	Numerator: Number of practices with a diabetes care improvement plan completed. Denominator: Number of practices
% of practices working in an integrated way with secondary care services	Numerator: Number of practices that are working collaboratively and regularly with the DHB diabetes specialist service. Denominator: Number of practices
% of practice nurses who are qualified as generalist diabetes nurses	Numerator: Number of practice nurses who have completed the requirements for recognition as a generalist diabetes nurse under the National Diabetes Nurse Knowledge and Skills Framework (NDNKSF) Denominator: Number of practice nurses

Indicator	Definition
% of patients who have a completed annual review dataset in their clinical record	Numerator: No of patients who have a completed annual review dataset in their clinical record as at the reporting date Denominator: Diabetes prevalence based on the virtual register
% of patients with HbA1c<64 mmol	Numerator: No of patients with HbA1c<64 mmol Denominator: No of patients who have a completed annual review dataset in their clinical record as at the reporting date
% of patients with HbA1c > 64mmol who are on insulin	Numerator: No of patients with Type 2 diabetes and HbA1c>64 mmol who have had an insulin prescription written within the previous 6 months. Denominator: No of with patients with Type 2 diabetes and HbA1c>64 mmol
% of patients with a CVR>15% and are on statin	Numerator: No of patients with diabetes and CVR>15% who have had a statin prescription written within the previous 6 months. Denominator: No of patients with diabetes and CVR>15%
% of patients with a blood pressure > 130/80 who are on 3 antihypertensive medications	Numerator: No of patients with diabetes and blood pressure > 130/80 who have had a prescription for at least 3 different antihypertensive medications written within the previous 6 months. Denominator: No of patients with diabetes and CVR>15%
$ of patients with microalbinuria who are on ACE-1 or A2RA	Numerator: No of patients with diabetes and microalbinuria who have had a prescription for ACE-1 or A2RA written within the previous 6 months. Denominator: No of patients with diabetes and microalbinuria
% of patients who have had retinal screening in the last two years	Numerator: No of patients who have a record of retinal screening in the last two years in their annual review dataset Denominator: Prevalence based on the virtual diabetes register
% of patients with high risk feet who have had a podiatry service in the last 6 months	Numerator: No of patients with diabetes and high risk feet who have received a podiatry service in the last 6 months. Denominator: No of patients with diabetes and high risk feet
% of patients with a diabetes related hospital admission in the reporting period	Numerator: No of patients with a diabetes related hospital admission in the reporting period Denominator: Prevalence based on the virtual diabetes register

Al measures will be reported quarterly

Monitoring

The quarterly reports will be aggregated and made available to the Local Diabetes Forum for review at their meetings.

Appendix 1: Membership of Steering Group

Bob Boyd, Consumer representative
Chris Masters, General Practitioner, Ropata Medical Centre
Fiona Angus, Podiatrist, HVDHB
Glenda Foster, Medical/Surgical Portfolio Manager, Planning and Funding HVDHB
Jasmine Plimmer, Kowhai Health Trust
John Larkin, Consumer representative
Judi Keegan, Primary Care Portfolio Manager, Planning and Funding HVDHB
Lise Kljakovic, General Practitioner, Upper Hutt health Centre
Louise Farmer, Clinical Nurse Manager, Specialist Diabetes Service HVDHB
Michelle Meads, Chief Executive, Te Awakairangi Health
Raymond Bruce, Specialist Diabetes Physician, Specialist Diabetes Service HVDHB
Sandy Dawson, General Practitioner
Sharon Reid, Manager, Kokiri Marae
Shayne Nahu, Senior Relationship Manager, Planning and Funding HVDHB