Annual Plan 2014/15

incorporating Statement of Intent 2014/15-2017/18
and Statement of Performance Expectations 2014/15

Hutt Valley DHB

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

05 MAR 2015

Dr Virginia Hope
Chair
Hutt Valley District Health Board
Private Bag 31907
Lower Hutt 5040

Dear Dr Hope

Hutt Valley District Health Board 2014/15 Annual Plan

This letter is to advise you I have approved and signed Hutt Valley District Health Board's (DHB's) 2014/15 Annual Plan for one year.

I wish to emphasise how important annual plans are for ensuring appropriate accountability arrangements are in place. I appreciate the significant work that goes into preparing your Annual Plan and thank you for your effort.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2014, Vote Health again received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Living Within our Means
DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Improvements through national, regional and sub-regional initiatives should continue to be a key focus for all DHBs.

I note that your DHB is planning a breakeven for 2014/15 and the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2014/15.

Better Public Services (BPS): Results for New Zealanders
Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

National Health Targets
Your Annual Plan generally includes a good range of actions that will lead to improved or continued performance against the health targets. As you are aware, there is one new addition to the target set for 2014/15. From quarter two, the 62 day Faster Cancer treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016.

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Although Hutt Valley DHB is performing well in most health target areas, in the year ahead, I would like you to particularly focus on improving recent results in the shorter stays in emergency departments target. I am also asking all DHBs to particularly focus on ensuring appropriate actions are implemented to support immunisation service delivery.

Care Closer to Home
I am pleased to see tangible actions in your Annual Plan that demonstrate how you will broaden the scope of diagnostic and treatment services directly accessible to primary care.

It is important that the development of rural service level alliance teams progresses during the year. It is expected that a rural service level alliance team develops and agrees a plan for the distribution of rural funding, in accordance with the PHO Services Agreement Version 2 (July 2014).

Health of Older People
I am pleased to note your commitment to continuing price or volume increases in home and community support services, implementing your fracture liaison service, and using interRAI-based quality indicators.

Regional and National Collaboration
Greater integration between DHBs supports more effective use of clinical, financial and other resources (such as technology). In particular, clinically-led collaboration across DHBs is essential, as sharing of expertise will contribute to the realisation of regional and sub-regional benefits. I expect DHBs to make significant contributions to delivering on regional planning objectives, and to priorities specific to their regions, that will help lead to financial and clinical sustainability.

DHBs have also committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to factor in benefit impacts for the Finance Procurement Supply Chain Initiative where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

Budget 2014
I also expect that you will deliver on Budget 2014 initiatives. This includes extending free doctors' visits and prescriptions for children aged under six to all children aged under 13 from July 2015.

Annual Plan Approval
My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware of the 3DHB laboratory work, and I expect you to keep the National Health Board involved in this process. You are reminded that you need to advise the National Health Board of any proposals that may require Ministerial approval as you review services during the year.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2014/15 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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Hon. Jonathan Coleman

Minister of Health

Date: 19.2.15

Hon. Bill English

Minister of Finance

Date: 24.2.15

Dr. Virginia Hope

Chairperson
Hutt Valley District Health Board

Wayne Guppy

Deputy Chairperson
Hutt Valley District Health Board

Graham Dyer

Chief Executive
Hutt Valley District Health Board

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Module 1: Introduction and Strategic Intentions

1.1 Executive Summary

This Annual Plan outlines to Parliament, the Minister of Health and the general public the performance intentions for Hutt Valley DHB for the next year as we work to improve, promote, and protect the health status of our local people.

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 & Coast DHBs (the three 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 three 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 DHBs recognise that 2014/15 is going be another year of challenges as we continue our programme of change to ensure we can live sustainably within our means. Further changes to some service configurations will be required as the DHBs consider the most efficient and client focussed ways of delivering services in local and sub-regional contexts.

Sub-regional collaboration

In late 2012, the three DHBs pooled their Planning and Funding functions into a single unit that is jointly directed by the DHB CEOs but is operationally managed by Capital & 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 the risk to service delivery and financials for the benefit of all three DHBs.

In early 2013 Graham Dyer was appointed joint CEO across Hutt Valley and Wairarapa DHBs and a single executive team was established across these two DHBs. This process is 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 & Coast DHB.

Across the three DHBs, a sub-regional strategy has been developed, and is described in section 1.3. The sub-regional vision is **Healthy People, Families and Communities** which will be achieved through:

- preventative health and empowered self-care;
- provision of relevant services close to home; and
- qualityhospital care and complex care for those who need it.

Alliancing with Primary Care

Across the districts, and in support of the Government's *Better, Sooner, More Convenient Health Services* (BSMC) 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. The DHBs acknowledge the participation of local primary care partners, through the Alliance Leadership Teams, in the development and endorsement of this Annual Plan.

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 Maori 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 & 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 Maori Partnership Board, to ensure Maori participation at all levels of service planning and service delivery for the protection and improvement of the health status of Maori.

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

Planning for the needs of our local and sub-regional 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 & Coast, MidCentral, Hawke's Bay, and Whanganui DHBs, and has been extensively revised in this, its fourth year, to drive our region more quickly towards greater efficiency across services we provide to the population of the lower North Island.
- At a sub-regional level, Wairarapa, Hutt Valley and Capital & Coast DHBs are continuing with their joint integration and efficiency programmes whilst maintaining a clear focus on the needs and provision of services to our 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* change activity.

The DHBs are committed to working across national and regional work programmes to actively improve our collective regional performance, while also contributing to a better performing health sector. In particular, the DHBs are key players in the on-going development and implementation of the Central Region's Regional

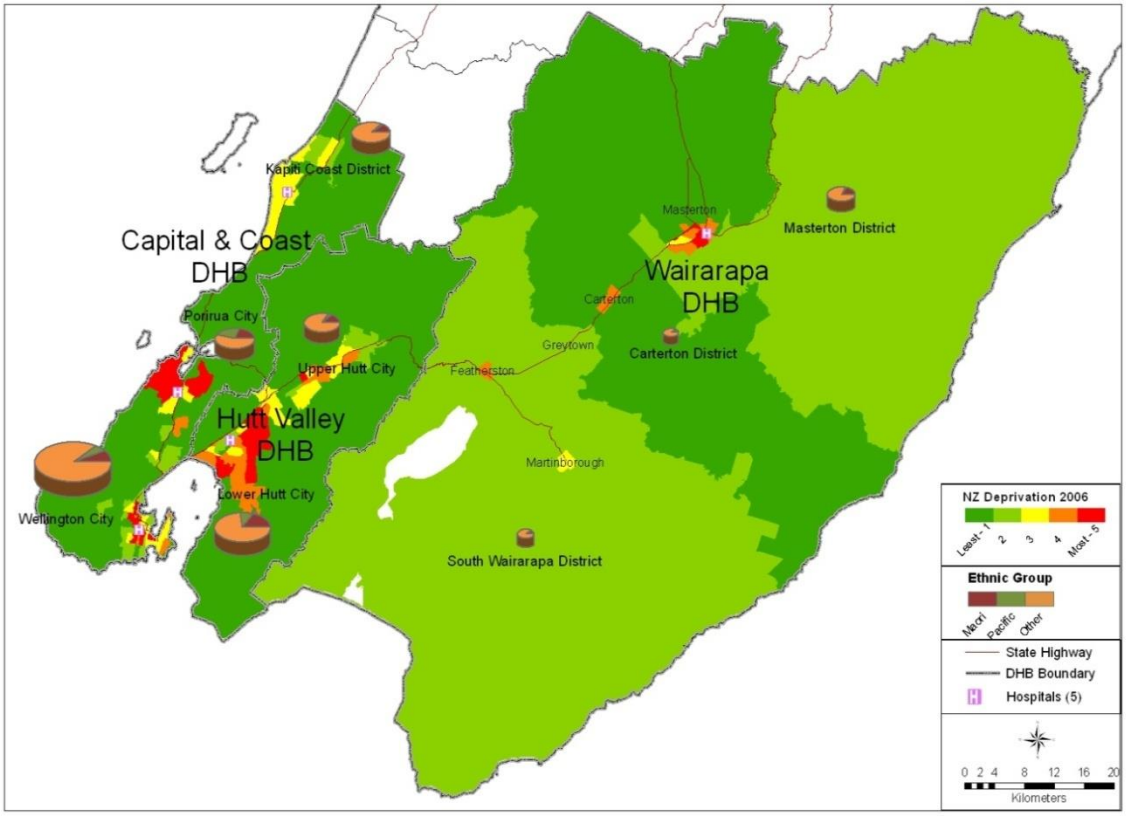
Services Plan, and in respect to contributing to national sector priorities such as the National Vulnerable Service Employment programme.

Population and Health Profile

Early results of the usually resident population from the 2013 Census show that growth has been higher in the Wairarapa than previous projections. Population projections at a DHB level based on the 2013 Census will not be available until mid-2014; therefore estimates based on the 2006 Census continue to be used.

The three DHB sub-region is home to nearly 11 percent of the national population in 2014 (487,930 people). The Wairarapa population is small (40,790 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. The Hutt Valley district (145,630 people) covers two Territorial Authorities (TAs): Lower Hutt City and Upper Hutt City. Capital & Coast is the seventh largest DHB in New Zealand, with a population twice that of Hutt Valley DHB (301,510 people) covering three TAs: Wellington City, Porirua City and the Kapiti Coast District south of Te Horo.

Figure 1: Map of 3DHB Sub-Region Population

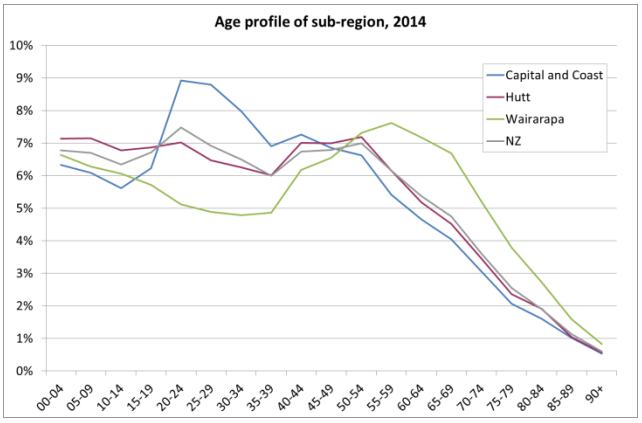


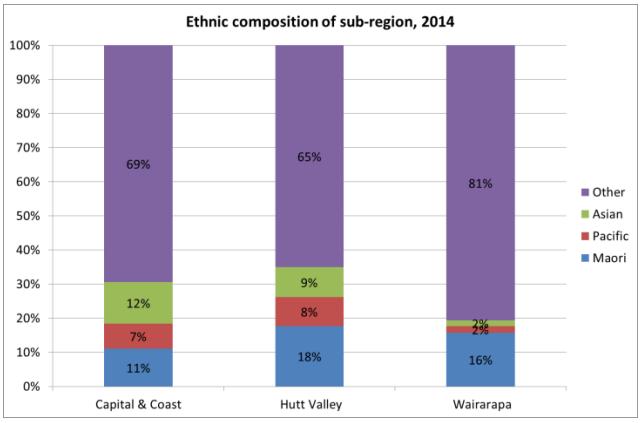
The Wairarapa population has a similar deprivation profile to the rest of New Zealand. However, there are areas of relatively high deprivation in Masterton and Featherston.

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

Overall, Capital & 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 and 42 percent living in quintile five areas 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).

Figure 2: 3DHB Age and Ethnicity Profiles





The most significant factor determining the health need of a population is age, with higher consumption of health resources as people age and develop more complicated needs and co-morbidities. In comparison to the national average Wairarapa and Capital & Coast have a smaller proportion of children whereas Hutt Valley's child population is greater. Capital & 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 & Coast has fewer than average.

The age profile varies significantly across the three Capital & Coast TAs whereas it is more similar across the Hutt Valley and Wairarapa. There are 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 Maori and Pacific affected at a younger age and experiencing a greater burden of long term conditions. The Maori populations of Wairarapa and Hutt Valley are higher than the national average of 15% whereas in Capital & Coast this is lower than average. There are significant Pacific populations living in both the Hutt Valley and Capital & Coast. Capital & Coast also has a large Asian population. The Maori 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

The groups identified below are expected to be higher users of health and disability services, and in 2014/15 the DHBs are continuing to focus on:

- *Ageing population and older people:* The proportion of older people in the population (including Maori) is increasing, resulting in escalating pressure on services for the elderly. This is set to continue over the next twenty years.
- *Disparities in Health Outcomes:* There are noted disparities in health outcomes for certain population groups, including Maori, Pacific Peoples, people living in high deprivation areas, and people who have a disability. These groups have poorer health outcomes, and for certain conditions have a higher burden of disease. To ensure people receive services when they need them, services must be accessible and acceptable. This addresses things such as cultural competency, physical access and cost and other barriers.
- *Maori health:* Many health conditions are more common for Maori adults than for other adults. These include ischaemic heart disease, stroke, diabetes, medicated high blood pressure, chronic pain and arthritis.[1] Maori have poor health outcomes across most indicators although differences are reducing for some areas such as immunisations and oral health. The leading causes of death for Maori adults between the ages of 25-44 were due to external causes such as car accidents and intentional self-harm (suicide). The leading causes of death for Maori adults aged over 65 were due to circulatory system disease or

[1] *The Health of Maori Adults and Children*, Ministry of Health, March 2013

cancer, with ischemic heart disease being the leading circulatory system disease. Each DHB has developed a Maori Health Plan (MHP), which sets out our intentions toward improving the health of Maori and their Whanau, and reducing health inequalities for Maori.

- *Lifestyle factors affecting health:* Lifestyle choices such as physical activity, healthy eating and not smoking can improve the health profile of individuals and the community as a whole. Maori have a lower prevalence of adequate fruit and vegetable intake, and Maori women have the highest percentage of smokers. Residents of the sub-region have lower levels of obesity than their New Zealand counterparts; however rates of physical activity have declined between 2006/07 and 2011/12 and are lower than the national average. In the sub-region there is a higher prevalence of hazardous drinking than our New Zealand counterparts[2].
- *Long term chronic conditions*: The burden of long term conditions continues to increase. Diabetes prevalence is increasing, with rates for Wairarapa at 5.1%, Hutt Valley 4.6% and Capital & Coast 3.8% as compared to a national prevalence of 4.9%[3]. Heart disease continues to be the leading cause of acute hospital admissions, and with increasing rates of obesity and physical activity further growth in diabetes and heart disease is expected. Respiratory conditions such as Asthma and Chronic Obstructive Pulmonary Disorder (COPD) also place a burden on patients. Management of these conditions is a focus of the DHB's work, particularly in the community. With an ageing population, the number of patients with multiple long term conditions will increase and these patients' health needs will become more complex.
- *Children and Young People:* While generally improving, health statistics for children in the sub-region are below national averages in some key areas. Children are more likely than adults to live in areas of high deprivation, they have high rates of hospitalisation and there are high and increasing child abuse notifications in the Wairarapa. Typically, children living in the most deprived areas have the poorest health status.

Population Change

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

Table 1: Population Profile

District	2014 population	2026 population	% change 2014-2026	% change average annual
Wairarapa	40,790	41,135	0.8	0.1
Hutt Valley	145,630	149,180	2.4	0.2
Capital & Coast	301,510	327,300	8.6	0.6
Sub-region	**487,930**	**517,615**	**6.1**	**0.5**

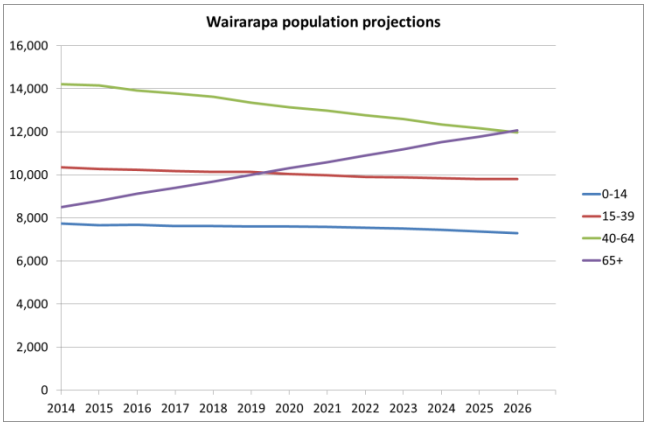
The sub-regional population is projected to increase an average 0.5% per year to 2026; slightly lower than national growth (0.8%). The growth is mostly going to occur in the Capital & Coast district (with Kapiti and Wellington the fastest growing areas) while modest growth is predicted for Hutt Valley and very little for Wairarapa (although Wairarapa population increased by approximately 6.5% from 2006 to 2013).

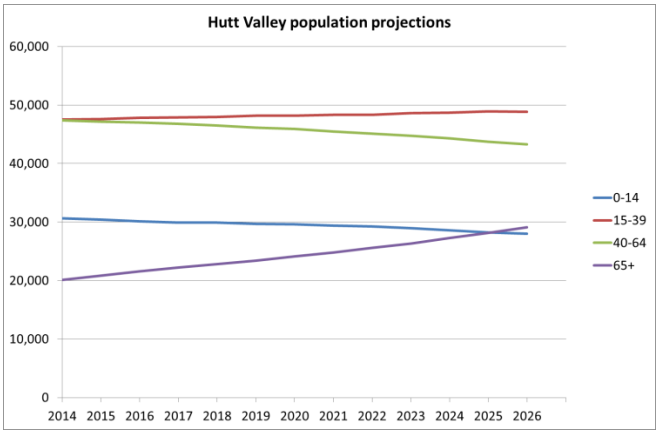
The Maori population of all three DHBs will increase and while significant Pacific growth is projected in Hutt Valley, very little is expected for Capital & Coast. The Asian populations across all three DHBs are projected to increase by around 30% between 2014 and 2026.

[2] Sub-regional data sourced from the New Zealand Public Health Survey 2011/12

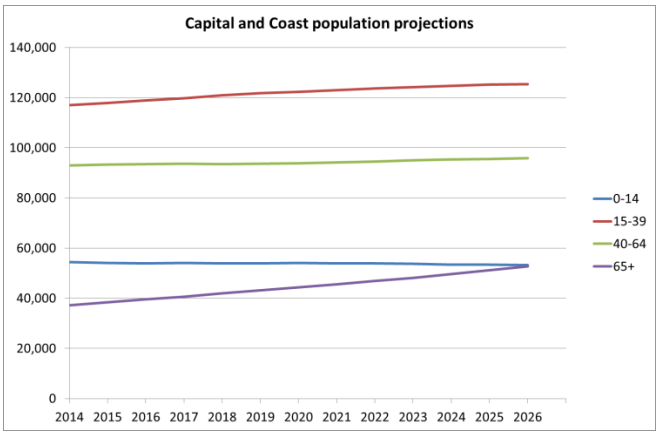
[3] *Virtual Diabetes Register,* Ministry of Health, 2011

Figure 3: Population Projections





The number of older people will increase by around 40% in each DHB between 2014 and 2026. As the number of people aged over 65 increases the sub-region 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. 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 2014/2015 the three DHBs will operate in an environment where the cost of service provision continues to stretch our financial resources. Individually, and collectively through the 3DHB work programme, the three DHBs have set an ambitious financial target across the sub-region which will require an acceleration of the efficiency changes already underway.

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 three years in either reducing deficits or eliminating the risk of significant budget blow-outs. Hutt Valley and Wairarapa DHBs have made significant progress in improving financial efficiency and sustainability limiting the financial risk to their organisations, while Capital & Coast has reduced its operating deficit of $60 million in 2008/09 to $10.8 million in 2012/13.

