STATEMENT OF INTENT

2013 - 2014
Hutt Valley

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Statement of Intent Sign-off

The Hutt Valley District Health Board's Statement of Intent for the financial year 2013/14 is approved.

Dr Virginia Hope
Chairperson
Hutt Valley District Health Board

Date: 17/6/2013

Keith Hindle
Board Member
Hutt Valley District Health Board

Date: 17/6/2013

MODULE 1: INTRODUCTION

MODULE 2: STRATEGIC DIRECTION

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MODULE 1: INTRODUCTION

1.1 EXECUTIVE SUMMARY

This Statement of Intent (SOI) outlines to Parliament, the Minister of Health and the general public the performance intentions for the DHB for the next three years as it works to improve, promote, and protect the health status of our local people.

The SOI, together with the Annual Plan, reflects our continued commitment to deliver on the Government's priorities and health targets within a tight fiscal environment. The way forward will require a range of efficiency and effectiveness initiatives including the further integration of primary and secondary health care services across our district and the advancement of the 3DHB work programme – a collaborative approach between Wairarapa, Hutt Valley and Capital and Coast DHBs (the 3 DHBs) to improve the way we deliver hospital and specialist services across the district boundaries.

To that end, this plan has been prepared using a single process with significant parts of the document shared across the 3 DHBs, reflecting our collaborative approach to service planning and delivery. Where activity, targets and budgetary information are specific to each District, these are presented uniquely for each DHB.

The DHB recognises that 2013/14 is going be another year of challenges as it continues its programme of change to ensure it can live sustainably within its means. Further changes to some service configurations will be required as the DHB considers the most efficient and client focussed ways of delivering services in local and subregional contexts.

In late 2012 the 3 DHBs pooled their Planning and Funding functions into a single unit that is jointly directed by the 2 DHB CEOs but is operationally managed by Capital and Coast DHB. It is now known as the Service Integration and Development Unit (SIDU) and its role is to provide a mix of strategic leadership and change management across the region. Funding pools remain specific to each DHB, but SIDU has the role of maximising opportunities for efficiencies whilst minimising service delivery and financial risk for the benefit of all 3 DHBs.

In early 2013 a joint CEO was appointed across Hutt Valley and Wairarapa DHBs and work began creating a single executive team across these two DHBs. This process is intended as a key enabler to bringing about operational efficiencies across the hospital services of both DHBs. It also provides a simpler mechanism in building collaborative approaches with the executive team of Capital and Coast DHB.

Across the districts, and in support of the Government's *Better, Sooner, More Convenient Health Services* approach, the DHBs have dedicated significant resource and focus to a partnership approach between each DHB's Hospital services and Primary Care delivery services to improve access to specialist services. Each DHB is operating a unique relationship and service development programme, but the goals are the same. Hutt Valley DHB acknowledges the participation of local primary care partners, through the Primary Secondary Strategy Group, in the development of, and agreement with this Statement of Intent.

1.2 CONTEXT

1.2.1 BACKGROUND

District Health Boards are responsible for providing and funding the provision of health and disability services. The statutory objectives of DHBs 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; and
- 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 Māori and other vulnerable population groups.

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

Health Sector Context

Wairarapa, Hutt Valley and Capital and Coast DHBs are three of 20 DHBs across New Zealand.

In addition to being required to meet their statutory objectives, DHBs recognise and respect the Treaty of Waitangi, and the principles of partnership, participation and protection. At a local level, each DHB works in partnership with its Māori Partnership Board, to ensure Māori participation at all levels of service planning and service delivery for the protection and improvement of the health status of Māori.

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

Planning for the needs of our local population is heavily influenced by our broader regional planning activity, as this will shape the location and delivery of services in the Central Region over the next five to ten years.

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

- The Central Regional Services Plan that has been developed between Wairarapa, Hutt Valley, Capital and Coast, MidCentral, Hawke's Bay, and Whanganui DHBs and has been extensively revised in this, its third year of being, to drive our region more quickly towards greater efficiency across services we provide to the population of the lower North Island.

- At a subregional level, Wairarapa, Hutt Valley and Capital and Coast DHBS are continuing with their joint integration and efficiency programmes whilst maintaining a clear focus on the needs and provision of services to their local populations. As noted previously, the 3DHB work programme is the key deliverable to ensure all three DHBs are able to provide sustainable, equitable and appropriate services to local communities and the broader population.

- Within the wider health sector, the DHBs continue to work with organisations such as Health Benefits Limited to improve the value we secure out of areas of procurement, and the Health Safety and Quality Commission to ensure we can provide the highest quality services to our clients.

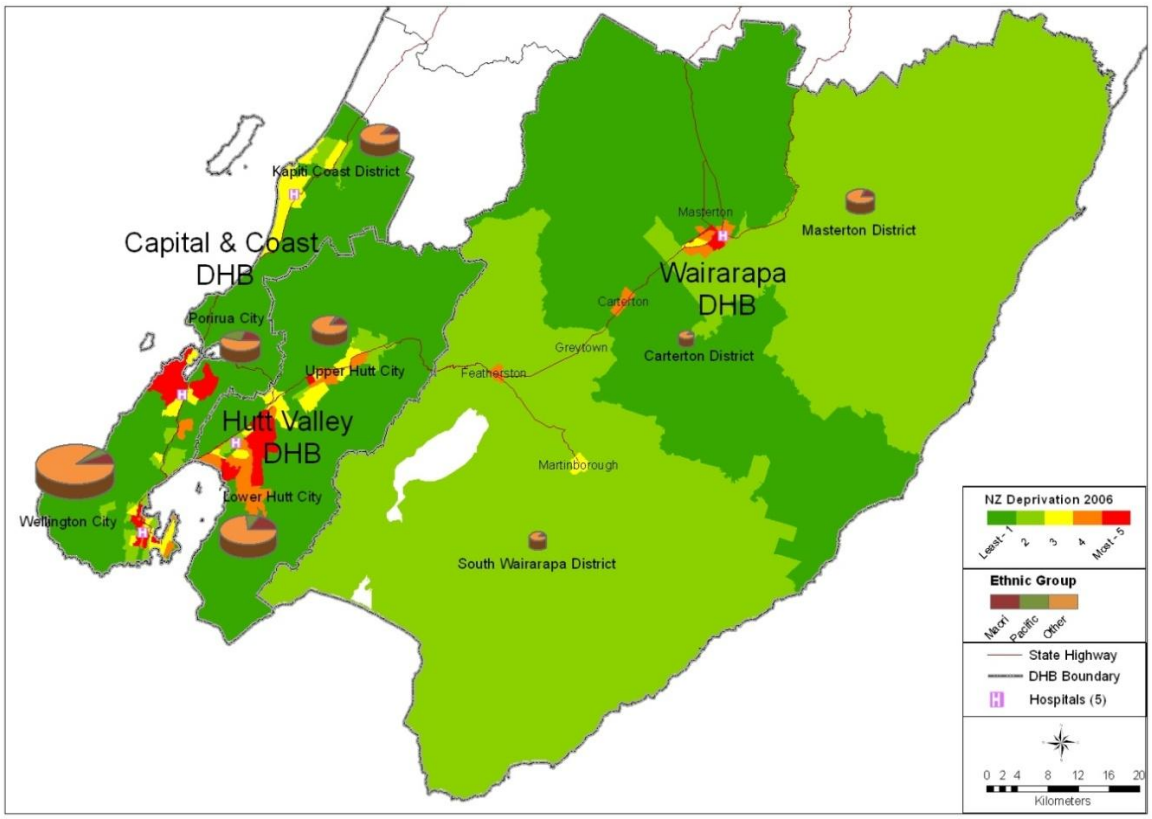
Across the region, the DHBs work individually and collectively with strategic partners to both improve health outcomes and efficiency in delivery. Of particular importance are the DHBs' active partnerships with our PHO partners in respect to the *Better Sooner More Convenient* (BSMC) change activity.

The DHBs are committed to working across national and regional work programmes to actively improve our collective regional performance, whilst also contributing to a better performing health sector. In particular, the DHBs are key players in the ongoing development and implementation of the Central Region's Regional Services Plan, and in respect to contributing to national sector priorities such as the National Vulnerable Service Employment programme.

Population and Health Profile

The 3DHB region is home to nearly 11 percent of the national population in 2013 (484,345 people). The Hutt Valley district, with a population half that of Capital and Coast (145,030 people), covers two TAs: Lower Hutt City and Upper Hutt City. Capital and Coast is the seventh largest DHB in New Zealand (298,600 people) covering three Territorial Authorities (TAs): Wellington City, Porirua City and the Kapiti Coast District south of Te Horo. The Wairarapa population is small (40,715 people) however it is spread across a large, geographic area: South Wairarapa District, Carterton District and Masterton District. Around half of the Wairarapa district population lives in an urban centre.

Figure 1 - Map of 3DHB Region Population



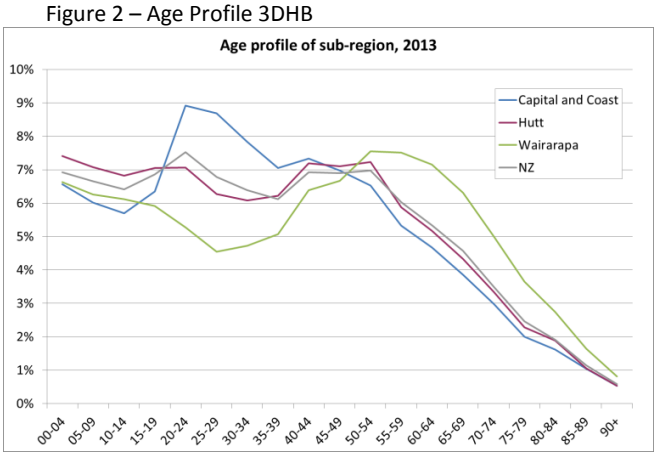
Overall, Capital and Coast has one of the least deprived populations in the country however the socio-economic profile of the three TAs is very different. Porirua is a city of contrasts with 30 percent living in quintile one areas (the least deprived) and 42 percent living in quintile five areas (the most deprived)

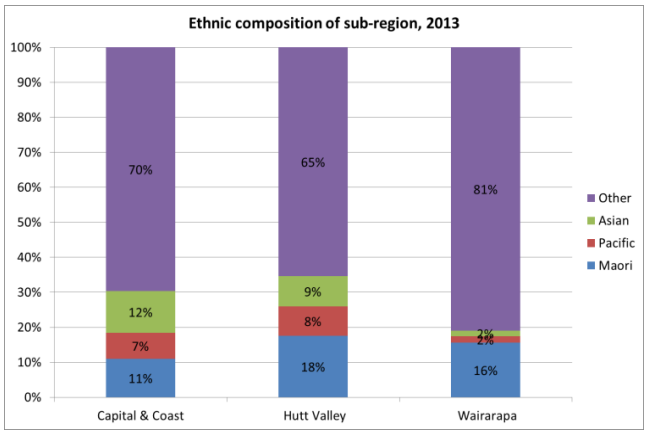
mainly in Porirua East. There are also pockets of deprivation in the south and east Wellington suburbs (parts of Newtown, Berhampore, Kilbirnie, Strathmore and Miramar).

A quarter of the Hutt Valley population lives in a quintile one area, however a quarter of the Lower Hutt population live in quintile five areas (particularly Naenae, Taita, Moera and parts of Petone, Stokes Valley, Wainuiomata and Waiwhetu).

The Wairarapa population is more evenly spread across the deprivation quintiles, however there are areas of relatively high deprivation in Masterton and Featherston.

Figure 2 – Age Profile 3DHB





Age is the most significant factor determining the health need of a population, with higher consumption of health resources as people age and develop more complicated needs and co-morbidities. In comparison to the national average Capital and Coast and Wairarapa have a smaller proportion of children whereas Hutt Valley's child population is greater. Capital and Coast has a large proportion of young to middle aged adults whereas Wairarapa has a smaller proportion. Wairarapa has a significant 'baby boomer' and older adult population while Capital and Coast has fewer than average.

The age profile varies significantly across the three Capital and Coast TAs whereas it is more similar across the Hutt Valley and Wairarapa. There is a very large proportion of older people living on the Kapiti Coast, a large proportion of children living in Porirua City and a large proportion of young to middle aged adults in Wellington.

Ethnicity is also a strong indicator of the need for health services with Māori and Pacific affected at a younger age and experiencing a greater burden of long term conditions. The Māori populations of Hutt Valley and Wairarapa are higher than the national average (15%) whereas in Capital and Coast this is lower than average. There are significant Pacific populations living in both Capital and Coast and the Hutt Valley. Capital and Coast also has a large Asian population. The Māori and Pacific populations are young in comparison to other ethnic groups with a greater proportion of children and fewer older adults. Wellington's Asian population has a significant proportion of young adults.

Health Needs – Hutt Valley DHB

The Hutt Valley DHB's health profile is gained through a comprehensive Health Needs Assessment (HNA)[1] 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 the 2008 HNA

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

and is being revised during 2012/13. 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 Whānau 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 ageing population.

Population Change

The demographics of the subregion will change over the next fifteen to twenty years, with varying rates of population growth but significant ageing across all three DHBs (as well as nationally).

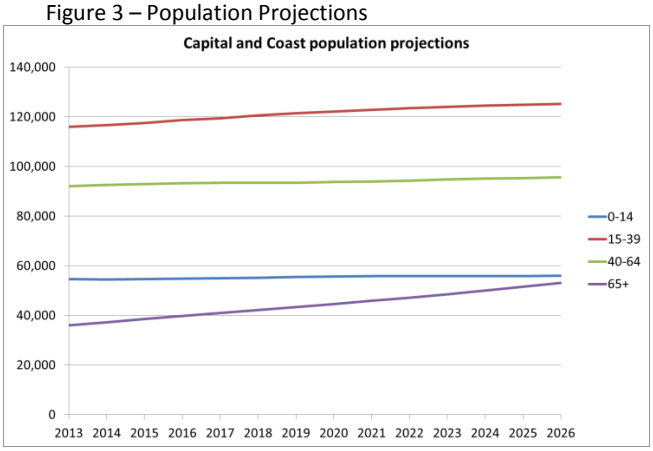
Table 1: Population Profile

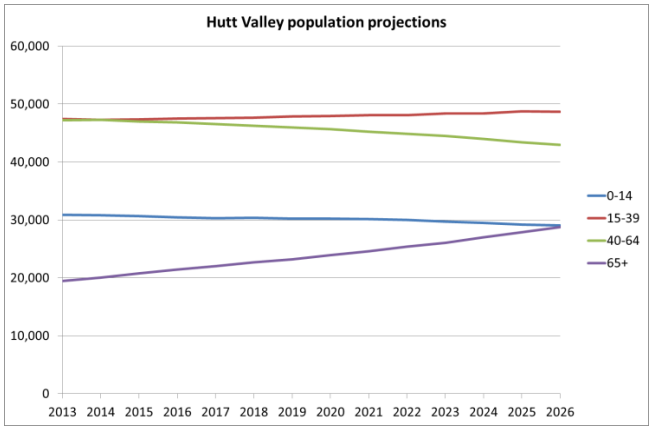
District	2013 population	2026 population	% change 2013-2026	% change average annual
Hutt Valley	145,030	149,420	3.0	0.2
Capital & Coast	298,600	329,920	10.5	0.8
Wairarapa	40,715	40,820	0.3	0.0
Subregion	**484,345**	**520,160**	**7.4**	**0.6**

The subregional population is projected to increase an average 0.6% per year to 2026; slightly lower than national growth (0.9%). The growth is mostly going to occur in the Capital and Coast district (with Kapiti and Wellington the fastest growing areas) while modest growth is predicted for Hutt Valley and very little for Wairarapa.

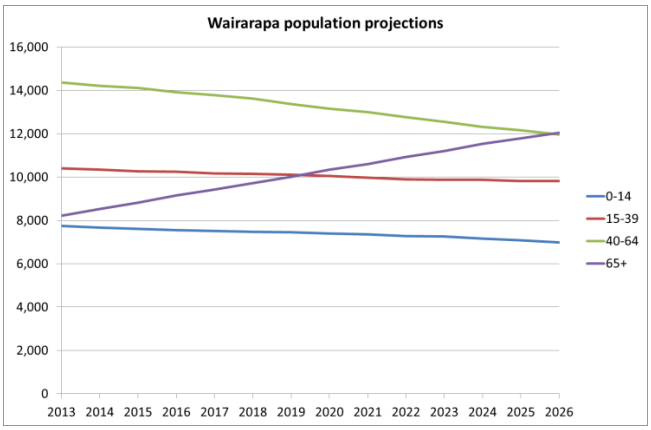
The Māori population of all three DHBs will increase and while significant Pacific growth is projected in Hutt Valley, very little is expected for Capital and Coast. The Asian populations across all three DHBs will increase and is projected to be larger than the Māori population in Capital and Coast by 2026.

Figure 3 – Population Projections





The number of older people will increase by around 50% in each DHB between 2013 and 2026. As the number of people aged over 65 increases the subregion will face challenges in terms of providing care and support to people in their own homes, capacity of residential care and demand for acute and complex healthcare services. Capital and Coast is the only DHB projected to have an increase in the number of children (although modest at 2.5% by 2026). In the Wairarapa, the population across all the life-cycle age groups under 65 will decline whereas the Hutt Valley can expect a slight increase in the youth and younger adult age groups.



1.2.2 OPERATING ENVIRONMENT

In 2013/2014 the 3 DHBs will operate in an environment where the costs of service provision continue to stretch our financial resources. Individually, and collectively through the 3 DHB work programme, the 3 DHBs have set an ambitious financial target which will require an acceleration of the efficiency changes already underway.

To be able to meet our forecasted subregional $7.2 million deficit position, the DHBs will continue improve service efficiency, reconfigure services to better meet the needs of clients, and in some circumstances, end service investment where the impact is minimal.

All three DHBs have made good progress over the past two years in either reducing deficits or eliminating the risk of significant budget blow-outs. Hutt Valley and Wairarapa have made significant progress in improving financial efficiency and sustainability limiting the financial risk to their organisations, while Capital and Coast has reduced its operating deficit of $60 million in 2008/09 to $10 million in 2011/12.

Sustainability and a focus on population health outcomes remain critical to all three DHBs. Robust impact assessments of the planned service changes are regularly undertaken and provided to the Boards, to ensure the DHBs are able to continue to provide services to the levels required within their service coverage schedules as agreed with the Ministry. The DHBs (through SIDU) continue to balance the financial savings requirements with the need to continually improve the client experience and quality of our services. This is dramatically improving the value for money the DHBs are securing out of their local health service investments.

External Influencers

As well as the health needs of the population, there are a range of external factors that impact on the DHBs and influence the decisions they make. These are built into the process of planning, funding and delivering health services across the regional population and in respect to the needs of local communities.

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.

Table 2: Economic Factors

Factor	Implications
The health sector recognises the need to reduce expenditure and reconfigure services to improve efficiency and financial sustainability of services	Prioritisation of funding to those most in need of health and disability services. Funding allocation to different services and different service providers based on the principle of addressing health inequalities and targeting at risk populations. The performance of the 3 DHBs' Hospital services relative to our peers. All 3 DHBs will continue to look for efficiencies in all that they do. Ongoing consolidation of provider contracts to increase economies of scale and reduce expenditure on administration will be required to ensure services are delivered to desired standards.

Social Factors

People are taking a more active interest in their health; they are better informed about their conditions and are more aware of options for treatment than in the past. At the same time public expectations are expanding, the health system is experiencing workforce shortages, and the recruitment and retention of health professionals can be difficult in an internationally competitive labour market.

Table 3: Social Factors

Factor	Implications
The public is becoming better informed about health	Patients have higher expectations of health professionals and health services. With the right information, people can take more responsibility for their own care (self-management).
People want services suited to their needs	Services become more patient centred and culturally responsive. Difficulty satisfying society's growing demands for health services means greater attention on what services are publicly funded and access criteria for those services.
Difficulty satisfying society's growing demands for health services	Greater attention on what services are publicly funded and access criteria to those services.
Continuing moderate levels of unemployment	Some people cannot afford to visit their GP, delaying early detection and treatment, increasing ED attendances and admissions to hospital that are potentially avoidable.

Clinical Engagement and Leadership

The DHBs continue to embrace the active involvement of clinicians in the planning and development of services to improve operational efficiencies across our organisations and improve health outcomes for the wider population and our local communities. Through our BSMC projects and clinical governance processes, clinicians are now regularly engaged in service prioritisation and development locally, subregionally and regionally.

Table 4: Engagement and Leadership

Factor	Implications
Greater involvement by clinicians in decision making	Continued development of processes and systems that ensure clinical engagement and involvement in planning and delivery of health services.
Increased focus on quality and safety of services	An increased focus on quality and safety of services can lead to better health outcomes. Meeting quality and safety guidelines and compliance may impose additional costs on DHBs.
Greater focus on planning and delivering services nationally and regionally	Changes to the way services are delivered at a local, regional and national level. Service capacity across DHBs is reorganised to ensure best use of available resources. Areas of mutual priority - particularly in respect to vulnerable services - are addressed through the Central Region's Regional Services Plan
Higher level of Service Integration between Hospital and Primary Care Services	Clients access services in a setting more close to home Efficiencies in service provision are achieved across the system

1.2.3 NATURE AND SCOPE OF FUNCTIONS

The DHBs receive funding from the Government to enable them to fund and provide health and disability services to the people who live in each district.

The DHBs work within the 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 New Zealand Public Health and Disability Act 2000).

This requires the DHBs to consider all health needs and services including:

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

It is the role of the DHBs to determine how these services can be provided to best meet the needs of the population. It is these four service groupings that comprise the different output classes used in our Statement of Forecast Service Performance (see Module 4).

The scale and scope of services the DHBs fund across each of these four output classes is influenced by the outcomes and priorities that the Government and each DHB want to achieve, as well as the Government's service coverage requirements and our assessment of the health needs across our communities. Whilst most of the services the DHBs fund are provided locally, there are a few specialist services that are delivered by health providers outside each DHB's catchment or indeed outside of the region.

Amongst the 3 DHBs, Capital and Coast is the largest regional provider hospital services, and has responsibility for providing a mix of specialist services to other DHBs in the Central Region. Hutt Valley

provides a smaller number of regional services, with the specialist plastics and rheumatology services located at its Hutt facility.

Service capacity and capability needs are managed across the DHBs and where services are provided by a DHB to a patient of a different domicile, that DHB is recompensed through the inter-district flow (IDF) mechanism for the services it has provided. This year SIDU will be developing an alternative approach to managing IDFs within the 3DHB service mix, ensuring services (in particular electives) are provided in a cost effective and sustainable way to each DHB, whilst ensuring equity of access is maintained across the regional population.

With the new SIDU structure now in place, the DHBs will plan and purchase services through this unit, while oversight will be maintained by each DHB in respect to services for their own communities. Each Board consists of eleven members (including the Chair), with Capital and Coast and Hutt Valley DHB Boards also having a Crown Monitor position appointed by the Minister of Health.

Each Board has a mix of elected (as part of the three-yearly local body election process) and appointed members. Virginia Hope is Chair of both Capital and Coast and Hutt Valley Boards, and Bob Francis is Chair of Wairarapa Board and a member of the Capital and Coast Board.

A joint Community and Public Health Advisory Committee (CPHAC) and Disability Services Advisory Committee (DSAC) has been established across the 3 DHBs. In addition to the statutory roles, these committees are now the key mechanisms whereby the work of SIDU and in particular the monitoring of progress across the 3DHB work programme takes place.

In addition to this joint committee, each Board operates a committee focussed on finance, risk and audit and there are two Hospital Advisory Committees (HAC) (one at Capital and Coast, and one for Hutt Valley/Wairarapa) to assist Boards discharge their responsibilities. Additionally, each DHB has its own Māori Advisory/Relationship group, and Capital and Coast and Hutt Valley also have an equivalent Pacific group. These forums are critical in assisting the DHBs in maintaining a focus on improving access to services and outcomes for these populations.

Each DHB operates its own governance mechanism in respect to supporting the primary secondary integration work within the Better Sooner More Convenient suites of activity. At Hutt Valley, integrative work is being developed and supported through the Primary Secondary Strategic Governance Group (PSSG). In the Wairarapa the Alliance Leadership Team (ALT) provides oversight of the work programme established as one of the early Ministry supported primary/secondary integration business cases. At Capital and Coast the integrative work streams are part of the Integrated Care Collaborative (ICC) with each ICC workstream having its own management mechanism.

The Provider Role

Across the three DHB subregion, there are four main hospital sites which provide a mix of services.

The DHBs provide a complex mix of secondary and tertiary services across the subregion. Services provided across our hospital arms include: emergency services; specialist medical and surgical services delivered in inpatient, outpatient and community settings; maternity services; paediatric services; mental health services; diagnostic services such as laboratory and radiology services; pharmacy services; allied health services; district nursing; and rehabilitation services. (See Module 3 for further details of the Hutt Valley Provider Arm).

The Funder Role

The SIDU is now the central planner and funder of services across the 3 DHBs. Its role is to maximise efficiency across the service continuum and across the district boundaries, whilst ensuring communities, families and individuals across the 3 catchments have equitable and appropriate access to services.

In addition to the funding SIDU makes available to the 3 DHBs' hospitals for the provision of services they provide, it also funds a range of other health and disability service providers to deliver services to the people of the three districts.

SIDU manages, on behalf of each DHB, a number of service agreements across a range of providers for the delivery of primary health services, Well Child services, public health services, oral health services, Māori and Pacific health services, community mental health services, community pharmacy and laboratory services, community diagnostic imaging services, aged residential care services, home based support services, and palliative care services. It also manages the cross-DHB payments for services provided for patients of other DHBs.

In funding these different services, the SIDU, on behalf of each of the three Boards, must manage the share of the national funding allocation in a financially responsible manner.

The funding received by each DHB is determined by the Government using the Population Based Funding Formula (PBFF), and is based on the number of people living in the district, taking into account different population factors, such as age, sex, ethnicity and levels of socio-economic deprivation and unmet need.

The population of each of the 3 DHBs will change differently over time, meaning service configuration will in certain areas be provided generically, but in others needs planned local responses.

The Hutt Valley population continues to rise, albeit at a much slower rate than the national average. The DHB has an increasing proportion of elderly, Māori and Pacific people within the population and fewer children. Hutt Valley DHB will receive an increase in funding for 2013/14 reflective of these demographic changes relative to national, as well as a contribution towards the cost pressures experienced by various service providers.

In total, Hutt Valley expects to receive $411.2m in 2013/14 from the Government to spend on health and disability services for the people of the DHB's catchment area. This represents an increase in funding of 2.32% over our 2012/13 funding allocation. Hutt Valley will also receive $65.4m to provide service to populations other than its own residents (funding envelope total $411.2m). Additional revenue is also earned on top of the funding envelope allocation, taking Hutt Valley's total budgeted revenue to $447.4m, which includes an adjustment to remove funding received relating to the contract with Aotea Pathology Ltd.

The Wairarapa DHB population continues to rise, albeit at a much slower rate than the national average. The DHB has an increasing proportion of elderly, Māori and Pacific people within the population and fewer children. Wairarapa DHB will receive an increase in funding for 2013/14 reflective of these demographic changes relative to national, as well as a contribution towards the cost pressures experienced by various service providers.

In total, Wairarapa expects to receive $116.0m in 2013/14 from the Government to spend on health and disability services for the people of the DHB's catchment area. This represents an increase in funding of 2.68 % over our 2012/13 funding allocation. Wairarapa will also receive $3.5m to provide services to populations other than its own residents (funding envelope total $119.5m). Additional revenue is also earned on top of the funding envelope allocation, taking Wairarapa's total budgeted revenue for 2013/14 to $135.1m.

The Capital and Coast DHB population continues to rise at a rate only slightly lower than the national average. The DHB has an increasing proportion of elderly and Māori people within the population and slightly fewer children. Capital and Coast DHB will receive an increase in funding for 2013/14 reflective of these demographic changes relative to national, as well as a contribution towards the cost pressures experienced by various service providers.

In total, Capital and Coast expects to receive $660.7m in 2013/14 from the Government to spend on health and disability services for the people of the DHB's catchment area. This represents an increase in funding of 2.08% over our 2012/13 funding allocation. Capital and Coast will also receive $ 175.3 m to provide services to populations other than its own residents (funding envelope total $ 836.0 m). Additional revenue is also earned on top of the funding envelope allocation, taking Capital and Coast's total budgeted revenue for 2013/14 to $952.2m.

Allocation of funding in 2013/14

How each DHB shares this funding amongst different service providers is a critical decision each year for the Board.

Hutt Valley DHB

Of the $447.6m Hutt Valley expects to receive in 2013/14, $230.2m will be spent on services provided by the DHB and the governance arm. The balance of $217.4m will be spent on services delivered by other primary care and community providers. This includes $77.2m in payments Hutt Valley expects to make to other DHBs for services they provide to its own residents (inter district flows).

Funding Allocation (GST exclusive)

Expenditure Category	2011/12 Audited $m	2012/13 Forecast $m	2013/14 Plan $m	2014/15 Plan $m	2015/16 Plan $m
DHB Provider Arm	218.7	223.1	226.9	229.8	232.9
Funder Arm	133.3	135.4	140.2	142.1	144.0
Services Purchased from Other DHBs (IDF Outflows)	79.3	80.8	77.2	78.0	78.7
Governance Arm	2.9	3.0	3.3	3.3	3.3
Total Allocated	**434.2**	**442.4**	**447.6**	**453.1**	**459.0**
Funding (excluding IDF inflows below)	387.3	394.0	396.1	401.3	406.8
Services provided for Other DHBs (IDF Inflows)	47.0	48.4	51.5	51.9	52.2
Total Funding	**434.3**	**442.4**	**447.6**	**453.1**	**459.0**
Surplus / (Deficit)	**0.1**	**(2.5)**	**0.0**	**0.0**	**0.0**

Wairarapa DHB

Of the $135.1m Wairarapa expects to receive in 2013/14, $64.2m will be spent on services provided by the DHB and the governance arm. The balance of $72.1m will be spent on services delivered by other primary care and community providers. This includes $26.2m in payments Wairarapa expects to make to other DHBs for services they provide to its own residents (inter district flows).

Funding Allocation (GST exclusive)

Expenditure Category	Actual 2011/12 $m	Forecast 2012/13 $m	Budget 2013/14 $m	Budget 2014/15 $m	Budget 2015/16 $m
DHB Provider Arm	61.6	60.6	61.6	61.6	63.0
Funder Arm	44.6	45.4	45.9	47.1	48.2
Services Purchased from Other DHBs (IDF Outflows)	26.7	26.1	26.2	26.8	27.5
Governance Arm	3.1	3.1	2.6	2.7	2.7
Total Allocated	**136.0**	**135.2**	**136.3**	**138.2**	**141.4**
Funding (excluding IDF inflows below)	125.8	128.5	131.6	134.6	137.7
Services provided for Other DHBs (IDF Inflows)	3.5	3.4	3.5	3.6	3.7
Total Funding	**129.3**	**131.9**	**135.1**	**138.2**	**141.4**
Surplus / (Deficit)	**(6.7)**	**(3.3)**	**(1.2)**	**0.0**	**0.0**

Capital and Coast DHB

Of the $952.2m Capital and Coast expects to receive in 2013/14, $637.9m will be spent on services provided by the DHB and the governance arm. The balance of $320.3m will be spent on services delivered by other primary care and community providers. This includes $67.6m in payments Capital and Coast expects to make to other DHBs for services they provide to its own residents (inter district flows).

Funding Allocation (GST exclusive)

Expenditure Category	Actual 2011/12 $m	Forecast 2012/13 $m	Budget 2013/14 $m	Budget 2014/15 $m	Budget 2015/16 $m
DHB Provider Arm	612.4	624.0	626.6	634.6	643.7
Funder Arm	253.3	250.5	253.2	259.9	269.0
Services Purchased from Other DHBs (IDF Outflows)	65.3	65.6	67.6	69.0	70.4
Governance Arm	8.2	8.7	10.8	10.8	10.8
Total Allocated	**939.2**	**948.9**	**958.2**	**974.2**	**993.9**
Funding (excluding IDF inflows below)	743.8	756.5	776.9	789.1	804.4
Services provided for Other DHBs (IDF Inflows)	175.5	182.5	175.3	185.2	189.5
Total Funding	**919.3**	**938.9**	**952.2**	**974.2**	**993.9**
Surplus / (Deficit)	**(19.9)**	**(10.0)**	**(6.0)**	**0.0**	**0.0**

MODULE 2: STRATEGIC DIRECTION

Each of the three DHBs has been operating with its own Vision, Values and Priorities over the past decade. As we move into a new era of the three DHBs aligning service development and provision for the wider population, a new strategic framework will be developed in consultation with communities to underpin a new cohesive way forward. This piece of work will be undertaken in the 2013/2014 financial year for rollout in 2014/2015.

In the interim, the vision and priorities of each Board remain intact, but for the purposes of the annual planning process and the development of the Statement of Intent, the Boards have agreed to a single operating framework that consolidates the visions and priorities to allow a clear intervention logic to be created from our collective activities and joint priorities.

In essence, this has been relatively simple to achieve for the year as an interim step toward a single framework, since the visions and strategic priorities have been very similar across the organisations for some time.

2.1 VISION

The Government's policy objective in healthcare is for New Zealanders to lead longer, healthier, and more independent lives. This Annual Plan is underpinned by (s)38 2.d of the Public Health and Disability Act 2000 and reflects the overall direction set out in the Act, in addition to addressing those areas outlined in the Minister's Letter of Expectations for 2013/14. Additionally, the strategic direction of this Annual Plan is consistent with and supports the DHB's Māori Health Plan.

Achieving this requires the actions of many stakeholders, including those operating outside of the three DHBs. The DHBs each play a key role in working across a wide range of stakeholders to influence their positive impacts on the social determinants of health in our communities. These stakeholders include individuals, families, community collectives, NGOs, local government, and central government agencies. Only through genuine partnership will true health improvement across our population be achieved.

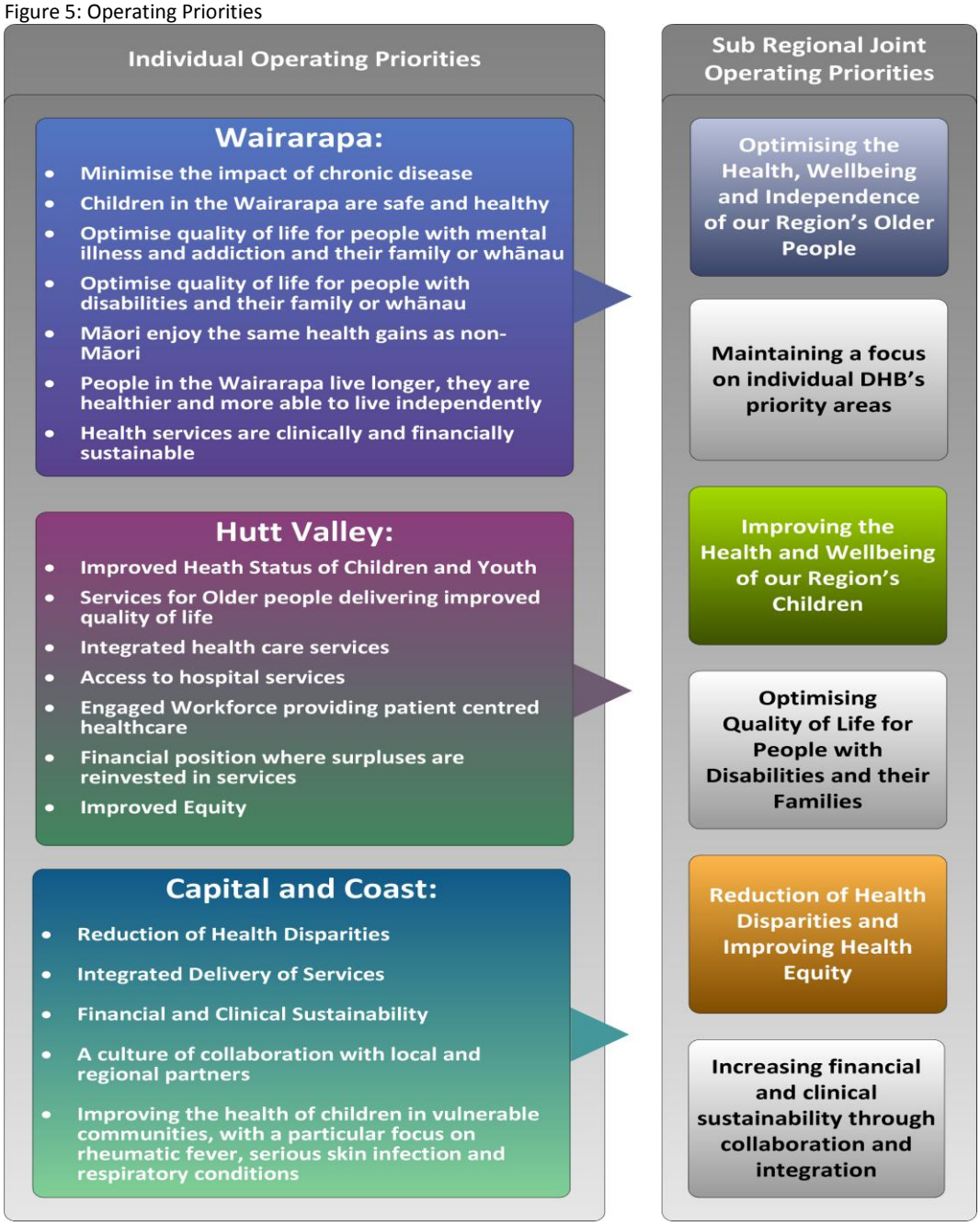
The Boards have agreed to consolidate their individual vision statements into a single operating vision for the purposes of joint planning in 2013/2014. Figure 4 refers.

Figure 4: Vision Statement

2.2 STRATEGIC OUTCOMES AND NATIONAL, REGIONAL AND LOCAL CONTEXT

The DHBs manage a mix of demand driven services and long term investment approaches within a paradigm that aims to improve each organisation's individual and collective capacity to meet the Government's service objectives, and the overall health of the regional and local populations. The Boards have agreed to consolidate their individual sets of priorities into a single set of operating priorities for the purposes of joint planning in 2013/2014 as shown in Figure 5:

Figure 5: Operating Priorities



National strategies to achieve the vision

The Government's priorities are expressed as a set of national targets which, as part of a larger balanced scorecard, provides a snapshot of how local DHBs are performing. These are described in Table 5.

Table 5: National Health Targets

Health Target	Description
Shorter stays in Emergency Departments 	95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours
Improved access to elective surgery 	More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year
Shorter waits for cancer treatment 	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.
Increased immunisation 	90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014, and 95 percent by December 2014.
Better help for smokers to quit 	95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care 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.
Better diabetes and cardiovascular services 	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Health Sector Agencies

The need for national initiative prioritisation was identified in December 2012, along with an initial analysis of affordability impacts on DHBs. Further work has been undertaken between National Health IT Board (NHITB), Health Benefits Limited (HBL) with the support of the Ministry of Health, to validate costs and benefit impacts and obtain NHITB and HBL feedback on possible national priorities for 2013/14.

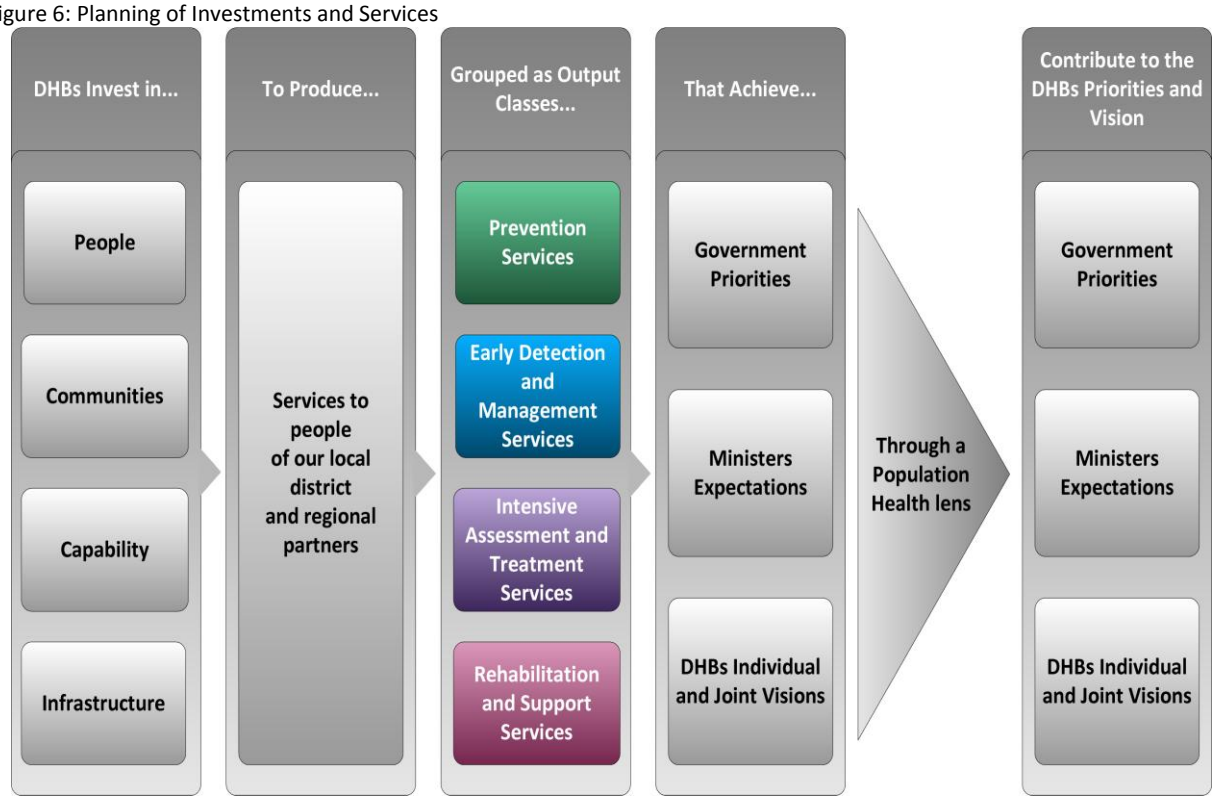
The National Entity Initiative Priorities expected to have financial impacts on Hutt Valley DHB are included in Table 6 below. Further details regarding the financial impacts, including costs and benefits to the DHB are included in Module 5 – Financial Performance.

Table 6: HVDHB National Entities Initiatives

Initiative
Finance, Procurement and Supply Chain(HBL)
Health Identity Programme

2.3 PLANNING APPROACH

Figure 6: Planning of Investments and Services



The planning of services across both the subregion and the districts to achieve outcomes at multiple levels is a complex exercise. SIDU therefore uses an intervention logic approach to provide assurance as to how raw funding is converted into tangible health outcomes. This approach provides assurances to the Executives and the Boards that the services we provide or purchase are well targeted and have a high probability of achieving the desired health outcomes or equity results over the medium or longer term. Figure 6 refers.

Supporting the logic model are a number of engagement mechanisms which ensure the decisions that the DHBs make involve the right mix of clinicians, planners and funders.

Integrative Approaches - Better Sooner More Convenient Healthcare
Each of the three DHBs across the subregion is engaged in locally developed primary/secondary integration work that contributes to the Minister's priority of better, sooner and more convenient healthcare.

The Hutt Valley Primary Secondary Strategic Governance (PSSG) Approach
The PSSG is an integrated primary and secondary multidisciplinary clinical group created to provide and contribute to clinical leadership across the primary-secondary continuum in the Hutt Valley.

Its agreed vision is "Keeping people in the community healthy".

Its goals have been established as:

- Ensuring seamless healthcare for people in the Hutt Valley
- Fostering high quality innovative integrated services – i.e. safe, patient centred, effective, timely, efficient, accessible, sustainable and equitable
- Identification and removal of barriers to communication and care
- Better management of preventative services, acute episodes, and long term conditions.

The PSSG's agreed functions include:

- Identifying and considering opportunities that exist across Primary/Secondary care to enhance the patient experience (including quality, access, and reliability)
- Developing, leading, and sponsoring a work programme in partnership with Hutt Valley DHB, Te Awakairangi Health PHO (TeAHN), and Ropata Medical Centre (Ropata)
- Providing advice regarding priorities across the primary/secondary care continuum
- Reviewing and assessing the clinical implications of proposed service changes and innovations across the continuum of care
- Assisting Hutt Valley DHB, TeAHN, and Ropata in determining and achieving strategic goals
- Modelling integrated clinical leadership amongst clinical colleagues.

Through PSSG, Hutt Valley DHB acknowledges the participation of local primary care partners, in the development of, and agreement with, this Statement of Intent. Please see the DHB's Annual Plan Module 3 for further details of the work programme and action plans agreed with PSSG.

The CCDHB Integrated Care Collaborative Approach
The Integrated Care Collaborative (ICC) is Capital and Coast's pan-health sector approach to looking at how and where services are delivered, and developing more cost effective and client centred approaches to improved personal and population health outcomes. It is the DHB's key mechanism to driving service change and achieve the Government's vision of Better, Sooner and More Convenient health services.

The ICC process is based upon the principles of *Triple Aim* change management. These are:

- to improve the quality, safety and experience of care

- to improve health and equity for all populations
- to gain the best value from the resources made available to the public health system

As a collaborative the ICC partners have begun a programme of action that will focus on a number of key areas for integrative change over the next 2-3 years. The activity is modelled on an improvement cycle used effectively by the National Health Service in the UK, which CCDHB has adapted to address the level of change and accountability required across the local system.

There are five areas of focus that have been identified as work streams to be taken forward within the ICC change process (refer Table 7). In turn, each of these areas of focus are tasked with improving a number of key performance indicators across the continuum of care. The areas of focus impact upon each other, and have vertical and horizontal integrative effects on overall sector performance. The diagram below demonstrates how and where in the continuum the projects will have a positive and sustainable impact on the achievement of better, sooner and more convenient health outcomes:

Table 7: ICC Work Programmes

ICC Project Integration	Number of Admissions	Length of Stay	Patient Outcome	Primary Care Activity	HHS Outpatient Community Activity
Acute Demand & After Hours	▼	►	▲	▲	►
Long Term Conditions	▼	►	▲	▲	▼
Communication between Primary and Secondary Care	►	▼	▲	►	▼
Health of Older People	▼	▼	▲	▲	►
Child Health Action Plan	►	►	▲	▲	►

The ICC Work Programmes are undertaken collaboratively with a wide number of partners across the health services continuum. These include:

Table 8 ICC Partners

CCDHB Hospital and Health Services	Compass Health Clinical Quality Board
SIDU Management Team	Well Health Clinical Quality Board
Compass Health Board	Ora Toa PHO Clinical Quality Board
Well Health PHO Board	Cosine Primary Health Care Network Clinical Quality Board
Ora Toa PHO Board	Cosine Primary Health Care Network Board
Nurse Maude – Care Coordination	Wellington Free Ambulance
Regional Public Health	

Through the ICC, local primary care partners have participated in the development of, and agreement with the Capital and Coast DHB Annual Plan.

The Wairarapa Alliance Leadership Team (ALT) Approach
Wairarapa DHB was an early adopter of the Better, Sooner, More Convenient health system goals, and to advance these, developed the Alliance Leadership Team (ALT) made up of clinicians from across the continuum of care, to provide the governance and leadership for whole of sector health care in the Wairarapa. The ALT works under an Alliance Charter which sets out a commitment to act in good faith to reach consensus decisions on the basis of "best for patient, best for system". The ALT is guided by Alliance principles which include:

- supporting clinical leadership, and in particular clinically-led service development;
- conducting themselves with honesty and integrity, and develop a high degree of trust;
- promoting an environment of high quality, performance and accountability, and low bureaucracy;
- striving to resolve disagreements co-operatively, and wherever possible achieve consensus decisions; and
- adopting a patient-centred, whole-of-system approach and making decisions on a ;Best for System; basis.

Supporting the ALT is a management group whose role is to manage and drive the work programme and deal with some of the system barriers that make integration difficult. A joint Clinical Governance Group will be established in 2013 to provide the whole of system approach to clinical governance in the Wairarapa, while maintaining a focus on leading the development and improvement of the systems and delivery of clinical care.

The DHB has been implementing an ongoing programme of work for the past three years called Tihei Wairarapa. This is our Better, Sooner, More Convenient Business Case to deliver more integrated health services in the Wairarapa; 2013 will be the fourth year of this programme of work. In 2013/14 we will continue a work programme focussed on acute care, mental health, whanau ora, and care of the frail elderly and people with long term conditions (LTC). A new feature of the work programme in 2013 will be the incorporation of activity related to maternal, child and youth health services across a range of primary and community providers with a view to providing a more integrated approach in the Wairarapa. Key planned activities include:

- full implementation of guided model of care across practices, hospital and community services for people with LTC;
- embed and monitor LTC pathways developed in year 2 and 3;
- implementation of the diabetes guided care pathway;
- embed new mental health services in primary care and extend to child and youth;
- continue to progress the Integrated Family Health Network (IFHN) across Wairarapa, enhancing the existing range of services collocated with general practices; and
- delivery of health targets – immunisations, smokers seen in primary care, and CVD risk assessment.

Through the ALT local primary care partners have participated in the development of, and agreement with the Wairarapa DHB Annual Plan.

Clinical Governance

A number of clinical governance groups have been established across the 3DHB region. Their purpose is to look at how services can be provided more efficiently and effectively across the wider population – improving both delivery and equity of access.

The clinical governance groups play an important role both in the operational planning of and across services and in supporting the ongoing development of the Regional Services Plan (RSP). Bringing together regional experts in local population health services (e.g. Child Health and Health of Older Peoples) within these clinical forums will ensure planners of future regional service configurations will be best informed. This will allow the Central Region DHBs to move more quickly and robustly towards achieving medium- and long-term efficiency gains for both their organisations and the local populations.

Fitting it all together

Figure 7: Intervention Logic Model

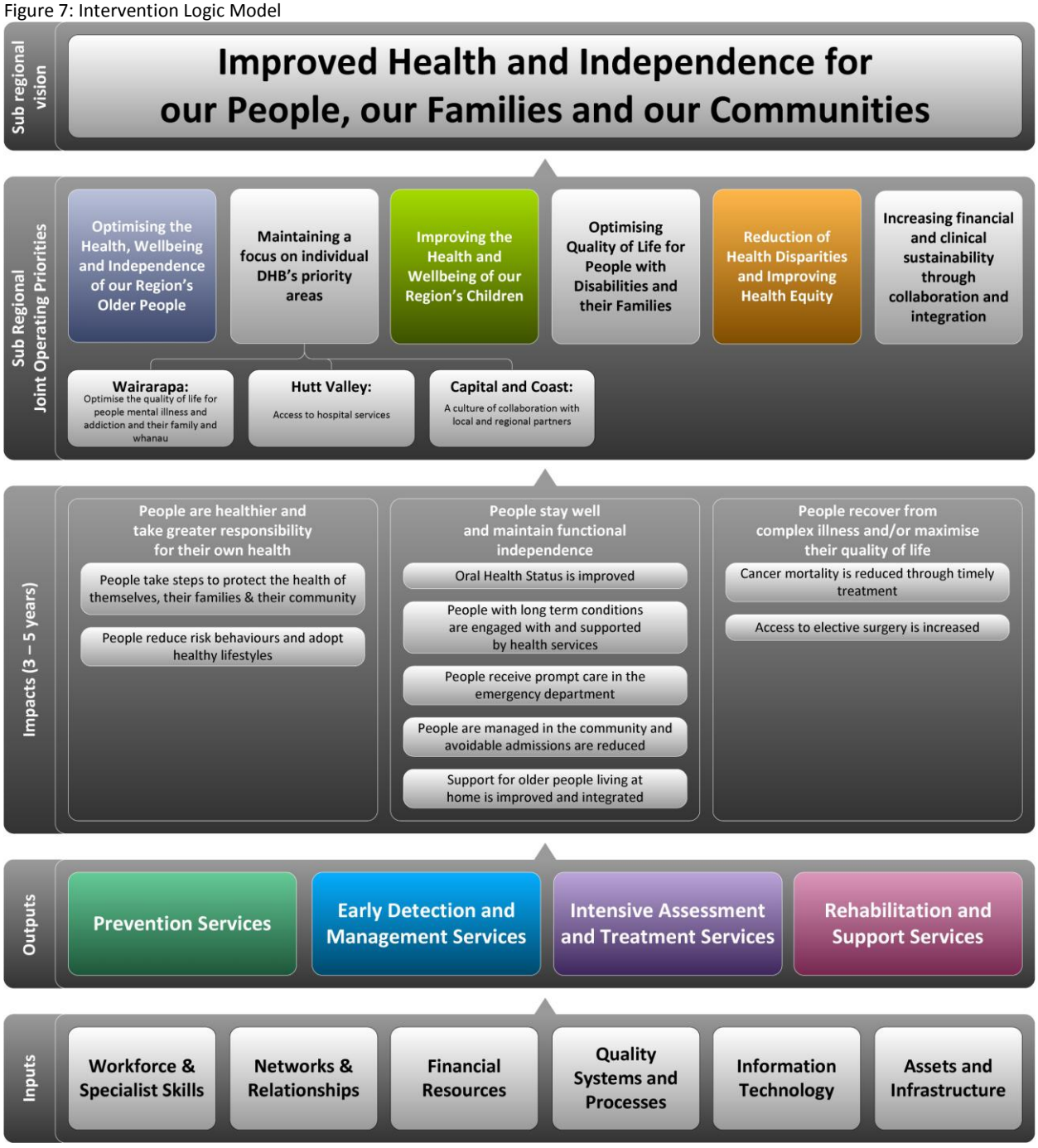


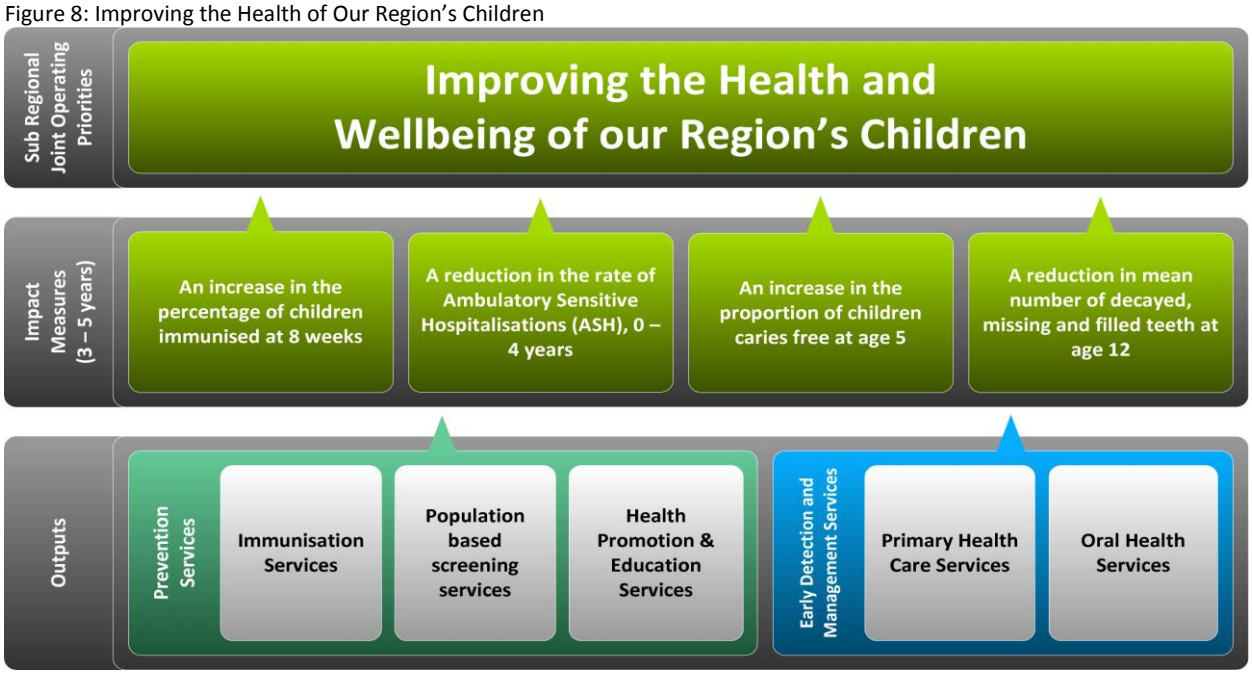
Figure 7 above shows the relationships between the inputs, outputs, impacts, and subregional joint operating priorities. Each layer of this diagram contributes to the next level up, however the relationships are complex and not necessarily one to one. DHBs can influence health outcomes, although the outcomes are also reflective of:

- socioeconomic determinants, such as income and housing;
- health literacy, or understanding of health problems and the health system;
- and the value individuals place on their health and health decisions.