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 people's experience and quality of our services. This is continually 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 sub-regional population while accommodating the needs of local communities.

New Zealand Economy

The Government has indicated that the pre-2008 rate of growth in health funding is unsustainable. The health sector recognises the need to reduce expenditure and reconfigure services to improve efficiency and financial sustainability of services. The implications of this are:

- 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 three DHBs' Hospital services relative to our peers. All three DHBs will continue to look for efficiencies in all that they do.
- On-going 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. People want services suited to their needs, resulting in services evolving to be more patient-centred and culturally responsive. 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.

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 Alliance Leadership Teams and clinical governance processes, clinicians are regularly engaged in service prioritisation and development locally, sub-regionally and regionally.

1.2.3 Nature and Scope of Functions

The DHBs receive funding from the Government 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, broken into output classes and defined by the Ministry of Health as:

Prevention

- 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.

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 Maori 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.

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.

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 will provide support for individuals.

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 output classes used in our Statement of Performance Expectations (see Module 3).

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. While 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 three DHBs, Capital & Coast is the largest regional provider of 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 service it has provided. 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 sub-regional population.

The DHBs plan and purchase services through SIDU, with each DHB Board maintaining oversight in respect to services for their own communities. Each Board consists of eleven members (including the Chair), Hutt Valley and Capital & Coast DHBs 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. Dr. Virginia Hope is Chair of both Hutt Valley and Capital & Coast DHB Boards, and Dr. Derek Milne is Chair of the Wairarapa Board and Deputy Chair of the Capital & Coast Board.

A joint Community and Public Health Advisory Committee (CPHAC) and Disability Services Advisory Committee (DSAC) was established across the three DHBs during 2012/13. In addition to the statutory roles, this committee is now the key mechanism 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 for Wairarapa/Hutt Valley and one for Capital & Coast) to assist Boards in discharging their responsibilities. Additionally, each DHB has its own Maori Advisory/Relationship group, and Hutt Valley and Capital & Coast DHBs also have a sub-regional Pacific group. These forums are critical in assisting the DHBs to maintain a focus on improving access to services and outcomes for these populations.

The Sub-Regional Disability Advisory Group (SRDAG) was established in late 2013 to ensure people with disabilities have a forum to enable their voices to be heard across the Wairarapa, Hutt Valley and Capital & Coast DHBs. SRDAG advises the three Boards and their Board Advisory committees on public health matters and disability support, as the 3DHBs work in partnership to integrate their services, enabling people living within the sub-region to enjoy a seamless healthcare experience, regardless of their individual needs.

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. In each DHB the Alliance Leadership Team (ALT) provides oversight of the work programme. At Wairarapa, the integration programme is known as Tihei Wairarapa, while at Hutt Valley the group is Hutt INC (Hutt Integrated Network of Care) and Capital & Coast has the Integrated Care Collaborative (ICC).

1.3 Sub-regional Strategy

Over the past few years, Wairarapa, Hutt Valley and Capital & Coast DHBs have been working in an environment of increasing collaboration. The "3DHB" programme began in 2011 as a clinical services plan to address inequities in access, workforce recruitment challenges and increasing demand. In 2012 a Memorandum of Understanding (MoU) was signed by the Board Chairs of the three DHBs agreeing to aligning processes across the three DHBs and creating single units where appropriate. With the MoU in place, greater progress has been made, with the creation in late 2012 of the Service Integration and Development Unit, a single team for planning and funding services across the sub-region. In early 2013, a single Chief Executive was appointed across Wairarapa and Hutt Valley DHBs, with a combination of the executive teams being completed across the two DHBs as well. Across the three DHBs, a single appointee has been made for each Director of People and Culture, CIO, Executive Director of Corporate, and Director of Maori Health. In early 2014, the Maori Health Teams will be brought together to facilitate improved health gains for Maori across the sub-region.

The speed of integration across the DHBs has gathered pace, and the next step is single hospital services operating across multiple sites. In 2013 work has been undertaken to determine the patient journey and how a single service operating across multiple sites might function. The Clinical Pathways which are being developed in early 2014 will be a key enabler to establishing seamless services across the sub-region.

Alongside the horizontal integration occurring across the three DHBs, there has been vertical integration across the whole of the health system through the Alliance Leadership Teams (ALTs). Tihei Wairarapa started in 2011 and has succeeded in reducing acute demand in the Wairarapa as well as establishing a flexible funding pool to enable service devolution to primary care. The Hutt INC (Integrated Network of Care), formerly PSSG (Primary-Secondary Strategy Group), began in 2012 and has had successes reducing admissions for gastroenteritis and cellulitis, two of the leading causes of avoidable admissions. The ICC (Integrated Care Collaborative) at CCDHB has undertaken work on health care pathways for frail elderly, and through the Diabetes Care Improvement Plan enabled diabetes specialist nurses to work practices to improve their capacity to manage patients with diabetes. While good progress has been achieved through these

programmes so far, we need to accelerate the pace of change since we recognise that services are best delivered, where possible, by patients' regular clinicians close to home.

At the centre of this work is a focus on the patient and Whanau. We have to make sure the services we are delivering are the right services in the right places. In designing services and service delivery, we aim to provide healthcare equitably and accessibly. The DHBs employ the Health, Quality & Safety Commission's New Zealand Triple Aim for quality improvement:

Figure 4: HQSC Triple Aim

With this focus, we have created a sub-regional vision of **Healthy People, Families and Communities** which will be achieved through:

- preventative health and empowered self-care;
- provision of relevant services close to home; and
- quality hospital care and complex care for those who need it.

To deliver on this vision, the future sub-regional health system needs to be configured to provide the right mix of services to our populations and where possible closer to their homes; be both clinically and financially sustainable; adopt unified models of best practice that serve our populations well; develop a unified culture of working; and adopt a continuous improvement approach to our service delivery.

There are several organisational enablers which will help the DHBs achieve Healthy People, Families and Communities. These are:

- An active purchasing approach to service coverage and population health
- An organisational development approach that creates the best working and operating environment
- A system development approach that maximises efficiencies and minimises waste
- A quality and safety approach that improves patient outcomes and eliminates risk
- A governance and management approach that encourages innovation and enables positive change

Our strategic areas of focus are acute demand management, older people's health and well-being, health promotion and prevention, long term conditions management, and improved health equity. These are not exclusive and there are many other areas of focus with active work programmes relating to the Government's priorities.

Acute Demand

Acute demand is the level of need for acute services. This includes acute appointments with GPs, afterhours primary care, the Emergency Department, and hospital services.

Over the past five years, the numbers of presentations to the emergency department and acute admissions to hospital have increased across the sub-region, although Wairarapa has recently had success in reducing these through the Tihei Wairarapa integration programme. In setting acute demand as an outcome area the three DHBs are acknowledging the need for a whole of system approach to healthcare service design and delivery and the importance of preventative care. The DHBs are committed to undertaking work to improve integration across the sector in our sub-region.

Older Persons

When we use the term Older Persons, we are referring to the 65+ population, which will increase by 40% between 2014 and 2026 in our sub-region. This will affect the delivery of healthcare services, as demand for health services increases with age. In primary care, this can be seen in the fact utilisation rates are highest for the 65+ population, reflective of the need to have a medical home to address long term conditions and complexities. On the hospital end of the spectrum, patients 65+ currently account for between 40-50% of medical events in the three DHBs. In addition to being nearly half of admissions, patients 65+ utilise approximately 60% of medical bed days; this is unsustainable with a growing 65+ population.

The ageing population will place a burden on the healthcare system, and in setting Older Persons as an area of focus the three DHBs will have to be innovative and responsive to patients. Improved use of advanced care planning and end of life care will give patients ownership of their health decisions. Consistent with our previous strategic outcome of 'optimising the health, well-being and independence of our older people', we aim for services to enable the older population to be healthier with services being better, sooner, more convenient, and delivered closer to home where possible.

Health Promotion & Prevention

Health promotion and prevention is used to describe activity that provides the population with information on staying healthy, or services which keep people healthy such as immunisation. Regional Public Health delivers health promotion and prevention activities across Wairarapa, Hutt Valley and Capital & Coast DHBs. The Health Promotion Agency is a national entity tasked with promoting health and wellbeing, enabling health promoting initiatives and environments, and informing health promoting policy and practice.

A focus on health promotion and prevention will encourage people to take responsibility for their own health, and in taking better care of themselves through healthy eating, exercise and not smoking, improve their long-term health outcomes. If we impact positively on delivering health promotion and prevention we can assist our population to be healthier.

Long Term Conditions

Long term conditions are diseases which people, once diagnosed, typically have for the rest of their lives. These include cardiovascular disease (CVD), diabetes, asthma, and chronic obstructive pulmonary disorder (COPD). CVD and diabetes are related to lifestyle habits, and can be prevented through healthy diet and exercise. Asthma and COPD are environmental, influenced by damp, mouldy housing or exposure to smoke. Through providing smoking cessation advice and support to quit, and working across government agencies to improve housing insulation and avoid overcrowding, the health sector across the three DHBs can make a difference in preventing these conditions and helping those who have them manage their conditions.

With improved health prevention and promotion and high quality integrated services, fewer people will be diagnosed with long term conditions and patients with long term conditions will be enabled to better manage their health. In empowering patients to manage their own conditions, we will be delivering services that are the best for the patient.

Improved Health Equity

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and the current models of care. Maori and Pacific have consistently poorer health outcomes, and if services are not culturally competent patients can find it hard to access services or know how to manage their health. Regardless of where Maori and Pacific people wish to receive their services, the overall health sector must be culturally responsive to their needs. We acknowledge our responsibility to design and deliver services that are accessible not only in getting to the services, but also providing what the patient needs, including cultural needs. Patients experiencing disability can also have trouble finding services that are accessible and responsive to their needs. With an ageing population, the number of patients experiencing disability will increase and we need to deliver services that meet patients' needs. There are many social determinants of health such as income and housing. Those living in deprived areas require services that are low-cost and easily accessible, as they too experience poorer health outcomes. With an increasing amount of services being delivered for the ageing population and the pace of technological change, services targeted at children and youth need to be not only accessible but also responsive to what these patients require. Health promotion and prevention can be particularly focussed on children and youth to ensure long term health gains for our population.

In choosing improved health equity as one of our outcome areas, the DHBs see improving the accessibility and responsiveness of services integral to the patient experience and to patients being empowered to take responsibility for their own health. If we positively impact on improving health equity we will achieve health gains for all groups in our population and ensure equity of access across the three DHBs and all population groups.

To support the outcome of improved health equity across the three DHBs, a quarterly equity report is presented to the Community and Public Health Advisory Committee (CPHAC). The set of equity indicators were selected based on the following criteria: priority area – for both the Government and Boards; coverage across the life-course; ready availability of data; measures of both the process of health care delivery and health outcomes; and consistency with the existing Maori Health indicators set.

There are three "headline indicators", for which aspirational targets are set to drive improvement in equity in key areas. The headline indicators of the report are preschool enrolment in dental services, cardiovascular risk assessments in primary care (health target), and the rate of did not attend (DNA) hospital outpatient appointments. The headline indicator areas represent some of the major contributors to avoidable morbidity in both children and adults. They have been chosen because there are documented disparities relating to either the indicator itself or downstream outcomes (for example, with respect to CVD inequities in cardiac surgical interventions and mortality rates). They are key measures of effective access to community-based, primary and secondary healthcare services and are amenable to intervention by DHBs and PHOs.

1.3.1 Sub-regional Strategy Overview

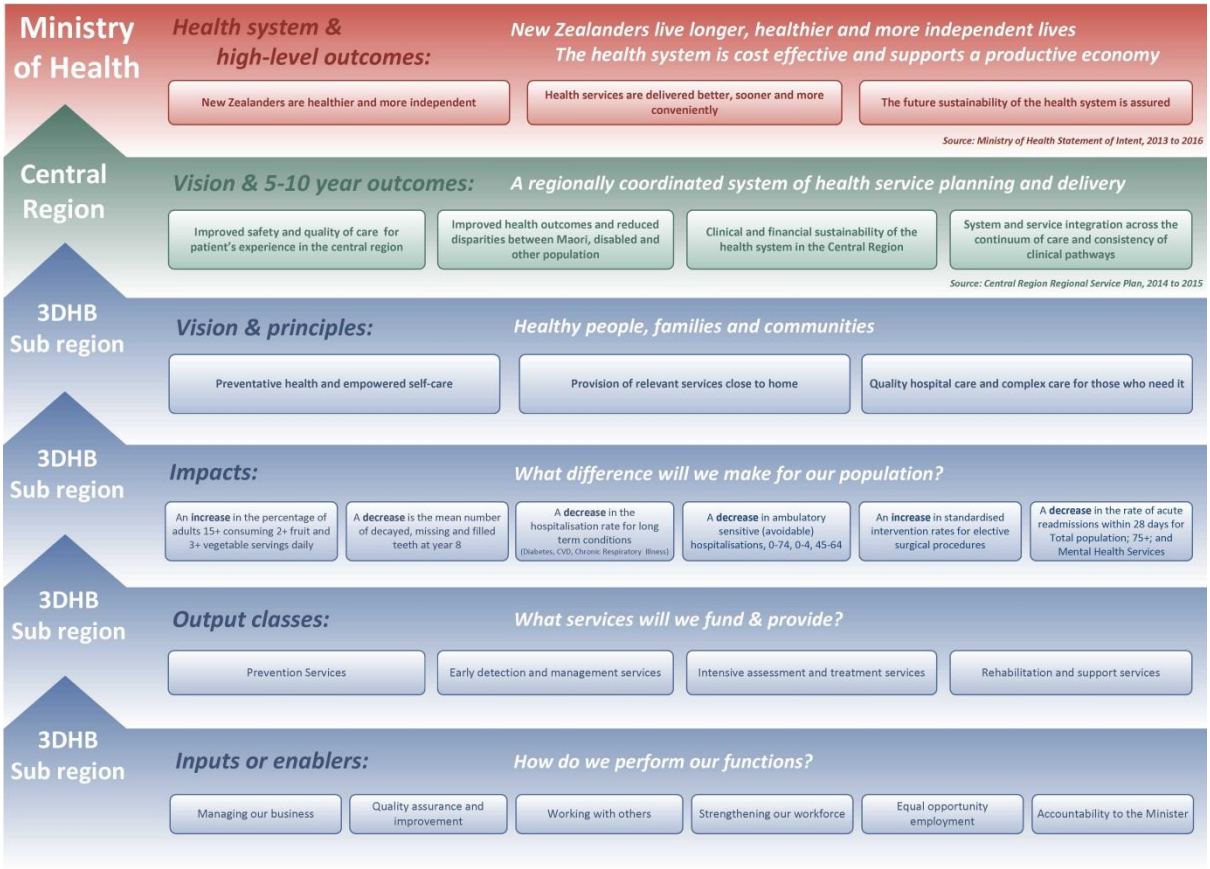
A way to present this strategy for our communities, patients, staff and partners in healthcare delivery is:

Table 2: Sub-regional Strategy

Sub-regional Vision	Strategic Areas of Focus	Through a system that	Enabled by
Healthy People, Families and Communities • preventative health and empowered self-care; • provision of relevant services close to home; • quality hospital care and complex care for those who need it	• Acute demand management • Older people's health and well-being, • Health promotion and prevention, • Long term conditions management • Improved health equity.	• Is configured to provide the right mix of services to our populations and where possible closer to their homes; • Is both clinically and financially sustainable; • Adopts unified models of best practice that serve our populations well; • Has developed a unified culture of working; • Adopts a continuous improvement approach to our service delivery.	• An active purchasing approach to service coverage and population health • An organisational development approach that creates the best working and operating environment • A system development approach that maximises efficiencies and minimises waste • A quality and safety approach that improves patient outcomes and eliminates risk • A governance and management approach that encourages innovation and enables positive change
Underpinned by Collective Values			

1.4 Strategic Graphic

To best depict how the sub-regional strategy interacts with the regional and national approaches, we have combined the sub-regional strategy with those of the RSP and Ministry of Health. This also shows how our work (outputs) and the impact on and outcome for our patients and populations link to the strategies. It is important to note that relationships are not one to one and there are a number of factors which can impact on health.



1.5 Sub-regional Impacts and Outcomes

Long-term outcomes are progressed not just through our work alone, but through the combined effects of all working across the health system and wider health and social services. Evidence about the state of our population's health and the environment in which they live helps us monitor progress towards our intended outcomes. As such, we identify performance indicators related to each outcome. Given the long-term nature of these outcomes, the aim is to make a measurable change over time rather than achieve a specific target. The information provided is the latest available at the time of publication; where possible this pertains to the 2012/13 year with a trend view.

The impacts are linked to output classes (as described in 1.2.3) and this is how measures are grouped in the Statement of Performance Expectations (Module 3).

1.5.1 Population health outcome: Improved Health Equity

What difference will we make for our population?

Overarching across the three components of our strategy is a focus on patient-centred care. This incorporates an outcome of improved health equity, to ensure the gains in health of our population are across all groups. Inequalities in access to and decisions over resources are the primary cause of health inequalities. Differential access to health services – and in the quality of care provided to patients – also contribute to unequal health outcomes. These structural inequalities may explain more of ethnic inequalities in health than is often recognised.

Although the overall Wellington sub-region has a relatively affluent, healthy population, there are pockets of deprivation concentrated in parts of Porirua, the south eastern suburbs of Wellington, parts of the Hutt Valley such as Naenae and Wainuiomata, and parts of Masterton. Over half of the Pacific population live in the most deprived areas and 29 percent of Maori live in the most deprived areas.

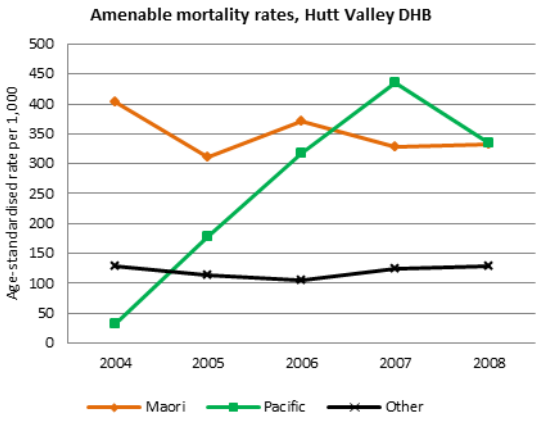
Maori and Pacific peoples die on average ten to fifteen years earlier than non-Maori non-Pacific, and experience significantly higher acute admission and avoidable mortality rates. Although access to some health care services has improved, outcomes often remain worse for Maori and Pacific. For example,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

Measures – The DHB measures progress through:

A reduction in amenable mortality rates for Maori & Pacific

- Amenable mortality is measured by identifying a set of conditions (causes of death) that can be prevented or treated by health care services. Premature deaths have been defined as deaths under 75 years of age.
- Maori and Pacific experience amenable mortality rates that are approximately three times the rate for non-Maori non-Pacific (2008 year).

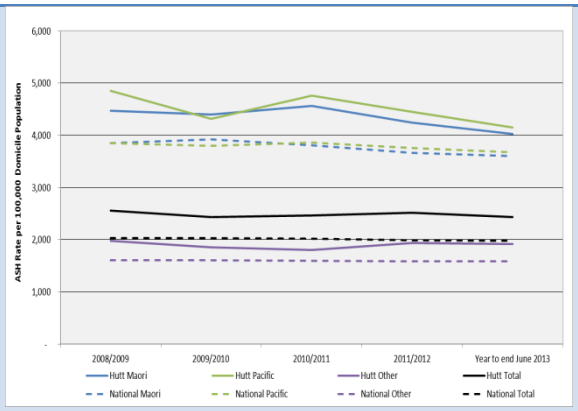
This measure links to the Early Detection & Management and Intensive Assessment & Treatment output classes.