The inputs are the items which are put into the local health system. The outputs, grouped by output classes as per the Statement of Forecast Service Performance (see Module 4), reflect the activities

undertaken by the local health system as described in the Annual Plan's Module 3 and assessed by the performance measures in Module 4. Annual activities are decided in response to population needs, service development priorities, and the guidance from the Minister and Ministry of Health. The impacts are the changes the DHB would like to see in the short to medium term (<5 years) as a result of the annual outputs. The 2013/14 joint operating priorities, developed from the three DHBs' 2012/13 local priorities, act as interim outcomes (5-10 years) that the DHBs aspire to achieve. As closer collaboration continues between the three DHBs, a single framework is intended for the subregion.

Figure 8: Improving the Health of Our Region's Children

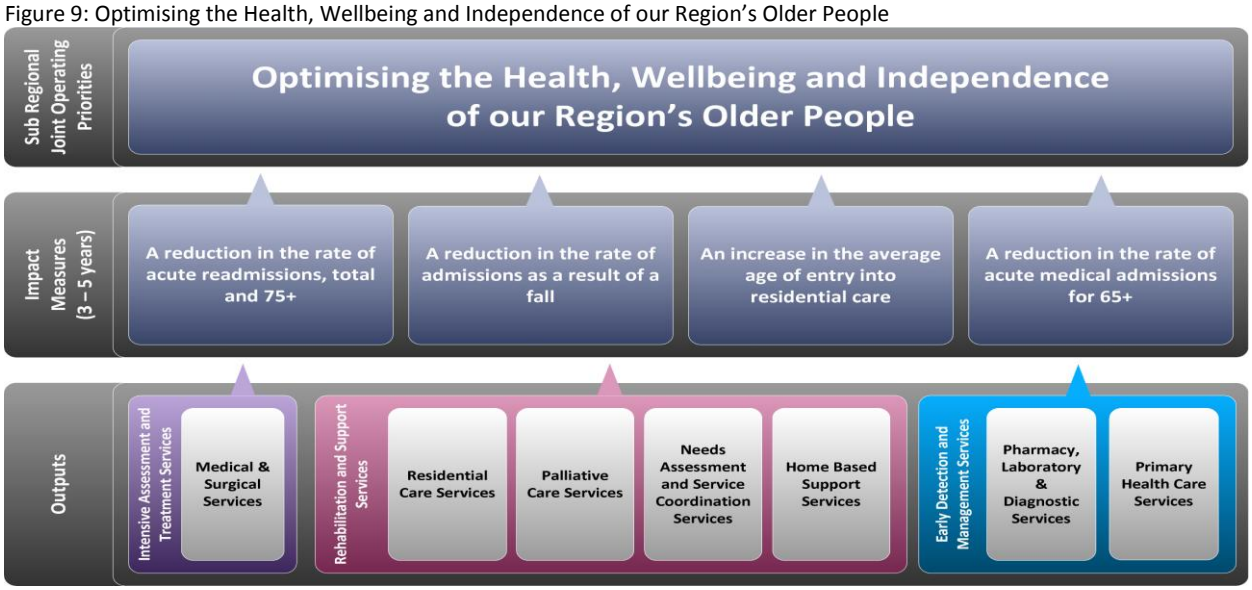


Across each subregional priority area, the DHB's performance will be the product of a spectrum of DHB services working together across a range of output classes. It is important to note that there is seldom a simple or linear relationship between a sub-regional priority and the work of DHB services. Figure 8 is provided to help show what the intended linkages are, and to enhance accountability by specifying which DHB service areas will be making some contribution towards Improving the Health of Our Region's Children. The DHB will regularly examine its progress relative to this sub-regional priority area by monitoring the four Impact Measures in Figure 8 through the Statement of Forecast Service Performance (Module 4) and the Ministry of Health's Non-financial Monitoring Framework (see Annual Plan Appendix 8.1).

Maintaining a focus on individual DHB's priority areas

While the DHBs' 2012/13 local priorities were well aligned and able to be brought into a set of subregional operating priorities, there were some that are specific to the local populations. These are reflective of system integration and functionality, and therefore have been included at the top of Figure 7.

Figure 9: Optimising the Health, Wellbeing and Independence of our Region's Older People

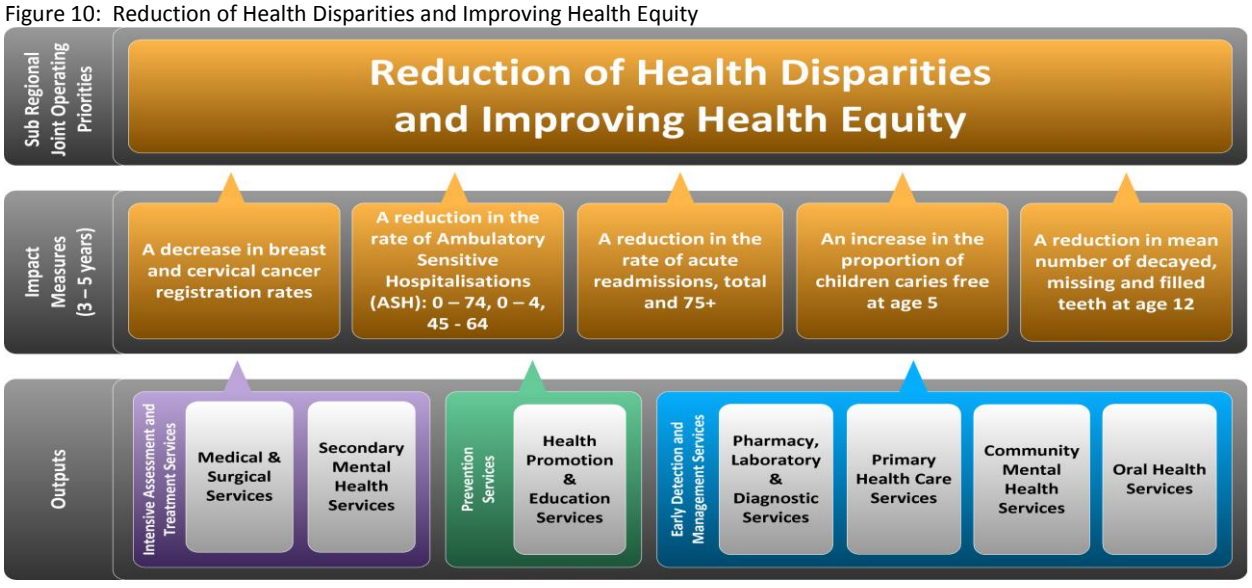


Across each subregional priority area, the DHB's performance will be the product of a spectrum of DHB services working together across a range of output classes. It is important to note that there is seldom a simple or linear relationship between a sub-regional priority and the work of DHB services. Figure 9 is intended to help show what the intended linkages are, and to enhance accountability by specifying which DHB service areas will be making some contribution towards Optimising the Health, Wellbeing and Independence of our Region's Older People. The DHB will regularly examine its progress relative to this sub-regional priority area by monitoring the four Impact Measures in Figure 9 through the Statement of Forecast Service Performance (Module 4) and the Ministry of Health's Non-financial Monitoring Framework (see Annual Plan Appendix 8.1).

Optimising quality of life for people with disabilities and their families

This subregional joint operating priority reflects the joint Hutt Valley and Capital & Coast disability strategy 2012-2017, and the Wairarapa local initiatives. Because success in this outcome is dependent on whole of system responsiveness and functionality, it is difficult to identify specific impact measures which confirm progress against the outcome. Progress is measured at an output level by the measures of annual activities (see Annual Plan Module 3) and projects undertaken in the joint Hutt Valley and Capital & Coast disability strategy. Disability strategy is detailed more fully in Section 2.4.

Figure 10: Reduction of Health Disparities and Improving Health Equity



Across each subregional priority area, the DHB's performance will be the product of a spectrum of DHB services working together across a range of output classes. It is important to note that there is seldom a simple or linear relationship between a sub-regional priority and the work of DHB services. Figure 10 is provided to help show what the intended linkages are, and to enhance accountability by specifying which DHB service areas will be making some contribution towards the Reduction of Health Disparities and Improving Health Equity. The DHB will regularly examine its progress relative to this subregional priority area by monitoring the five Impact Measures in Figure 10 through the Statement of Forecast Service Performance (Module 4) and the Ministry of Health's Non-financial Monitoring Framework (see Annual Plan Appendix 8.1).).

Increasing financial and clinical sustainability through collaboration and integration
This outcome is reflective of system integration and functionality, and therefore has been included at the top of the diagram. Success in this outcome is dependent on programmes of closer collaboration and integration such as the 3DHB HSD, and local programmes like Tihei Wairarapa, Hutt Valley's Primary-Secondary Strategy Group, and Capital and Coast's Integrated Care Collaborative. Detailed information on activities is provided in the Annual Plan's Module 3.

2.4 OTHER SIGNIFICANT DHB PLANS

Inequalities in access to and decisions over resources are the primary cause of health inequalities. These structural inequalities may explain more of ethnic inequalities in health than is often recognised.

Māori and Pacific Health
Although Hutt Valley DHB overall has a relatively affluent, healthy population, a quarter of the population live in high deprivation areas concentrated in Naenae, Taita, Moera and parts of Petone, Stokes Valley, Wainuiomata and Waiwhetu. A large proportion of the Pacific and Māori population live in the most deprived areas of the Hutt Valley.

Māori and Pacific peoples die on average ten to fifteen years earlier than non-Māori non-Pacific, and experience significantly higher acute admission and avoidable mortality rates. Although access to some health care services has improved, outcomes often remain worse for Māori and Pacific. For example, although Māori and Pacific are no more likely to be diagnosed with cancer (any type) than non-Māori non-Pacific, they are more likely to die from their cancer.

Māori Health Plan
The DHB has developed a Maori Health Plan (MHP), which sets out its intentions toward improving the health of Maori and their whānau, and reducing health inequalities for Maori. The plan has been submitted in line with Ministry of Health requirements. As in past years, the development of this year's MHP has been guided by the input and engagement of local Māori networks. The Māori Partnership Board (MPB) advises strategically at a governance level directly to the Board, whilst at an operational level the Māori Health Services Development Group (MHSDG) has informed the service planning and delivery through advice to the executive management team.

Established long-term relationships, partnerships and understandings exist across a wide range of health and social sector services and groups, including Māori providers, and Nga Iwi Māori – mana whenua and taurahere alike. Several interagency services and non-government networks are also important for the DHB. These networks provide opportunities to address the social determinants of health for Māori and others.

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

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

When compared with non-Māori in the district, Māori experience:

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

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

- Continuing our positive engagement with our community providers, including through the cluster of Whānau Ora providers, with a focus on education, prevention and outreach services particularly amongst Māori, Pacific and low-income people, and
- Working more closely with primary care to address: long term conditions, avoidable hospitalisation, and to reinforce education and prevention, particularly amongst people with higher needs.

Our district priorities have been identified in conjunction with the DHB's Maori Partnership Board. They are: Child Health, Immunisation, Breastfeeding, Oral Health, 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 MHP 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 Disability 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.

Wairarapa, Hutt Valley and Capital and Coast District Health Boards now share the advice of a joint Community Public Health Advisory Committee (CPHAC)/Disability Support Advisory Committee (DSAC). This change recognises the increase in shared initiatives between the DHBs, and the need for neighbouring communities to work together. A shared CPHAC/DSAC improves integration between the three DHBs, and provides opportunities for equity through alignment of initiatives.

In 2012/13, Hutt Valley and Capital and Coast DHBs produced an initial shared disability strategy implementation plan, called *Valued Lives, Full Participation.* The plan outlines how we will continue to engage with people with disabilities and value their advice. The Hutt Valley Disability 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 are continuing to encourage 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.

2.5 KEY IMPACTS AND MEASURES OF PERFORMANCE

Shorter Stays in ED	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment
Government Expectation **95% of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.**	**Government Expectation** **More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.**[2]	**Government Expectation** **All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.**[3]
Why is this target area important: This target is reflective of a whole of system approach to managing acute demand, strong clinical leadership and a commitment to improving the quality of care for patients across the whole continuum. ED length of stay is also seen by the Government as an important measure of the quality of acute care in public hospitals. Long stays in ED are reflective of overcrowding, which can lead to compromised standards of privacy and dignity for patients and are linked to negative clinical outcomes for patients, such as increased mortality and longer inpatients lengths of stay. The target is also reflective of the flow of patients through the hospital and how well different departments interact.	**Why is this target area important:** The Government wants the public health system to deliver better, sooner, more convenient health care for all New Zealanders. In order to achieve this, the growth in elective surgical discharges must keep up with population growth. This in turn will increase access and achieve genuine reductions in waiting times for patients. All patients have the right to: clarity about whether they will receive publically funded treatment, timeliness in terms of those who are given a commitment to treatment receiving that treatment in a timely manner (a maximum of five months) and fairness in ensuring that prioritisation status is based on a patient's level of health need compared to other patients.	**Why is this target area important:** Cancer is the leading cause of death and a major cause of hospitalisation in New Zealand. Timely cancer treatment is important to improve outcomes and provide a better quality of life. The target measures one part of a patient's journey with cancer and provides an indicator of how well the system is working. Māori and Pacific populations have proportionately higher cancer incidence compared to other populations. Providing support to improve access to treatment and ensure sufficient treatment capacity are both important factors in ensuring Māori and Pacific people have equitable outcomes.
HVDHB contribution: 95% of people presenting at HVDHB ED will be admitted, discharged or transferred within six hours.	**HVDHB contribution:** HVDHB will maintain compliance with all eight Elective Services Patient flow Indicators (ESPIs). 4,946 elective surgery discharges will be provided by the HVDHB in 2013/14.	**HVDHB contribution:** All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

[2] The national health target definition of elective surgery excludes dental and cardiology services.

[3] The national health target definition excludes Category D patients, whose treatment is scheduled to ensure effective sequence of radiation treatment with chemotherapy of other anti-cancer drugs.

		
Increased Immunisation Rates	**Better Help for Smokers to Quit**	**More Heart and Diabetes Checks**
Government Expectation 90% of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95% by December 2014.	**Government Expectation** 95% of patients who smoke and are seen by a health practitioner in public hospitals and 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. Within the target a specialised identified group will include: Progress towards 90% 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.	**Government Expectation** 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.
Why is this target area important: 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. Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and not sufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). Coverage for two year olds demonstrates whether children have received the full series of infant immunisations, when they are most vulnerable.	**Why is this target area important:** Smoking kills an estimated 5,000 people in New Zealand every year, and smoking-related diseases are a significant cost to the health sector. Smoking is also a major contributor to inequalities in health and to a number of long-term conditions, including heart disease, cancers and respiratory disease. Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt health professionals to routinely ask about smoking status and provide smokers with brief advice and support to prompt quit attempts and quit success.	**Why is this target area important:** Long-term conditions comprise the major health burden for New Zealand now and in the foreseeable future. These conditions are the leading cause of morbidity and disproportionately affect Māori and Pacific people. As the population ages and lifestyles change, these conditions are likely to increase significantly. Improving outcomes for people with diabetes and CVD will take a whole of system approach that encourages healthier lifestyles, supports early diagnosis, management plans and access to treatment. The targets measure one part of the journey and can provide an indication of how well long-term conditions are being identified and managed in primary care.
HVDHB contribution: 90% of HVDHB eight month olds fully vaccinated by July 2013. 90% of HVDHB Māori eight month olds fully vaccinated by July 2013. 90% of HVDHB Pacific eight month olds fully vaccinated by July 2013.	**HVDHB contribution:** 95% of hospitalised smokers will be provided with advice and help to quit smoking by July 2014. 90% of smokers attending primary care will be provided with advice and help to quit smoking by July 2014. Progress towards 90% of pregnant smokers at the time of confirmation of pregnancy in general practice or booking with LMC are offered advice & support to quit.	**HVDHB contribution:** 90% of the eligible adult population in HVDHB will have had their CVD check assessed in the last five years by 30 June 2014.

2.6 SECTOR COLLABORATION

Working Nationally

There are two approaches utilised for development of services at a national level; national services and national service improvement programmes. Effective as of 1 July 2013, national services have been identified as shown in Table 9.

Table 9: National services

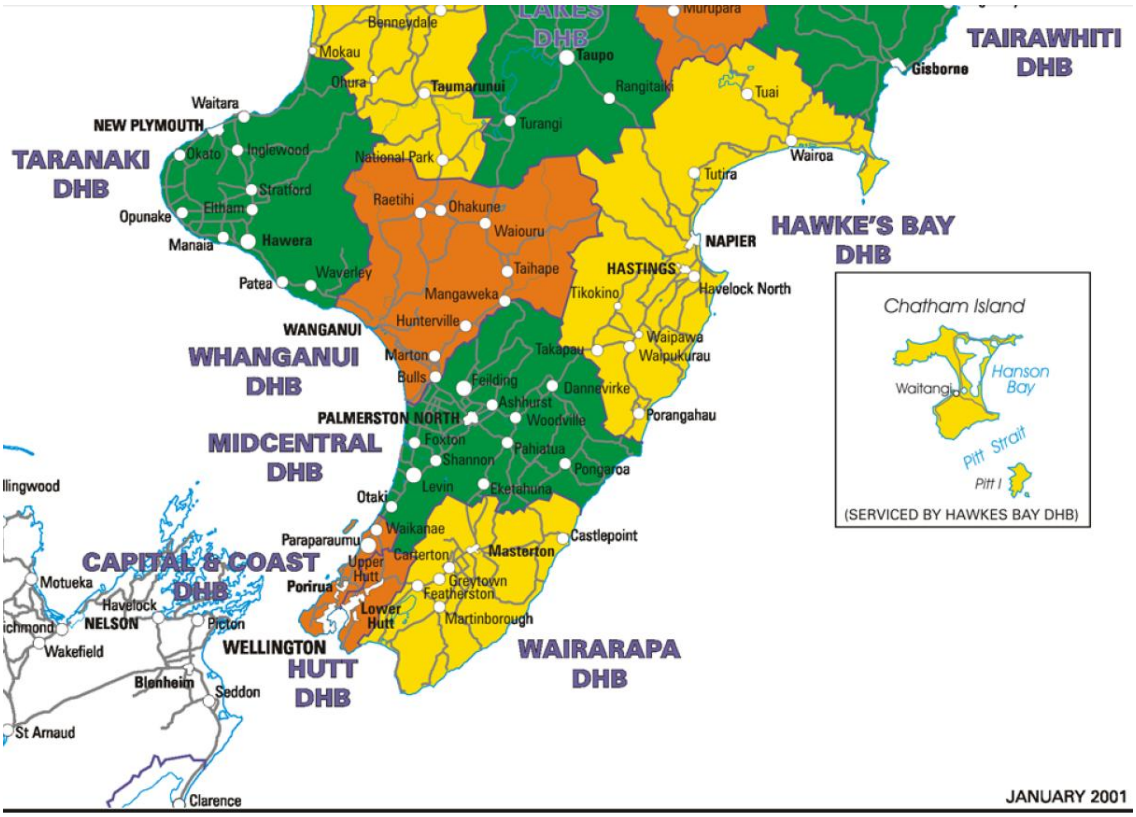
Intestinal Failure
Renal Transplantation
Hyperbaric Medical Service

During 2013/14 a national service improvement programme is being run around services relating to complex epilepsy. We will continue to support national services and national service improvement programmes.

Working across the Broader Central Region DHB Grouping

The three DHBs are part of a wider collection of DHBs known as the Central Region DHB Group. The Central Region covers the Lower North Island, and comprises Wairarapa DHB, Hutt Valley DHB, Capital and Coast DHB, Mid-Central DHB, Whanganui DHB and Hawke's Bay DHB. A map of the Central Region is set out below. This region serves a population of over 870,000.

Figure 11: Central Region



Services provided by Capital and Coast DHB through its Hospital Services arm to the region are:

Table 10: Regional Services Based at Capital & Coast DHB

Clinical Genetics	Oncology	Haematology
Cardiothoracic Surgery	Neurology	Tertiary Paediatrics
Tertiary Cardiology	Neurosurgery	Tertiary Neonatal
Chronic Pain Service	Renal	Immunology
Vascular Surgery	Urology	Ophthalmology
Forensic Mental Health	Methadone programme	Infectious diseases
Regional Mental Health speciality services		

Services provided by Hutt Valley DHB through its Hospital Services arm to the region are:

Table 11: Regional Services based at Hutt Valley DHB

Plastic Surgery	Maxillofacial and Burns services	Reconstructive Surgery
Rheumatology Services (subregional)	Eating Disorder Service	Regional Screening
Regional Public Health		

The Central Region Services Plan

The Regional Services Plan (RSP) has been developed by the six Central Region DHBs to provide an overarching framework for future planning, and sets the region's short and medium term priorities to 2016/17. It builds on the Regional Clinical Services Plan (2008) and the 2011/12 RSP.

The RSP is the overarching strategy for all Central Region DHB Annual Plans for 2013/14 onwards. This includes agreed common Annual Plan assumptions, clarity about planned inter-district activity flows, changes to service models (including workforce appointments) and capital investment.

The active involvement of representatives from across all six DHBs has helped create a positive environment for the next steps in regional collaboration. The leadership and engagement of health professionals in these processes ensures that work plans and planning principles are owned by those directly involved in the delivery of health services in the Central Region.

The priorities for inclusion in the RSP in 2013/14 include:

Table 12: RSP Priorities 2013/14

National and regional Priority area	Objectives
1. Better public services for the reduction of rheumatic fever	Implement effective rheumatic fever prevention and reduction programmes, especially in areas of high incidence
2. Elective services	To improve access to elective services by increasing the level of first specialist assessments (FSAs) and surgery and reducing waiting times; and to improve equity by improved prioritisation of patients
3. Long term conditions – Cancer services	People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care) and have access to services that maintain good health and independence
4. Long term conditions - Cardiovascular services (Acute Coronary Syndrome)	• Improving access to cardiac diagnostics, specialist assessment and intervention where appropriate • Reducing waiting times for cardiac services – elective and non- elective services • Improving access to evidence based services and outcomes for people with suspected ACS • Improving access to and waiting times for PCI, angiography and cardiac surgery
5. Long term conditions – Stroke services	Better Sooner More Convenient Health Services for New Zealanders in relation to Stroke Services means improved and more timely access to organised stroke services meaning more patients survive stroke events, and the likelihood of subsequent stroke events is reduced.
6. Mental Health and Addictions	Improving access and effectiveness of services particularly for priority groups across the region: for people with eating disorders, adult and youth forensic services, perinatal and maternal services, and addiction services.
Regional priority plan:	
7. Regional Radiology	Deliver Better Sooner More Convenient Health Services for New Zealanders in relation to radiology with the objective that all New Zealanders are provided with a patient focussed and regionalised radiology service that is high quality, timely, affordable and therefore sustainable.

Non- clinical priorities/ regional enablers	
8. CRISP	Support the delivery of integrated health services by developing core regional applications supporting Common Clinical Information available from 2013 and a foundation to support Community Information, Hospital Information and Shared Care Plan in the future is established.
9. Regional Training Hub	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.
10. Workforce	Develop a comprehensive plan that will support new models of delivery, the change processes and the prioritise workforce pressure areas for strategy development and action across the region.
11. Regional funding models and mechanisms	Review regional funding mechanisms to develop a planned and managed approach to demand for high cost services and to reduce volatility
12. Capital planning	Describe key service planning issues that will impact on capital investment and will outline a work programme to address the issues and align the asset management plans with the local and regional service plans.

In addition, the six DHBs in the region will also continue to contribute to the following regional networks and priorities:

- *Health of Older People Network* - Health of Older people is a national, regional and local priority. As the population ages, there will be an even greater demand for health services.
- *Renal Network* - The network exists to ensure the population of the region have improved equitable and timely access to renal services. It will also be investigating the possibility of greater alignment of renal services across the region.
- *Māori Health* - A reduction in health inequalities must remain a core focus of our regional work, ensuring that our DHBs pool their resources and understanding of how to reduce health inequalities, and implement a monitoring plan to ensure health inequalities are addressed at all organisational levels.
- *Population Health* - The region believes a 'whole of system' approach to the delivery of integrated services must include community based preventative services. Investment in preventative measures will, over time, help maintain and potentially improve peoples' health standards, reduce pressure on the health care services and avoid hospital admissions.
- *Quality and Safety* - The region is committed to working towards a zero preventable harm culture and with the establishment of the Clinical Board is already making positive steps towards enhancing patient outcomes across the region.

Regional Governance and Leadership

A revised governance and leadership framework is detailed in the RSP. There will be three key governance groups that oversee all clinical and business service activities:

1. The Regional Governance Group (RGG), supported by the Regional Maori Relationship Board Forum
2. The Central Region CEOs
3. Regional Executive Committee (REC)

Collaboration with other regional DHBs to improve service delivery efficiencies – 3 DHB Health Service Development Programme

The 3DHB Health Service Development Programme (3D HSD) is a collaborative programme between Wairarapa, Hutt Valley and Capital and Coast DHBs that has been running for over two years, focussed on the joint planning of health services. The service development programme is clinically led with managerial support enabling a collaborative partnership approach to be achieved while delivering on the Triple Aim vision (Figure 12).

Figure 12: HQNZ Triple Aim

The three DHBs collectively and individually face challenges in relation to service sustainability. The key factor in relation to these challenges is the population catchment size required to ensure clinical service and financial viability.

The Subregional Clinical Leadership Group (SRCLG) supports collaboration between the DHBs to advance improvements in the quality of patient care, manage risk and improve processes, sustain our workforce, and make the best use of our resources to a greater extent than

working separately. The SRCLG has gone on to support an ongoing programme of clinically led work which considers the optimal configuration of services across the three districts to provide equitable access to the subregional population.

Following the submission of the 2012/13 Annual Plans by the three DHBs, the Minister of Health issued a letter requesting that the three DHBs submit a collective breakeven plan. The *3DHB Subregional Savings Plan* developed by Health Partners Limited in collaboration with the three DHBs has subsequently been accepted by the Minister and the three DHB Boards, and proposes a range of projects and activities that will deliver improved financial performance across the three DHBs.

The focus of the 3D HSD programme is to take a whole of system approach spanning the health continuum to enable the greatest gain to the patient/whānau experience, population health and clinical and financial sustainability consistent with the Triple Aim Approach. This comprehensive programme of work is supported by a 3D Programme Office, resourced from existing SIDU capacity and reporting to SRCLG, and combined CPHAC and the 3 District Health Boards. Good progress has already been made. The following tables reflect the agreed work programme for 2013/14, made up of a range of enablers and clinical workstreams that make up the 3D HSD Programme.