A reduction in the ambulatory sensitive hospitalisation (ASH) rates (0-74)

- 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 ambulatory sensitive hospitalisations in the Hutt Valley is higher than the national rate for all groups. It 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.

This measure links to the Prevention Services and Early Detection & Management output classes.

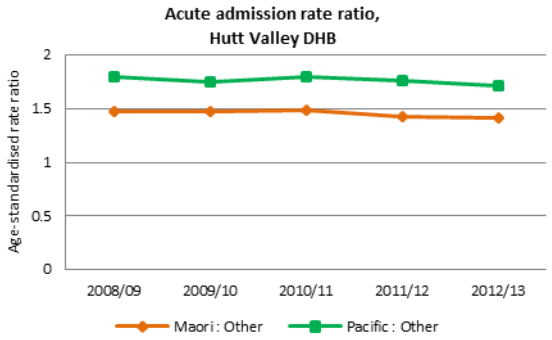


Source: Ministry of Health, 2013

A reduction in acute admissions for Maori & Pacific

- Maori are one-and-a-half times more likely to be admitted acutely to hospital than non-Maori non-Pacific.
- Pacific peoples are twice as likely to be admitted acutely to hospital as non-Maori non-Pacific.

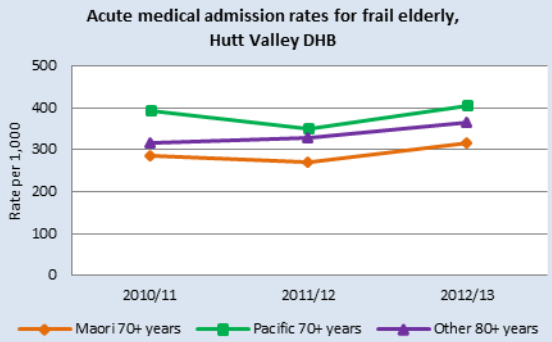
This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in acute medical admission rates for Maori and Pacific frail elderly

- The age groups have been set based definitions used in current programmes of work for frail elderly
- Rates of acute medical admissions are high across all groups and particularly for Pacific Peoples. Rates for Maori 70+ are declining, which is positive.

This measure links to the Rehabilitation & Support output class.



1.5.2 Population health outcome: Preventative Health

What difference will we make for our population?

Preventative health services provide the population with health literacy, or an understanding of how their daily choices affect their health, and protect the population to keep them healthy. Healthy eating, active living, and not smoking are some of the factors which can prevent diseases or poor health in the longer term.

Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disease, heart disease and strokes. Supporting the population to say no to tobacco smoking is an important opportunity to target improvements in the health of populations with high need and to improve Maori health.

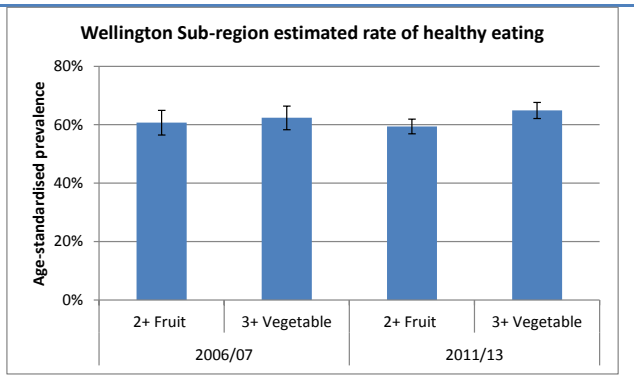
Current trends indicate sustained increases in obesity in New Zealand's adult population. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy. Supporting the population to maintain healthier body weight through improved nutrition and physical activity levels is fundamental to improving the health and wellbeing of the population and to the prevention of chronic conditions and disability at all ages.

Measures – The DHB measures progress through:

An increase in the percentage of adults 15+ 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.

This measure links to the Prevention Services output class.

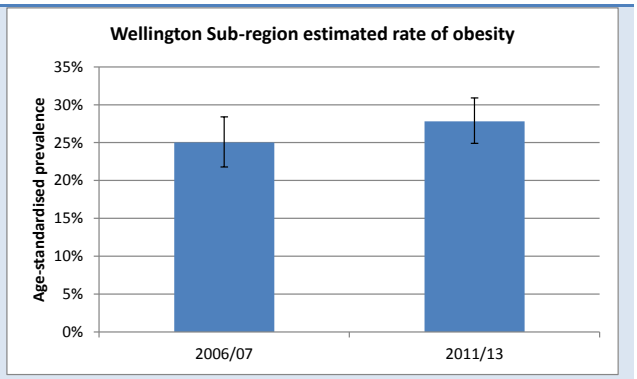


Source: NZ Health Survey, results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs

A reduction in obesity prevalence amongst the population 15+

- Obesity rates are increasing across New Zealand. With effective preventative measures, including people being more active and eating more healthily, obesity rates can be reduced. Reducing obesity rates will reduce the incidence of related preventable diseases, including diabetes and cardiovascular disease.
- There has been an increase in the estimated rate of obesity in the population. Work is ongoing to provide information on healthy eating and the benefits of an active lifestyle, to enable our population to live longer, healthier lives.

This measure links to the Prevention Services and Early Detection & Management output classes.

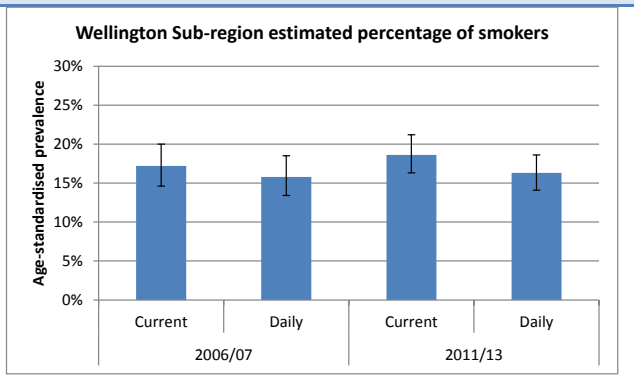


Source: NZ Health Survey, results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs

A reduction in smoking rates for the sub-region's 15+ population

- Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care.
- While the estimated prevalence of current smokers has increased in the sub-region's population, the rate of daily smokers has decreased. It is anticipated over time, with reduced uptake of smoking as teenagers, that overall smoking rates will decrease.

This measure links to the Prevention Services output class.

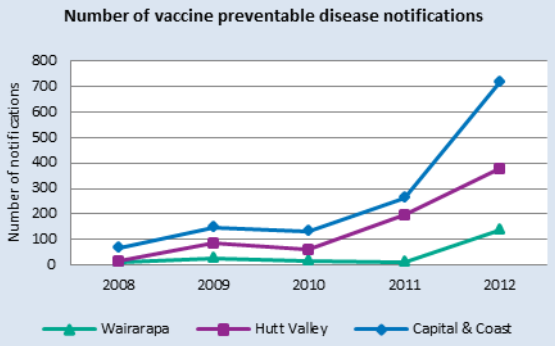


Source: NZ Health Survey, results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs

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.

This measure links to the Prevention Services and Early Detection & Management output classes.



Source: Environmental Science & Research surveillance reports

1.5.3 Population health outcome: Preventative Health: Improved child and youth health

What difference will we make for our population?

Outcomes for the current generation of children and young people will determine the future success or failure of the community and society as a whole. The relatively short periods of time which gestation, infancy, childhood and adolescence occupy have more power to shape the individual than much longer periods of time later in life.

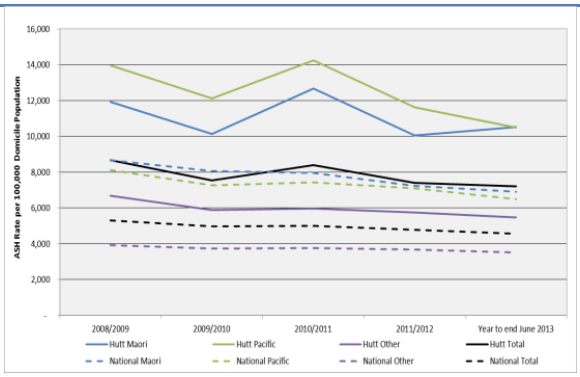
The health status of young people and expectant mothers is most strongly influenced by environmental determinants of health outside of the services the DHB provides. However the DHBs have a focus on influencing change that supports healthier environments; on ensuring younger populations have a healthy start to life; and on addressing the inequalities between population groups to improve overall population outcomes.

Measures – The DHB measures progress through:

A reduction in ambulatory sensitive hospitalisations of children (0-4)

- Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.

This measure links to the Prevention Services and Early Detection & Management output classes.

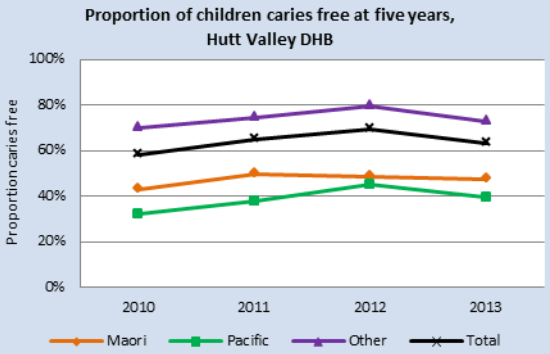


Source: Ministry of Health, 2013

Increased proportion of children caries free at five 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.

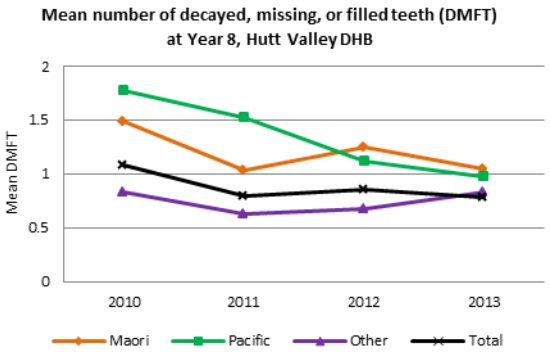
This measure links to the Early Detection & Management output class.



Decrease in the mean number of decayed, missing or filled teeth (DMFT) at Year 8

- Maori 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.
- The DHB has a declining trend in the mean number of decayed, missing or filled teeth, which is good. The 2012 mean DMFT for all ethnicities is below the national mean of 1.16.[4]

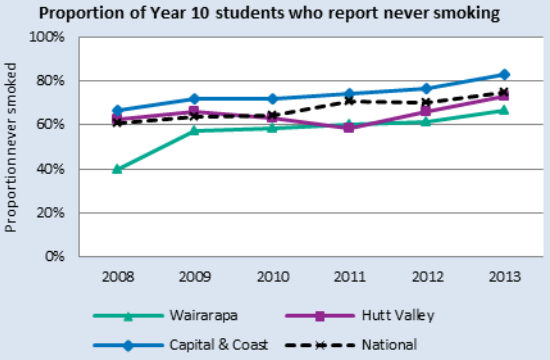
This measure links to the Early Detection & Management output class.



An increase in the proportion of year 10 students 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.
- A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.
- There is an increasing trend of Year 10 students who report never smoking.

This measure links to the Prevention Services output class.



Source: Action on Smoking and Health Year 10 Survey

[4] 2013 National results not yet available.

1.5.4 Population health outcome: Empowered Self-Care

What difference will we make for our population?

The impact of long-term conditions in terms of quality of life and cost to the health system is significant. Early diagnosis and intervention and improved disease management provide major opportunities for improving health outcomes; particularly for Maori and Pacific people, who have disproportionately higher rates of many long-term conditions.

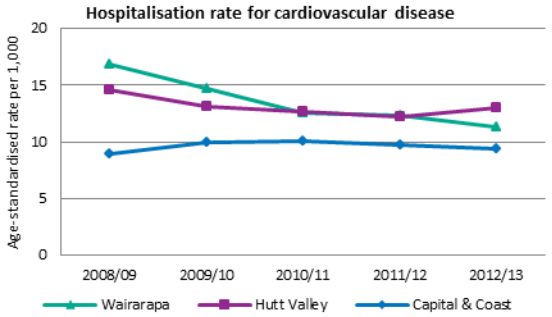
Empowering people to manage their long-term conditions and seek appropriate intervention early will result in a reduction in the proportion of the population seeking urgent care or requiring acute admission to hospital. Improving access to alternative pathways of care will ensure people are being given the right treatment in the right place; improving health outcomes, reducing pressure on hospital resources and enabling investment in other priority areas.

Measures – The DHB measures progress through:

A reduction in the hospitalisation rate for cardiovascular disease (CVD)

- Cardiovascular disease (CVD) includes heart attacks and strokes - which are both substantially preventable with lifestyle advice and treatment for those at moderate or higher risk.

This measure links to the Prevention Services and Early Detection & Management output classes.

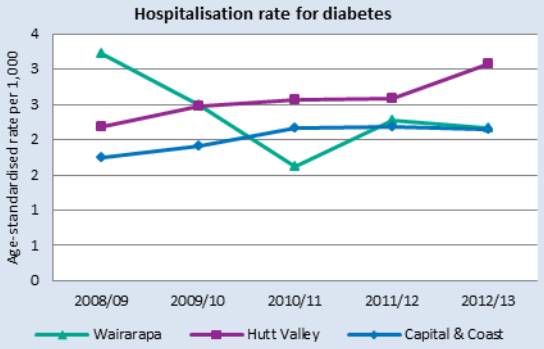


Source: National Minimum Dataset

A reduction in the hospitalisation rate for diabetes

- Diabetes is defined by the body's inability to control blood glucose. Diabetes is a chronic condition, which can cause kidney failure, eye disease, foot ulceration and a higher risk of heart disease if not well managed.
- Supporting people to manage their diabetes well reduces acute admissions to hospital.
- The number of diabetics has been increasing at a rate of approximately 8% a year. While the aim is to reduce diabetes hospitalisations, given the rate of increase in the number of diabetics, the maintenance of the hospitalisation rate over 2011/12 and 2012/13 is positive.

This measure links to the Prevention Services and Early Detection & Management output classes.

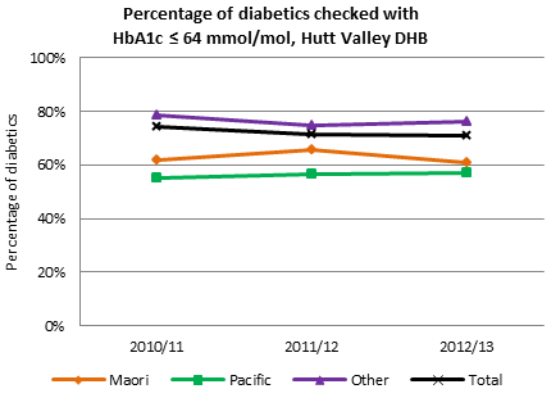


Source: National Minimum Dataset

Increased proportion of diabetics checked with satisfactory or better blood glucose control (HbA1c less than or equal to 64 mmol/mol)

- Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as lower limb amputation, kidney failure and blindness, and will improve people's quality of life.

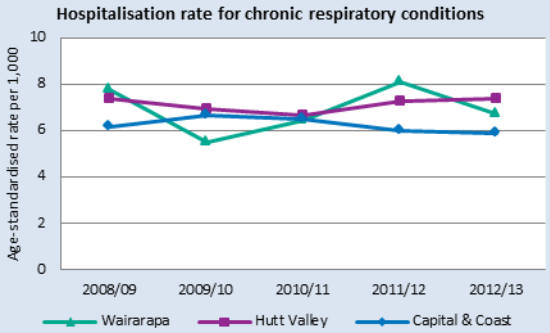
This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in the age standardised hospitalisation rate for chronic respiratory conditions

- The most common chronic respiratory conditions include asthma and chronic obstructive pulmonary disorder (COPD).
- With improved management of chronic respiratory conditions, those with these conditions can have better health and reduced hospital admissions from acute episodes and complications.

This measure links to the Prevention Services and Early Detection & Management output classes.



1.5.5 Health Services Outcome: Services Closer to Home

What difference will we make for our population?

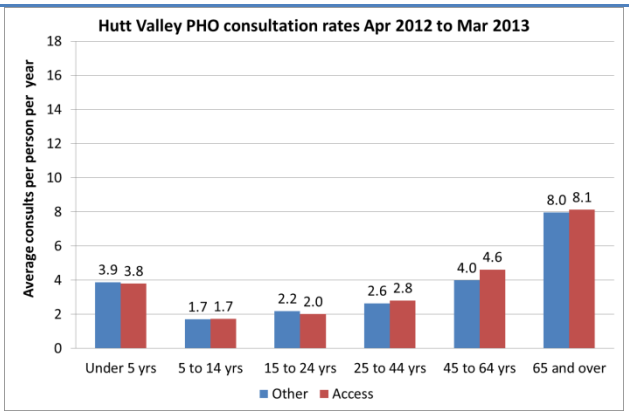
We are working to better integrate health services across the continuum to better provide the services patients require closer to their homes. When services are delivered closer to the patient's home they can better access services and have a relationship of trust with their regular GP, nurse or other clinician. This allows patients to use services when they need them and empowers them to manage their health.

Measures – The DHB measures progress through:

The utilisation rate of primary care by age group[5]

- When people are able to access primary care when they need it, they can receive treatment earlier, have better continuity of care, and sometimes even prevent a hospital admission. Improved utilisation of primary care appropriate to the needs of the age group reflects patients' ability and willingness to visit their medical home of primary care for their medical treatment.

This measure links to the Early Detection & Management output class.

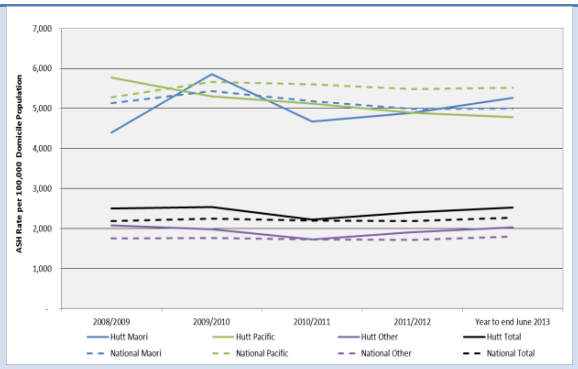


[5] Data for year to March 2013.

A reduction in ambulatory sensitive hospitalisations of adults (45-64)

- Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.

This measure links to the Prevention Services and Early Detection & Management output classes.

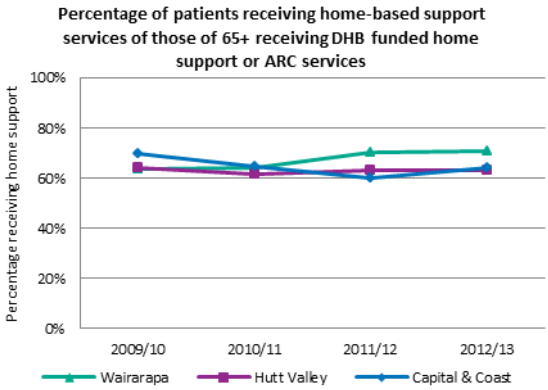


Source: Ministry of Health

Maintain or increase the proportion of patients receiving home based support services of those 65+ who receive DHB funded home based support or aged residential care services

- When people receive the adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities.

This measure links to the Rehabilitation & Support output class.