This is a combination of work identified by the SRCLG and the actions identified in the *3DHB Subregional Savings Plan*. Specific workstream indicators and milestones are being developed within each workstream as an integral part of service development.

Table 13: 3 DHB Work programme 2013-2014 - Summary

3 DHB Work programme 2013-2014 - Summary		
Outcome areas	**Status**	**Oversight Body**
Enablers		
Capacity Modelling / Optimal facilities	ACTIVE	SRCLG
Sub Regional policy alignment for: • HR • IT • Health	ACTIVE	SRCLG
Sub regional SMO teams	ACTIVE	SRCLG
Sub regional management RMOs	ACTIVE	SRCLG
Single Communication Team	TO BE INITIATED	Boards
Single HR Team	TO BE INITIATED	Boards
Executive team amalgamation HV and WDHB	ACTIVE	HV & W Boards
Funder arm value for money review	ACTIVE	CPHAC
IT Service alignment CC and HVDHB	ACTIVE	FRAC
Provider team amalgamation HV / WDHB	ACTIVE	HAC HV and W
CAPEX spend review	TO BE INITIATED	A/R and FRAC
Clinical Work Streams		
ENT	ACTIVE	SRCLG
Gastroenterology	ACTIVE	SRCLG
Child Health	ACTIVE	SRCLG
Ophthalmology	TO BE INITIATED	SRCLG

Orthopaedics	ACTIVE	SRCLG
Non melanoma skin cancer	Pre project discussion	SRCLG
Palliative care initiative (MOH funding)	ACTIVE	SRCLG
Amalgamation HV and CCDHB Laboratories	ACTIVE	SRCLG
Sub-regional radiology service	ACTIVE	SRCLG
Reducing outsourced electives	TO BE INITIATED	HAC
Critical Care Management	Pre project discussion	SRCLG
Clinical Work streams for further discussion 2013-2014		
Anaesthesia	Pre project discussion	SRCLG
Mental Health	Pre project discussion	SRCLG
Health of Older People	Pre project discussion	SRCLG
Dermatology	Pre project discussion	SRCLG
Sub-regional Clinical Governance	Pre project discussion	SRCLG

Table 14: 3 DHB Work programme 2013-2014 – Detail

The DHBs will undertake the following:	Actions to improve performance	Health system success is measured by:	In support of systems outcomes
Scope and agree subregional clinical service model of care for the following clinical work streams • ENT • Gastroenterology • Child Health • Orthopaedic	Implement sub-regional referral pathways for common ENT conditions Develop and implement a sub-regional approach to community ear health services Investigate a business case to provide a sustainable sub-regional head and neck surgery sub-speciality Develop and implement a sub-regional approach to colonoscopy referral and wait list Develop and agree a sub-regional model of care for child health Participate in the development of and implementation of regional approach to paediatric surgery Scope and agree a sub-regional approach to orthopaedic services	A single population approach for specific services is embedded across the three DHBs Clinical leadership drives projects and service changes are facilitated by comprehensive project management Sub-regional Clinical Leadership Group provides oversight and endorsement of all project milestones Equity of access for services across the sub region	Improved patient/whānau quality, safety and experience of care A whole of health system approach is applied Improved health outcomes Best value for 3 DHB health system resources Enabling workforce to support 3 DHB service development
Scope and develop a Lower North Island Palliative Care Clinical Network with support from Health Workforce New Zealand	Secure project management support from Health Workforce New Zealand Scope project and agree implementation plan	Lower North Island Palliative Care Clinical Network established by June 2014	Improved patient/whānau quality, safety and experience of care A whole of health system approach is applied
Undertake pre-project scoping and identify a project mandate to support a sub-regional approach to: • Ophthalmology • Non –melanoma skin cancer • Critical Care Management	Data and business analysis is undertaken for each of the projects as part of scoping Clinical leadership identified for each project and potential steering group membership	A single population and subregional approach to clinical service delivery Equity of access to services across the sub-region Clinical leadership drives project mandate and	Improved patient/whānau quality, safety and experience of care A whole of health system approach is applied

	Project mandate agreed for each project	service changes, facilitated by comprehensive project management	Improved health outcomes Best value for 3 DHB health system resources
Develop and progress implementation of a laboratory strategy to inform future direction and configuration of laboratory services across the subregion.	Scope and implement a project based on the strategy document to advance the integration of laboratory services in 2013/14.	Streamlined and integrated service delivery for laboratory services for sub-region Ongoing arrangements are in place at the end of current agreements in October 2014 Equity of access to services across the sub-region	Best value for 3 DHB health system resources Best use of resources (Clinical and financial sustainability)
A sub-regional approach to radiology services is scoped and preferred option agreed	Data and business analysis is undertaken to support project mandate and proposed options Preferred option identified and implementation plan agreed Progress implementation plan	Equity of access to services across the sub-region Clinical leadership drives project mandate and service changes, facilitated by comprehensive project management	Best value for 3 DHB health system resources Best use of resources (Clinical and financial sustainability) Enabling workforce to support 3 DHB service development
Scope and undertake detailed modelling for optimal use of facilities.	Data, business analysis and bench marking is undertaken to support project mandate. Proposed options are investigated with clinical leadership	System capacity information is well understood and utilised by clinical work streams in considering subregional service development	Improved patient/whānau experience Improved quality of care Efficient use of infrastructure investment
Undertake a funder arm review across 3 DHBs	Implement agreed “value for money” processes and review for all contracts expiring in 2013/14 Identify ongoing opportunities for efficiencies		Efficient use of investment Best use of resources (Clinical and financial sustainability)

Align CC/HVDHB IT Service Alignment	Refer to Module 2 RSP		
Scope and implement a single communications team across the three DHB	Refer to Module 3 Stewardship section for further details of subregional Communications development		
Corporate policies and procedures in Human Resources, Occupational Health and Information Technology will be reviewed with the objective of developing common processes Scope and implement a single Human Resources team across the three DHB	Refer to Module 3 Stewardship section for further details of subregional Human Resources team		Enabling workforce to support 3 DHB service development Best value for 3 DHB health system resources
Develop and implement a subregional approach to the recruitment and deployment of SMO teams across the DHB's in line with the implementation of integrated clinical services	Refer to Module 3 Stewardship section for further details of subregional Workforce Development plans		Best value for 3 DHB health system resources Best use of resources (Clinical and financial sustainability) Enabling workforce to support 3 DHB service development
Implementation of a single HV/WDHB Executive Team Structure			
Amalgamate HV/WDHB provider teams			

MODULE 3: STEWARDSHIP

3.1 MANAGING OUR BUSINESS

This section details how the three organisations manage their business effectively and efficiently to deliver on the priorities described in their Plans. It shows how the DHBs' high level strategic planning translates into action in an organisational sense within the DHBs and details the supportive infrastructure requirements to achieve this. As both funders and deliverers of health services, the DHBs must operate in a fiscally responsible manner and be accountable for the assets they own and manage.

Governance and Organisational Structure

The three DHBs have governance and organisational structures as required by the New Zealand Public Health & Disability Act 2000 (NZPHDA).

The Boards of Wairarapa, Hutt Valley, and Capital & Coast DHBs assume the governance role and are responsible to the Minister of Health for the overall performance and management of the DHBs. The responsibilities of the Boards include:

- Setting strategic direction and policies which are in line with Government objectives and priorities
- Appointing the Chief Executive
- Monitoring the performance of the organisation and the Chief Executive
- Ensuring compliance with the law (including the Treaty of Waitangi), accountability requirements and relevant Crown expectations
- Maintaining appropriate relationships with the Minister of Health, Parliament, Ministry and the public.

The Boards comprise members elected by the community and appointed by the Minister of Health. The Boards have recently changed the structure of the advisory committees required by the NZPHDA: Community & Public Health Advisory Committee (CPHAC), Hospital Advisory Committee (HAC) and the Disability Support Advisory Committee(DSAC). From the beginning of 2013 the three DHBs have moved to a subregional CPHAC and DSAC , comprising members from the Wairarapa, Hutt Valley and Capital and Coast Boards. This is to allow greater subregional planning and funding of services across the collective population. The Wairarapa DHB Hospital Advisory Committee has also been combined with the Hutt Valley DHB Hospital Advisory Committee as a result of the executive teams coming together and to facilitate the greater alignment of the two Provider Arms.

Both the Wairarapa and Capital and Coast DHBs have maintained non-statutory committee (WDHB Audit & Risk Committee and CCDHB Finance Risk and Audit Committee) to help the Boards meet local responsibilities. Membership of these committees is a mix of Board members and community representatives. Each of the 3 DHBs also works in partnership with its Māori Partnership Board, to ensure Māori participation at all levels of service planning and service delivery for the protection and improvement of the health status of Māori. Hutt Valley and Capital and Coast DHBs also work with their Subregional Pacific Health Strategy Group to ensure a Pacific Health focus for service planning and service delivery.

Whilst the Boards are responsible for the DHBs' overall performance, operational and management matters are assigned to the respective Chief Executives who are supported by the respective Senior Leadership/Executive Management Teams.

The three DHBs are committed to the philosophy and practice of clinical leadership where clinicians are accountable for outcomes they have the ability to affect. To facilitate this, an organisational structure has been implemented that ensures active, robust decision making and partnership between clinicians and management across the Wairarapa and Hutt Valley DHBs, and is also in place at Capital & Coast DHB.

Performance Reporting

In Hutt Valley DHB performance against Government targets, annual planning obligations and financial performance is monitored by the Chief Operating Officer, the Funder Arm (now SIDU), Executive Management Team and the Board (including through the Board's Hospital Advisory Committee).

Three years ago the Wairarapa DHB implemented a comprehensive balanced scorecard (BSC) reporting framework as the core of its performance management framework. This is reviewed on an annual basis to ensure the key measures reported against in the BSC are aligned to the delivery of the AP. The various measures included in the BSC are allocated across the Board who receive a regular report against the allocated measures. In addition the BSC report is reviewed monthly by the Senior Leadership Team.

In Capital & Coast DHB, performance against Government targets, annual planning obligations and financial performance is monitored by the Chief Executive, the Chief Operating Officer, the Executive Management Team, SIDU and the Board (including the Board Committees).

As part of the closer working relationships with the Wairarapa and Capital and Coast DHBs, consideration is being given to what a subregional performance framework might look like. This work is being progressed by SIDU as part of the 3D subregional work programme.

Funder Interests

Funder interests are now part of the responsibility of the SIDU which replaced the three Planning and Funding departments across the Wairarapa, Hutt Valley and Capital and Coast DHBs. SIDU is responsible for ensuring:

- streamlined planning, funding, information and reporting processes across the subregion;
- development of a clear shared strategic direction for the subregion;
- working in partnership with clinicians to create more effective integrated models of care;
- increasing value for money through effective purchasing; and
- a disciplined system for contracting, financial analysis reporting and audit across the subregion.

Our funding processes through SIDU closely follow the Office of the Auditor General's procurement guidelines which includes contestable provider selection. This allows the DHBs to compare proposals from a number of providers, including pricing, in order to find the most effective provider for the services sought. There are some circumstances where a contestable provider selection process may not be appropriate. The funder arm funds a range of providers in the wider health sector. Management of funding agreements includes formal performance monitoring and auditing by external organisations as well as continuing an informal relationship to ensure accountability for service value.

Summaries regarding Funder and Provider funding details for each DHB for 2013/14 can be found in section 1.2.3.

SIDU applies industry and public sector standard practices that ensure best practice financial management at both the macro- and micro- level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable to the Chief Executives and Boards. A clear, documented management and financial delegation framework ensures the highest level of financial accountability. At a micro level, funding providers requires a commercial approach coupled with the need to ensure our NGO providers remain viable. An ongoing tight fiscal environment continues to put pressure on greater reliance on financial management and our providers to deliver sustainable value for money health services.

SIDU ensures value for money in its purchasing of appropriate and targeted services through the following mechanisms:

- The Memorandum of Agreement (MoA) development, monitoring and management for services provided by the Provider Arm;
- Regular population needs assessment and strategic planning around service delivery targeted to local populations, ensuring the DHB is matching service delivery to demand;
- The development of local services that are strongly supported by intervention logic modelling and defined by robust service specifications;
- Robust and effective contract management and performance monitoring; and
- Effective demand management and service pricing strategies – ensuring the DHB is able to meet minimum service requirements across population groups within a constrained financial envelope, whilst managing increased demand and complexity of patient care (e.g – health of older peoples).

SIDU continues to develop its service delivery strategy across a range of primary and community care services. As funding becomes tighter, more emphasis is placed on maximising efficiencies within the models of care whilst ensuring client's needs in the community are delivered in as fair and robust a way possible.

Pursuant to s25 of the New Zealand Health and Disability Act 2000 (the Act) DHBs are permitted and empowered to negotiate and enter into an service agreement (and amendments to service agreements) which they consider necessary or desirable in fulfilling their objectives and/or performing their functions pursuant to the Act.

Across the three DHBs, the management of risk in funding arrangements is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk.

The year ahead sees further refinement of the service delivery models in primary care and mental health. The 3 DHBs, through SIDU, continue to review services and programmes for cost effectiveness and value for money, along with ensuring the intervention logics around the areas in which we invest are robust to ensure targeting to areas of priority to the DHB. SIDU Service Integration teams are working across the three DHBs to develop constructive and inclusive approaches with providers to ensure the resulting service configurations are sustainable and outcome focussed.

The Wairarapa DHB employs a rigorous risk management process. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

Provider Interests

The concept of value for money is evident in all phases of the review of service performance for the three DHBs.

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 1.2.3.

The resources required to deliver these services include:

- $178.3m of land buildings, clinical and other equipment mostly located on the Hospital campus
- $222.3m of revenue mainly provided by the Crown
- 1754 full time equivalent staff members

The performance of the Hutt Valley 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 Memorandum of Agreement (MoA). In 2013/14 the funding is $187.8m**,** with a national pricing programme determining the price of each purchase unit. A further $34.5m largely comes from direct contracts for service with the Ministry of Health, ACC and other DHBs.

There are planned efficiencies of $12.8m assumed in these budgets which specifically relate to a range of efficiency programmes within the Hutt Valley Provider Arm. We are estimating a deficit for the Provider Arm of ($4.3M) for 2013/14 (to be offset in other activities of the DHB) to ensure an overall 2013/14 breakeven position for Hutt Valley DHB.

Wairarapa DHB works closely with the Health Round Table to ensure it is aware of both best practice, and best performers, in Australasia for public hospitals, and follows up on what is required for Wairarapa DHB to be on the leading edge of best practice. The Wairarapa DHB places a very high emphasis on quality to help drive good outcomes at an affordable price, with quality and safety being a key component of the delivery of their Triple Aim strategy. There is continuous work on reviewing and implementing improvements to clinical pathways, which are focused on delivering patient centred results. This work is also a feature of the broader subregional work programme.

Wairarapa DHB Provider Arm risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various risks to the DHB. High organisation risks are reviewed monthly by the Senior Leadership Team and every two months by the Board's Audit & Risk Committee, to ensure that appropriate attention is given to these risks. To help ensure that services are delivered to an acceptable standard, Wairarapa DHB Provider Arm clinical results are reported on a regular basis within the DHB including to the Clinical Board.

The Wairarapa Provider Arm will be moving towards greater alignment and integration with the Hutt Valley Provider in the 2013/14 year.

Capital and Coast DHB's Provider Arm provides a mix of secondary and tertiary services to local, regional and national populations. Most of the services are provided out of the main Wellington Regional Hospital campus in Newtown, with a mix of out-patient, orthopaedic and rehabilitation services delivered out of the Kenepuru campus in Porirua.

The resources required to deliver these services include:

- $500 million of land, buildings, clinical and other equipment mostly located on the hospital campus
- $620 million of revenue mainly provided by the Crown
- 4332 full time equivalent staff members

Base funding for the Provider Arm is agreed between the funder and provider at the beginning of each financial year, with a national pricing programme determining the price of each purchase unit. A further $83 million comes directly from contracts with the Ministry of Health, ACC, other DHBs and other external sources.

The services provided by the Provider Arm are reflected in a formal Price-Volume Schedule (PVS) with the Funder actively monitoring the Provider's performance against this and a range of service specifications relevant to the various services operated within the Provider Arm.

In 2012/2013 the Capital and Coast Provider Arm made further progress towards achieving its priorities, which are consistent with the Minister's Health Targets (see Modules 2 and 3). Clinical engagement (encompassing clinical leadership) and engagement with the wider primary care and community services sectors are critical to further gains being achieved.

A comprehensive recovery plan is in place to address issues along the health continuum and establish sustainable clinical and financial outcomes. The recovery plan is substantially based on productivity and efficiency as opposed to service reduction, and continues to be a revenue/cost reduction led recovery rather than a service reduction recovery. The principle continues to be that implementation occurs by Directorate and through Clinical leadership, reinforcing the development of an accountable culture. This has required and continues to require:

- developing a comprehensive understanding of the cost and revenue drivers
- understanding the impact of actions and benefits of strategy along the health continuum
- transparency and accuracy in reporting
- addressing deeply held organisational cultural issues
- establishing and enabling accountable leadership at all levels with a focus on clinical leadership, and
- building organisational capability – leadership, staff, systems, processes, skills, business acumen

Our key areas of priority for 2013/14 include:

- Revenue maximisation
- Personnel management and costs
- Supplies management

The Annual Plan provides for a further $4 million reduction in deficit from $10 million in 2012/13 to $6 million in 2013/14. This will result in a cumulative deficit reduction of $91.6 million against the Recovery Plan in 2008. The 2013/14 plan shows $21.3 million of required savings to achieved this target which includes some 2012/13 initiatives not fully achieved. A performance management framework remains in place within the Capital and Coast Provider Arm to monitor performance against these initiatives and to mitigate risks as they arise.

Audit and review

SIDU coordinates a Routine Audit Programme to assess the extent to which NGO providers are complying with terms of their contract(s) with the three DHBs. Additional issues based audits can be

commissioned if there are particular concerns about a provider's performance. The Central Region Technical Advisory Service Ltd (CRTAS) coordinates this Routine Audit Programme. In addition to the Routine Audit Programme, Audit & Compliance (Sector Services) and MedSafe provide additional audit and investigation services on behalf of the DHBs.

The Procurement Guidelines for Funder Arm Services require that service agreements are reviewed at least on an annual basis. This is an opportunity for us to assess how well a provider has performed over the term of an agreement, review the services that we have purchased, and review and improve our contract documentation.

The three Provider Arm services are actively involved in regular programmed internal audits as well as the annual statutory audit to ensure the accuracy and integrity of the DHBs' financial results. Additionally, there are certification and assurance audits carried out to verify service provision to acceptable standards.

Wherever possible, all three DHBs endeavour to coordinate audit activity with other DHBs, in particular the subregional DHBs.

3.2 BUILDING CAPABILITY

When considering the development of capability, whether that is capabilities in workforce, innovation, infrastructure or Information Technology, in order to develop a sustainable health system the three DHBs need to consider all health services providers – those within the local region, and those providing services outside of the DHB district for each of the three DHBs' DHB- domiciled patients.

Workforce

It is recognised at a national, regional, subregional and local level that sustainable services rely on a stable, accessible, fit for purpose, clinical and non-clinical workforce. The three DHBs are committed to support the initiatives of HWNZ and partnering with our regional, subregional neighbours and local partners in developing a workforce that is fit-for-purpose for the next 15 years. This will require both a planned approach (focus on vulnerable services at a regional level and service initiatives via the 3D and 2D programmes and DHBs' work at a local level) as well as opportunistic intervention e.g. when vacancies arise, service reviews occur.

The Wairarapa, Hutt Valley and Capital & Coast DHBs all have goals to be an employer of choice in their areas, and, as good employers and responsible health care providers, are obligated to ensure that the right clinician is providing the right care at the right time in the right place. This necessitates a systemic review of roles and scopes of practice and consideration of who is best placed to provide the care, which may be different from who has been providing the care in a more traditional service delivery model. The 3 DHBs also actively involve staff in the development and renewal of the policies and procedures on a regular basis to support consistent practice across the 3 DHBs.

The 3 DHBs are committed to providing a focus on equal opportunities (EEO) and encourage applicants from diverse and varied backgrounds to apply for roles.

The 2D and 3D programmes both have a workforce development and training component. As services transition to a subregional focus, tailored workforce plans will need to be developed to support and enable the transition. This will consider new roles, alternative rostering arrangements, training and non-clinical support requirements.

Throughout all of these initiatives a key area of focus will be the development of the Māori clinical workforce. The future workforce will be supported by encouraging – through interaction with schools and workforce agencies – the enrolment of Māori children in technical and science related subjects and mentoring their developments through college and professional training institutions.

Information Technology

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 is the key enabler for the development of a sustainable, fit-for-purpose information technology infrastructure in the Central Region. 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. CRISP is also aligned with, and will support, the other regional initiatives and National Health IT Board programmes (subject to ordinary business case processes).

The Wairarapa/Hutt DHB CEO, Graham Dyer, is the CRISP Sponsor and is, and will continue to be, a prime advocate for the implementation of this initiative.

Work is underway across the subregion to implement a 3DHB ICT function to deliver on the CRISP programme over the next three years. This will require prioritisation and pooling of the limited resources and expertise across the subregion while also ensuring that ICT infrastructure, systems and services swiftly enable the subregional and regional outcomes.

In tandem to this regional and subregional development, shared care records for Wairarapa, Capital and Coast, and MidCentral DHBs (across primary, community and secondary care providers) will continue to be rolled out utilising the Manage My Health Medtech software. This will support/dove tail with the implementation of Phase 2 CRISP in four years' time.

Infrastructure

The three DHBs have Asset Management Plans (AMP) which are prepared to assist in determining the ongoing capital requirements to meet the DHBs' service objectives (refer to Module 7 for details of Financial Performance). These plans are prepared to best practice standards in New Zealand and incorporated into the RSP and Regional AMP. These various plans are critically reviewed for their value for money prospects for health care delivery, with an eye for being prepared for emerging health needs. Funding for clinical services requires a commercial approach which is based on nationally based Price/Volume (P/V) schedules.

Hutt Valley DHB

Hutt Valley DHB's asset management program enables the DHB to continuously update its 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
Capital Expenditure
For the Year Ended 30 June

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Approved / Baseline Expenditure					
Property and Plant	1,199	2,042	3,000	3,000	3,000
Clinical Equipment	951	1,065	2,000	2,000	2,000
Computer Equipment	1,275	2,812	1,850	1,850	1,850
Other Equipment	88	42	100	100	100
Motor Vehicles	-	-	-	-	-
Total Baseline	**3,513**	**5,961**	**6,950**	**6,950**	**6,950**
Strategic (Approved)					
Central Region Information Systems Plan (PMS, EMR, PACS, RIS, ED, eReferrals, WhiteBoard) Programme	223	1,487	2,168	1,037	-
Finance Procurement Supply Chain	-	810	736	381	-
Citrix Farm	-	-	1,000	-	-
e-Pharmacy	-	-	500	-	-
MRI Scanner	-	-	2,300	-	-
Laboratory Information Systems	-	943	747	-	-
Total Approved	**223**	**3,240**	**7,451**	**1,418**	**-**
All Other Approved Projects	21,759	11,237	1	-	-
Total Capital Expenditure	**25,495**	**20,438**	**14,402**	**8,368**	**6,950**
Financed By					
Internally Sourced Funding	104	-	-	-	-
Equity Injections for Deficit Support	-	-	-	-	-
Depreciation	11,031	12,068	13,795	14,600	15,314
Sale of Fixed Assets	615	299	-	(5)	(5)
Equity Injections for Capital Expenditure	4,323	1,532	-	-	-
Private Debt	3,191	-	-	-	-
CHFA Debt	22,100	-	-	-	-
Other (Includes Cash Reserves)	4,122	19,991	13,452	12,845	19,072
Total Finance	**45,486**	**33,890**	**27,247**	**27,440**	**34,381**

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 Māori sites of significance.

Our planned capital expenditure for 2013/14 is $14.4m.

Wairarapa DHB

As part of Tihei Wairarapa the Wairarapa DHB considered a range of options for the development of an IFHN on the Wairarapa Hospital site and also for the South Wairarapa region. These conversations with Primary Care and General Practice have recently been reinvigorated and will continue to be progressed through the 2013/14 Tihei Wairarapa work programme.

The Wairarapa DHB continues to have conversations with the largest GP practice, Masterton Medical Ltd, and other general practices regarding other integration opportunities and the shifting of services closer to the patient in line with the expectations of Government.

The old hospital site has now been sold and during 2012/13 the DHB has largely completed a process of transferring existing staff out of old hospital facilities (with the exception of those services noted below).

Wairarapa DHB completed the development of the Oral Health Hub, funded by the Ministry of Health as part of the Wairarapa DHBs Oral Health Business Case. The Oral Health Hub is located at Masterton Intermediate School and consists of a two chair clinic with the ability in the future to commission a third chair, and is the base for the district's Dental Therapists and Dental Assistants.

A number of other infrastructure projects will be progressed in 2013/14. These include:

- The relocation of stores, clinical records, and FOCUS offsite to the Corporate Office in Russell Street
- Completing a new build on the Hospital site for the maintenance team and for therapy equipment stores
- Co-location of some community based mental health services into the new build currently underway for the Pathways/CareNZ service.

Options are currently being explored for a suitable community based site for the Population Health Team who continue to lease space on the old hospital grounds. Site options are being explored to accommodate the changes that result from the 2D work programme including the accommodation of a new executive team and the development of hot desks space to allow clinical and administrative staff to move between hospital sites.

Capital & Coast DHB

Infrastructure and support is seen as a key enabler to support clinical staff to deliver services to our patients and continues to be a key priority. The Hospital will participate in the national shared services work programme to ensure the objectives of this work are achieved. It has also identified a number of other areas of focus where our infrastructure requires development and improvement.

The areas of focus for 2013/14 include:

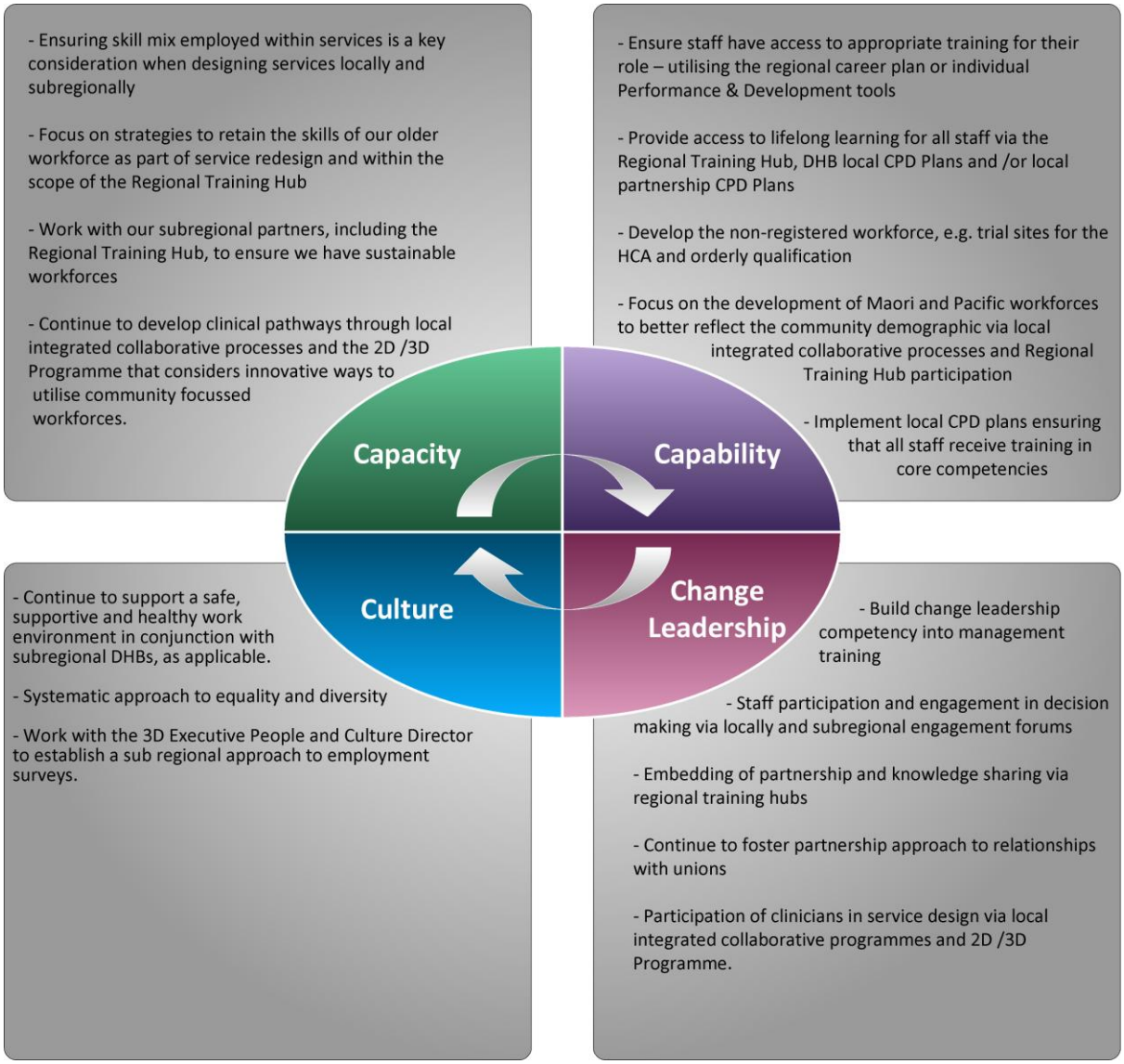
- Continued IT/IM developments following the implementation of EHR2 (electronic Health Record) in 2010/11 and the development of the Central Region Information Services Plan (CRISP) over the next three years
- Corporate system development and enhancement including Payroll system improvements
- Disaster Recovery and Business Continuity
- Rollout of the Manage My Health Medtech software across primary and community services
- Non Clinical Support service initiatives including procurement and supplies management, further roll out of the electronic rostering system
- Linkage with the national regional and subregional initiatives

3.3 STRENGTHENING OUR WORKFORCE

Ensuring that we have a fit for purpose and capable workforce is a key strategy for all three DHBs. The vision of the 3DHBs' Workforce Plans are to work collaboratively with health providers to ensure as a subregion, the DHBs recruit, develop and maintain a collaborative skilled workforce focused on the health needs of the population. Individual DHB plans sits within the wider context of subregional and regional directions for developing and maintaining a sustainable health workforce within the changing health environment across the whole of system. The RSP reflects the expectation of HWNZ and focuses on Regional Training Hubs, radiology recruitment, the regional implementation of the National Services Reviews, Clinical Leadership and career planning.

Within the context of HWNZ strategy, the subregional Workforce plan focuses on capacity, capability, culture and change leadership as depicted in Figure 13 below.

Figure 13 – Workforce Plan



The intent of the subregional Workforce Development Plan is to:

- identify the main workforce demands, and the potential challenges, that the three DHBs will be faced with over the next five years and
- articulate the workforce outcomes, strategies and policies that will support and enable the broader subregion to address these challenges.

After analysis of the current and predicted external environment and context, and the needs of the organisation as defined in policy, legislation, national and regional service planning, the four main health related issues impacting on the subregional DHBs' workforce were determined to be:

- The ageing workforce
- The increasing health gap between Māori and others
- Increased generalisation and evolution of clinical roles resulting from the integration of primary and secondary health care provision, and
- Growing emphasis on regional models of care.

The Workforce Development Plan predominately focuses on the impact that local and regional strategies will have on the workforce of the subregion and is considered a first step towards the three DHBs having a comprehensive and integrated workforce strategy that will encompass the primary and NGO sectors. This plan focuses on the priority areas and supports sustainable outcomes that strengthen the workforce of the three DHBs, both as independent DHBs, and DHBs within a subregional and regional context.

Continued collaboration in the area of human resources and workforce development across the subregion is demonstrated by the appointment of a 3DHB Executive Director for People and Culture (ED P&C). The intent of this role is to ensure that our workforce plans and organisational requirements are aligned. The new ED P&C 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 in the tables below. This plan will factor in the requirements of HWNZ, the 3DHB subregional plans and the workforce sections of the Regional Services Plan (RSP).

The three DHBs are aware of the new HWNZ model for allocating postgraduate education funds. They will ensure that the required information is provided to the HWNZ on the mix and numbers of trainees, including their location. The requirements of the 70/20/10 model of funding will be implemented. A process will be developed to ensure that the changed reporting requirements can be met.

The suggested prioritisation to vulnerable or critical specialities will require further engagement with HWNZ to develop a model that suits small to medium-sized DHBs, in order to access the 10% funding allocated to this area. Further opportunities to develop an enhanced subregional approach to training will be explored.

The Regional GMs Human Resources have met with the Regional Director for the Training Hub to engage on the regional workforce plan and to align workforce activity.

The workforce plans for DHBs will be increasingly linked to subregional work around integrated services, for example, in the Laboratory and Radiology service reviews. As new models of care develop, consideration will be given to current and future workforce needs, and opportunities, such as professions working at the top of their scope, will support the workforce development.

All workforce strategies will be underpinned by the triple aim, which puts the patient at the centre of all endeavours, and says patient needs will be served best when we simultaneously provide the

services which make the most difference to health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost.

Health Workforce New Zealand (HWNZ)
The three DHBs acknowledge the aim of HWNZ to implement a range of initiatives designed to recruit, retain and develop the workforce in all specialties and in all areas, ensuring NZ has the right mix and numbers of people to provide world class health care. This leadership direction provided by HWNZ forms the basis of planned subregional and regional workforce development as outlined below.

HWNZ tasked 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.

The focus for the Central Region Training Hub services plan for 2013/14 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 15: Workforce Plans

Workforce Plans - Service, Directorate, HHS and Subregional		
Activity	**Intention**	**Measured by:**
Develop baseline 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 (OAG) 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 DHBs' 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	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

	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).	implemented as per HWNZ requirements Improved flow of career planning information for the RMO population across the subregion. Extended GPEP training (GP vocational training) is supported across the subregion. Learning and Development strategy is implemented Strategic Objectives for Learning, Development and Research are progressed against milestones. Further progress towards opportunity for an extended scope of practice (participation towards the implementation of at least three innovative clinical placements across the region

Table 16: Recruitment and Retention

Recruitment and Retention		
Activity	**Intention**	**Measured by:**
Explore opportunities for joint appointments across the region as vacancies arise in line with the RSP and subregional work programme Enhance recruitment and candidate management tools and functions Collaborate with subregion 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 for clinical and non-clinical roles Consistent contractual approach to contractors and locums. Take a collaborative approach with subregion/regional DHBs on recruitment processes.	Systems, policies and procedures are aligned across the subregion (region). Evidence of joint appointments where value added is demonstrated Regular recruitment and retention reporting

Table 17:Leadership Capability and Development

Leadership Capability Development		
Workforce Development Activity	**Intention**	**Measured by:**
Enhance 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 the three DHBs 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	Leadership framework is in place Leadership roles are filled by our own staff Evidence of collaborative operational and clinical leadership and decision making

	opportunities to develop their leadership capabilities	

Table 18: Staff Engagement

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 (refer strategy), 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 to continue (commenced 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

Table 19: Learning and Development

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 DHBs, 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 Simulations involved in national strategy development for regional/ national approach to Skills and Simulations	Three year Learning and Development Strategy developed and launched in early 2012. The strategy outlines five key principles that will ensure that CCDHB becomes a learning organisation. The strategy is operationalised through Learning and Development Strategic objectives. These will continue to be implemented in 2013/14 Maximise use of expertise, resources and systems through collaboration with other DHBs and stakeholders in the subregional, 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 • Develop Learning and Development Culture at CCDHB • Embed Service Excellence Framework • Enhance Research culture at CCDHB • Strong relationships exist with other DHBs, health sector agencies, tertiary providers and other key stakeholders Learning Management system is in place & aligned across subregion MOU is in place for the region re Skills and Simulations

3.4 QUALITY AND SAFETY

The three DHBs are committed to ensuring that the patient is at the centre of everything that we do and that the DHBs strive to achieve the best outcomes for our patients consistent with our Triple Aim approach (refer Section 2.4).

Listening to our communities' and consumers' voices is a priority and the DHBs have established different ways of accessing consumer feedback.

Wairarapa DHB

The DHB has a consumer's resource consisting of ten consumer representatives with a wide and diverse range of healthcare needs and experiences. Over the next year we are going to be using their experience to assist in service development (e.g. developing patient literature, providing advice on policies and procedures in the hospital) and ensuring our patients receive safe, high quality patient centred healthcare.

The three DHBs are also committed to implementing the range of initiatives being rolled out by the HQSC. These include:

- Improving medication safety
- Mortality review
- Reportable events
- Falls management
- Clinical effectiveness
- Global trigger tools.

Other improvement projects

Hutt DHB – Clinical Engagement

The Hutt Valley Primary Secondary Strategic Governance (PSSG) approach is an integrated primary and secondary multidisciplinary clinical group created to provide and contribute to clinical leadership across the primary-secondary continuum in the Hutt Valley with an agreed vision of "Keeping people in the community healthy". Its goals have been established as:

- Ensuring seamless healthcare for people in the Hutt Valley
- Fostering high quality innovative integrated services – i.e. safe, patient centred, effective, timely, efficient, accessible, sustainable and equitable
- Identification and removal of barriers to communication and care
- Better management of preventative services, acute episodes, and long term conditions.

The implementation of the 2D programme with Wairarapa DHB provides further stimulus for progressing clinical engagement at all levels within both organisations. Increasing clinical leadership within decision making and planning frameworks within the 2D framework will continue to be a high priority for 2013/14.

Wairarapa DHB

The DHB is continuing to work with the HQSC on other initiatives, and is actively participating in both the development of Quality Accounts and the development of National Clinical Indicators. Wairarapa DHB is also undertaking the IHI Global Trigger Tool training to monitor patient safety and harm. Key

clinical staff are undertaking the training this year and will be using the results to form part of our quality accounts next year.

Wairarapa DHB is providing data to the HQSC on key quality markers. To date we have provided baseline data for falls management and perioperative safety.

The DHB is introducing an Early Warning Score (EWS) and the ISBAR communication tool at Wairarapa Hospital. The EWS is designed to identify early signs of clinical deterioration and provides a structured escalation process to ensure appropriate intervention occurs in a timely manner. This is a national patient safety initiative aimed at the early recognition and appropriate management of the deteriorating patient.

Capital and Coast DHB - Clinical Engagement

Capital and Coast DHB continues to have a strong commitment to making clinical engagement real at all levels within the organisation. Clinical leadership within decision making and planning frameworks are central to our structure and philosophy of service management. The continued development of semi-autonomous directorates within the Provider Arm and improvement of information systems to support decision making by clinicians continues to be a key focus, along with our 3D HSD programme.

The key areas of priority for 2013/14 include:

- Continued development of clinical leadership capability
- Development of the regional training hub in conjunction with the DHBs within the region
- Integration of clinical thought in Clinical Governance and service development through the ICC programme of work and the operation of the ICC Leadership Group
- Continued devolution of responsibility and accountability within directorates to Clinicians
- Continuing to build on our clinical governance, leadership and engagement processes, which will in turn strengthen our safety and quality culture and improve the quality of our services
- Strengthened integration of clinical and non-clinical governance.

Primary Secondary Clinical Governance

Capital and Coast DHB's focus this year is on maximising efficiency and service quality gains by leveraging off of the interface between hospital services and primary care through the ICC work programme. Particular areas of focus continue to include:

- Implement the work streams committed to under the ICC programme
- Improve communication between the primary secondary interface – continually exploring opportunities to deliver better, sooner more convenient healthcare
- Improve equity of access and care to services through robust and sustainable clinical pathways and
- Improve ethnicity and disability data collection

3.5 ORGANISATIONAL HEALTH

The three DHBs are committed to developing and maintaining clinically and financially sustainable organisations. This is reliant on having high performing Governance Boards and committee structures, high performing DHB Senior Leadership Teams and high performing clinical workforces with supporting infrastructure within the Provider Arms.

We will ensure our Boards and Leadership Teams have the necessary skills and capacity to ensure the success of our organisations, making training opportunities available where this is appropriate.

All three DHBs will follow 'good employer' practices and EEO principles.

Hutt Valley DHB

The DHB is committed to developing a workforce profile and understanding the needs and expectations of its workforce. We are committed to promoting leadership opportunities and a positive culture for our organisation.

Workforce development and clinical engagement are fundamental to ensure that we continue to provide high quality and effective services. Through supporting flexibility and fostering innovation, and providing leadership and skill development opportunities, Hutt Valley DHB endeavours to promote equity, fairness and a safe and healthy work environment.

Wairarapa DHB

The Wairarapa DHB will continue to develop our Provider Arm's workforce in conjunction with the Hutt Valley DHB and support the development of the wider health workforce and promote and foster a professional and supportive working environment. We will also seek to ensure we have sufficient health workers with the right skills in the right place at the right time delivering the services our population needs. This will increasingly take a subregional focus in the coming year.

Having the right workforce to deliver high quality, effective services is critical if we are to realise our high level outcomes: provision of health services that are clinically and financially sustainable, and people in the Wairarapa live longer, they are healthier and more able to live independently.

To support achievement of these outcomes, the Wairarapa DHB aims to be an employer of choice, offering employees flexibility, opportunities for innovation, skill development and leadership. The DHB also aims to develop a reputation as a preferred employer among health workers.

As a 'good employer', the Wairarapa DHB will continue to grow a positive organisational culture, ensuring the fair and proper treatment of employees in all aspects of their employment. This will be achieved by ensuring all human resource policies and procedures are equitable and fair, and by providing a work environment where employees are able to develop new skills and have opportunities to work in professionally challenging and rewarding roles.

The Wairarapa DHB believes that it will benefit from a diverse workforce and is committed to recognising and valuing different skills, talents, experiences and perspectives of employees.

Capital & Coast DHB

Capital and Coast DHB has made significant progress towards achieving its priorities through the adaptation of its internal culture and systems. There has been an improvement in financial performance achieved by a focussed approach to the management of costs and the maximisation of revenue opportunities.

An essential element in continuing to achieve and improve our performance is the support through clinical engagement (encompassing clinical leadership) and the wider community through establishing and sustaining such programmes as Primary and Secondary Clinical Governance, and Subregional and Regional collaboration and cooperation.

The DHB continues to see it as essential that clinical staff and managers work closely to provide continued high quality, cost effective, services for our population.

Workforce and the ability to ensure sustainability of service delivery continue to be a key area of focus. Good progress has been made with the establishment of the shared services model to strengthen the delivery of Paediatric Oncology services to the region.

Areas where the DHB is currently experiencing difficulty with recruitment and maintaining service delivery are in some of sub specialty areas and include: Medical Oncology, Medical Physicists, Gynaecology Oncology, Maternal Fetal Medicine and some areas with the Allied Health disciplines.

In 2013/14 Capital and Coast DHB will continue to:

- Further develop its recruitment strategy and processes to ensure compliance with the DHB's Equal Employment Policy, that the impact on service delivery is minimised, regional solutions are maximised and key vacancies are filled
- Develop workforce plans in line with the framework developed by Health Workforce NZ and to minimise the impact on service delivery where there are critical vacancies
- Strengthen our clinical quality and patient safety culture as we move toward the development of a service excellence framework
- Work with the subregional partner DHBs to develop new models for delivering services which will strengthen those services which currently have areas of vulnerability improving their sustainability and maximise the use of available resources
- Work in collaboration with the region to maximise the use of regional resources, strengthen the workforce across the region and to strengthen the services that the DHB provides to the region
- Concentrate on financial sustainability to ensure that Capital and Coast DHB lives within its means and that the budget targets are achieved
- Improve relations across the primary secondary interface through the development of joint initiatives which maximise the utilisation of resources and improve services and health outcomes for patients.

3.6 REPORTING AND CONSULTATION

The three DHBs provide regular reporting to the Minister of Health as outlined in Table 20 below. In accordance with s 141 (1) (g) Crown Entities Act 2004 each of the three DHBs will consult with the Minister via the Ministry of Health on any significant developments not covered in this plan.

Table 20: Reporting and Consultation

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

3.7 SHARES INTERESTS OR SUBSIDIES

Wairarapa, Hutt Valley and Capital and Coast DHBs, with other Central Region DHBs, have joint ownership of the Central Regional Technical Advisory Service (CRTAS). CRTAS provides support to the Central Region DHBs so they are able to meet the New Zealand Health Strategy and the New Zealand Public Health and Disability Act 2000 objectives. CRTAS is funded by the DHBs on an annual budget basis to provide services.

Hutt Valley 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 CRTAS. Any proposal to do so would need to be approved by the Board and the Minister of Health.

The Wairarapa DHB also has a wholly owned subsidiary company – Biomedical Services New Zealand Limited (Biomed) which has its own board of directors and reports on a regular basis to the Wairarapa DHB as their owner. Biomed provides testing and servicing of patient related equipment to a number of DHBs, NGOs, and private hospitals throughout New Zealand.

MODULE 4: STATEMENT OF FORECAST SERVICE PERFORMANCE

4.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

Measuring our performance

As the major funder and provider of health and disability services in our district, we aim to make positive changes in the health status of our population. The decisions we make about which services will be funded and delivered will have a significant impact on the health of our population and will improve the effectiveness of the whole Hutt Valley health system.

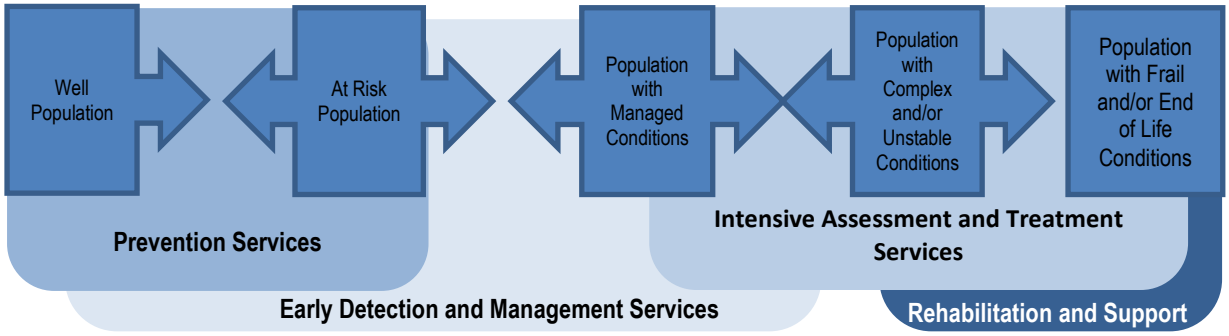


FIGURE 14: Scope of DHB Operations – Output Classes Against the Continuum of Care

In the Statement of Forecast Service Performance, the DHB links outputs to the desired medium-term impacts, which in turn influence achievement of long-term outcomes (outlined in Module 2). It is important to note that linkages will not always be directly quantifiable or separately identifiable. Many factors influence the impacts to which the DHB seeks to contribute. In addition, many of the impacts will not be seen within a single year, and trend data will be necessary to develop a view as to whether the impacts sought are eventuating.

In the more immediate term, we evaluate our performance by providing a forecast of planned performance (what services or 'outputs' we will deliver in the coming year). We then report actual performance against this forecast in our end-of-year Annual Report. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the current year. They therefore reflect a reasonable picture of activity across the whole of the Hutt Valley health system.

In order to present a representative picture of performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs:

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

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure '*volumes*'. The number of services delivered or the number of people who receive a service is often less important than whether '*the right person*' or '*enough*' of the right people received the service, and whether the service was delivered '*at the right time*.'

In order to best demonstrate this, we have chosen to present our forecast service performance using a mix of output measures. Outputs are categorised by type of measure, reflective of whether the output is targeting coverage (C), quality (Q), quantity (volume (V)), or timeliness (T). These help us to evaluate different aspects of our performance and we have set targets against these to demonstrate the standard expected.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T

Target Setting

Wherever possible, we have included the past year's baseline data to support evaluation of performance at year end. In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption the funding growth will be limited. Targets tend to reflect the objective of maintain performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Baseline data for measures is for the 2011/12 year except where otherwise specified. National data, where available, is provided in line with the measure's baseline period.

It is also important to note a significant proportion of the services funded/provided by the DHB are demand driven, such as laboratory tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided to give the reader context in terms of the use of resource and capacity, however these are not seen as targets and are provided for information to give context to the picture of performance.

Our targets also reflect our commitment to reducing inequalities between population groups, and hence some measures appropriately reflect a specific focus on high need groups. Wherever possible measures will be monitored with a focus on reducing inequalities, and targets aim for equitable outcomes for all of the DHB population.

Where does the money go?

The table below presents a summary of the 2013/14 budgeted financial expectations by output class.

Revenue	Total ($000s)
Prevention	20,172
Early Detection & Management	112,640
Intensive Assessment & Treatment	255,429
Rehabilitation & Support	59,390
Total	**447,631**

Expenditure	Total ($000s)
Prevention	20,478
Early Detection & Management	108,418
Intensive Assessment & Treatment	258,845
Rehabilitation & Support	59,890
Total	**447,631**

4.2 OUTPUT CLASSES AND MEASURES OF DHB PERFORMANCE

Output Class: Prevention Services

- Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance

the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

- Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.
- Preventative 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, population health protection services such as immunisation and screening services.
- On a continuum of care these services are public wide preventative services.

Local 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 DHBs, Primary Healthcare Organisations, private and non-governmental organisations e.g. Māori providers, Well Child providers, Sports Trust and local and regional government.

Regional Public Health (RPH) is a regional service within Hutt Valley DHB, serving the populations of Wairarapa, Hutt Valley, and Capital & Coast DHBs, and working under the shared strategy for population health "Keeping Well". Regional Public Health delivers:

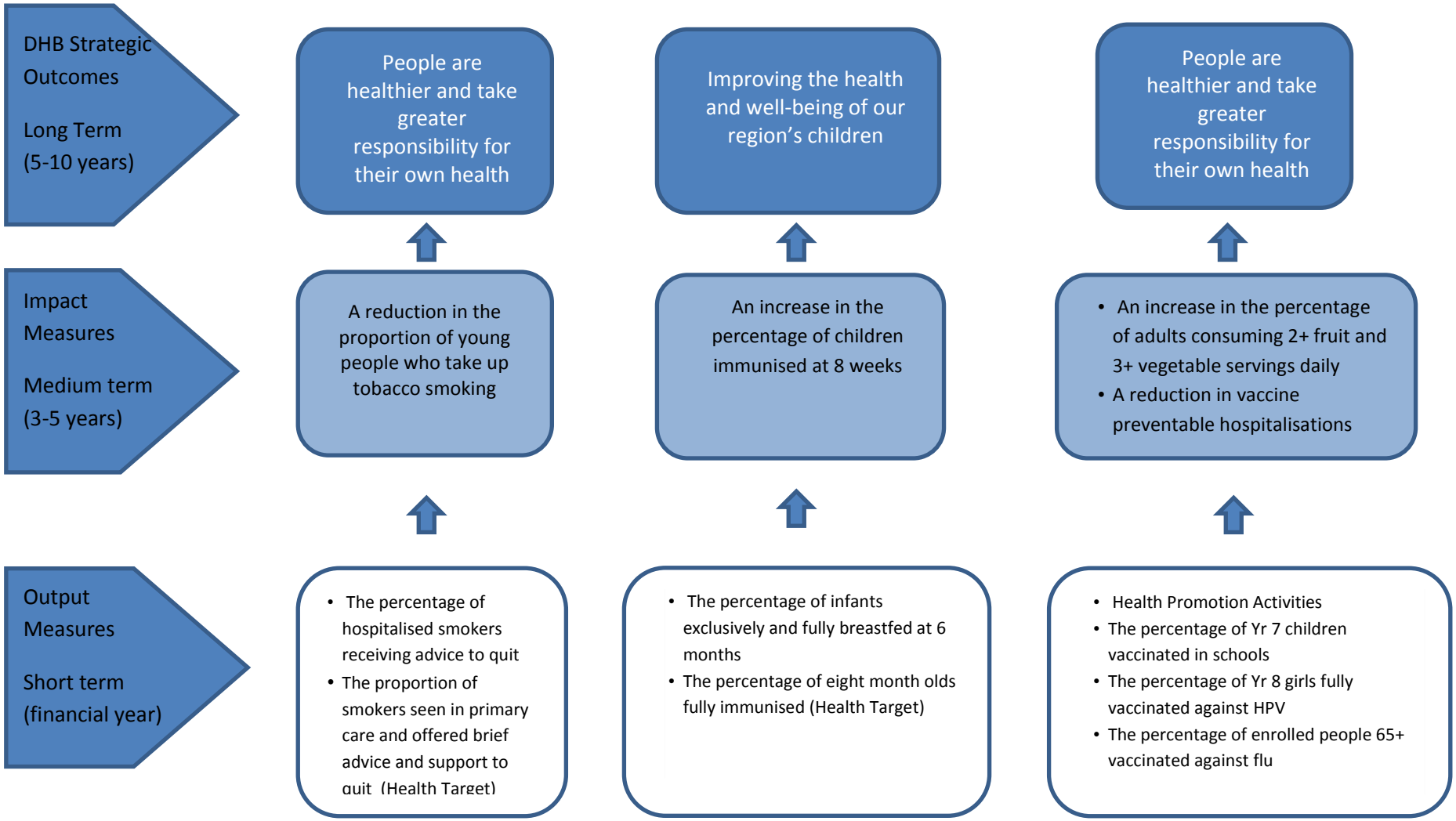
- Health Promotion Services and Education Services; working with the district's communities, local government and government agencies to ensure that the settings in which people live, work, play and learn can support healthy choices.
- Statutory and Regulatory Services; address such issues as sanitation,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

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 Wairarapa, Hutt Valley, and Capital & Coast DHB regions.
- Hutt Valley DHB provides one of the 12 regional National Cervical Screening Programme coordination services throughout New Zealand. Screening is delivered by primary and community care providers.

In 2013/14 Hutt Valley DHB will increase its work with primary health care providers to reduce the risk of chronic diseases and cancer, reduce the burden of preventable hospitalisations and increase immunisation and cancer screening rates. Hutt Valley DHB will continue to work with the district's communities and local government to ensure healthier environments (e.g. clean air, safe water, healthy housing).

Intervention Logic: Prevention Services Output Class

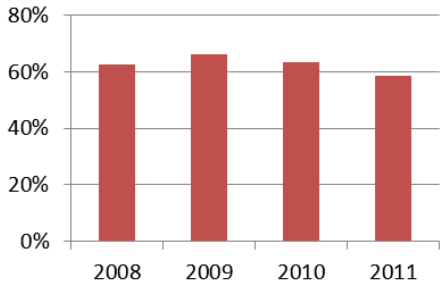


Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

An increase in the proportion of young people who report never smoking

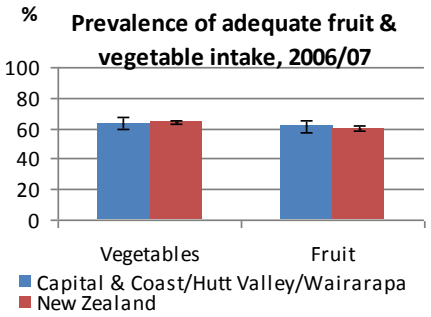
- Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.
- Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.