1.5.6 Health Services Outcome: Quality hospital care and complex care for those who need it

What difference will we make for our population?

Improved patient-focused, clinically driven pathways will provide the flexibility for early intervention and planned readmission where clinically appropriate, and will support improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to establish more stable lives.

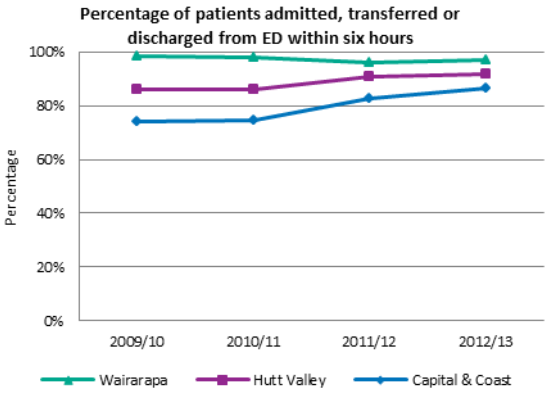
Overseas experience shows that systemic changes to the way care is offered to patients can lead to measurable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia, and hospital-acquired infections in patients.

Measures – The DHB measures progress through:

The percentage of patients admitted, transferred or discharged from the Emergency Department within six hours

- Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through DHB services. It also demonstrates a commitment to addressing the needs of patients and valuing their time.
- Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through management of acute demand in the community, improved capacity in ED and supported discharge into services in the community.

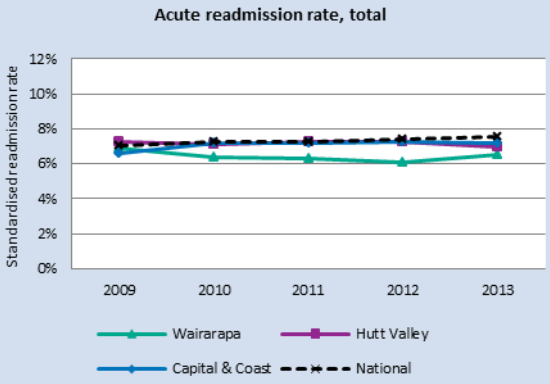
This measure links to the Intensive Assessment & Treatment output class.

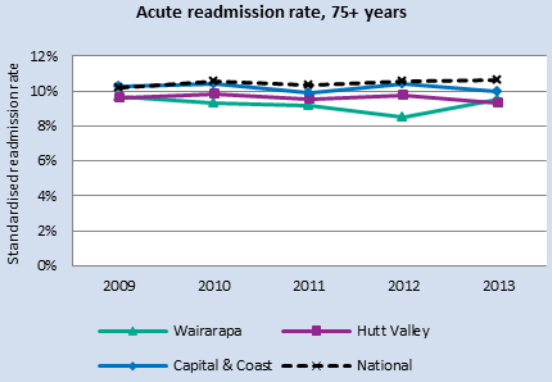


A reduction in the standardised rate of acute readmissions within 28 days, Total & 75+

- 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 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[6]

This measure links to the Intensive Assessment & Treatment output class.





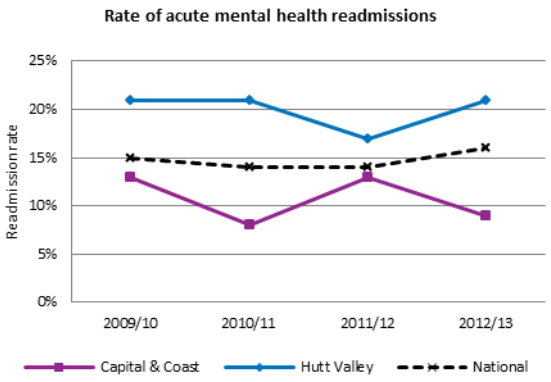
Source: Ministry of Health

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

A reduction in the rate of acute readmissions within 28 days to Mental Health Services

- 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.

This measure links to the Intensive Assessment & Treatment output class.

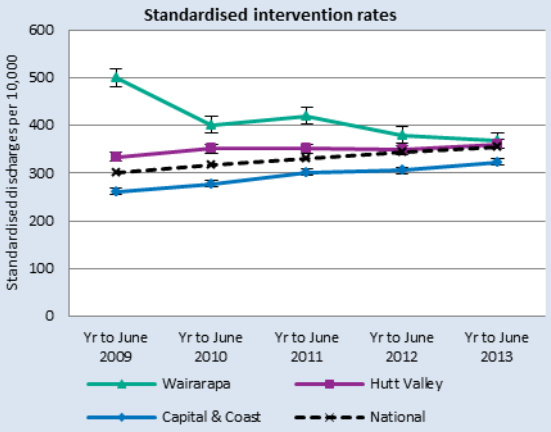


Source: National Mental Health Key Performance Indicators

Maintain or increase standardised intervention rates (SIR) for elective services

- One of the areas of focus for elective services is the level of service being provided to the DHB's population (as measured by Standardised Intervention Rates), and the level of service being provided for identified key conditions, including cardiac procedures, major joint replacement and cataract procedures.
- As standardised intervention rates for the Wairarapa have been historically high, by more closely aligning to the national average the DHB is ensuring the sustainability of its services into the future.

This measure links to the Intensive Assessment & Treatment output class.



1.6 Other Key Plans

1.6.1 Maori Health Plan

The DHB has developed a Maori Health Plan (MHP), which sets out its intentions toward improving the health of Maori and their Whanau, and reducing health inequalities for Maori. The plan has been developed in line with Ministry of Health requirements and is available on the DHB's website.

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

1.6.2 Sub-regional New Zealand Disability Strategy Implementation Plan 2013-2018

A Sub-regional Disability Forum in June 2013 led to a community mandate for a sub-regional approach to disability planning and a renewed energy for improving health outcomes for all who experience disability irrespective of age, ethnicity, gender or locality. The outcomes of the forum have laid the foundation of the

Sub-regional New Zealand Disability Strategy Implementation Plan. The plan implementation will be overseen by a newly appointed Sub-regional Advisory Group which will link into CPHAC and DSAC and support the Executive Leadership Teams in each DHB. The plan is available on each DHB's website.

1.6.3 Regional Public Health (RPH) Plan

RPH is a sub-regional public health service, serving the populations of Wairarapa, Hutt Valley, and Capital & Coast DHBs. Because many of the strongest influences on health and wellbeing come from outside the health sector, RPH provides services that are coordinated with other sectors such as social, housing, education, and local government sectors, as well as coordinating with other health sector providers. The complete RPH plan is available on the RPH website, www.rph.org.nz .

1.6.4 Regional Services Plan

The Regional Services Plan (RSP) outlines the work to be led by Central Region Technical Advisory Services (CTAS) for Wairarapa, Whanganui, MidCentral, Hawkes Bay, Hutt Valley and Capital & Coast DHBs. The activities in the Regional Services plan are based on Ministry and Central Region priorities, and are those which allow for the greatest gains if done regionally. Local activity based on the Regional Services Plan will be identified in this Annual Plan with "**Regional Alignment:** Refer to Regional Services Plan".

Module 2: Delivering on Priorities and Targets

This section sets out our key activities, actions, and outputs for 2014/15 to deliver on each of the priorities outlined in the Minister's Letter of Expectations, Health Targets, and other priorities identified in Module 1. These are presented in the tables in this module. They have been developed with our primary care partners, through our Alliance Leadership Team process, with our sub-regional DHB colleagues, and our Maori relationship groups.

2.1 Priorities and Targets

2.1.1 Implementing Government Priorities

The Ministry of Health and DHBs are charged with giving effect to the overarching goal for the health sector of Better, Sooner, More Convenient (BSMC) health services for all New Zealanders, including Better Public Services. Key principles that are foundational to planning in order to achieve BSMC services are:

- using an alliancing approach to service planning in which Alliance Leadership Teams involving the appropriate primary/secondary clinicians and primary/secondary managers jointly agree service priorities along with appropriate funding levels. Refer to the new PHO Services Agreement and Alliance Agreement which took effect 1 July 2013.
- using a whole of system view to determine the most efficient model of service delivery. Ensuring service planning is not done in silos, including using alliancing principles to jointly plan and agree service models with appropriate stakeholders for other services (e.g. community clinicians and NGOs)[7]
- providing a model of care that incorporates a range of 'hospital' services to be delivered within community/primary care settings
- active engagement of 'front-line' clinical leaders/champions in health services delivery planning across the sector at both local and regional levels
- integrating/coordinating clinical services to provide greater accessibility and seamless delivery
- strengthening clinical and financial sustainability
- making better use of available resources
- ensuring total population measures and targets are applied to all ethnic groups and that all targets and measures replicated in any other plans (e.g., Maori Health Plans) are consistent with those in APs and RSPs.

Four important policy drivers have been identified through which the health sector may best utilise resources to achieve BSMC services:

- **Better Public Services (including Social Sector Trials)**: The Government's Better Public Services targets and the Social Sector Trials will help drive this integrated approach that puts the patient and user at the centre of service delivery. DHBs are expected to work closely with other sectors such as education and housing

[7] Refer to the Alliance Leadership Charter for a description of alliancing principles.

specifically to improve the child immunisation rate, reduce the rate of rheumatic fever, deliver the Prime Minister's Youth Mental Health Project and the Children's Action Plan.

- **Regional collaboration:** DHBs working together more effectively, whether regionally or sub-regionally.
- **Integrated care:** both clinical and service integration, to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home.
- **Value for Money:** is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

2.1.2 2014/15 Minister's Letter of Expectations

Government priorities are presented in the Minister's Letter of Expectations. The areas of priority focus are:

Health Targets

1. Shorter Stays in Emergency Departments
2. Improved Access to Elective Surgery
3. Shorter Waits for Cancer Treatment/ transitioning to Faster Cancer Treatment
4. Increased Immunisation
5. Better Help for Smokers to Quit
6. More Heart and Diabetes Checks

Better Public Services (including Social Sector Trials)

- Reducing Rheumatic Fever
- Prime Minister's Youth Mental Health Project
- Children's Action Plan
- Whanau Ora

System Integration

- Diabetes and Long Term Conditions
- Stroke
- Acute Coronary Syndrome (ACS)
- Improved Access to Diagnostics
- Faster Cancer Treatment
- Cardiac
- Primary Care
- Health of Older People
- the Mental Health Service Development Plan
- Maternal and Child Health

National Entity Priority Initiatives

- Health Benefits Limited (HBL)
- Health Workforce NZ (HWNZ)
- Health Quality Safety Commission (HQSC)
- National Health IT Board
- Health Promotion Agency (HPA)
- PHARMAC

Improving Quality

Actions to Support Delivery of Regional Priorities

Living Within Our Means

2.2 Better Public Services and all of Government Initiatives (including Social Sector Trials)

Context

Across the three DHBs, there is an increased focus on working with children and young people to support long term outcomes of improved health and wellbeing for our population. We are increasingly aiming for:

- Early intervention to prevent disease e.g. focus on immunisation and primary mental health services for youth
- Ensuring treatment is as close to home as possible e.g. increasing services available in the primary care setting
- Working with our intersectoral partners to ensure people receive services from the most appropriate provider and, where possible, minimise duplication of services by different entities. In the Wairarapa and Porirua we are working with the Social Sector Trials to improve health outcomes by taking an intersectoral approach. We are also focussing on early treatment of sore throats to prevent rheumatic fever across the sub-region.

Objectives

A system that provides Better Public Services is one that has:

- Fully immunised children
- More responsive mental health services for youth
- Early identification and support for vulnerable children
- Decreasing incidence of rheumatic fever.

2.2.1 Increasing Immunisation (Health Target)

Area	Actions	Indicators of Success
Increased Immunisation (Health Target)	Sub-region • Actions to support increasing infant immunisation rates (six weeks, three months and five months immunisation events) from 90 per cent of eight-month-olds to 95 percent by December 2014: o maintain an immunisation steering group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit; and that participates in regional and national forums o work with primary care partners to monitor and increase new born enrolment rates to 100% o In collaboration with primary care stakeholders develop systems for seamless handover of mother and child as they move from: maternity care services to general practice and WCTO services • A project to design a sub-regional system of enrolment to publically funded infant services is occurring in 2013/14. Recommendations for a sub-regional newborn enrolment system will be delivered June 2014, with implementation to follow as is feasible. Enrolment is targeted to B-enrol, NIR, WCTO, Oral health, BCG, and NBHS. **Refer** to 2.3.2 Maternal and Child Health • In 2013/14 HVDHB and CCDHB PHOs discussed devolving NIR administration and governance to primary care and made a joint decision to review NIR administration and immunisation related services in 2014/15. A sub-regional review will be undertaken of all immunisation related services to ensure the configuration of services continues to contribute to increasing immunisation rates.	• 95% of eight month olds fully vaccinated by 31 December 2014. • 98% of newborns are enrolled with general practice by three months • 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) • Narrative report on DHB and interagency activities to promote immunisation week

	Hutt Valley DHB • The DHB monitors and evaluates immunisation coverage through the reports provided by the MoH, running NIR reports, running overdue reports every 6 weeks, these are posted to the practices. The DHB also works with the PHOs and their Outreach teams if the reports indicate that a practice is struggling. • The NIR administrator checks daily on the immunisation status of the children in the paediatric ward. If any of the children are overdue the ward is notified and asked if the child can be immunised prior to discharge. There is also staff education and updates. • The DHB will work with NGOs through maintaining working relationships with First start in Taita, and PHOs and OIS to promote immunisation in our community. The DHB will work with WINZ to provide information to the staff so that they have the knowledge to support their clients' immunisation. The DHB will hold quarterly meetings with stakeholders (e.g. includes all WCTO providers), asking them for agenda items to be discussed around the table. We provide feedback at these meetings from the Immunisation co-ordinator, NIR, SBVS and OIS. There are also guest speaker (e.g. Med Officer of Health) presentations on relevant topics, e.g. Flu. Rotavirus. • Immunisation meetings are held quarterly, chaired and co-ordinated by the regional Public Health Immunisation team.	• 95% immunisation coverage at 8 months and 2 years is attained. • Decision on location of NIR administration for sub -region • All children attending hospital are up to date with immunisations. • Intersectoral collaboration leads to improved immunisation coverage.

2.2.2 Prime Minister's Youth Mental Health Project

Area	Actions	Indicators of Success
Improve responsiveness and accessibility of youth mental health services (Prime Minister's Youth Mental Health Project)	Sub-region **Youth Health Service Level Alliance** SIDU in partnership with its key youth health primary care providers will develop a Youth Health Service Level Alliance to oversee development of work to Improve responsiveness and accessibility of youth mental health services (Prime Minister's Youth Mental Health Project) and determine local needs and agree service provision and funding. The Youth Health Service Level Alliance will oversee the implementation of the following during 2014/15: • Youth Health Primary Care Workforce Development Plan • Youth Clinical Pathways (subject to prioritisation by HealthPathways Programme) • Quality Improvement Measuring Outcomes Framework **Youth Health Primary Care Workforce Development Plan** Develop a Youth Health Primary Care Workforce Development Plan, to build primary health workforce capacity and capability in responding to youth health issues. Focusing on: • Improving youth mental health and AOD identification and intervention • Work with PHOs and practices to make practices more youth-friendly • Combining training resources across the sub-region and train a wider range of health professionals on youth health issues. • Integrating training to ensure those working in NGOs, general practice, DHB provider arms and youth speciality services have the opportunity to learn from each other. • Building the youth health workforce and the number of trained youth specialist health professionals • Developing strategies to retain competent staff	Youth Health Primary Care Workforce Development Plan by December 2014 Quantify some development e.g. primary mental health workforce by 30 June 2015 National plans for implementation of phased waiting time targets that by 2015 will enable: • 80 percent of youth to access mental health and Youth AOD services within three weeks; • 95 percent to access mental health and Youth AOD services within eight weeks of contact. Clinical Pathways for three youth services (subject to prioritisation by HealthPathways Programme) Improve the follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction

Area	Actions	Indicators of Success
	• Developing career pathways in youth health • Developing a workforce that is able to meet the needs of Maori and Pacific young people • Improving access to training and post graduate study within the sub-region **Youth Clinical Pathways (subject to prioritisation by HealthPathways Programme)** Development of localised youth health clinical pathways as a mechanism for identifying services, referral mechanisms, service specifications and more usefully identify gaps and boundary issues and issues at the interface, e.g. rheumatic fever, primary mental health Identification of points of access in the community and development of referral systems into the primary mental health service, to ensure comprehensive coverage for all youth within the DHB region including a clear two-way system between SBHS and the primary mental health service. **Quality Improvement Measuring Outcomes Framework** Develop and implement an outcomes evaluation framework for youth health e.g. the framework being developed within Kapiti Youth Support YOSS. **Improve access to mental health and Youth AOD services through wait time targets and integrated case management.** CCDHB is currently undertaking a wait-time project to map the referral process starting from when the referral is processed by Te Haika (single point of entry) and ending with the first face to face CAMHS contact and ascertain whether delays are present in the current referral system. Recommended actions will be identified using PDSA (plan do study act) cycles. Service redesign across the 3DHBs to consider the continuum of care will be progressed to support this outcome. To deliver this outcome DHBs will ensure key NGO stakeholders involved in service redesign initiatives. **Review and improve the follow-up care for those discharged from mental health and Youth AOD services** Currently the Werry Centre is developing guidelines for Child and Adolescent Mental Health Services to use when discharging young people from mental health services. The below actions will be undertaken using the Werry Centre guidance when available. To improve the follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services, the DHBs with an alliancing approach, will: • Define client pathway for this group of youth and determine associated assessments and follow up care with an agreed primary care provider • Define the components of a discharge plan including follow-up and re-engagement processes • Collect baseline data of the percentage of youth discharged from mental health and Youth AOD services into primary care being provided with follow-up care plans, by 30 June 2015 - monitored via the audit process • Work with primary care providers to ensure that the discharge plan can be activated within 3 weeks	(Improvement to be monitored by the Youth Health Service Level Alliance) • Improved follow-up care for those discharged from mental health and Youth AOD services. • Mental Health providers from primary and secondary services attending Strengthening Families, Youth Offending Team, and High and Complex Needs meetings, participating in Gateway Assessments and the functions of the Children's Action Plan. • Te Whare Marie are using the CAPA approach • Improved services for Maori and Pacific populations who choose to use mainstream services.