Data Source: Action on Smoking & Health Yr 10 survey

An increase in the percentage of adults consuming 2+ fruit and 3+ vegetable servings daily

- Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect people against obesity, CVD, diabetes and some common cancers and contributes to maintaining and healthy body weight.
- Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.



The percentage of eight week olds fully vaccinated

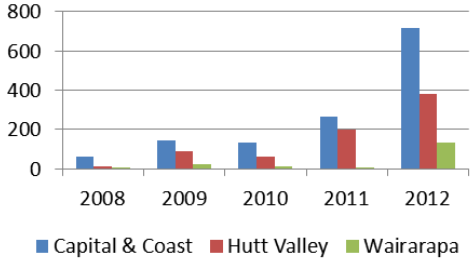
- Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people.
- In order to have timely immunisation by eight weeks there are a number of health services which need to be aligned, such as the lead maternity carer, PHO enrolment, Well Child enrolment and NIR registration. It also requires timely completion of the Well Child and GP six week checks.

Data not yet available.

New age group for Ministry of Health monitoring.

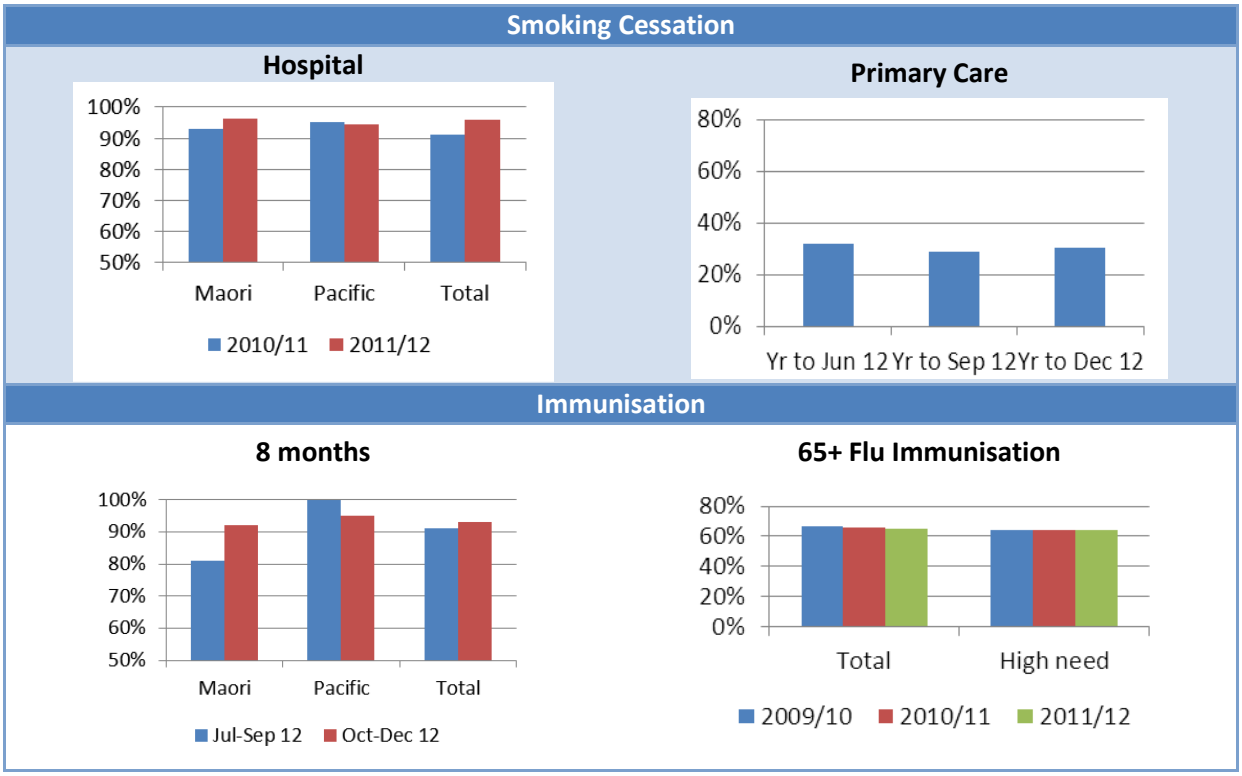
A decrease in the number of vaccine preventable disease notifications

- Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people.
- Recent years have had an increase due to Pertussis outbreaks in the region. In the longer term, with increased immunisation, it is expected the number of vaccine preventable disease notifications will decrease. Regional Public Health reports figures for Pertussis have started to decline in early 2013.



Historical Performance

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.



Performance Measures: Prevention Services

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline[4]	Target 2013/14	National
Immunisation Services				
Health Target: The percentage of eight month olds fully vaccinated	C	93%	**90%**	89%
The percentage of Yr 7 children vaccinated in schools	C	65%	**70%**	
The percentage of Yr 8 girls vaccinated against HPV	C	58%	**60%**	
The percentage of enrolled people over 65 years vaccinated against flu[5]	C	65%	**66%**	
High Needs		64%	**64%**	
Smoking Cessation				
Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	96%	**95%**	95%
Health Target: The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking	C	30%	**90%**	43%

[4] Year to December 2012
[5] Baseline year to December 2012

Health Promotion Services			
Measure	**Type of Measure**	**Baseline**	**Target 2013/14**
The number of schools and early childhood services receiving health promotion visits	V	138	**138**
Minimum number of housing assessments	V	200	**200**
The percentage of infants exclusively and fully breastfed at 6 months	C	25%[6]	**27%**[7]
The number of diseases investigated	V	2685	**2700**
The number of environmental health investigations	V	550	**550**
The number of new client referrals by school health nurses	V	650	**650**

Output Class: Early Detection and Management

- Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori 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.
- On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Local Environment

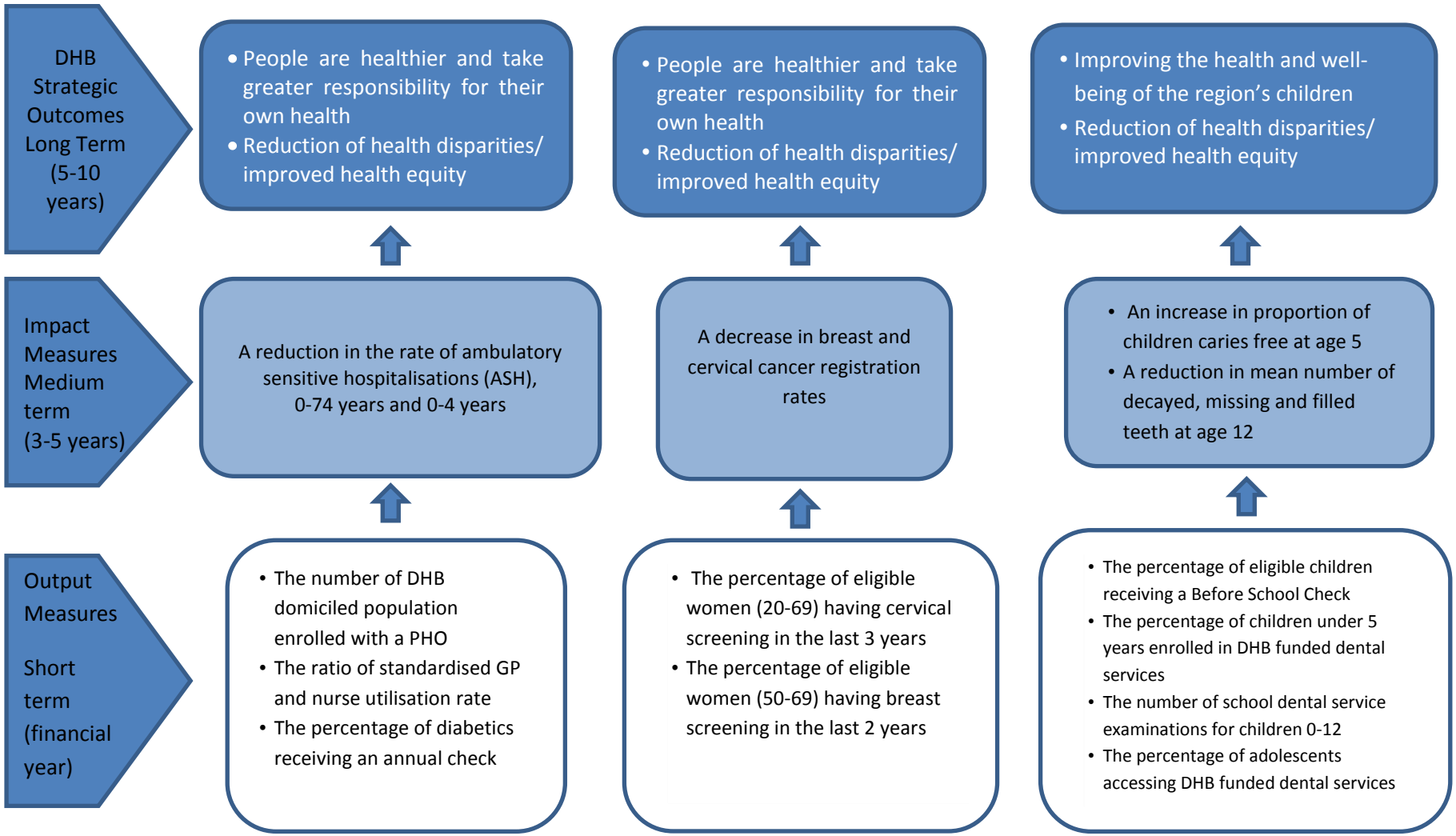
There is one Primary Healthcare Organisation (PHO) in the Hutt Valley: Te Awakairangi Health Trust, with Cosine PHO operating as a cross boundary PHO contracted to Capital & Coast DHB. There are 28 practices in the Hutt Valley district and the best estimate is that approximately 97% of Hutt Valley's population is 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, Hutt Valley DHB supports a number of local primary health care programmes including:

The Community Dental Service encompasses the Hutt Hospital Dental Unit and the Regional School Dental Service. Adolescent oral health services are delivered by private dentists contracted by the DHB.

The Community Pharmacist Service is provided for the HVDHB population by 29 pharmacies in the district. Some prescriptions are filled by pharmacies outside of the district. The Community Referred Laboratory Service is provided under contract by Aotea Pathology for the Hutt Valley and Capital & Coast DHB populations.

[6] Plunket data only
[7] National target

Intervention Logic: Early Detection and Management Output Class

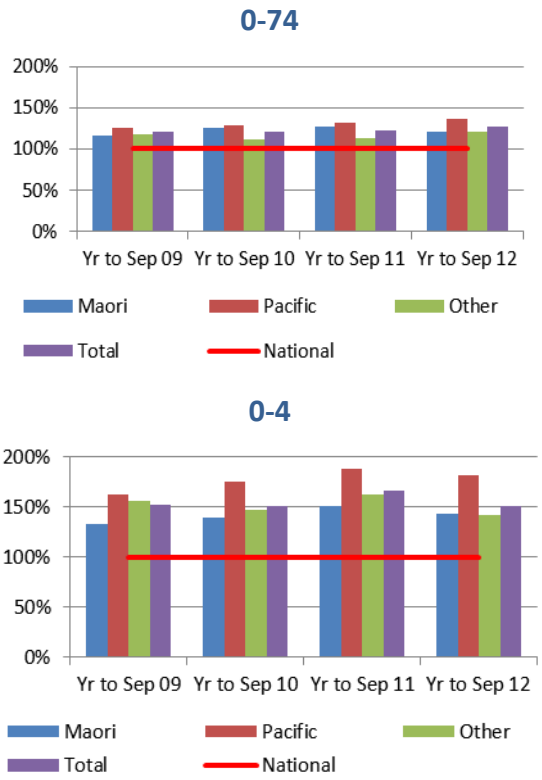


Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

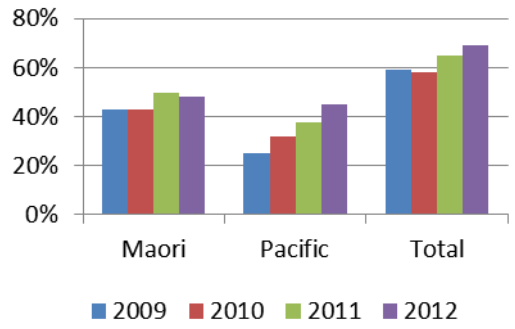
A reduction in ambulatory sensitive hospitalisation (ASH) rates, 0-74 and 0-4

- There are a number of admissions to hospital which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention, and the continuum of care across the system.
- The rate of preventable hospitalisations represents a substantial and avoidable burden on the health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment across the whole system.



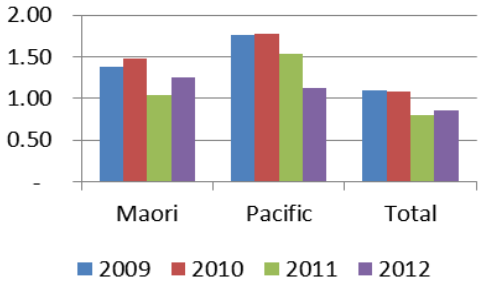
An increase in the proportion of children caries free at 5 years

- Regular dental care has life-long benefits for improved health. While water fluoridation can significantly reduce tooth decay across all population groups, prevention and education initiatives are essential to good oral health.
- Oral health outcomes are a good proxy measure of early contact with effective health promotion and prevention services. It also serves as an indicator of risk factors, such as poor diet, and therefore can provide other benefits in terms of improved nutrition and healthier body weights.



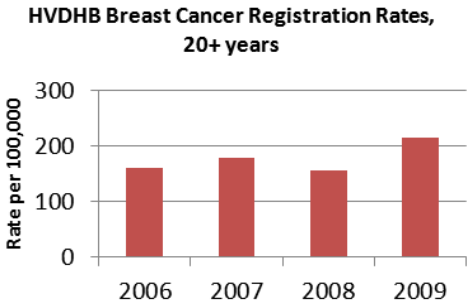
A decrease in the mean number of decayed, missing and filled teeth at 12 years

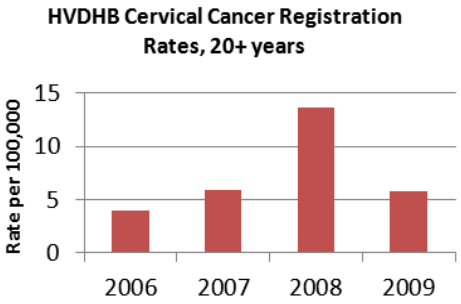
- Māori and Pacific children are more likely to have decayed, missing or filled teeth, and improved oral health is a good proxy measure of equity of access to services and the effectiveness of mainstream services in targeting those most in need.



A decrease in the breast and cervical cancer registration rates

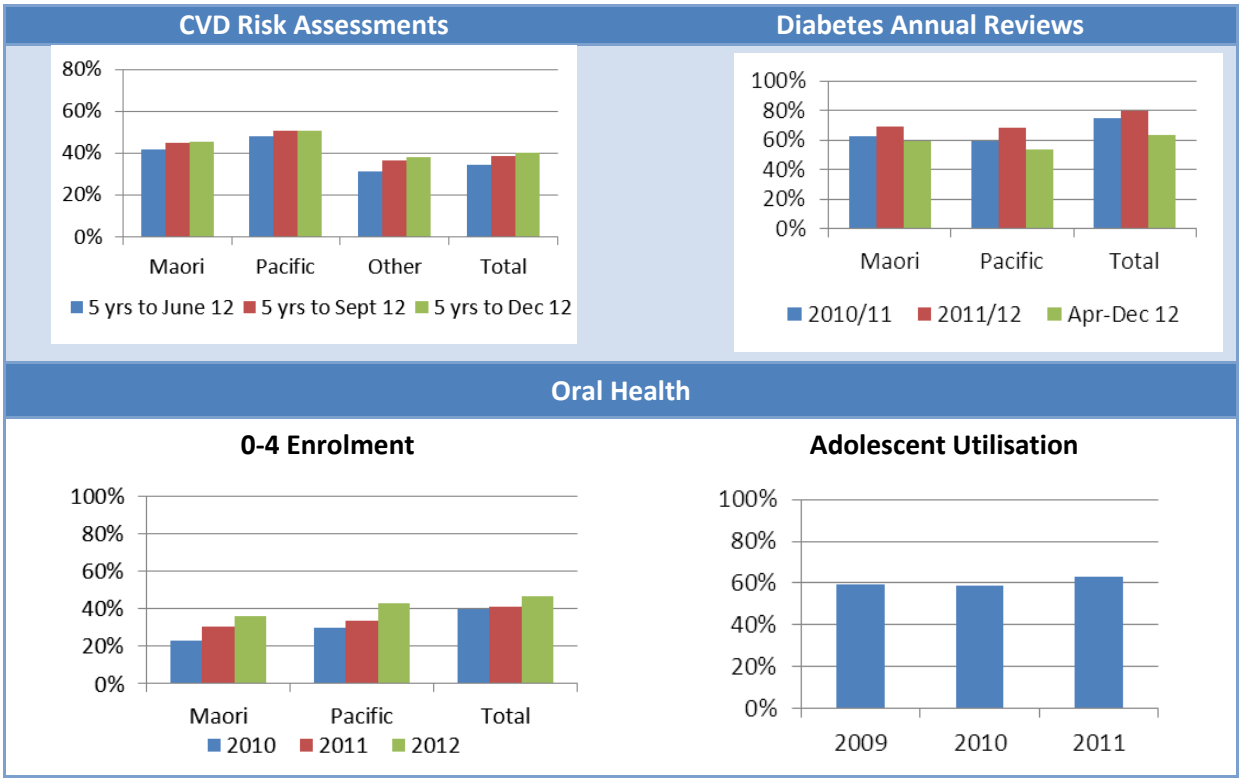
- Breast screening reduces the chances of dying from breast cancer by about 30% if aged between 50-65 and by about 45% if aged between 65-69. Cervical screening reduces the chance of developing cervical cancer by about 90%.
- To assess the impact of screening programmes over the medium term, Hutt Valley DHB monitors cancer registration rates (incidence). HVDHB has not set targets for this indicator due to the time lag in cancer registration data becoming available.





Historical Performance

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.



Performance Measures: Early Detection and Management Services

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline[8]	Target 2013/14	National
Primary Care Services				
The number of DHB domiciled population enrolled in a PHO	V	140,494	**140,859**	
Māori		21,501	**21,879**	
The percentage of the PHO enrolled population enrolled in Care Plus	C	4%	**4.5%**	
The ratio (high need: non high need) of standardised GP and nurse utilisation rate	V	1.03	**>1.03**	
Health Target: The percentage of eligible people assessed for CVD risk within the last five years	C	40%	**90%**	**55%**
The percentage of diabetics receiving an annual check	C	79%	**75%**	
Screening Services				
The percentage of eligible children receiving a Before School Check	C	80%	**90%**	
High Need		81%	**90%**	
The percentage of eligible women (20-69) having cervical screening in the last 3 years[9]	C	80%	**≥80%**	
Maori		63%	**80%**	
Pacific		70%	**80%**	
The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	77%	**≥70%**	
Maori		69%	**≥70%**	
Pacific		70%	**≥70%**	

Oral Health Services					
Measure	Type of Measure	Baseline 2012	Target		**National**
As oral health measures are reported on a calendar year the Ministry of Health requests targets be specified for each year.			**2013**	**2014**	
The percentage of children under 5 years enrolled in DHB funded dental services	C	47%	**65%**	**85%**	63%
The total number of dental examinations by the dental service for children 0-12, Hutt Valley population	V	17,403	**17,822**	**18,210**	
The percentage of adolescents accessing DHB funded dental services[10]	C	63%	**85%**	**85%**	72%

[8] Baselines year to December 2012.

[9] Data from National Screening Unit for breast and cervical screening. Targets aligned to national targets. Baseline for Cervical screening for 3 yrs to 31 December 2012.

[10] 2011 year baseline

Output Class: Intensive Assessment and Treatment Services

- Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. 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
  - Emergency Department services including triage, diagnostic, therapeutic and disposition services

- On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Local Environment

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.

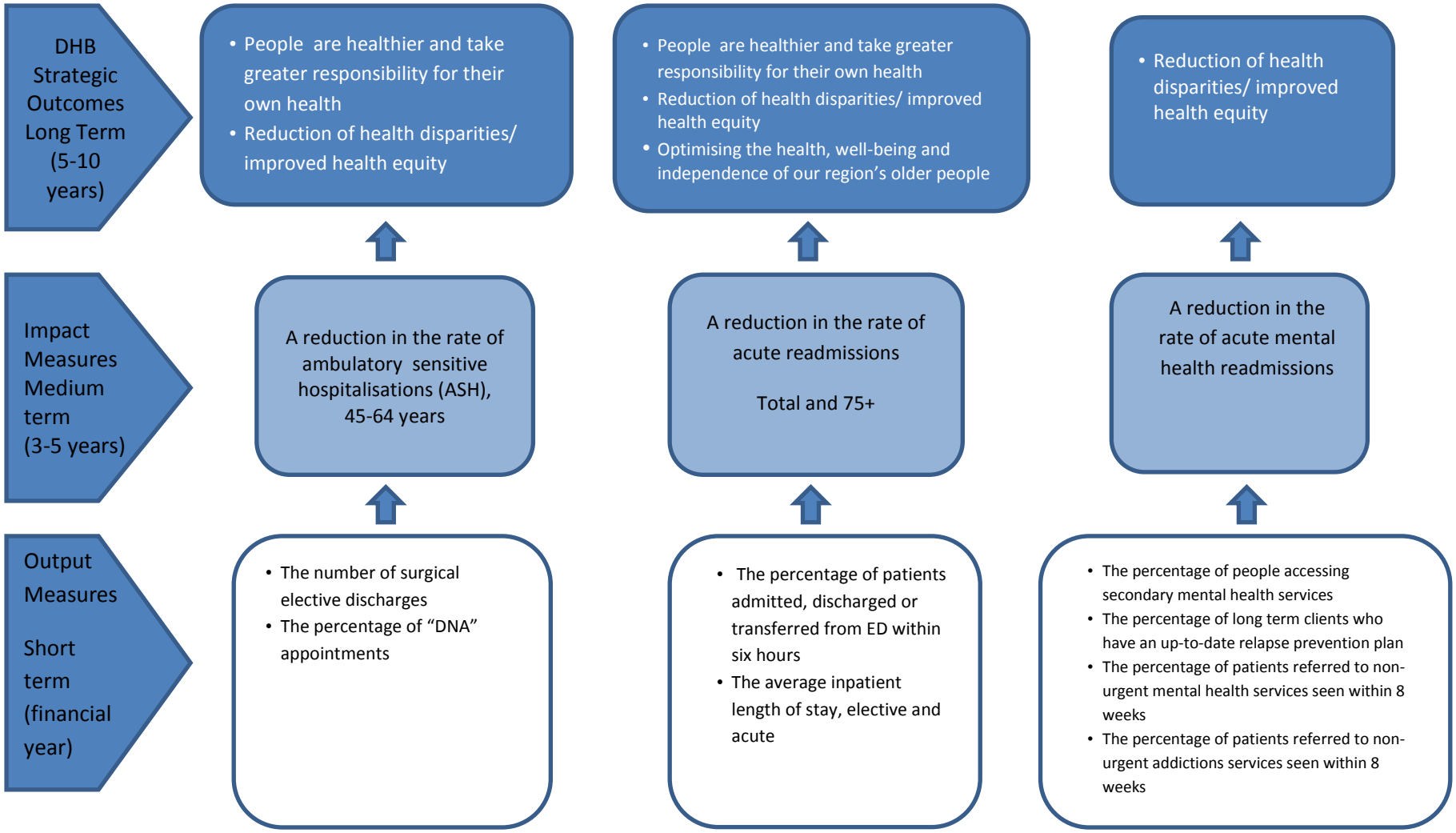
Hutt Valley DHB provides a regional Plastic Surgery/Maxillofacial and Burn Unit covering a population (Wairoa to Blenheim) of over 1 million people. Some of our services are also provided to Canterbury and Otago. We are also the only public hospital in New Zealand providing treatment for vascular birthmarks.

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. Hutt Valley DHB is 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 in highest need of mental health services represent around 3% of the population. Hutt Valley DHB currently funds Mental Health and Addiction Services provided by Hutt Hospital and NGO providers, including a range of regional specialty services primarily delivered by Capital & Coast DHB. These services include Alcohol and Drug Rehabilitation services, Day services, Māori Health services, and the Central Regional Eating Disorder Services.

Intervention Logic: Intensive Assessment and Treatment Services

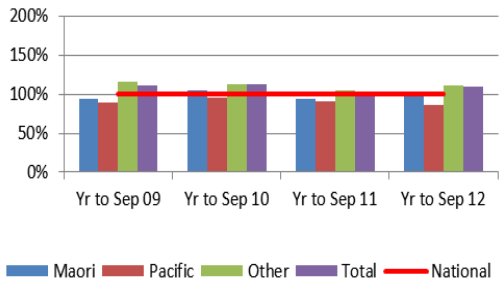


Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

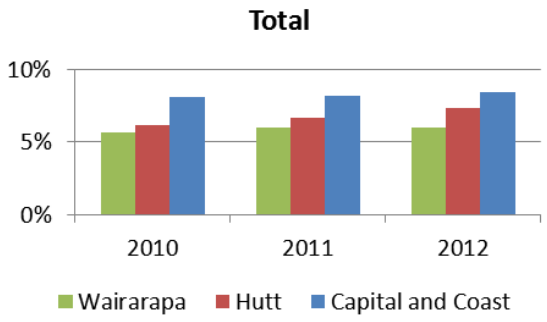
A reduction in ambulatory sensitive hospitalisation (ASH) rates, 45-64

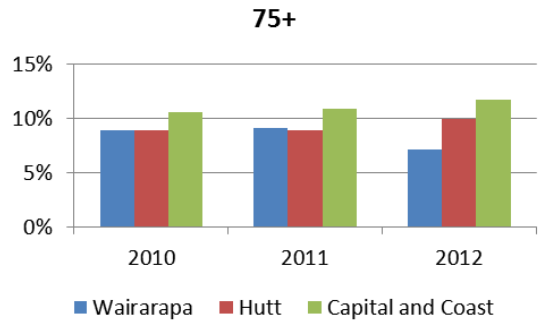
- There are a number of admissions to hospital which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention, and the continuum of care across the system.
- The rate of preventable hospitalisations represents a substantial and avoidable burden on the health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment across the whole system.



A reduction in acute readmissions, Total & 75+

- Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services. Through the intermediate outcome that people receive better health and disability services, the measure contributes to the high level outcome of HVDHB residents living longer, healthier and more independent lives.
- The following actions and activities are examples of initiatives that have a proven impact on this measure:
  - Focus on effective management of long term conditions
  - Process mapping and redesign of patient pathways
  - Initiatives to improve hospital discharge processes
  - Appropriate referral from secondary to primary and community based services[11]

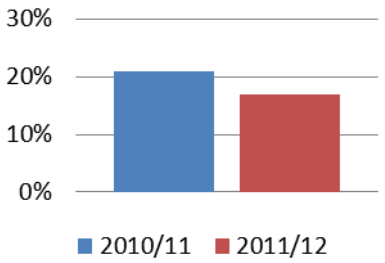




[11] Ministry of Health Non-Financial Reporting Template, 2012/13

A reduction in mental health acute readmissions

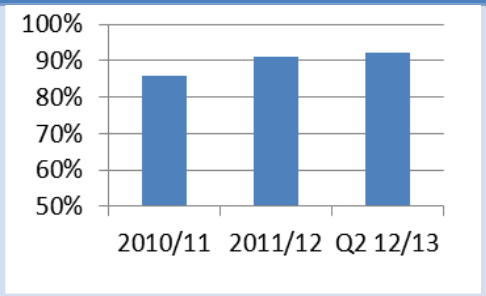
- Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital.
- This indicator helps identify if investigation into the functioning of the system is needed to determine any areas in which it might be breaking down. Improved performance on this measure demonstrates better whole of system performance.