Area	Actions	Indicators of Success
	• Explore opportunities to ensure clients can access primary care for follow up in a timely and accessible manner (e.g. to remove cost, transport barriers) • Ensure services are youth friendly, have staff experienced working with youth, culturally competent and provided to meet the health needs of Maori and Pacific populations. • Participate in centrally facilitated processes to improve coordination between health, education, child youth and family and other intersectoral partners. • Develop jointly agreed transfer of care processes with primary care • Improve follow up care for those discharged from mental health and Youth AOD services • Improve data collection systems. • Improve access to mental health and Youth AOD services through wait time targets and integrated case management. • Follow-up care plans should be provided with the expectation that they are activated by the primary care provider within three weeks of discharge from secondary services. • Ensuring services are culturally competent and provided to meet the health needs of Maori and Pacific populations **Refer** to 2.3.3 Mental Health and Addiction Service Development Plan	
	Hutt Valley DHB **Support the Alliance Leadership Team – Hutt INC** Support the Alliance Leadership Team Hutt INC to implement its work programme with the objective to improve the responsiveness of primary care to youth. Hutt INC is establishing a mental health workstream, with the first initiative being a discharge planning project which will cover adult and youth service users. The Mental Health Discharge Planning (Adult and Youth) Project aims to smooth transitions and improve outcomes for adult and youth service users discharged from secondary mental health services to primary care through clearer information, increased collaboration and integration across the mental health sector, and to increase confidence for all involved. Support youth health pathway development and implementation; tailor for Hutt Locality (TeAHN and VIBE); identify issues that will be needed to provide follow up to issues Once pathway is developed, facilitate training and upskilling of general practice staff (GPs, practice nurses, community health workers) in youth health responsiveness, tools, referrals to and from other services (VIBE, School health, specialists services) Improve access for primary care to specialist youth health advice, included adolescent physician and adolescent psychiatrist Increase enrolment of young people with general practice and monitor uptake Support further youth mental health service delivery as new funding becomes available, and ensure services are responsive to Maori and Pacific young people	**Hutt Valley DHB**

2.2.3 Children's Action Plan

Area	Actions	Indicators of Success
Protect our children through the Children's Action Plan	Sub-region **3DHB Governance Arrangements -** Implement governance arrangements and engagement processes across the 3 DHBs and with primary and community partners regarding implementation of the Children's Action Plan. **Actions** • Complete the stocktake of services for vulnerable pregnant women, children and parents across the care continuum for the 3 DHBs identifying service coverage, wait times, capacity issues and gaps. • Develop a service development plan utilising the stocktake to inform the steps that will be taken towards ensuring the right mix and intensity of services to support vulnerable pregnant women, children and parents. • Link service planning with the implementation of the Mental Health and Addiction Service Development Plan and Healthy Beginnings: Developing Perinatal and Infant Mental Health Services • Review process to ensure the identification, assessment and referral responses to vulnerable children and their families through Violence Intervention Programmes (VIP) in designated services: child and maternal health, alcohol and drugs, mental health, sexual health and emergency department • Ensure Family Violence Intervention Guidelines: Partner and Child Abuse and resources are incorporated into DHB programmes, and activities, including intersectoral collaboration for integration of safety planning for vulnerable families across primary, community and acute health services • Continue to progress the VIP training role out to DHB professionals to recognise signs of abuse and maltreatment in designated services, coordination of partner abuse and child abuse and neglect programmes to support increased identification of vulnerable children. Planning VIP training role out to primary care will also be undertaken. • Renew and review the Memorandum of Understanding (MOU) with Child Youth and Family, Police and DHBs for interagency collaboration for child protection and Schedules 1 and 2 to support better integration across health and social services for vulnerable families. The MOU would become a 3DHB agreement. • Complete the Vulnerable Pregnant Women clinical pathway project and implement across the sub-region. • Complete implementation of the National Child Protection Alert System (NCPAS) and workforce training by October 2014 across all three DHBs • Increased identification of vulnerable pregnant women may impact on referred services • Review current Shaken Baby Prevention programme coverage in each DHB for coverage and effectiveness • Consider the relationship with development of the Children's Action Plan, the development of the 3DHB Paediatric service and Primary health initiatives.	• Complete engagement process and establish 3 DHB Governance arrangements by 30 March 2015. • Complete stocktake of services for vulnerable pregnant women by 30 September 2014. • Develop service plan by 30 March 2015. • Achieve audit scores of 70/100 for each of the child and partner abuse components of VIP programmes. • Implement NCPAS by 30 June 2015

2.2.4 Reduced Incidence of Rheumatic Fever

<table>
<tr><th>Area</th><th>Actions</th><th>Indicators of Success</th></tr>
<tr><td rowspan="2">Reduced Incidence of Rheumatic Fever</td><td>
<h4>Sub-region</h4>
In 2013/14 a sub-regional rheumatic fever plan was developed. The aim of the sub-regional rheumatic fever prevention plan is to reduce the incidence of Rheumatic Fever in the region through a programme of work focussed on prevention, treatment and follow-up of rheumatic fever. The plan is part of the Government's Rheumatic Fever Prevention Programme (RFPP) which is working to improve outcomes for vulnerable children and achieve the goal of reducing the incidence of rheumatic fever in New Zealand by two thirds to a rate of 1.4 cases per 100,000 people by June 2017. The key components of the plan are:
1. To prevent the transmission of Group A Streptococcal throat infections in the Wairarapa, Hutt Valley and Capital & Coast DHB region. This will be achieved through:
a. The development and implementation of a pathway to identify and refer high risk children to comprehensive housing, health assessment and referrals services, in 2014/15.
b. The development of the Housing and Health Capability Building Programme and implementation of insulation referral process for high-risk patients, in 2014/15.
c. Raising community awareness, in 2014/15 and ongoing.
2. Actions to treat Group A Streptococcal infections quickly and effectively. This will be achieved through:
a. The provision of training and information for primary care providers, in 2014/14 and ongoing.
b. Development of an audit tool for the treatment of sore throats in primary care
c. Ongoing sore throat swabbing in schools, this will also include review of the model in 2014/15.
d. The development and wider use of standing orders for primary care (high risk practices).
3. Actions to facilitate effective follow-up of identified rheumatic fever cases. This will be achieved through:
a. The tracking of the timeliness of antibiotics through the rheumatic fever register with annual audit and stakeholder meetings.
b. Appropriate mechanisms for annual training of hospital medical staff to be explored and implemented in 2014/15.
c. The implementation of an audit process to follow up on all cases of rheumatic fever (root cause analysis process undertaken) by RPH. For Hutt Valley and Capital & Coast DHBs, this will include quarterly reporting on the lessons learned and actions taken.
d. The development and implementation of a clinical pathway from diagnosis through to the end of bicillin course.
</td><td>
In 2014/15 a 40% reduction from baseline in rates of rheumatic fever hospitalisations (cases/100,000 population) is the target.

Rates at baseline and target rates for rheumatic fever hospitalisations (cases/100,00 population) for Wairarapa, Hutt Valley and Capital & Coast DHBs

<table>
<tr><th></th><th>2009/10-2011/12</th><th>2014/15</th></tr>
<tr><th>DHB</th><th>Baseline year (3-year average rate)</th><th>40% reduction from baseline</th></tr>
<tr><td>Wairarapa</td><td>0.0</td><td>0.0</td></tr>
<tr><td>Hutt</td><td>4.9</td><td>2.9</td></tr>
<tr><td>Capital & Coast</td><td>2.9</td><td>1.8</td></tr>
</table>
Development of a Rheumatic fever clinical pathway
</td></tr>
<tr><td>
<h4>Hutt Valley DHB</h4>
Rapid Response (walk in clinic) services established (as a pilot)
Engagement with the Pacific Health and Wellbeing Collective to ensure key messages are reaching Pacific families
</td><td>
See PP28: Reducing Rheumatic fever, reported quarterly
<=4 acute rheumatic fever initial hospitalisations
<=rate of 2.9 per 100,000
</td></tr>
</table>

2.2.5 Whanau Ora

Area	Actions	Indicators of Success
Whanau Ora	Hutt Valley DHB • Continue the development and implementation of a Te Awakairangi Whanau Ora - Hauora Framework that enables **agreed** actions and intentions of the DHB, associated health sector partners and the Whanau Ora Collectives (Te Runanganui O Taranaki Whanui led "Te Awakairangi Whanau Ora" and Kokiri Hauora & Social Services "Takiri Mai Te Ata" Programmes of Action),to contribute to the collective impact of realising the vision of "Whanau Ora for all", across all levels of the DHB, Primary care and Public/Population health programmes *i.e. Governance, Strategic and Operational levels* • Develop and implement effective contracting and reporting processes which enable 'Whanau Ora Outcomes' to be achieved, improving on and expanding the current *Integrated Contracts* in place and potential opportunities for joint funding with PHO – primary care. • Identify workforce capability and capacity needs across WO Collectives, DHB/SIDU and Primary care services and workforce to utilise Results / Outcomes Based Accountability tools and resources in conjunction with Health Quality & Safety Commission (HQSC) Triple Aim quality improvement across all health services • Build on Maori Health Services Development Group and specific Maori Health Services Management (inclusive of WO Collective Programme Managers) 6mthly forum to identify health workforce priorities across services, planning and programme evaluation opportunities to enhance professional development and Maori health workforce development i.e. Summer Public Health Programmes, Tu Kaha Central Regional bi-annual Maori Health Workforce conference, PHA, Nursing, NZIM, Mauri Ora specific to health and other determinants of health • Continue local work between primary care and Whanau Ora collectives to expand shared health promotion initiatives, reduce the impact of long term conditions and improve child health through collaborative initiatives that identify and support whanau to determine their health pathway of Whanau Ora journey. • Continue to improve on the pathways 'referrals and information sharing' across services at Primary health care level, secondary and tertiary care services to support whanau presenting to ED, Patient Clinics etc. picked up within the DNA project led by Maori Health Unit • Align and ensure the priorities and actions identified within the HVDHB Maori Health Plan are realised as a joint DHB, Primary care and Whanau Ora action plan	• A re-established and strengthened Maori Relationship Board at a Governance level between HVDHB, Manawhenua -Te Atiawa and Taura Here Maori and Whanau Ora Collectives • Continued support for the Maori Health Service development Group to provide operational level advice and guidance to planning, funding and hospital/community level services. • RBA and MBIE[8] strategies and actions implemented across all service development and contracts with Whanau Ora Collective services, and others • Continue to support Manu Tipuranga Scholarship programmes and Hauora Maori opportunities to grow local Te Awakairangi Maori health workforce through tertiary study and training. • Maori Health Service Provider Management forums identify MPDS / MPCAT opportunities and options • Participate and support Secondary and community based services and Primary care presence at annual festival Te Ra O Te Raukura, TRY-athalon events, Kaumatua Olympics and other Maori/Iwi led activities • Established pathways and referral systems in place, with regular monitoring and measuring of improvements reported on. • Maori Health Plan priorities and actions agreed, supported and enabled across joint DHB, Primary care and Whanau Ora/Maori Health Service sector

[8] Ministry of Business, Innovation & Employment

2.3 System Integration

Context

A new PHO Services Agreement, Alliance Agreement along with an Alliance Charter took effect 1 July 2013. To strengthen clinical integration this plan has been jointly developed with our primary care partners. . A key development for system integration in 2014/15 will be the progression to Service Level Alliances for Long term Conditions including Diabetes; Youth health services; and in the case of Wairarapa, Rural Health Services. A key focus for 2014/15 will be embedding the key enabling infrastructure, the shared care record and Health Pathways, which were implemented in 2013/14. Along with this, the implementation of a mechanism for enable Primary Options for Acute Care (POACs) will be progressed.

Clinical governance underpins all work streams and each Alliance Leadership Team (ALT) has their individual work programme but the integrated work streams focus broadly on five key themes:

- Enablers
- Acute demand and Afterhours
- Long term conditions
- Health of older people and
- Maternal and Child health

Objectives

A health system that is well integrated provides a sustainable system where people receive services from the right person, at the right time and in the right place. The Government's health policy, Better, Sooner, More Convenient, set out the vision for an integrated health system with patients at the centre, where care is delivered closer to home by trusted, motivated health professionals working together in an effective, efficient manner.

2.3.1 Improved Integration and Partnership with Primary Care

Area	Actions	Indicators of Success
Improved integration and partnership with Primary Care	Sub-region The aims of the sub-regional integration programmes are to provide the best health care for our patients and population through improved experience, safety and quality of care with easy access and equity to all populations. The effect of the approach is to remove barriers between the hospital and community to create a single health service. This section of the Annual Plan has been developed in collaboration with the sub-region's Alliance Leadership Teams (Tihei Wairarapa, Hutt INC and ICC). A joint meeting was held in November 2013 followed by smaller group meetings with primary care from January to May, and sign off by the respective ALTs at their meetings in June. Clinical governance underpins all work streams and each ALT has their individual work programme but the integrated work streams focus broadly on five key themes: • Enablers • Acute demand and Afterhours • Long term conditions	• Improvement in the acute demand curve for the district • Reduced growth in emergency department attendances • Reduced growth in local acute inpatient admissions • Reduced growth in local acute bed days (product of LOS and Discharges) • Improving Patient and Population Outcomes

Area	Actions	Indicators of Success
	• Health of older people and • Maternal and Child health The work adopts the triple aim approach: • Improved quality, safety and experience of care • Improved health and equity for all populations • Best value for public health system resources Where appropriate the sub-region is working collaboratively to implement initiatives across the sub-region. The three DHBs will implement the Integrated Performance Incentive Framework when available.	
	Enablers Key projects implemented in 2013/14 will continue to be embedded and utilisation extended in 2014/15: • Health Pathways o 2013/14 transitioned the existing Hutt pathways to 3DHB pathways and sub-regional health pathways platform live o 2014/15 consolidate pathways development across sub-region o Embedding governance structure o Increasing awareness and utilisation of pathways already completed o 21 new transformational pathways developed o localisation of 80 standard pathways • Shared care record o Embed the shared care record in hospital particularly ED o Protocol for governance over data sharing across the system o This infrastructure has the capacity to enable increasing communication between primary and hospital clinicians and once the initial implementation is embedded opportunities for more registered health practitioners to access the record will be considered in 2014/15 e.g. pharmacists. o Increase GPs using shared care record o Ensure information available via record e.g. identification of frail elderly patients, those with disabilities o Patients able to access their own information via portal o Provide access for GPs to Concerto (hospital records) o Facilitate uptake of the patient portal through linked contracts with shared care record provider • Workforce o Shared approaches to workforce development e.g. new nursing graduates • Primary Options for Acute Care	Number of transformational pathways developed across the sub-region Number of pathways localised across the sub-region % of GPs participating shared care record % of GPs with access to Concerto. % of practices making the patient portal available. Pathway & POAC infrastructure in place $ Funding distributed via POACs(target $500,000 CCDHB, HVDHB $500,000 and WDHB funded from the flexible funding

Area	Actions	Indicators of Success
	○ To support the implementation of Clinical Pathways and other strategies to reduce inappropriate hospital admissions such as DVT and Cellulitis ○ Build on current POAC developments and widen the POAC scheme over a period of three years across the 3 DHBs. The key elements of the developments will include coordination services and packages of care. ○ There will be a sub-regional approach to POACs including governance and systems such as funding mechanisms, referral for primary care and reporting. ○ The impact of implemented initiatives will be monitored monitored to ensure triple aim objectives are met. For 2014/15 there will be funding committed towards POAC implementation.The 3 DHBs will work with their respective ALTS and the Health Pathways team to further determine the priorities and detailed workplan for POAC implementation	pool established in 13/14) Flexible funding pool in place in all three DHBs 1,250 POAC packages of care 14/15
	Acute demand and Community health services integration Across the sub-region a whole of system approach is being taken to develop and implement more person centred models of community health service provision for the frail elderly and other individuals with complex needs that make up the bulk of hospital bed days. This will contribute to reduced mortality and morbidity, and to reduced hospital bed days. This programme of work is aligned with and includes the initiatives under the governance of the respective integrated Alliance leadership teams in each DHB. The model of care will be developed with the DHB's alliance partners, and in consultation with staff and unions. The implementation will be over a three year period. Key elements are likely to include: • Risk stratification and proactive care: use of risk stratification algorithms to identify at risk individuals (focusing on the frail elderly and those with complex needs), and to develop, implement and continuously update patient centred care plans. • Community Health GP Multi-disciplinary teams (known as PC3 in the Hutt Valley): alignment of district nursing, allied health and care coordination roles to create multidisciplinary teams working together with general practices in local clusters serving enrolled populations. • Urgent care response: Ability to put in place rapid home based care packages • Clinical integration of systems for the multidisciplinary teams to ensure integrated workflows Hospital capacity will be managed to ensure that community based provision can be expanded sustainably • feedback and metrics to each General practice and aligned MDT indicating their actual and target ED admissions, and occupied bed days The outcome is intended to be coordinated care for those with complex needs, who will otherwise deteriorate and use hospital services. Funding for the Community GP MDT services for at risk individuals will come primarily from existing hospital,	Indicators of Success Reduction in Hospital bed days against current acute demand projections for 2014/15. proposed target is a reduction of 4000 bed days against current acute demand projections in 2014/15 • Reduction in average Length of Stay • Maintain or reduce ED Presentations • Reduce Hospital Admissions • Reduce Aged residential care facility use rates among those aged over 75 Baselines to be established Minimum of one cluster in year one of three year programme Targets to be confirmed and agreed by ALTs (Tihei, Hutt INC and ICC) in Q1

Area	Actions	Indicators of Success
	community and primary care resources.	
	Long term conditions **Refer** to 2.3.5 More Heart and Diabetes Checks (Health Target) and 2.3.6 Diabetes and Long Term Conditions, and to the acute demand section above. Key initiatives: • Diabetes Care Improvement Plan • Maintain focus on CVD/Stroke • New focus on patients presenting with respiratory conditions in 2014/15 (COPD/Asthma)	
Improved integration and partnership with Primary Care	**Health of older people** Align Frail Elderly Pathways across the sub-region Key projects in the integrated care work programme are: • Clinical pathway for managing Frail elderly in the community • Implement and embed the dementia pathway in the community • Supported discharge project initiated (noted above in the Acute demand workstream) ***Clinical pathway for managing Frail elderly in the community*** • Embed the frail elderly pathway into general practice the community e.g. o Use of agreed criteria to identify and 'READ' code patients who meet the criteria o undertaking baseline assessments o advanced care planning o thumb nail social history o information accessible via shared care record ***Embed dementia pathway*** o direct access to CT scans by general practice ***Supported discharge with timely community support services - see section on acute demand above*** • Community support services available 24/7 • Response time appropriate to needs but within 2/4 hours	Reduction in ED presentations by frail elderly Reduced LOS for frail elderly No increase in readmissions for frail elderly
	Child health **Refer** to 2.2.1 Increasing Immunisation (Health Target), 2.2.3 Children's Action Plan, 2.2.4 Reduced Incidence of Rheumatic Fever, and 2.3.2 Maternal and Child Health	
	Improved Access to Specialist Services *Non-Melanoma Skin Cancer* Working group to complete the clinical service design for a sub regional non-melanoma skin cancer removal service.	