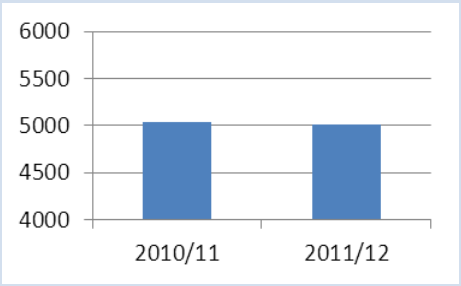
Historical Performance

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.

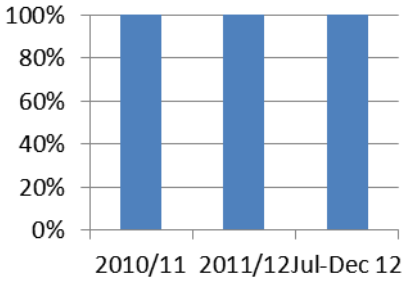
ED 6 hour rule



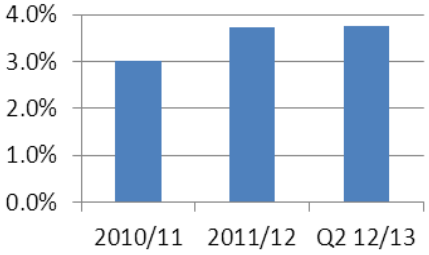
Elective Discharges



Cancer Treatment within 4 weeks



Mental Health Access Rate



Performance Measures: Intensive Assessment and Treatment Services

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline	Target 2013/14	National
Medical and Surgical Services				
Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	91%[12]	**95%**	93%
Health Target: The number of surgical elective	V	5,018	**4,946**	

[12] Performance for October-December 2012

Measure	Type of Measure	Baseline	Target 2013/14	National
discharges				
The average length of stay for inpatients (days)[13] – Acute	T	4.60	**4.60**	4.52
Elective		3.21	**3.21**	3.43
Number of fertility treatments provided for the Central Region	V	303	**>=303**	
Quality Measures				
The percentage of "DNA" (did not attend) appointments for outpatients	Q	8%	**7%**	
Māori		17%	**15%**	
Pacific		16%	**15%**	
The ratio of first specialists assessments (medical & surgical) to follow up appointments	Q	1: 2.6	**<1: 2.6**	
The percentage of mothers breastfeeding on discharge	Q	77.8%	**>77.8%**	
The number of central line acquired bacteraemia infections in ICU	Q	0	**0**	
The rate of falls per 1000 bed days	Q	7.2	**<7.2**	
The rate of medication errors per 1000 bed days	Q	4.48	**<4.48**	
Cancer Services				
Health Target: The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	100%
Mental Health and Addictions Services				
The percentage of people accessing secondary mental health services	C	3.74%	**4.10%**	
The percentage of people accessing secondary mental health services, 0-19		3.06%	**3.84%**	
Māori		3.97%	**3.84%**	
The percentage of people accessing secondary mental health services, 20-64		4.23%	**4.14%**	
Māori		7.56%	**4.14%**	
The percentage of long term clients who have up-to-date relapse prevention plans	Q	97%	**>95%**	
The percentage of patients referred to non-urgent mental health services who are seen within eight weeks	T	78%	**95%**	
The percentage of patients referred to non-urgent addictions services who are seen within eight weeks	T	84%	**90%**	

[13] Baseline 2012 calendar year

Output Class: Rehabilitation and Support

- Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services.
- On a continuum of care these services provide support for individuals.

Local Environment

The population of older people (65 years and over) in the district is 19,755[14] or 14% of the Hutt Valley total population compared with 14% for New Zealand. The Hutt Valley 65 plus population is projected to increase by 53% between 2012 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.

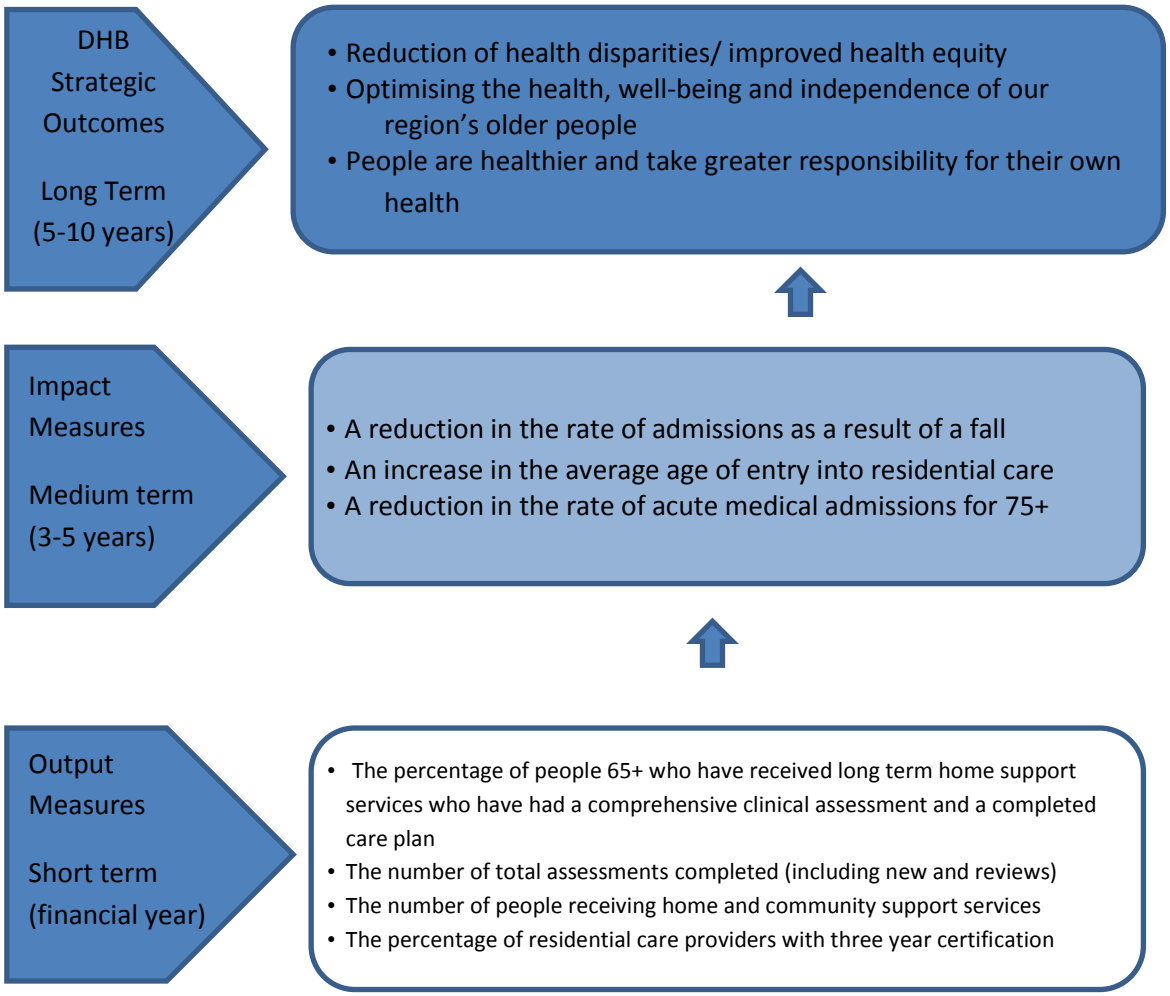
Palliative care is care provided to terminally ill people to assist them to make the most of their life that remains and to ensure that patients die comfortably. Specialist palliative care is provided by Te Omanga Hospice to people in the community, at residential aged care facilities and at Te Omanga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

The DHB seeks to improve accessibility and responsiveness of services to people with disabilities. Disability relates to the interaction between the person with the impairment and the environment. The focus for the HVDHB is twofold, 1) to work cross-sectorally to ensure that disability needs are met as part of HVDHB health (business as usual) services and 2) where business as usual cannot meet a need, examine and implement activity to ensure that there is ease of access to services for disabled people.
Planned activities are outlined in Capital & Coast and Hutt Valley District Health Boards' Valued Lives, Full Participation Implementing the New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities in our District, 2012-2016.

Hutt Valley DHB provides a range of services to support older people maintain their health and to recover from illness or injury. These include physiotherapy, occupational health, dietetic, community nursing, and social work services.

[14] Based on Statistics New Zealand projections for 2013/14

Intervention Logic : Rehabilitation and Support Output Class

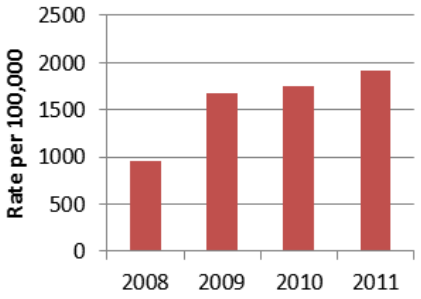


Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

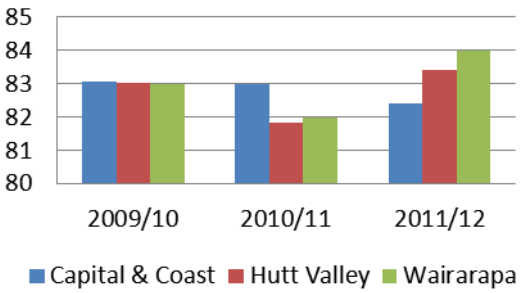
A reduction in the rate of admissions as a result of a fall, 65+

- Falls are a commonly used indicator in the health older persons sector, both nationally and internationally. High rates of falls can be associated with: osteoporosis, lack of physical activity, medications, impaired vision, and environmental hazards.[15] People who suffer a fall tend to have poorer health outcomes after the fall incident, and therefore reducing falls will improve the health of our older people.
- Improved performance to this measure will promote and protect good health and independence, as older people will be able to do more things for themselves and potentially remain in their own homes for longer. It will also reduce the impact on other services which provide treatment or interventions for falls.



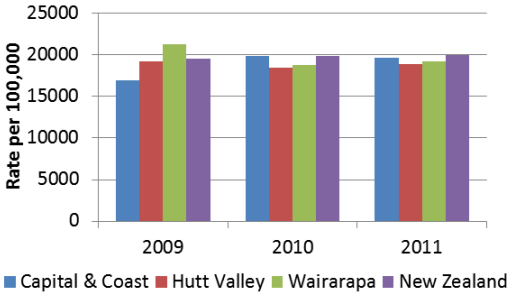
An increase in the average age of entry into Aged Residential Care

- With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. Increasing the average age of entry into Aged Residential Care is a marker of service configuration suitable to the population's needs.
- A 2008 study found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy."[16] This shows the importance of efforts to help older people maintain their independence.



A reduction in the rate of acute medical admissions for 65+

- Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services. Through the intermediate outcome that people receive better health and disability services, the measure contributes to the high level outcome of HVDHB residents living longer, healthier and more independent lives.
- The following actions and activities are examples of initiatives that have a proven impact on this measure:
  - Focus on effective management of long term conditions
  - Process mapping and redesign of patient pathways
  - Initiatives to improve hospital discharge processes
  - Appropriate referral from secondary to primary and community based services[17]



[15] Ministry of Health Non-Financial Reporting Template, 2011/12

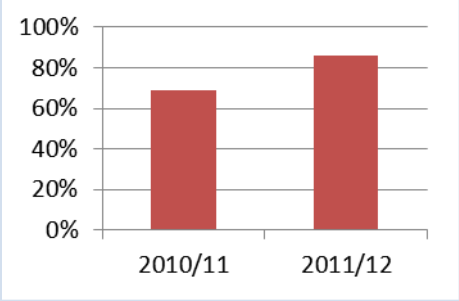
[16] Hambleton, Penny, Sally Keeling, & Margaret McKenzie (2008). "Quality of Life is…:The Views of Older Recipients of Low-Level Home Support." *Social Policy Journal of New Zealand (33).*

[17] Ministry of Health Non-Financial Reporting Template, 2012/13

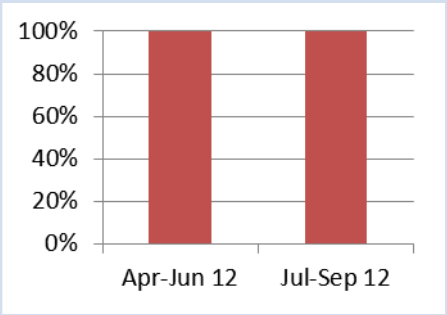
Historical Performance

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.

ARC Certification levels



InterRAI Assessments



Performance Measures: Rehabilitation and Support Services

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline	Target 2013/14
The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan[18]	Q	100%	**>95%**
The number of total assessments (including new and review) [19]	V	2,495	**2,500**
The number of people receiving home and community support services	V	1,913	**1,880**
The number of home based support hours	V	244,118	**254,000**
The number of respite days	V	1,737	**1,895**
The number of subsidised aged residential care bed days	V	309,404	**313,531**
The percentage of residential care providers meeting three year certification standards[20]	Q	86%	**90%**
The number of Disability Forum meetings (subregional and local)	V		**2**

[18] Data for Jul-Sep 2012 quarter. This is a new measure in 2012/13.
[19] Rather than a true target the DHB would like to achieve, it is expected that actual volumes will fall within a range around this level of expected volumes for this and the following six measures.
[20] Excluding new providers and facilities as these are required to have a one year certification

MODULE 5: FINANCIAL PERFORMANCE

5.1 MANAGING FINANCIAL RESOURCES

The Hutt Valley DHB financial position for 2013/14 is breakeven with a forecast breakeven position in out years.

5.2 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).

5.2.1 Summary of Operating Budget

Our operating forecast for 2013/14 and for the outyears is for breakeven.

Key Financial Information is in the following table:

Key Financial Information

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

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Revenue	434,049	442,365	447,631	453,148	458,987
Expenditure	(433,945)	(444,883)	(447,631)	(453,148)	(458,987)
Revaluation of Land and Buildings	-	-	-	-	-
Total Comprehensive Income	**104**	**(2,518)**	**-**	**-**	**-**
Total Property, Plant & Equipment	177,774	182,029	178,338	170,899	162,902
Total Equity	68,308	67,322	67,330	67,330	67,330
Term Borrowings	79,139	70,998	76,798	66,348	80,798

5.2.2 Funding Advice

Funding advice was received in November 2012 that included additional funding for 2013/14. The total increase of 1.63% included a 0.89% increase for relieving cost pressures, and an increase of 0.74% for demographic and other funding changes.

5.2.3 3DHB Subregional Savings Plan

Following the submission of the 2012/13 Annual Plans by the three DHBs, the Minister of Health issued a letter requesting that the three DHBs submit a collective breakeven plan. The *3DHB Subregional Savings Plan* developed by Health Partners Limited in collaboration with the three DHBs has subsequently been accepted by the Minister and the three DHB Boards, and proposes a range of projects and activities that will deliver improved financial performance across the three DHBs. Potential savings from initiatives in that report, which are part of the 3D HSD work programme, have been included in the budget assumptions for each DHB. These are allocated across the three DHBs' total funding as follows:

Capital and Coast DHB $7.5m
Hutt Valley DHB $6.0m
Wairarapa DHB $1.9m

5.3 ASSUMPTIONS

The key assumptions have been included in our preparation of the forecast financial statements for 2013/16. Our Statement of Accounting Policies is included as Appendix 6.1.

General Assumptions:

- No external deficit funding will be required during the planning period.
- Capital expenditure of up to $14.4m is planned for 2013/14.
- We have assumed a replacement of our financial management system during 2012/13 at a total cost of $1.9m over three years. Our current system is no longer supported and we are working on options with HBL and healthAlliance.
- The last revaluation occurred in June 2012, 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 2013 is not expected to show a material movement.
- The investment in a joint venture referred to in this plan relates to ownership of assets from the CRISP project.
- 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 are not expected to materially impact the cost of supplies or capital expenditure.
- Hutt Valley DHB's share of the national population based funding formula will be 3.19% in 2013/14, and 3.17% in 2014/15.
- Revenue increase from population based funding and demographic changes have been included based on the advice received with a further increase planned of $5.1m in 2014/15 and in 2015/16.
- No change in capital charge rate of 8%.
- Additional compliance costs e.g. Archives Act changes may be met out of retained earnings.
- The Forecast Statement of Comprehensive Income 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.
- 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 2012, 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 2012, 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 but in addition to this some provisions have been made for increased volumes where it is considered that the base volumes are lower than what will be expected in 2013/14.

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.
- There will be no new Government health service initiatives which will need to be funded from existing resources.

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.

5.3.1 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. To mitigate this risk the budgets do include some provisions for adverse wash-ups which have been based on expected volumes.

- 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.

5.3.2 OutYears 2014/15 to 2015/16

We have assumed base revenue increases of $5.1m for both 2014/15 and 2015/16 years. Both years reflect the impact of service reconfigurations.

5.4 EFFICIENCY INITIATIVES

The DHB needs to achieve $15.9m of savings in 2013/14 to reach a breakeven 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 programme 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 $15.9m in 2013/14, $16.4m in 2014/15 (increment of $0.5M) and $17.1m in 2015/16 (increment of $0.7M). 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 Operations 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
- 3DHBs service reconfiguration which includes: rationalisation of SIDU, amalgamation of the Wairarapa & Hutt Valley executive, HR, and communications team.
- 3DHBs service reconfiguration will also result in the consolidation of the Hutt Valley & CCDHB laboratory and radiology functions.
- Conducting a value for money review of the funder arm contracts as part of the 3DHB strategy.

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.

5.5 Strategy for disposing of assets

The DHB regularly reviews its fixed asset register, and undertakes fixed asset audits in order to dispose of assets which are surplus to requirements. This ensures that the DHB reduces its level of capital to the minimum consistent with the supply of contracted outputs.

5.6 Disposal of Land

All land that has legally been declared to be surplus to requirements will be disposed of following the statutory disposal process defined in the Public Works Act 1991, the Health Sectors Act 1993, the New Zealand Public Health and Disabilities Act 2000, the Reserves Act

1977 and the Māori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi.

5.7 DEBT AND EQUITY

Under the ED theatre business case we have drawn down $60m of debt to fund the project. An assumption has been made that loans due for repayment will be rolled over.

Term Debt - CHFA Loans	Repayment Date	Amount $M	Interest Rate
Core Loan	15-Dec-17	$19.00	6.535%
Loan 1	15-Apr-14	$4.50	5.490%
Loan 2	15-Dec-18	$4.50	5.970%
Loan 4	15-Apr-16	$2.00	5.520%
Loan 5	15-Apr-16	$5.00	5.020%
Loan 6	15-Mar-19	$5.00	5.685%
Loan 7	15-Apr-15	$4.00	4.500%
Loan 8	15-Dec-18	$5.45	5.090%
Loan 9	15-Dec-15	$5.45	4.240%
Loan 10	15-Dec-18	$6.00	3.710%
Loan 11	15-Apr-14	$6.00	2.915%
Loan 12	15-Jun-20	$5.00	3.355%
Loan 13	15-May-21	$5.10	3.450%
Loan 14	30-Jun-16	$2.00	2.750%
		$79.00	

5.8 FINANCIAL TABLES

Financial Performance

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

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Income					
Operating Income	433,866	441,996	447,301	452,816	458,652
Interest	472	369	330	332	335
Total Income	**434,338**	**442,365**	**447,631**	**453,148**	**458,987**
Expenditure					
Personnel Costs	153,240	153,825	156,830	155,600	157,158
Depreciation	11,031	12,068	13,793	14,600	15,314
Outsourced Services	5,874	7,891	8,708	7,991	7,623
Clinical Supplies	26,496	23,896	23,594	25,424	26,350
Infrastructure & Non-Clinical Expenses	24,923	28,498	27,281	29,464	29,756
Other District Health Boards	79,348	80,803	77,184	77,961	78,741
Non Health Board Providers	133,322	137,902	140,241	142,108	144,045
Total Expenditure	**434,234**	**444,883**	**447,631**	**453,148**	**458,987**
Net Surplus/(Deficit)	**104**	**(2,518)**	**-**	**-**	**-**
Other Comprehensive Income					
Revaluation of Land and Buildings	-	-	-	-	-
Total Comprehensive Income	**104**	**(2,518)**	**-**	**-**	**-**

DHB Provider
Forecast Statement of Comprehensive Income
For the Year Ended 30 June

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Income					
Operating Income	216,975	220,114	222,263	224,163	226,403
Interest	472	369	330	332	335
Total Income	**217,447**	**220,483**	**222,593**	**224,495**	**226,738**
Expenditure					
Personnel Costs	151,640	152,233	156,759	155,525	157,083
Depreciation	11,029	12,066	13,793	14,599	15,314
Outsourced Services	5,519	7,550	6,704	5,965	5,576
Clinical Supplies	26,496	23,891	23,594	25,424	26,350
Infrastructure & Non-Clinical Expenses	24,515	28,001	26,723	28,909	29,194
Internal Allocations	(530)	(601)	(636)	(644)	(651)
Total Expenditure	**218,669**	**223,140**	**226,937**	**229,778**	**232,866**
Net Surplus/(Deficit)	**(1,222)**	**(2,657)**	**(4,344)**	**(5,283)**	**(6,128)**
Other Comprehensive Income					
Revaluation of Land and Buildings	-	-	-	-	-
Total Comprehensive Income	**(1,222)**	**(2,657)**	**(4,344)**	**(5,283)**	**(6,128)**

Governance and Administration
Forecast Statement of Comprehensive Income
For the Year Ended 30 June

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Income					
Operating Income	3,218	3,135	3,269	3,301	3,335
Interest	-	-	-	-	-
Total Income	**3,218**	**3,135**	**3,269**	**3,301**	**3,335**
Expenditure					
Personnel Costs	1,599	1,592	71	75	75
Depreciation	2	2	-	1	-
Outsourced Services	354	341	2,004	2,026	2,047
Clinical Supplies	-	5	-	-	-
Infrastructure & Non-Clinical Expenses	409	497	558	555	562
Internal Allocations	530	601	636	644	651
Total Expenditure	**2,894**	**3,038**	**3,269**	**3,301**	**3,335**
Total Comprehensive Income	**324**	**97**	**-**	**-**	**-**

DHB Funder
Forecast Statement of Comprehensive Income
For the Year Ended 30 June

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Income					
Operating Income	396,966	407,190	412,745	418,233	423,724
Total Income	**396,966**	**407,190**	**412,745**	**418,233**	**423,724**
Expenditure					
Hutt Provider Arm and Governance	183,582	188,443	190,976	192,881	194,810
Other District Health Boards	79,348	80,803	77,184	77,961	78,741
Non Health Board Providers	133,034	137,902	140,241	142,108	144,045
Total Expenditure	**395,964**	**407,148**	**408,401**	**412,950**	**417,596**
Total Comprehensive Income	**1,002**	**42**	**4,344**	**5,283**	**6,128**
Expenditure Breakdown					
Personal Health	313,374	324,973	326,349	330,325	334,310
Mental Health	40,878	40,214	39,300	39,701	40,098
DSS	52,358	52,953	54,112	54,520	55,066
Public Health	319	662	660	671	678
Maori Health	1,220	1,252	1,231	1,287	1,300
Hutt Governance	3,097	3,009	3,156	3,182	3,214
Total Expenditure	**411,246**	**423,063**	**424,808**	**429,686**	**434,666**

Movements in Equity

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

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Equity as at 1July	**64,088**	**68,308**	**67,322**	**67,322**	**67,322**
Capital Contributions from the Crown	4,323	1,532	-	-	-
Repayment of Equity to the Crown	(207)	-	-	-	-
Total Comprehensive Income for the Year	104	(2,518)	-	-	-
Equity as at 30June	**68,308**	**67,322**	**67,322**	**67,322**	**67,322**

Financial Position

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

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Assets					
Current Assets					
Cash and Cash Equivalents	29,217	8,982	9,201	17,398	24,894
Debtors and Other Receivables	12,680	12,945	13,042	13,328	13,580
Inventories	1,431	1,389	1,389	1,389	1,389
Total Current Assets	**43,328**	**23,316**	**23,632**	**32,115**	**39,863**
Non Current Assets					
Property, Plant and Equipment	177,774	182,029	178,338	170,899	162,902
Intangible Assets	3,999	5,518	6,914	6,703	6,336
Investment in Joint Ventures	223	-	-	-	-
Trust and Bequest Funds	997	1,063	1,063	1,063	1,063
Other Investments (Loans)	-	2,520	5,424	6,842	6,842
Total Non Current Assets	**182,993**	**191,130**	**191,739**	**185,507**	**177,143**
Total Assets	**226,321**	**214,446**	**215,371**	**217,622**	**217,006**
Liabilities					
Current Liabilities					
Creditors and Other Payables	47,229	32,263	32,601	33,544	34,330
Employee Entitlements and Provisions	20,751	25,161	25,748	27,048	25,646
Borrowings	3,051	10,792	4,992	15,442	992
Total Current Liabilities	**71,031**	**68,216**	**63,341**	**76,034**	**60,968**
Non Current Liabilities					
Employee Entitlements and Provisions	6,846	6,847	6,847	6,847	6,847
Borrowings	79,139	70,998	76,798	66,348	80,798
Trust and Bequest Funds	997	1,063	1,063	1,063	1,063
Total Non Current Liabilities	**86,982**	**78,908**	**84,708**	**74,258**	**88,708**
Total Liabilities	**158,013**	**147,124**	**148,049**	**150,292**	**149,676**
Equity					
Crown Equity	44,285	45,817	45,817	45,817	45,817
Revaluation Reserves	50,368	50,368	50,368	50,368	50,368
Retained Earnings	(26,345)	(28,863)	(28,863)	(28,863)	(28,863)
Total Equity	**68,308**	**67,322**	**67,322**	**67,322**	**67,322**
Total Equity and Liabilities	**226,321**	**214,446**	**215,371**	**217,614**	**216,998**

Cash Flow

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

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Cash Flows from Operating Activities					
Cash Receipts	449,687	441,547	447,262	452,530	458,400
Payments to Providers	(225,720)	(218,705)	(217,474)	(220,069)	(222,786)
Payments to Suppliers and Employees	(195,671)	(215,998)	(206,004)	(206,628)	(211,807)
Goods and Services Tax (Net)	1,205	(65)	-	-	-
Capital Charge Paid	(5,425)	(5,001)	(5,496)	(5,556)	(5,612)
Net Cash Flows from Operating Activity	**24,076**	**1,778**	**18,288**	**20,277**	**18,195**
Cash Flows from Investing Activities					
Interest Received	472	369	330	332	335
Proceeds from Sale of Property, Plant and Equipment	27	299	-	(5)	(5)
Purchase of Sale of Property, Plant and Equipment	(25,297)	(17,843)	(11,498)	(6,950)	(6,950)
Investments	(223)	(2,297)	(2,904)	(1,418)	-
Net Cash Flows from Investing Activity	**(25,021)**	**(19,472)**	**(14,072)**	**(8,041)**	**(6,620)**
Cash Flows from Financing Activities					
Equity Contribution	4,323	1,532	-	-	-
Loans Raised	25,600	(401)	-	-	-
Interest Paid	(3,366)	(3,672)	(3,997)	(4,039)	(4,079)
Payment of Finance Leases	(310)	-	-	-	-
Repayment of Equity	(207)	-	-	-	-
Net Cash Flows from Financing Activity	**26,040**	**(2,541)**	**(3,997)**	**(4,039)**	**(4,079)**
Net Increase / (Decrease) in Cash Held	25,095	(20,235)	219	8,197	7,496
Cash and Cash Equivalents at Beginning of Year	4,122	29,217	8,982	9,201	17,398
Cash and Cash Equivalents at End of Year	**29,217**	**8,982**	**9,201**	**17,398**	**24,894**