Area	Actions	Indicators of Success
	Recommended sub-regional service to be assessed for funding and implementation by SIDU and DHB operational representatives Progress implementation of service development plan following SIDU and DHB operations input. Finalise the implementation of service development plan, Non-Melanoma Skin Cancer Pathway, and review of work programme. *Second Surgical List* Hold an initial meeting between primary care and hospital clinicians to identify additional elective surgical lists. Establishment of systems and processes to support primary care access to one elective surgical list Agreed primary care access to one elective surgical list implemented *Access to specialist advice* Improving and embedding the pathways for primary care access to specialist nurse and/or doctor advice for three high-demand services Three Respiratory pathways agreed by HealthPathways governance group. Identified Clinical Editor and subject matter expert (i.e. Respiratory Physician) Develop and finalise 3 pathways Education provided to relevant clinicians. Pathways published on website	Completed by end of quarter: Q3 Monitoring of Pathways utilisation
	Hutt Valley DHB **Enablers** • Implementation of Manage My Health (MMH) in Hutt Valley primary care o General practices progressively participate in MMH and provide key patient information o Hospital clinicians, especially ED, and after hours clinicians able to access key information o Patients able to access their own information via portal • Workforce o Shared approaches to workforce development, especially new nursing graduates, GP registrars, and scholarships, building on the results of the primary care sustainability project • Flexible Services Pool. Hutt INC has agreed to commence a Flexible Services Pool in 2014/15 that at its inception includes, and will expand from: • Specialist nursing(diabetes, cardiac, respiratory) and CVD funding, DCIP and podiatry funding, Care Plus, primary nurse education (cardiac continuum, respiratory, diabetes) • Community nursing and outreach nursing • After hours – telephone triage service, primary care funding for ED after hours • Youth Services	Hutt Valley DHB FSP commenced by 30 September 2014

Area	Actions	Indicators of Success
	Acute demand Improving and embedding the pathways for primary care access to specialist nurse and/or doctor advice for high-demand services ○ Implementation of dementia pathway ○ Align frail elderly pathways and implement across primary care and community services *Expanded Access to Radiology* With input of primary and secondary care, confirm priorities for expanded access to community radiology. Review expenditure and expand access to remain within budget. Seek support from Radiology Advisory Group (RAG) for mandatory use of clinical access criteria. Update access criteria to reflect completed HealthPathways. Monitor and review referral patterns through RAG. Further review expenditure and consider further expansion of access to align across the sub-region. If expansion agreed, update access criteria on HealthPathways. Budgets (All figures ex GST) for community radiology for the 3 DHBs are as follows: WDHB - $999,865; HVDHB - $1,146,920; CCDHB - $2,393,249 *Primary Options for Acute Care (POAC)* Establish key links with services involved in treatment of Cellulitis and DVT. Confirm radiology pathways for DVT. POAC launched with established Co-ordination role and Provider CME & training Process established for ED & MAPU to refer cases Identification of additional POAC service(s) At least 5 sites active and managing cases. Monitoring of activities due to capacity constraints in Primary Care Further 3 sites across the Hutt Valley active and managing cases. *Primary Care Sustainability Project* Complete draft Report including key recommendations and undertake formal engagement process with Primary Care Strategic Plan for future service provision, business configurations and workforce enhancement completed Subject to Identification of Investment funding, development of an implementation plan for recommendation of strategic plan Progress implementation plan with primary care	Completed by end of quarter: Q1 after hours, Q3 regular hours

Area	Actions	Indicators of Success
	Primary Care Capacity After hours subcommittee of the acute demand workstream established Q4 2013/2014. Outcome of the work will impact on acute demand during regular hours Complete analyses services system pressures and identify key areas for action Initiate possible identified service model relating to Nurse Triage telephone services Establishment of after-hours flexible service pool Progress further service changes identified in Q1 analysis Review and evaluate changes in after-hours model of care to identify priority area(s)	

2.3.2 Maternal and Child Health

Area	Actions	Indicators of Success

Maternal and Child Health	Sub-region
	• Actions to improve the access that pregnant women, babies, children and families have to services that maintain good health and independence:
	  ○ Timely registration with an LMC:
	  ○ MCGG targeting via media outlets and utilizing electronic websites
	  ○ Electronic Website i.e. provide information on maternity services in the district; and the process of finding a midwife/LMC in the district
	• Newborn enrolment
	  ○ An enrolment project is underway to design a single sub-regional enrolment system for publically funded infant services; a Working Group of key stakeholders is established. Recommendations for a sub-regional new-born enrolment system will be delivered June 2014, with implementation to follow as is feasible. Enrolment is targeted to B-enrol; NIR; Well Child Tamariki Ora (WCTO); Community Oral Health Services; BCG; NBHS.
	• B4 School Check: Develop closer collaboration with PHOs to support sharing of enrolment lists, develop models of care based on the health care home concept, and promote the B4SC
	• Pregnant women, babies, children and families have improved health outcomes
	• Services for pregnant women, babies, children and families are of high quality and are nationally consistent:
	  ○ Maternity Quality & Safety Programme – see DHB specific activities
	  ○ Continued sub-regional roll-out of "Pregnant? 5 Things to do within the first 10 weeks" campaign based on MidCentral. Roll-out through community newspapers, local cinemas, commercial radio, Maori and Pacific radio, street posters, posters placed inside Go Wellington buses and general
		• At least 80 percent of women register with an LMC by week 12 of their pregnancy.
		• 98% of newborns are enrolled with general practice by three months
		• track number of hits to site each month
		• Systems are in place to ensure enrolment of all newborn babies with WCTO and Community Oral Health Services
		• At least 90 percent of children receive a B4 School Check (B4SC), including at least 90 percent of children living in high deprivation areas
		• Improved timeliness of B4SC
		• Improved quality and safety of maternity services including improved access, outcomes and

Area	Actions	Indicators of Success
	practice surgeries. The campaign will also make use of the DHBs' social media websites, the intranet pages and internal communications. ○ Gestational Diabetes: Implement the national guideline for the screening, diagnosis and management of gestational diabetes after its release during 2014/15 **Well Child Tamariki Ora (WCTO)** *Access* • Infants (0-12 months) receive all WCTO core contacts in their first year of life ○ Ensure that family/ Whanau have the best opportunity to engage with the service regarding their infant receiving all scheduled WCTO assessments (i.e. within recommended time frames). Text message system will be trialled; has been successful in Wairarapa. ○ Analyse attendance decline for core 4 (Plunket already identified) and any week day specific issues. ○ Plan and implement a robust enrolment referral system to transition from the LMC to WCTO. *Outcomes* • Mothers are smoke free at two weeks postnatal • Children live in smoke free homes • Consistent referral process for priority high needs pregnancies that will include a WCTO interface. ○ Explore process through Quitline referrals for opportunities to engage WCTO in the antenatal period. ○ WCTO collective to discuss their interface with the LMC sector and Tobacco–free coordinators ○ DHB to meet with LMC sector for support on a model of referral using Quitline if possible (or alternatives) *Quality* • Children with an LTL score of 2-6 at the B4SC are referred to oral health services. ○ Oral Health will lead the WCTO QIF for QUALITY B4SC Lift-the-lip programme specifically working with WCTO and other key stakeholders. Training to be provided to WCTO and B4SC staff; prompt tool developed and piloted	consumer satisfaction as measured by national and DHB data analysis and surveys, reduced variation in performance against the NZ Maternity Clinical Indicators • A nationally consistent approach to the screening, diagnosis and management of gestational diabetes • Improved performance against WCTO Quality Indicators measuring access • ≥86% of mothers to be smoke free at two weeks postnatal in the sub-region. • 90% of children in the sub-region to be living in smokefree homes at B4SC. • ≥86% of children in the sub-region with an LTL score of 2-6 are referred to oral health services by December 2014.
	Hutt Valley DHB Refer to: Hutt Valley DHB Maternity Services Quality & Safety Programme Update 2013 and Strategic Plan 2014. An example of actions for 2014 are included below: • Plan is to develop a monitoring system of measurable outcomes for this group of vulnerable women. The metrics will be established in Jan – March 2014, with a review phase in April with any modifications. • Development of pregnancy pack for GP surgeries to be given to women who present with positive pregnancy	Hutt Valley DHB • track number of hits to site • newsletter produced • MAU review completed and recommendations shared • Vulnerable Women's Group

Area	Actions	Indicators of Success
	test • Media campaign in conjunction HVDHB & CCDHB to promote early registration with LMC - 5 things to do when you're pregnant • Linking with 3 DHB project for single system enrolment to publically funded infant services • Work with B4SC provider partners to improve the B4SC programme achieved by sharing information monitor timeliness of B4SC and improve timeliness as identified • Hutt maternity has some well-developed and established forums, processes and tools embedded now. For example Hutt currently has FTEs allocated to both Clinicians and Support staff, and for payments for our consumer representatives. These will be sustained in 2014/15 but continued provision of these is subject to funding in outyears.	review completed; process for monitoring of outcomes completed and implemented. • By mid-2014 have a set group of measurable outcomes for Vulnerable Women's Group.

2.3.3 Mental Health and Addiction Service Development Plan

Context

In December 2012, Cabinet signed off the national document, *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (SDP).* The SDP sets the direction and is government policy for mental health and addiction service delivery across the health sector and clearly articulates prioritised service development plans.

It articulates Government expectations about the changes needed to build on and enhance the gains made in the delivery of mental health and addiction services in recent years. It outlines key priority actions aimed at achieving further system-wide change to make service provision more consistent and to improve outcomes both for people who use primary and specialist services and for their families and Whanau. Mental health promotion, prevention and destigmatisation will be critical to achieving the vision.

The SDP provides further impetus for mental health and addiction services to increase national consistency in access, service quality and outcomes for people who use services, for their families/ Whanau, and for their communities. The SDP builds on recent policy documents including the Mental Health Commission's publication of *Blueprint II: Improving mental health and well-being for all New Zealanders (2012)*. The documents differ somewhat in their focus. The Blueprint II documents cover a 10 year period, span health and social services and signal wider social responsibilities. On the other hand, the SDP has a five year timeframe and a narrower focus on prioritised actions for the health sector.

The SDP outlines key priority actions for the next five years aimed at achieving further system wide change and enhancing our performance in order to improve consistency of service provision and improve outcomes for those individuals, families, and Whanau who use services. These priority actions fall into four overarching themes:

- Better use of resources/value for money
- Improving primary–specialist integration
- Cementing and building on gains for people with the highest needs
- Intervening early in the life cycle to prevent later problems

Objectives

DHBs are required to lead, have joint accountability or contribute to 56 of the 100 SDP actions identified as "DHB" actions. Prior to completing the MOH Quarter 1 (30 September 2013) report submission to the MOH, DHBs completed a stocktake and gap analysis to determine which actions had already been achieved or are in progress and on-going for 2013/14 and the likely actions for 2014/15.

Once the Ministry of Health had a view of DHB led activities; the Ministry combined the DHB view with Ministry led activities. For 2014/15 DHBs are required to identify and deliver initiatives contributing to the following:

- Better use of resources/value for money
- Cementing and building on gains for people with the highest needs
- Implementation of the New Zealand Suicide Prevention Strategy 2006-2015 (and Action Plan)
- Drivers of Crime

Area	Actions	Indicators of Success
	Better use of resources/value for money	

Mental Health Services Development Plan	**3DHB Strategic Framework**
	Improve the integration of delivery of Mental Health & Addiction services with primary care and NGO services, reduce inequalities, and meet identified population need and national requirements across a 3DHB setting
	• Strengthen the collaborative and integrated approach to mental health and addictions service planning to create "a more unified and improved health and disability system" through an alliancing approach
	• Use alliance approach to develop a model of care that links specialist mental health services more effectively with the patient's health home –primary care
	• Co-design service options and system enablers that better meet the needs of, children, youth, adults, older people, Maori, Pacific, people with disabilities and refugees that takes into account primary care, community care, secondary care and the links with the wider health sector and government agencies
	• Develop service options across the mental health and addictions system which identify areas of dis-investment and reinvestment
	• Establish a partnership approach to designing services with users of services.
	• Develop service options across the mental health and addictions system which identify areas of dis-investment and reinvestment to ensure ring-fence expectations will be met.
		• Improved mental health and wellbeing, physical health and social inclusion through expanded access to integrated mental health and alcohol and other drug services
		• Improved quality, safety and experience of care
		  • Promote partnership and choice in the delivery of care
		  • Increased accountability for care quality
		  • There is measurable, planned progress towards recovery and resilience
		• Data collection systems across organisations are robust
		• Increased value for money through:
		  • Increased access through more responsive services
		  • Enhanced integration and responsive pathways
		  • Addressing service gaps through a reduction in siloed funding streams
		• Sub-regional participation and collaboration in the development of increased flexible options for community care and development of partnerships between primary, specialist services and community

Area	Actions	Indicators of Success
		services to ensure sufficient investment in mental health services is available to maintain the expected level of access and quality of services.
	Cementing and building on gains for people with the highest needs	
	Mental health and addiction service capacity for people with high and complex needs Improve the integrated delivery of Mental Health & Addiction services for adults and older people who often have co-existing medical conditions, resulting in high prevalence use of health services. Reduce inequalities which meet identified population need and national requirements for people with high prevalence disorders for moderate to severe impact. • Review and co-design services for adults (and older people) to identify more efficient and patient centred ways of delivering services to a 3DHB population setting • Use alliance approach to develop a model of care that links specialist mental health services more effectively with the patient's health home –primary care and supports delivery of high quality physical primary health care to those with complex mental health needs.	• An integrated response where people receive support that is appropriate and timely provides increased resiliency of this population with reduced costs of secondary and tertiary medical/surgical services provision. • Adult service models are reviewed in line with national frameworks for mental health and addiction service, (including older people with high-prevalence conditions) across 3DHB population level by 31 December 2014 • Co- design changes have been made to models of care that enable more people to be supported within available resources by 30 June 2015 • Improved performance of the sub-regional wide system for people with high and complex needs.
	Delivering increased access for adults with high prevalence disorders Improve the integration of Mental Health & Addiction services with primary care and NGO services which meet identified population need and national requirements for people with high prevalence disorders and/or moderate to severe impact • Review and co-design services for adults (and older people) people with low prevalence and/or high needs to identify more efficient ways of delivering services at a 3DHB population level including inclusive of: ▪ Primary care ▪ General Adult Mental Health Services ▪ Adult AOD services • Develop new models of care that support stepped care through provision in general practice settings where possible, and closer relationships between CMHT staff and primary care • Using an alliancing approach, integrate with primary mental health services to allow seamless transition – e.g. thru movement from a referral to a booking approach.	• Increased availability of specialist advice and support to primary care and NGO mental health and addiction services to reduce demand on outpatient and inpatient specialist care • Increase access to integrated primary care and NGO mental health and alcohol and other drug (AOD) services
	Advocacy Services	• New service model is solution-centred advocacy

Area	Actions	Indicators of Success
	Implement a 3DHB sub-regional independent advocacy service designed to assist independent advocates in effectively lobbying for service users	which is underpinned by a philosophy of working with people accessing mental health and addiction services • A comprehensive 3DHB population approach to independent advocacy services is available
	People with deafness and mental health problems Continue to improve access for people that are deaf and who have experienced mental illness and or addition problems or both – through increasing awareness amongst health workers and services/organisations about deaf individuals, families and their communities and improving the pathway to and from mental health and addiction service across the sub-region. o 3DHB reviewing interpreter policy o Specialist MH interest group to further work plan on improving support for assessment of deaf clients	•Undertake a review of interpreter policy across 3 DHBs by June 2015 •Work plan developed for improving access for people with deafness within mental health services •Develop a mental health component within a 3 DHB wide Sign Language Policy by June 2015 •Limited and safe us of VRI is tested by June 2015
	Implementation of the New Zealand Suicide Prevention Strategy 2006-2015 (and Action Plan)	
	Suicide prevention plan: o train health workers to identify and support individuals with self-harm injuries or at risk of suicide and refer them to the services they need o develop and implement district suicide prevention and postvention plans • Facilitate integrated cross-agency collaboration in respect to suicide prevention and response to suicide clusters/contagion	• Programme to umbrella local workforce development will be developed by 30 June 2015. • Delivery of training workshops and seminars on suicide prevention, assessment and management for community organisations by 30 June 2015 including: • QPR1 (Questions Persuade, Refer) - a "Gatekeeper" training promoted to schools, NGOs, DHB staff, alcohol and drug providers, parents, etc.; • ASIST (Applied Suicided Intervention Training), two day training for community • workers; and • QPR3 (Question, Persuade, Respond) a high level training for general practitioners, mental health and addiction practitioners. • At least two communications with schools and GPs about best practice, recent resources and available training by 30 June 2015.

Area	Actions	Indicators of Success
		• Identify cross-agencies' from central and local government agencies, community based health and social service agencies that have a role in responding to a suicide and working with those affected by the death by 30 September 2014. • Increased membership in the DHB led Community Suicide Postvention Co-ordinating Group (CPCG) across the 3DHB districts from five core members: Child, Youth and Family; Child and Adolescent Mental Health Services (Wairarapa, HV and CC DHBs); Group Special Education, Police and Regional Suicide Postvention Response Co-ordinator to lead a co-ordinated postvention response to a suicide in their community. • Determined by the nature of the suicide and those people affected, seven agencies and/or community based health and social service agencies have signed a CPCG participation agreement by 30 June 2015.
	Drivers of Crime	
	Youth access to Primary care Improve the integrated delivery coordination and integration between primary & specialist services through developing infrastructure. o Co-design a single well-integrated service/system for an exemplar youth alcohol and other drug (AOD) service in the greater Wellington Region o Evaluate exemplar outpatient youth AOD services Refer to: 2.2.2 Prime Minister's Youth Mental Health Project	• Youth alcohol and other drug/co-existing problems (AOD/CEP) specialist role/s to support assessment and interventions for young people with substance abuse and coexisting mental health problems established by 31 December 2014 • Service model supports primary health providers based in Youth One Stop Shops and School Based Health Service • Data collection systems across organisations are robust • Service provision is integrated within youth friendly services, minimises barriers to accessing support and maximises opportunities to access a

Area	Actions	Indicators of Success
		comprehensive range of health and social support services for youth. • Evaluation report with recommendations by 30 June 2015
	Infant and Maternal Mental Health Implement the 3DHB Perinatal, Maternal and Infant Mental Health Strategy encompassing a stepped care, cross agency pathway of care.	• 80% signed Memorandum of Understanding (MOU) with partner agencies for all levels of care (primary, NGO, secondary and partner agencies). • Training in the use of mental health screening and psychosocial assessment protocol tools completed • By 30 June 2015 the number of under fives accessing secondary mental health services has increased by 20% from baseline numbers reported in November 2013 Central Region Regional Service Plan Maternal and Infant Mental Health initiative . • Evaluation of utilisation and efficacy of Perinatal, Maternal and Infant Mental Health strategy completed by 30 June 2015.
	Addictions Increase AOD treatment through improved integrated delivery coordination and integration: o Community-based offenders in the sub-region: Evaluate Community Based Offenders service to determine extent of improved access o Review and co-design well-integrated service/system services for AOD medical detoxification beds o Co-design a single well-integrated service/system for Methamphetamine and other drugs community managed withdrawal packages of care. o Integrate NGO and specialist AOD services to rationalise service provision and meet demand for AOD counselling in primary care settings	• Assessments and appropriate treatment services have been provided to at least an additional 250 community-based offenders by 30 June 2015 • Evaluation report with recommendations by 30 June 2015 • Increased referrals and responsiveness for AOD medical detoxification beds • Increased access to alcohol and other drug (AOD) services integrated with medical detox and other community bases AOD treatment support options
	Youth Forensic	**Regional Alignment:** Refer to Regional Services Plan

Area	Actions	Indicators of Success
	Increase access to specialist services for youth offenders	2014/15 for regional activity
	Welfare Reforms	
	Improving service users employment rates Increased specialist employment services which increase service users employment opportunities of their choice Employment support services standardised	• Effective employment services support is available from both employment and clinical staff to service users by 30 June 2015 • Service Users actively participate in employment services and support • Vocational services are integrated with mental health services rather than clinical services brokering services users to separate employment services • Standardised supported employment across the 3DHBs, is effective in achieving work placements (paid and non-paid) at a higher rate than non-standardised employment interventions
	Hutt Valley DHB Hutt INC is establishing a mental health workstream, with the first initiative being a discharge planning project which will cover adult and youth service users. The Mental Health Discharge Planning (Adult and Youth) Project aims to smooth transitions and improve outcomes for adult and youth service users discharged from secondary mental health services to primary care through clearer information, increased collaboration and integration across the mental health sector, and to increase confidence for all involved. Improve access to mental health and Youth AOD services through wait time targets and integrated case management. • Service redesign across the 3D HSD to consider the continuum of care will be progressed in 2013/14 to support this outcome. **Refer** to 2.2.2 Prime Minister's Youth Mental Health Project	Hutt Valley DHB National plans for implementation of phased waiting time targets that by 2015 will enable: • 80 percent of youth to access mental health and Youth AOD services within three weeks; • 95 percent to access mental health and Youth AOD services within eight weeks of contact. Child and Youth clinical pathway in use by September 2014.