Capex

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

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Approved / Baseline Expenditure					
Property and Plant	1,199	2,042	3,000	3,000	3,000
Clinical Equipment	951	1,065	2,000	2,000	2,000
Computer Equipment	1,275	2,812	1,850	1,850	1,850
Other Equipment	88	42	100	100	100
Motor Vehicles	-	-	-	-	-
Total Baseline	**3,513**	**5,961**	**6,950**	**6,950**	**6,950**
Strategic (Approved)					
Central Region Information Systems Plan (PMS, EMR, PACS, RIS, ED, eReferrals, WhiteBoard) Programme	223	1,487	2,168	1,037	-
Finance Procurement Supply Chain	-	810	736	381	-
Citrix Farm	-	-	1,000	-	-
e-Pharmacy	-	-	500	-	-
MRI Scanner	-	-	2,300	-	-
Laboratory Information Systems	-	943	747	-	-
Total Approved	**223**	**3,240**	**7,451**	**1,418**	**-**
All Other Approved Projects	21,759	11,237	1	-	-
Total Capital Expenditure	**25,495**	**20,438**	**14,402**	**8,368**	**6,950**
Financed By					
Internally Sourced Funding	104	(2,518)	(1,056)	-	-
Equity Injections for Deficit Support	-	-	-	-	-
Depreciation	11,031	12,068	13,793	14,600	15,314
Sale of Fixed Assets	615	299	-	(5)	(5)
Equity Injections for Capital Expenditure	4,323	1,532	-	-	-
Private Debt	3,191	-	-	-	-
CHFA Debt	22,100	-	-	-	-
Other (Includes Cash Reserves)	4,122	19,991	10,934	9,269	14,496
Total Finance	**45,486**	**31,372**	**23,671**	**23,864**	**29,805**

FTEs

DHB Provider
FTEs by Class
For the Year Ended 30 June

	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Medical	238	229	235	232	232
Nursing	709	701	687	668	668
Allied Health	422	413	437	425	425
Non-Allied Health	136	130	130	130	130
Management/Clerical	326	289	306	299	299
Total FTEs	**1,830**	**1,762**	**1,796**	**1,754**	**1,754**

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

	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Medical	0	0	-	-	-
Nursing	-	-	-	-	-
Allied Health	-	-	-	-	-
Non-Allied Health	-	-	-	-	-
Management/Clerical	17	14	1	1	1
Total FTEs	**17**	**14**	**1**	**1**	**1**

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

	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Medical	238	229	235	232	232
Nursing	709	701	687	668	668
Allied Health	422	413	437	425	425
Non-Allied Health	136	130	130	130	130
Management/Clerical	343	303	307	300	300
Total FTEs	**1,847**	**1,776**	**1,797**	**1,755**	**1,755**

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

$000s	2011\12 Audited	2012\13 Forecast	2013\14 Plan	2014\15 Plan	2015\16 Plan
Income					
Operating Income	21,611	20,767	20,156	20,358	20,562
Interest Income	15	19	16	17	17
Total Income	**21,626**	**20,786**	**20,172**	**20,375**	**20,579**
Expenditure					
Personnel Costs	13,092	12,734	11,989	12,109	12,230
Depreciation	276	439	795	835	827
Outsourced Services	853	972	1,007	1,017	1,027
Clinical Supplies	1,852	954	1,035	1,045	1,056
Infrastructure and Non Clinical Expenses	709	1,099	955	965	974
Other District Health Boards	-	-	62	63	63
Non Health Board Providers	1,006	1,633	1,226	1,238	1,251
Capital Charge	225	237	238	240	243
Interest Expense	62	62	62	62	62
Internal Allocations	2,995	3,070	3,109	3,140	3,171
Total Expenditure	**21,072**	**21,201**	**20,478**	**20,715**	**20,904**
Net Surplus / (Deficit)	**555**	**(415)**	**(306)**	**(340)**	**(325)**

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

$000s	2011\12 Audited	2012\13 Forecast	2013\14 Plan	2014\15 Plan	2015\16 Plan
Income					
Operating Income	116,582	113,821	112,629	115,114	117,573
Interest Income	10	12	11	11	11
Total Income	**116,591**	**113,833**	**112,640**	**115,125**	**117,584**
Expenditure					
Personnel Costs	13,182	8,257	5,151	5,202	5,254
Depreciation	480	584	773	853	841
Outsourced Services	686	211	1,060	1,071	1,082
Clinical Supplies	1,147	934	504	509	514
Infrastructure and Non Clinical Expenses	1,272	1,311	902	911	920
Other District Health Boards	11,834	12,191	14,570	14,716	14,863
Non Health Board Providers	79,699	83,607	82,993	84,336	85,696
Capital Charge	628	895	916	925	934
Interest Expense	41	41	41	41	41
Internal Allocations	3,006	1,802	1,508	1,523	1,538
Total Expenditure	**111,975**	**109,833**	**108,418**	**110,088**	**111,683**
Net Surplus / (Deficit)	**4,615**	**4,000**	**4,222**	**5,037**	**5,901**

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

$000s	2011\12 Audited	2012\13 Forecast	2013\14 Plan	2014\15 Plan	2015\16 Plan
Income					
Operating Income	237,444	249,455	255,127	257,363	259,936
Interest Income	447	338	302	304	307
Total Income	**237,891**	**249,793**	**255,429**	**257,667**	**260,243**
Expenditure					
Personnel Costs	123,401	129,297	136,216	134,780	136,128
Depreciation	10,266	11,034	12,214	12,902	13,637
Outsourced Services	4,245	6,619	6,217	5,475	5,081
Clinical Supplies	22,269	20,773	20,795	22,598	23,496
Infrastructure and Non Clinical Expenses	14,968	16,846	15,791	17,858	18,036
Other District Health Boards	61,913	63,749	58,891	59,484	60,079
Non Health Board Providers	4,386	4,482	5,988	6,000	6,060
Capital Charge	4,105	4,325	4,339	4,382	4,426
Interest Expense	2,798	3,544	3,893	3,933	3,974
Internal Allocations	(6,718)	(5,642)	(5,500)	(5,555)	(5,610)
Total Expenditure	**241,631**	**255,028**	**258,845**	**261,858**	**265,308**
Net Surplus / (Deficit)	**(3,740)**	**(5,235)**	**(3,414)**	**(4,191)**	**(5,065)**

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

$000s	2011\12 Audited	2012\13 Forecast	2013\14 Plan	2014\15 Plan	2015\16 Plan
Income					
Operating Income	58,229	57,954	59,389	59,982	60,583
Interest Income	1	1	1	1	1
Total Income	**58,229**	**57,955**	**59,390**	**59,983**	**60,583**
Expenditure					
Personnel Costs	3,565	3,537	3,474	3,509	3,544
Depreciation	9	11	11	11	11
Outsourced Services	89	89	424	428	433
Clinical Supplies	1,227	1,235	1,260	1,273	1,285
Infrastructure and Non Clinical Expenses	106	126	133	135	136
Other District Health Boards	5,601	4,864	3,661	3,698	3,735
Non Health Board Providers	48,231	48,180	50,034	50,534	51,040
Capital Charge	8	8	8	8	8
Interest Expense	2	2	2	2	2
Internal Allocations	716	770	883	892	901
Total Expenditure	**59,555**	**58,822**	**59,890**	**60,491**	**61,095**
Net Surplus / (Deficit)	**(1,325)**	**(868)**	**(501)**	**(508)**	**(512)**

APPENDIX 6.1: STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY

The Hutt Valley District Health Board (Hutt DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. Hutt DHBs ultimate parent is the New Zealand Crown.
Hutt DHBs primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, Hutt DHB has designated itself and the group as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).
Hutt DHB has a 16.67% share of a joint venture company Central Regional Technical Advisory Services Limited which is incorporated and domiciled in New Zealand.

BASIS OF PREPARATION

Statement of compliance

The Budgeted financial statements of Hutt DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).
The budgeted financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base

The budget financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, buildings, and forward foreign exchange contracts at fair value.

Functional and presentation currency

The budget financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of Hutt DHB and its joint venture is New Zealand dollars (NZ$).

SIGNIFICANT ACCOUNTING POLICIES

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

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Ministry of Health (MoH) revenue

Hutt DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of Hutt DHB meeting its objectives.
Revenue from the MoH is recognised as revenue when earned.

ACC contracted revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Revenue from other DHBs

Inter district patient inflow revenue occurs when a patient treated within the Hutt DHB region is domiciled outside of Hutt Valley. The MoH credits Hutt DHB with a monthly amount based on estimated patient treatment for non-Hutt Valley residents within Hutt Valley. An annual wash up occurs at year end to reflect the actual non-Hutt Valley patients treated at Hutt DHB.

Interest income

Interest income is recognised using the effective interest method.

Rental income

Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of services

Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance date.

Donations and bequests

Donations and bequests to Hutt DHB are recognised 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.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Interest expense

Hutt DHB has elected to defer the adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, borrowing costs are recognised as an expense in the financial year in which they are incurred except to the extent they are directly attributable to the acquisition or construction of a qualifying asset.

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.
At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of forecast financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.
The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether Hutt DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straightline basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Debtors and other receivables

Debtors and other receivables are recorded at their face value, less any provision for impairment.

A receivable is impaired when there is objective evidence that Hutt DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, 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. 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 surplus or deficit. 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 (that is, not past due).

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that Hutt DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are stated at the lower of cost, determined on a weighted average basis, and current replacement cost, adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Property, plant, and equipment

Property, plant, and equipment consists of the following asset classes:

- land;
- site improvements;
- building service fitout;
- plant and equipment (includes computer equipment);
- leased assets ; and
- motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years.

The carrying values of land and buildings are assessed annually by independent registered valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

All other asset classes are carried at depreciated historical cost.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to Hutt DHB and the cost of the item can be measured reliably.

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

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to Hutt DHB 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 surplus or deficit as they are incurred.
Depreciation
Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The estimated useful lives of major classes of assets have been estimated as follows:

Site Improvements	4 to 80 years
Building Services Fitout	2 to 36 years
Plant and equipment	2 to 9 years
Computer equipment	3 to 7 years
Leased assets	3 to 8 years
Motor vehicles	5.5 to 12.5 years

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.
Capital work in progress is not depreciated. The total cost of a project is transferred to a fixed asset category on its completion and is then depreciated.

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.
Costs that are directly associated with the development of software for internal use 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.
Costs associated with the development and maintenance of Hutt DHBs website 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 financial year is recognised in the surplus or deficit.
The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:
Computer software - useful life 10 years, amortisation rate 10%

Impairment of property, plant, and equipment and intangible assets
Property, plant, and equipment and intangible assets are reviewed for indicators of impairment as at each balance date. 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 value in use.
Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where Hutt DHB would, if deprived of the asset, replace its remaining 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 in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same 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 other comprehensive income and increases the asset revaluation reserve for that class of asset. 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.

Creditors and other payables
Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.
Borrowings are classified as current liabilities unless Hutt DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where Hutt DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if Hutt DHB expects to settle the liability within 12 months of the balance date.

Employee entitlements
Short-term employee entitlements
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.
These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, long service leave, retiring gratuities, continuing medical education leave and expenses, and other entitlements for example sick leave.
A liability for sick leave is recognised to the extent that 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 that it will be used by staff to cover those future absences.
A liability and an expense are recognised for bonuses where the Hutt DHB has a contractual obligation or where there is a past practice that has created a constructive obligation.
Long-term entitlements
Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, long service leave, retirement gratuities, continuing medical education and expenses, and other entitlements

such as 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, the likelihood that staff will reach the point of entitlement, and contractual entitlement information and the present value of the estimated future cash flows.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver and the Government Superannuation Fund are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

Hutt DHB 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 an increased share of the 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 surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

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 expenditure 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.

ACC Partnership Programme

Hutt DHB belongs to the ACC Partnership Programme whereby it 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 Hutt DHB 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 Hutt DHB has responsibility under the terms of the Partnership Programme. Hutt DHB has chosen a stop loss limit of 250% of the standard levy.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Crown equity;
- accumulated surpluses; and
- revaluation reserves.

Revaluation reserves

These reserves are related to the revaluation of land and buildings to fair value.

Goods and services tax

All items in the forecast financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of forecast financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hutt DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Cost allocation

Hutt DHB has determined the cost of outputs using the cost allocation system outlined below.

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

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs using appropriate cost drivers such as full time staff numbers, staff head count numbers or floor space used.

Critical accounting estimates and assumptions

In preparing these forecast financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

Estimating useful lives and residual values of property, plant, and equipment

The useful lives and residual values of property, plant, and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires Hutt DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Hutt DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by physical inspection of assets and an asset replacement programme.

Hutt DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgment as to whether the agreement transfers substantially all the risks and rewards of ownership to Hutt DHB. Judgment is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of forecast financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. Hutt DHB has exercised its judgement on the appropriate classification of leases, and have determined two lease arrangements are finance leases.

APPENDIX 6.2 GLOSSARY OF TERMS

Term	Meaning
ACS	Acute coronary syndrome (ACS) refers to any group of symptoms attributed to obstruction of the coronary arteries.
Activity	In the context of Strategic Planning, Activities refers to the tasks, duties, projects, systems or processes that the planning entity uses to convert its Inputs (see Inputs) into Outputs (see Outputs).
ALOS	Average Length of Stay - a way of monitoring how long it takes for a particular health service to be delivered, from admission to discharge.
ALT	Alliance Leadership Team – the central decision making hub of an Alliance Contract, which provides a single flexible funding pool for doctors, nurses, pharmacists and other health professionals to pursue collaborative healthcare initiatives programmed by the Ministry of Health.
AMP	Asset Management Plan
AOD	Alcohol and Other Drugs
A/R	Wairarapa DHB Audit and Risk Committee
ASH	Ambulatory sensitive hospital admissions (ASH) are those admissions (mostly acute) that are considered by expert opinion to be potentially avoidable through interventions in out-of-hospital settings. They are an outcome indicator used to evaluate access to primary health care (e.g., GP visits).
B4SC	Before School Checks - one of the services offered under the Well Child/Tamariki Ora programme. This check occurs at age 4 to ensure any health issues that may affect learning are identified prior to the child beginning school.
BSMC	Better, Sooner and More Convenient – the name of the government's initiative to promote increased primary/specialist integration and collaboration. The original BSMC discussion document, produced by health minister Tony Ryall, can be found online at: http://www.national.org.nz/files/__0_0_health_lowres.pdf
CAMHS	Child & Adolescent Mental Health Services.
CAP	The Children's Action Plan (CAP) provides a high level programme framework for the Government's White Paper for Vulnerable Children (2012). It outlines a range of cross-government interventions targeting vulnerable children who are at risk of harm now or in the future.
CCDHB	Capital & Coast District Health Board. The district health board covering Wellington, Porirua and Kapiti (excluding Te Horo, Otaki and Otaki Forks Census areas) Territorial Authorities
CEO	The Chief Executive Officer (CEO) holds the highest possible delegation from a District Health Board (under the Public Health and Disability Act) for management matters relating to that DHB

Term	Meaning
CFO	Chief Financial Officer. The COO holds a delegation from the CEO, usually for matters relating to routine management of financial information services.
COO	Chief Operating Officer. The COO holds a delegation from the CEO, usually for matters relating to routine management of hospital health services (HHS).
CPHAC	Community and Public Health Advisory Committee - one of the three advisory committees that DHBs are required to establish under the NZ Public Health and Disability Act .
CPSA	District Health Boards are responsible for funding community pharmacy services to 900 community pharmacies in New Zealand through the Community Pharmacy Services Agreement (CPSA). The Pharmacy Services Advisory Group (PSAG) was set up to provide advice on operational aspects relating to the Agreement and a review group advises on any necessary changes.
CRISP	The Central Region Information Systems Plan (CRISP) is a major Information and Communication Technology (ICT) work programme within the Central Region RSP. This programme will deliver a range of clinical information systems, and includes the development of a Central Region ICT Strategy.
CRTAS	Central Region Technical Advisory Services
CVD	Cardio Vascular Disease - a class of diseases that involve the heart or blood vessels (arteries, capillaries, and veins)
DCIP	The Diabetes Care Improvement Package (DCIP) is a community and primary care based programme, building on core diabetes services that were already being provided, to improve outcomes for people with diabetes. The package may differ between DHBs, depending on the needs in the area. DHBs may choose to deliver this through innovative nurse-led services such as practice clinics, patient group education or community outreach, which may include the up skilling of staff.
DHB	District Health Boards (DHBs) were established by the Public Health and Disability Act to pursue the Act 's objectives. The Act also outlines the breadth of functions that DHBs have for the pursuit of their objectives.
DLT	Directorate Leadership Team - in the Wairarapa and Hutt Valley DHB bilateral restructure (March 2013), three directorates were created, each led by directorate leadership teams (DLTs).
DSAC	Disability Services Advisory Committee - one of the three advisory committees that DHBs are required to establish under the NZ Public Health and Disability Act .
ECE	Early childhood education (also early childhood learning and early education) refers to the formal teaching of young children by people outside the family or in settings outside the home. "Early childhood" is usually defined as before the age of normal schooling.
ED	Emergency Department

Term	Meaning
EQI	The Endoscopy Quality Improvement Programme (EQI) is a workforce development programme which aims to ensure all New Zealanders receive the same high standard endoscopy care, no matter where they live in the country. The programme is operationally based at the Bay of Plenty DHB, headed by clinical leaders Dr. David Theobald and Jenni Masters. The programme has been piloted at Waitemata, Lakes, Wairarapa and Canterbury DHBs and will be rolled-out nationally in stages, starting February 2013.
ERAS	Enhanced Recovery after Surgery (ERAS) programmes are also known as fast-track, rapid or accelerated surgery. The approach is evidence-based and involves a selected number of individual interventions that, when implemented as a group, demonstrate a greater impact on outcomes than would be the case if they were implemented individually. The underlying goal of ERAS is to enable patients to recover from surgery and leave hospital sooner, by minimising the stress responses on the body during surgery.
ESPIs	Elective Services Patient Flow Indicators - There are six ESPIs which the MOH uses to monitor the performance of DHB elective services within hospital & specialist services: - DHB services that appropriately acknowledge and process all patient referrals within 10 working days - Patients waiting longer than six months for their first specialist assessment (FSA) - Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT) - Patients given a commitment to treatment but not treated within six months - Patients in active review who have not received a clinical assessment within the last six months - The proportion of patients treated who were prioritised using nationally recognised processes or tools
ESPWP	The Elective Services Productivity and Workforce Programme (ESPWP) has been established with Cabinet approval to support and promote significant transformations in elective services productivity, and seeks proposals from DHBs to enhance elective services surgical discharges and productivity, patient outcomes, and cost effectiveness. The ESPWP supports the Government's policy of increasing average elective discharges nationally by 4000 per year, and there is a particular focus on DHBs who would need to increase their average discharges by more than 25% to meet their local demand over the next years.
FCT	The Faster Cancer Treatment (FCT) programme is part of the National Cancer Programme led by the Ministry of Health. It aims to improve the quality and timeliness of services for patients along the cancer pathway, and links with other programmes of work that will improve cancer diagnostic and treatment services.
FMIS	Finance Management Information System
GP	General Practitioner
HAC	Hospital Advisory Committees – responsible for monitoring the financial and operational performance of hospitals and related services

Term	Meaning
HBL	Health Benefits Limited. HBL is a shared services organisation set up to help DHBs deliver quality healthcare at a lower cost by working smarter and reducing duplication and administrative costs. HBL is owned by the New Zealand Government and is mandated to find ways of delivering greater quality to health delivery through more efficient processes.
HEEADSSS	The HEEADSSS assessment is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with a young person. HEEADSSS also provides an ideal format for a preventive health check. It provides information about the young person's functioning in key areas of their life: H – Home E – Education & Employment E – Eating & Exercise A – Activities & Peer Relationships D – Drug Use/Cigarettes/Alcohol S – Sexuality S – Suicide and Depression S – Safety
HHS	Hospital Health Services - Health services managed and/or delivered by Hospital employees, as opposed to NGOs or community based organisations.
HVDHB	Hutt Valley District Health Board, covering Lower and Upper Hutt Territorial Authorities.
ICC	Integrated Care Collaborative – a CCDHB programme aimed at promoting increased integration and cooperation between primary and specialist services.
IDF	Inter-District Flow - a way of monitoring the funding exchanged between DHBs for services that are provided to each other's populations
IFHN	Integrated Family Health Network - a primary/specialist integration programme underpinning the Wairarapa DHB Tihei Wairarapa Primary Care
Inputs	Resources put into a system, or expended in its operation to achieve an output or result - in a strategic planning context this typically refers to resources within the control of the planning entity, such as funding, staff, time, rental and equipment, but can also include the contribution of other organizations in kind or in cash.
KPI	Key Performance Indicators (KPIs) refer to any essential data collection(s) required for performance monitoring. This data can be used to promote stakeholder accountability, to stimulate a desired level of performance, and to facilitate the effective exercise of routine management control. KPIs can be used to monitor the performance of specific activities, programmes, portfolios, polices or strategies.
LMC	Lead Maternity Carer - Most LMCs are midwives, though GPs and obstetricians may also carry out the role and/or work collaboratively with midwives as needed.

Term	Meaning
LTC	Long Term Conditions - The National Health Committee defines a long term condition as any on-going, long-term or recurring condition that can have a significant impact on people's lives. Long term conditions include diabetes, cardiovascular disease (including stroke and heart failure), cancer, asthma, chronic obstructive pulmonary disease, arthritis and musculoskeletal disease, dementia and mental health problems and disorders.
MDM	Multi-Disciplinary Meetings (MDMs) are deliberate, regular meetings either face-to-face or via videoconference at which health professionals with expertise in a range of different specialities discuss the options for patients' treatment and care prospectively. Prospective treatment and care planning involves making recommendations in real time, with an initial focus on the patient's primary treatment. MDMs facilitate a holistic approach to the treatment and care of the patient.
MHP	Māori Health Plans (MHPs) are fundamental planning, reporting and monitoring documents, which underpin the DHB's efforts to improve Māori health and reduce the disparities between Māori and non-Māori. An MHP provides a summary of a DHB's Māori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to undertake to address health issues in order to achieve indicator targets set nationally, regionally and at district level.
NGO	Non-Government Organisation - any legally constituted organisation which operates independently from the government. The term is fairly generic and typically includes a wide variety of community based organisations, including charitable trusts, incorporated societies and commercial service providers.
NIR	The National Immunisation Register (NIR) is a computerised information system that has been developed to hold immunisation details of New Zealand children. The purpose of the NIR is to assist New Zealand to improve its immunisation rates. Improved immunisation coverage will offer individual protection against vaccine-preventable diseases and protection for the community against recurring epidemics.
Outputs	Outputs are the result of Activity (see Activity) - outputs specify the quality, volume and timeliness of the work, goods, or services planned or produced by the planning entity.
Outcomes	Outcomes refer to the contribution of an Activity towards some kind of change for a target population. At the highest level, the New Zealand Health Sector uses a 'Triple Aim' outcomes framework, which seeks a balance between the effects on Population Health, the Experience of Care and the Efficiency of the Healthcare System.
PBFF	Population Based Funding Formula - a method used by the Ministry of Health to determine how New Zealand's health budget ought to be distributed across DHBs.
PCI	Percutaneous Coronary Intervention (PCI), commonly known as coronary angioplasty or simply angioplasty, is a non-surgical procedure used to treat the stenotic (narrowed) coronary arteries of the heart found in coronary heart

Term	Meaning
	disease.
PHO	Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.
PPP	The PHO Performance Programme (PPP) has been developed by District Health Boards (DHBs), the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a Primary Health Organisation (PHO). The Programme aims to: - Encourage and reward improved performance by PHOs in line with evidence-based guidelines - Measure and reward progress in reducing health inequalities by including a focus on high need populations
PSSG	Primary Secondary Strategy Group - The first meeting of the Hutt Valley Primary Secondary Strategy Group took place on 17 February 2011. This integrated hospital and community multidisciplinary group will meet monthly. Members are a mix of four hospital and five primary care clinicians, with some senior DHB clinical leaders and managers to help implement clinical decisions. The group's purpose is to improve primary and secondary integration to assist in keeping people of the Hutt Valley well and in the community.
REC	The Regional Executive Committee (REC) is the peak executive and clinical leadership committee in the Central Region Leadership Framework, reporting through to the regional CEOs. It comprises senior management and clinical representatives and consumer representation from across the region and it's objective is to ensure that the region takes a co-ordinated approach to planning and delivery.
RGG	Regional Governance Group - All six DHBs within the Central Region have given support to new Regional Governance Arrangements, including the establishment of a Regional Governance Group. This will include the development of a set of principles to guide decisions of the Central Region's regional governance group, including in those principles the principle that the outcome of decisions of that group must not increase inequalities. The new Regional Governance Group is to hold its inaugural meeting in March. One of the Group's first tasks will be to review its terms of reference and re-submit these to the six shareholder boards for approval. Another task is to determine the board composition for TAS.
RSP	Regional Services Plan - since the New Zealand Public Health and Disability Amendment Act was passed in 2010, each DHB region in the country jointly prepares an RSP, which describes in detail how DHBs in the region will plan and work together on a regional basis. The plans are designed to support vulnerable services, give everyone better access to health services, link to the National Health Targets and improve health across the whole region

Term	Meaning
SBHS	The School Based Health Services (SBHS) programme receives funding from the government for 38,000 young people in all decile 1 and 2 secondary schools, alternative education and teen parent units. However, over the next four years, extra nurses will be embedded in all decile 3 secondary schools, expanding the nurse-led School Based Health Service (SBHS) to a further 18,000 potentially at-risk young people as part of the Prime Minister's Youth Mental Health Project.
SDP	Rising to the Challenge: The Mental Health and Addiction Service Development Plan (SDP) 2012–2017 sets out the Government's vision to guide the mental health and addiction sector, as well as clear direction to planners, funders and providers of mental health and addiction services on Government priority areas for service development over the next five years. The Plan focuses on four key areas: - making better use of resources - improving integration between primary and secondary services - cementing and building on gains for people with high needs - delivering increased access for all age groups (with a focus on infants, children and youth, older people and adults with common mental health and addiction disorders such as anxiety and depression
SIDU	The Service Integration and Development Unit - the establishment of SIDU in 2012 amalgamated the Planning and Funding functions of the Wairarapa, Hutt Valley and Capital and Coast District Health Boards under a single sub regional directorate.
SRCLG	The Sub Regional Clinical Leadership Group (SRCLG) is led by clinicians from the Wairarapa, Hutt Valley and Capital & Coast District Health Boards, and has developed a significant work programme to develop services across the sub region. This work programme is identified as the '3D' or 3 DHB Health Services Development programme.
TAs	Territorial Authorities – Territorial Authorities are the second tier of local government in New Zealand, below regional councils. There are 67 territorial authorities: 13 city councils, 53 district councils, and the Chatham Islands Council.
TAVI	Transcatheter Aortic Valve Implantation - Catheter insertion of a new aortic valve to treat aortic stenosis. Aortic stenosis occurs when the aortic valve, which separates the main pumping chamber of the heart from the circulation, becomes partially narrowed. This reduces the flow of blood out of the heart. Transcatheter aortic valve implantation may be an alternative to surgical valve replacement in patients for whom conventional aortic valve replacement is not suitable, or who at very high risk.
WCTO	Well Child/Tamariki Ora (WCTO) is a free service that is offered to all New Zealand children from birth to five years. Services include: - Eight checks between 4-6 weeks of age to 4-4.5 years - B4 School Check at 4-4.5 years, including a free eyesight and hearing test
WDHB	Wairarapa District Health Board, covering Carterton, Masterton, and South

Term	Meaning
	Wairarapa Territorial Authorities.
YOSS	Youth One Stop Shops (YOSS) provide a range of accessible, youth-friendly health and social services at little or no cost to young people, including primary health care, sexual and reproductive health, family planning and mental health services. The majority of clients are aged between 15 and 24 years.