2.3.4 Better Help for Smokers to Quit (Health Target)

Area	Actions	Indicators of Success
Better Help for Smokers to Quit (Health Target)	Sub-region **Hospital Services** The 3 DHB provider arms will: • promote ABC smoking cessation and NRT competency training for all health professionals to ensure they are competent to: • ask their patients about their smoking status • give identified smokers brief advice to quit, • prescribe suitable pharmacotherapy, and • make a strong recommendation to use support in addition to medication • refer patients to smoking cessation support services • document smoking status and support offered to patient • provide regular feedback to wards and departments on their individual progress toward the target. • ensure wards have appropriate documentation for smoking status and know how to capture it. • devolve feedback and audit processes to CNMs and nurse educators. • ensure Smokefree champions are located within each health service SIDU will: • provide cessation referral processes through the 3DHB Health Pathways	• 95% of patients who smoke and are seen by a health practitioner in public hospitals will be offered brief advice and support to quit smoking • 90% of patients who smoke and are seen by a health practitioner in primary care will be offered brief advice and support to quit smoking
	Primary Care We will: • Promote ABC smoking cessation training for all health professionals to ensure they are competent to: - ask their patients about their smoking status - give identified smokers brief advice to quit, - prescribe suitable pharmacotherapy, and - make a strong recommendation to use support in addition to medication - refer patients to smoking cessation support services. - document smoking status and support offered to patient • Promote the identification of Smokefree champions within each health service • Work in partnership with primary health care providers through the PHO Advisory Group	• 90% of patients who smoke and are seen by a health practitioner in primary care will be offered brief advice and support to quit smoking

Area	Actions	Indicators of Success
	(PHOAG) to strengthen current networks and focus on the primary care health targets Better Help for Smokers to Quit and More Heart and Diabetes Checks. PHOs will continue to provide support and resources to practices to assist the achievement of the health targets	
	Pregnant women We will: • Work with our maternity services, general practitioners and Well Child/ Tamariki Ora providers to raise awareness of the smoking in pregnancy issue and promote ABC or EBI training. • Establish a link between maternity services and the Quitline so that midwives are able to text patient details immediately to the Quitline pregnancy service • Help to develop local networks between LMCs, maternity services, and smoking cessation providers • Provide ABC smoking cessation training, through the CCDHB ABC Facilitator and HVDHB Smokefree Coordinator (working across Wairarapa and Hutt Valley) to 100% of in-house hospital midwives • Provide the Quitline "Quitting Smoking for Baby" resource • Provide all midwives and general practitioners and Well Child providers with ABC training that is specific to pregnant women	• 90% of pregnant women who identify as smokers at confirmation of pregnancy in general practice or booking with a Lead Maternity Carer will be offered advice and support to quit smoking
	Smoke free Aotearoa 2025 By 2025, less than 5 per cent of the DHB's population will be a current smoker. To help progress towards this target in 2014/15 we will: • Develop a sub-regional 3DHB Tobacco Control Plan • Review Smokefree Policies • Contribute to tobacco control activity within the 3DHB sub-region including: - improving referral pathways and feedback loops between primary care health services and smoking cessation services - linking smoking cessation promotion and activities with other population health interventions such as monitoring CVD risk, GRx promotion, and healthy lifestyle programmes - Working with RPH to influence social and environmental change to support Smokefree Aotearoa 2025 - Link with TAs and NGOs to support and promote Smokefree Aotearoa 2025 and create more smokefree areas	By 30 June 2015 we will have: • Reviewed Tobacco Control Plans • Reviewed Smokefree Policies • Reviewed Smokefree signage

2.3.5 More Heart and Diabetes Checks (Health Target)

Area	Actions	Indicators of Success
More Heart and Diabetes Checks (Health Target)	Sub-region In 2014/15 we will: • Utilise the funding increase in 2013 to enable ongoing support for primary care to deliver on the health target and ensure its sustainability 2014/15 • Ensure the expertise, training and tools needed are available to successfully complete the CVD risk assessment and management to meet clinical guidelines • Ensure that IT systems that have patient prompts, decision support and audit tools exist, are used and fully report performance. • Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen current networks and focus on the primary care health targets More Heart and Diabetes checks and Better help for smokers to quit. • Support Health Promotion Agency in its work on CVD awareness and publicity campaigns	Health Target – More Heart and Diabetes Checks • 90 per cent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years.
	Hutt Valley DHB Primary Care will: • Implement practice-specific actions to increase the number of CVDRA, including an extended funding model that enables practices to provide free checks to a targeted population Invest in further Decision Support and Reporting Tools for both practices and other service providers within the Primary Care network. Further roll out of BPAC decision tools which will enable preparation of monthly lists of patients requiring checks, and inter-practice comparison reports • Continue promotion activities that encourage people from the target populations to seek a Heart and Diabetes Check. To maintain performance, the PHOs will continue their current approach which includes: • Working with each individual practice on implementing a business plan • Point of care testing • Text to remind tool installed • Publicity and promotion activities An integrated provider approach, e.g. with pharmacies, Kokiri and Pacific Health workers, will be investigated and implemented if effective. This work will also link to the integrated model for Long Term Conditions management. **Refer** 2.3.6 Diabetes and Long Term Conditions	

2.3.6 Diabetes and Long Term Conditions

Area	Actions	Indicators of Success
Diabetes and Long Term Conditions	Sub-region • Progress work on a sub-regional Long term condition framework in 2014/15 • We will continue to progress the Diabetes Care Improvement Plans (DCIPs) developed in 2013/14 and work towards consistency of plans and implementation across the sub-region • Diabetes is the long term condition of focus and ensuring DCIPs are delivering the expected outcomes is the primary focus for DHBs. Successful models developed for DCIP can then be utilised for other services.	• Linkage with Ambulatory Sensitive Admissions to Hospital (ASH) rates (SI1) • Rate of enrolled people aged 15-74 in the PHO with diabetes and the most recent HbA1c during the past 12 months of equal to or less than 64 mmol/mol) (PP20)
	Hutt Valley DHB The current DCIP includes: • Funded annual reviews for targeted groups • More individual patient education sessions • Continued access to podiatry, retinal screening and dietetic services • Workforce development (including additional workforce development from 2013/14) • Self management programmes We plan to continue at least the current service levels in 2014/15 (including the services provided with additional funding). It is now timely to review the DCIP with a view to providing more flexibility for practices to provide services to meet the needs of their populations. There has also been identified a need for additional community podiatry services and outreach services. Primary care will develop an integrated model for Long Term Conditions management with an initial focus on diabetes. This will include the following actions: • Develop specific improvement plans with practices and their clinicians; • Assist practices to invite patients overdue for annual reviews including a text reminder system; • Promotion activities that encourage people from the target populations to seek a Heart/Diabetes Check • Promote self–management strategies and tools to people with diabetes; • Investigate a shared care approach across general practices, pharmacies and other providers • Implement Primary Options coordination function to support general practice in managing patients with acute and complex needs • Update education programmes for general practitioners, practice nurses and other primary care staff; • Invest in further Decision Support and Reporting Tools for both practices and other service providers within the Primary Care network.	Hutt Valley DHB Number of referrals to self-management programmes Review the DCIP in Q1 (including the results in the Atlas of Health Care Variation for Diabetes once published) and present findings to Hutt INC for a decision on any changes. Implement agreed changes from Q2

2.3.7 Shorter Stays in Emergency Departments (Health Target)

Area	Actions	Indicators of Success
Shorter Stays in Emergency Departments (Health Target)	Sub-region In 2014/15 the sub-region DHBs will be looking to build on the high performance already achieved on this health target Across the sub-region a whole of system approach is being taken to address acute demand and enable the achievement of the Shorter stays in ED Health Target. This will support quality clinical outcomes for patients such as decreased mortality and reduced lengths of stay in hospital. This programme of work is aligned with and includes the initiatives under the governance of the respective integrated Alliance Leadership Teams in each DHB. It includes: • Preventative and proactive care in primary and community care settings to avoid the necessity for ED presentation or acute admission e.g. clinical management of frail elderly in the community, diabetes care improvement plans • Alternatives settings for management of patients e.g. clinical pathways for the management of selected conditions in primary care e.g. cellulitis, DVT and gastroenteritis. • Alternative access to diagnostics e.g. access to radiology in the community • Efficiency within ED and MAPU including: o Diagnostic/analysis work to identify the main factors impacting on ED length of stay o improved access to early specialists assessment through the model of care for internal medicine • Discharge processes. e.g. ensuring community support services that respond rapidly for patients not requiring hospital admission or to enable discharge at the appropriate time The DHBs will also be developing ED Quality Frameworks during 2014/15.	o 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours. o Reduction in growth of ED presentations o Decrease in growth in Acute admission rate o Hospital Occupancy rate o Average LOS for acute admissions o Representations to ED o Readmissions
	Hutt Valley DHB • Work with primary care to link patients who present at ED without a GP to a primary care practice • Integrated approach with primary care targeting high user group – identifying individuals presenting to ED o Regular meetings between ED and primary care o Identifying patients who could be re routed into acute primary care appointments available at primary care practice • Increased access to diagnostics in the community e.g. radiology • Maintain focus on dashboards (Inpatient, ED and Theatre Whiteboard) to manage bed capacity • Continue to use Trend Care to ensure resources (staff and beds) meets acuity needs • focus on improving clinical outcomes and decreasing patient decompensation by prolonged stays. • 2014/15 explore admitted short stay surgical cases with view to earlier discharge • Maintain and extend focus on early supported discharge from MAPU and ED	Hutt Valley DHB Variation response Trend care coordinating need and supply Discharges after 11pm

2.3.8 Increased Access to Diagnostics

Area	Actions	Indicators of Success
Improved Access to Diagnostics	Sub-region • Achieve identified waiting time targets by more efficient use of existing resources; making improvements to referral management and patient pathways; and investing in workforce and capacity as required • Participate in activity relating to development and implementation of the National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to the NPF as required • Work with regional and national clinical groups to contribute to development of improvement programmes. **Radiology (CT/MRI)** • Review potential of two department multi site delivery of radiology across the three DHBs • Increase resource capability and quality at Hutt Hospital with new MRI • Progressive implementation of common community referred access criteria for radiology services • Ensure support to POAC through access to diagnostics **Colonoscopy** • Development of single service multi site model for gastroenterology • Improve waiting times and quality of endoscopy / colonoscopy services by: o implementing the Endoscopy Quality Improvement (EQI) programme o identifying and implementing improvements to colonoscopy services	Refer PP29: Improving waiting times for diagnostic services: • CT and MRI – 90% of accepted referrals for CT scans, and 80% of accepted referrals for MRI scans will receive their scan within six weeks (42 days) • Diagnostic colonoscopy – 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 60% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days) • Surveillance colonoscopy – 60% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date • New MRI at Hutt Hospital operational by 30 September 2014 • Representation, attendance and participation in national and regional clinical group activities. o Agreed system changes are implemented.

2.3.9 Increased Access to Elective Surgery (Health Target)

Area	Actions	Indicators of Success
Improved Access to Elective Surgery (Health Target)	Sub-region • Electives funding will be allocated to support increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care. • Standardised intervention rates and/or other mechanisms (such as demand analysis) will be used to assess areas of need for improved equity of access. • Patient flow management will be improved to achieve further reductions in waiting times for electives. No patient will wait longer than five months during 2014, and waiting times are reduced to a maximum of four months by the end of December 2014.	• Electives Health Target achieved for each DHB • Refer to SI4: Elective services standardised intervention rates For each DHB, standardised intervention rate targets of: • Major Joints 21 per 10,000 pop • Cataracts 27 per 10,000 pop • Cardiac Surgery target 6.5 per 10,000 pop

Area	Actions	Indicators of Success

	• Identify actions to support improvements in electives access, quality of care, patient flow management, or that maximise available capacity and resources.
	• All DHBs have systems, including theatre systems, in place to manage the acute impacts on elective activity
	• Implement Waiting list and Capacity management actions:
	  • reporting on weekly regional waiting lists available to COOs
	  • Enhance existing escalation system for outlier waiting lists in each DHB
	  • Agreed actions are implemented to address early identification of problems and variations in performance
	• Patients will be prioritised for treatment using national, or nationally recognised, tools, and treatment will be in accordance with assigned priority and waiting time
	• Participate in activity relating to development and implementation of the National Patient Flow system, including amending data submission for FSA referrals as required.
	
	Regional Alignment: Refer to Regional Services Plan 2014/15 for regional activity
		• Elective Services Patient Flow Indicators expectations are met, and all patients wait four months or less for first specialist assessment and treatment from January 2015
		• Refer to Ownership Dimension performance measures for Inpatient Length of Stay (OS3).
		• Include measures for any local projects/actions identified
		• Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions
		• Patient level data for referrals for FSA are reporting into new collection.

	Hutt Valley DHB Continued commitment to maintain achievement of target for elective surgical discharges. We will continue to ensure that our access is not affected so that on-going delivery will continue, and this is monitored monthly at the electives meeting. The delivery will continue to be achieved by utilising theatre capacity, managing acute presentations in an appropriate manner and monitoring to reduce day of surgery cancellations. Surgeon to be appointed across Hutt Valley and Capital & Coast DHBs. Specialty to be confirmed.	Hutt Valley DHB Delivery against agreed volume schedule, including a minimum of 5,014 elective surgical discharges in 2014/15 towards the Electives Health Target Recruitment completed as soon as practicable. Timeframe will depend on availability of suitable candidates.

2.3.10 Cardiac Services

Area	Actions	Indicators of Success
Cardiac Services	Sub-region • Deliver a minimum target intervention rate for cardiac surgery, set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access • Ensure appropriate access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests etc. • Manage waiting times for cardiac services, so that no patient waits longer than five months for first specialist assessment or treatment during 2014, and reduce waiting times to a maximum of four months by the end of December 2014 • Undertake initiatives locally to ensure population access to cardiac services is not significantly below the agreed rates. This includes cardiac surgery, percutaneous revascularisation and coronary angiography o Work within Health Pathways project will identify the need and priority for pathway development for primary care access to secondary and tertiary services. These can then be implemented in accordance with the priority that is determined. **Regional Alignment:** Refer to Regional Services Plan 2014/15 The sub-region will: • Incorporate sub-regional requirements as part of the full regional service review • Incorporate sub-regional development and implementation plan and roadmap into regional service review	• Refer PP29: Improved access to diagnostics. 90% of people will receive elective coronary angiograms within 90 days. • Elective Services Patient Flow Indicators: all patients wait five months or less for first specialist assessment and treatment during 2014, and less than four months during 2015 • Refer SI4: Standardised Intervention Rates o Cardiac surgery: 6.5 per 10,000 of population o Percutaneous revascularisation: 12.5 per 10,000 of population o Coronary angiography: 34.7 per 10,000 of population • By 31 July 2014 • By 30 September 2014
	Hutt Valley DHB	Hutt Valley DHB • Agreement to a minimum of 96 total cardiac surgery discharges for Hutt Valley population in 2014/15 (delivered by regional service)

2.3.11 Acute Coronary Syndrome

Area	Actions	Indicators of Success
Acute Coronary Syndrome	Sub-region • Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention • Develop processes, protocols and systems to enable local risk stratification and transfer of appropriate high risk ACS patients • We will work in collaboration with the Central Cardiac Network to implement the Acute Chest Pain Pathway (as advice on this is developed). o Review and modification of existing pathways o Implementation of new or revised pathways and guidelines o Staff education **Regional Alignment:** Refer to Regional Services Plan 2014/15 for regional activity	• 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') • Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
	Hutt Valley DHB • Protocols are already in place to enable local risk stratification and transfer of high risk ACS patients, e.g. o Protocol in place with Wellington Free Ambulance to transfer high risk ACS cases directly to Capital & Coast DHB. o Recording GRACE scores for ACS patients who are transferred to Capital & Coast DHB. • Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention: o Implementation of ANZACS-QI has occurred o The Trend Care work flow acuity tool will be utilised to capture better information regarding ACS patients to improve patient flow.	Hutt Valley DHB

2.3.12 Stroke Services

Area	Actions	Indicators of Success
Stroke Services	Sub-region **Regional Alignment:** Refer to Regional Services Plan 2014/15 for regional activity • Support national and regional clinical stroke networks to implement actions to improve stroke services. • Sub-regional stroke thrombolysis network by Telephone or TeleStroke implemented by December 2014	• 6 percent of potentially eligible stroke patients thrombolysed • 80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.

	Hutt Valley DHB
	• We have had a Stroke Unit since 2008
	• We have a Quality Assurance and Education programme for Stroke. It comprises regular meetings:
	  ○ Monthly Medical Meeting where thrombolysis cases, interesting patients and any mortality issues are discussed. Attended by all Medical Registrars
	  ○ Monthly Stroke Interest Group. This has a multidisplinary focus with speakers choosing a subject of interest to the whole team e.g. dyspraxia, continence, role of stroke foundation field workers
	  ○ 6 Monthly Stroke Thrombolysis Audit. A review of all cases in the preceding six months looking at process and outcomes. Attended by all members of the Department of Medicine
	  ○ 6 Monthly Thrombolysis Education for Medical Registrars when they start their attachment
	  ○ 6 Monthly General Stroke and TIA education for Medical Registrars again at the beginning of their attachment.
	• Upskilling of medical ward nurses
	  ○ A Strategic Plan for Nursing Education is being developed. Stroke will be an important part of this. A series of face to face tutorials will be developed to complement the current online training.
	• Thrombolysis education – incorporated in above.
	• Streamlining referral and treatment pathway for TIA to create a single point of entry for TIA and stroke
		Hutt Valley DHB
		
		Face to face tutorials delivered by 31 December 2014.

2.3.13 Health of Older People

Area	Actions	Indicators of Success
Health of Older People	Sub-region The model of care is under development; see acute demand and community health services portion of 2.3.1 Improved Integration and Partnership with Primary Care. The outcome is intended to be coordinated care for those with complex needs, who will otherwise deteriorate and use hospital services. **Rapid response and discharge management services (Wrap Around Services)** The emphasis on improving the continuum of care across the whole of system will continue through the Integrated Care Programmes (Tihei Wairarapa, Hutt INC, and ICC). Sub-regional health pathways will be developed based on the Canterbury Health Pathways. Local referral details for each district will be incorporated into the sub-regional Health Pathways. The DHBs will align across the sub-region to support integration of systems developed to support early discharge. Timely and safe discharge home from hospital will be supported through daily community health/NASC liaison with inpatient areas. **Refer** 2.3.1 Improved Integration and Partnership with Primary Care and 2.3.7 Shorter Stays in Emergency Departments (Health Target) **Home and Community Support Services (HCSS) for Older People** Annual benchmarking across Central Region DHBs will include quality measures which will inform future development. The DHB will participate in implementing quality improvements which are identified through the national Complaints Categorisation project. Such participation will occur as sub-regional actions. Participation in sub-regional review of HCSS services and models. InterRAI data will be used to inform this review. **Dementia Care Pathways** The development of common clinical pathways across the sub-region will be a priority for the coming year, with an early focus expected to be on the Dementia Care Pathway. Local developments achieved to date will be incorporated into the sub-regional pathway, accompanied by specific local adaptations (e.g. links to local resources and referral systems).	Participation in the development of sub-regional health pathways. Local referral pathways mapped and used by primary care, community services and hospital staff to ensure a shared understanding and enhance individuals' journeys. Annual regional benchmarking completed Evidence of continued price or volume increases based on receipt of Budget 2013 funding. The fee for service prices for long term home and community support which will continue to be aligned across Hutt Valley and Wairarapa DHBs. Review completed Development of a sub-regional clinical pathway for dementia care, with local adaptations.

Area	Actions	Indicators of Success
	Through Multidisciplinary and specialist support enable more equitable access, timely diagnosis in primary care and more targeted referrals to specialists. **Refer** 2.3.1 Improved Integration and Partnership with Primary Care	
	As part of implementing the national Dementia Care Framework, the DHBs will provide behavioural support advice Walking in Another's Shoes –experiential training for support workers and clinical staff in residential care dealing with dementia. **Regional Alignment: Refer Regional Services Plan 2014/15.** In line with the Dementia Care Framework, the DHB will also adopt the Central Region Advanced Care Planning framework, in conjunction with the PHOs, and will support the regional phased training programme **Fracture Liaison Service** An FLS steering group will operate across the sub-region with representation from Hutt Valley and Capital & Coast DHBs. Wairarapa will be represented through the Hutt Valley DHB. This group will consist of a multidisciplinary team including various clinician and management perspectives, IT and primary care representation. The group will be responsible for developing treatment protocols across the three DHBs and monitoring the operation of this service. Monitoring indicators have yet to be confirmed. The steering group will have oversight across the sub-regional DHBs for matters relating to the Fracture Liaison Service. Data collection and analysis is occurring across the Wairarapa, Hutt Valley and Capital & Coast DHBs and a treatment protocol for people presenting to ED with fragility fractures will be developed and shared across the 3 DHBs. **Comprehensive Clinical Assessment in residential care (InterRAI Ltcf)** The three DHBs will work to support ARC providers in their uptake of the use of InterRAI Ltcf. This support will be through the involvement of the InterRAI systems clinician for the 3 DHBs. The three DHBs will also be supporting the 'train the trainer' model in ARC to ensure sustainability. Advice and assistance for ARC providers will continue from the DHB Lead Clinician and provision of training assistance as available. Resource will continue to be provided through the Systems Clinician for record transfers. The DHB will be regularly monitoring the uptake of InterRAI LTCF in terms of ARC staff training and use of the tool.	Walking in Another's Shoes implemented for a cohort of residential care support staff. Demonstration to Home-based support in CCDHB and aged residential care in Wairarapa by June 2015, led by TAS. This will inform implementation in the Hutt Valley in outyears. Behaviour advisory service available for residential care, for advice and support Staff will be supported to attend DHB level 2 training for Advanced Care Planning as coordinated by CTAS Steering group established and a process for identifying people who present to ED with a fragility fracture is in place. A treatment protocol for people presenting to ED with fragility fractures will be developed and shared across the 3 DHBs. All facilities will be trained or engaged with training for use of this assessment tool Continued DHB support and monitoring of use of InterRAI in residential care facilities.
	HOP Specialists	

Area	Actions	Indicators of Success
	HOP specialists will continue to provide clinical and educational input for residential and primary care and maintain specialist inputs through; • Assessment, education and advice with regard to specific clients • Shared case review • Multidisciplinary forums (e.g. weekly MDT meeting for shared clients, dementia MDT meeting for people with complex dementia) • Education forums This specialist support for residential and primary care will be maintained at the current level, and monitored through any reported problems with ARC providers accessing appropriate specialist input.	
	Hutt Valley DHB **Rapid response and discharge management services (Wrap Around Services)** The previous development of the Geriatric Liaison role has enabled a smoother and more holistic journey for older people across the health continuum. Work on pathways for frail elderly will strengthen the linkages between DHB, primary care and health of older people providers (see 2.3.1 Improved Integration and Partnership with Primary Care). **Comprehensive Clinical Assessment in residential care (InterRAI Ltcf)** Hutt Valley DHB intends to mentor another nurse specialist into the ARC education programme to enable more facilities to join	Number of facilities in this programme increased to 10

2.3.14 Shorter Waits for Cancer Treatment

Area	Actions	Indicators of Success
Shorter Waits for Cancer Treatment / Faster Cancer Treatment	Sub-region • Maintain timeliness of access to radiotherapy and chemotherapy by: o Monitoring wait times o Maximising use of existing resources o Continuing implementation of the priority areas for each year identified in the National Medical Oncology Models of Care Implementation Plan 2012/13, including: ▪ continue to implement e-prescribing into both cancer centres ▪ SMO workforce priorities as identified by national plan o Implementing priority areas for the year identified in the regional radiation oncology capital and service plans (plan to be developed by June 2014) • Improve timeliness and quality of the cancer patient pathway from the time patients are referred into the DHB through treatment to follow-up / palliative care by: o identifying and implementing improvements to the quality of faster cancer treatment indicator data including ensuring that reporting meets the data quality expectations as agreed in the DHB's 2013/14 'Support for improving the faster cancer treatment indicator reporting' contract o making the faster cancer treatment data collection systems /processes part of business as usual o Continuing to explore systems to support active patient tracking, aligned to CRISP and national patient flow o improving the functionality and coverage of multidisciplinary meetings (MDMs) across the region o beginning to implement the national tumour standards of service provision o undertaking a review of three tumour standards (different tumour types to the review undertaken in 2013/14), and identify priority areas for action based on reviews. o supporting cancer nurse coordinators • Development of pathways for tumour streams via Health Pathways • Development, design and implementation of multi-site single service for gastroenterology. This design will follow the recently developed template for single services. This work programme will be nimble to respond to any service single leadership and accountability that may occur during this period. • Identify the considerations and decisions needed for operational activity and responsibility	Performance maintained against the **Shorter waits for cancer treatment health target** (radiotherapy and chemotherapy) – all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy, Improvements in the performance against the **policy priority (PP30) faster cancer treatment indicators**: • 62 day indicator - 85% of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days by July 2016 (From quarter 2, this will become the health target and the title will be **Faster Cancer Treatment**) • 31 day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) Monitor through **policy priority (PP24) improving waiting times – cancer multidisciplinary meetings** improvements to the coverage and functionality of multidisciplinary meetings. Monitor through six-monthly **crown funding agreement variation – appoint cancer nurse coordinators reporting.** Monitor through **policy priority (PP29) waiting times for diagnostic and surveillance /follow-up colonoscopy.** **See** 2.3.8 Increased Access to Diagnostics Implementation Q4. Project steps completed by end of quarter

Area	Actions	Indicators of Success
	for progress • Consolidate operational activities that have no dependencies on single funding or single accountability. **Regional Alignment:** Refer to Regional Services Plan 2014/15 for regional activity	
	Hutt Valley DHB o monitor provider DHBs	

2.4 Sub-regional Priorities

2.4.1 Maori Health

Improving Maori Health continues to be a priority for the three DHBs. The DHBs will continue to apply/support strengths based approaches, recognise the diversity of Maori society and work beyond "a one size fits all" view. This will be achieved by understanding the challenge of working with traditional values in modern times and making the best from collective resources and collaborative action.

While the current health sector environment is likely to have an impact in 2014/15, it is important that the DHBs make the best use of our existing resources to ensure better, more efficient and more effective care for Maori and their Whanau within our districts.

Area	Actions	Indicators of Success
Maori Health	**See Maori Health Plan** Increase Maori workforce capacity. Maintain key links with Maori bodies at local, regional and national forum. Monitor and report on Maori Health gain areas. **Refer** 2.2.5 Whanau Ora	Report learning / achievements of Maori / Maori health at local, regional, national and international levels. A minimum of two reports on Maori Health gain areas.

2.4.2 Pacific Peoples' Health

This section has been developed by the sub-regional Pacific Collective alongside the DHBs' Pacific Health Units.

Area	Actions	Indicators of Success
Pacific Peoples Health	For 2014/15 the following areas are the key priorities for the sub-region for Pacific Peoples' Health: Child heath: reduction of dental caries amongst Pacific children, greater knowledge and use of community dental hubs Clinical Pathways: development of better Pacific Models of Care to improve Pacific utilisation of general practice and a reduction in DNA rates To address DNA and service access issues for Pacific people with disabilities through improved liaison and targeted navigation using data gathered from disability alerts To improve communication and awareness among Pacific people about the issues facing Pacific people with disabilities using media such as including disability voices on Pacific radio Long Term Conditions (Management of LTC): Diabetes, Cardiovascular (as above- creation of specific Pacific Models of Care) Workforce development: clinical cultural competence, ensure appropriate demand and supply strategies to encourage active placements Cultural competence training includes the compounding issues of disability for those Pacific people who experience disabilities Mental health and addictions: improvements to the availability of specialist mental health services to Pacific. Increased focus at the 4-17% of Pacific population with moderate to high need (primary mental health, secondary care volumes) Elderly: greater emphasis at carer support services which are culturally appropriate to Pacific clients and families	• Reduced dental caries at Yr 8 for Pacific children (PP10) • Reduced ASH admissions for Pacific children for dental conditions (SI1) • Reduced did not attend (DNA) rates for Pacific • Improved visibility and access for Pacific people with disabilities • Improved networks and connection with the Pacific Disability community • Better understanding of disability health issues • Improved management of conditions for Pacific Peoples with diabetes and CVD • Health workforce supported to provide culturally appropriate care to Pacific • Strengthen Pacific health workforce by: - % of Pacific graduates recruited through the NETP programme - 100% Pacific Nurses enrolled on the PDRP programme

2.4.3 Disability

Area	Actions	Indicators of Success
Disability	Align disability policy across the three DHBs • Develop regional clinical panel for improved clinical and placement options • Align single high level disability responsiveness policy CCDHB with Hutt Valley and Wairarapa • Develop a policy in conjunction with the deaf community for NZ Sign Language to be used across the three DHBs • Report and provide recommendations to the three DHBs on Health Passport Evaluation Align human resource policies across the three DHBs as they relate to staff with disability One sub-regional forum and three local for a per year to contribute to annual planning and best practice Review physical requirements across all sites through high level access audit Sub-regional Disability Advisory Group with support from Maori and Pacific representatives integrates needs of Maori and Pacific people with disability into existing plans Identify research findings to analyse gaps in access to disability support services for Maori and Pacific people led by Maori and Pacific disabled people Network of champions across the three DHBs is established and published on the DHB intranets and internets as a resource to improve access Identify clinical champions for disability responsiveness Regular 3DHB disability newsletter established	One high level disability responsiveness policy Regional clinical Panel in place Five year disability responsiveness plan is developed with targets for each DHB annually NZ sign language policy developed Fora completed and outcomes published Access audit completed Maori Partnership Board and Sub-Regional Pacific Health Group endorse representatives on Sub-regional Disability Advisory Group Champion network is supported, coordinated and evaluated by SIDU across three DHBs Reduced barriers to hospital services measured by increased compliments and reduced complaints 4 newsletters per year
	Hutt Valley DHB Disability icon data increases and dashboard of indicators is developed	Hutt Valley DHB Baseline of data is achieved to measure • utilisation • Admission and readmission • DNAs • ASH

2.4.4 Living within our means

Better, Sooner, More Convenient Health Services for New Zealanders in relation to 'Living within our Means' is about the health system managing the sustainable delivery of services for its population. It does this by:

- Purchasing and productivity improvement to deliver more efficiently and effectively across all providers
- Tight cost control to limit the rate of cost growth pressure
- Service reconfiguration to support improved national, regional, and local service delivery models, including regional and sub-regional collaboration

Area	Actions	Indicators of Success
Living within our Means	• Operate within agreed financial plans • Appropriate clinical and executive leadership • Improved length of stay and community care through Frail Elderly Pathway (**refer** 2.3.1 Improved Integration and Partnership with Primary Care, Health of Older Persons portion) • Review model of care for some medical specialities • Improved management of nursing demand and resources • Use of clinical pathways as they become available (**refer** 2.3.1 Improved Integration and Partnership with Primary Care, Enablers portion) • Improved property management, e.g. energy efficiency • Continue the implementation of Shared Services actions aligned with Health Benefits Limited (HBL) work programmes as agreed	• System Integration 3: Ensuring delivery of Service Coverage • Ownership OS3: Inpatient Length of Stay • Ownership OS8: Reducing Acute Readmissions to Hospital • Output 1: Output Delivery against Plan.

2.5 Links to National and Regional Work Programmes

2.5.1 National Entity Priority Initiatives

The DHBs will also contribute to National Entity Priority Initiatives, as outlined below.

Health Benefits Limited (HBL)

The DHBs will commit resources to the implementation of HBL's Finance, Procurement and Supply Chain (FPSC) initiative, and fully factor in expected budget benefit impacts. The DHBs are committed to working in partnership with HBL to progress the Food Services, Linen and Laundry Services and National Infrastructure Platform business cases. The DHBs will commit resources to the decision reached in relation to these Detailed Business Cases. The DHBs will commit resources to the decision reached in relation to progressing the Indicative Case for Change for the Human Resources Management Information Systems initiative to the next stage. The DHB will commit to existing 2013/14 levels of funding ($18,000) for HBL's Banking and Insurance initiative.

National Health IT Board

The DHBs are committed to implementing electronic medicines reconciliation (eMR). In 2014/2015 the DHBs will continue our participation in CRISP which includes the development of an eMedicines Reconciliation module and national templates for electronic Discharges.
The DHBs commit to implementing the regional Clinical Workstation (CWS) (Orion, Concerto) and Clinical Data Repository (CDR). In 2014/2015 the three DHBs will

- Continue participation in the CRISP Regional Clinical Portal Programme.
- CCDHB Local Implementation Project will be initiated in 2014/15 to prepare the DHB to transition to a regional Clinical Workstation and Data Repository sometime in 2014/15 -2015/16.

The DHBs will implement a Patient Administration System (PAS) in alignment with the regional plan. The PAS will be implemented at our DHBs by 2017/18. As an interim measure, Wairarapa DHB will transition to a supported Patient Administration System in 2014/15.

Note: There are significant dependencies on the CRISP Programme and any delays in this programme will result in changes to the plans above.

To contribute to the National Patient Flow dataset, the DHB commits to collecting First Specialist Assessment (FSA) referral information, including outcomes of referrals, from July 2014 (Phase 1); and to collecting Phase 2 information from July 2015.
A Shared Care Record is currently live in Wairarapa and Capital & Coast, allowing hospital based services, in particular, ED, to have access to a summary view of primary care information. Work is underway for this to be implemented in Hutt Valley. The DHBs in collaboration with the relevant PHOs plan to extend the access to other clinical roles and care settings including Community Pharmacists. The three DHBs will develop an implementation plan with relevant PHOs to enable individuals to have access to their own health information.

Health Quality Safety Commission (HQSC)

The DHBs will commit to meeting infection control expectations in accordance with Operational Policy Framework - Section 9.8. The DHBs will continue development of infection management systems at our local DHB level. The DHBs commit to surveying patient experience of the care they received using the national core survey, at least quarterly. The DHBs will meet expectations in accordance with Operational Policy Framework Section 9.3 & 9.4.6. The DHBs will continue to commit resources to support the current ePrescribing and eMedicines installation in place as part of CRISP. The DHBs will continue to support, analyse and improve performance against the HQSC Quality Markers such as falls, peri-operative care, and pressure sores. **Refer** to 2.5.2 Improving Quality

Health Workforce NZ (HWNZ)

The DHBs support the regional approach being taken to addressing key workforce requirements on diabetes nurse prescribers. The DHBs support the regional approach being taken to addressing key workforce requirements on GPEP 2 registrars. The DHBs support the regional approach being taken to addressing key workforce

requirements on sonographers. The DHBs will support the growth of the medical workforce by aligning training funding to the 70/20/10 model to be implemented by July 2015.

For more detail on workforce planning and activities for 2014/15, **Refer** 5.3 Strengthening Our Workforce.

National Health Committee

The DHBs will support the NHC work programme by engaging with and providing advice on the burden of disease documents. The DHBs will support the NHC work programme by referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate. The DHBs will support the NHC work programme by providing expert clinical opinion to working and advisory groups on health technology assessments where possible. The DHBs will not introduce emerging technologies where the NHC has recommended that these technologies should not be introduced. The DHBs will support the NHC work programme by providing expert business opinion to working and advisory groups on health technology assessments where possible. The DHBs will support the NHC work programme by providing clinical research time to design and run field evaluations where possible. The DHBs will support the NHC work programme by referring technologies that are driving fast-growing expenditure and that have not been prioritised for assessment at a national level, to the Regional Prioritisation Network where appropriate.

Health Promotion Agency (HPA)

The DHBs will support national health promotion activities for health targets – **Refer** 2.3.4 Better Help for Smokers to Quit (Health Target) and

2.3.5 More Heart and Diabetes Checks (Health Target). The DHBs will support work undertaken by the Health Promotion Agency on preventing Fetal Alcohol Spectrum Disorder. The DHBs will comply with the requirements of the Sale and Supply of Alcohol Act 2012, including enabling the Medical Officer of Health to comply with their specific responsibilities and duties outlined under the Act.

PHARMAC

The DHBs will support PHARMAC in commencing its interim procurement role for hospital medical devices, including committing to implement new national medical device contracts, when appropriate. While hospital medical devices category management establishment has been identified as a national entity priority initiative, the DHBs and the Ministry do not expect this to have an impact on the 2014/15 planning. While hospital medical devices interim budget management has been identified as a national entity priority initiative, the DHBs and the Ministry do not expect this to have an impact on the 2014/15 planning. The DHBs will support PHARMAC to progress its hospital pharmaceuticals management function. While hospital pharmaceuticals budget management has been identified as a national entity priority initiative, the DHBs and the Ministry do not expect this to have an impact on the 2014/15 planning.

2.5.2 Improving Quality

Area	Actions	Indicators of Success
Improving Quality	• Support the Quality & Safety Markers (QSMs) with a focus on achieving: o 90 percent of older patients are given a falls risk assessment ▪ 14/15 audit schedule focuses on auditing the compliance against the standard ▪ 14/15 the chair of the falls management group is presenting at the nurses education sessions to reinforce the practise of assessing and documenting the falls risk assessments ▪ Wairarapa, Hutt and Capital & Coast are adopting the falls signalling initiative introduced as part of the falls project to support effective falls assessment, this will be in place 14/15 ▪ Wairarapa are introducing an electronic incident management system in line with Hutt to ensure that the reporting is timely, effective and more user friendly. ▪ CCDHB has an active Falls Prevention Committee led by a CNM and ADON who agree, implement and monitor multiple falls prevention actions. o 80 percent compliance with good hand hygiene practice ▪ 14/15 training an extra gold hand hygiene auditors in Wairarapa and Hutt DHBs ▪ CCDHB to implement hand hygiene facilities at every bed to enable staff, and families of patients to improve hand hygiene. ▪ Actively promoting the messaging for consumers "its ok to ask your healthcare professional if they have cleaned their hands" o all three parts of the surgical safety checklist used 90 percent of the time ▪ Wairarapa is introducing the 5 steps to safe surgery March 2014 to fall in line with Hutt. This will be enhanced by the HQSC Perioperative Harm Reduction project. For 14/15 we will be working with the Open team focussing on: • All members of the perioperative team have an important part to play in increasing the safety of the patient • Consumers need to be actively involved and provided information on safety aspects of their perioperative journey • Improve local teams ability to implement the interventions • Improve the capability and capacity of clinical champions to coach and mentor peers	• Performance updates published by HQSC and included in DHB local quality accounts • Quarterly Reporting on patient experience as set out in performance measure DV3 'Improving patient experience' • Wairarapa, Hutt and Capital & Coast are part of the regional patient safety/open for better care group producing updates and sharing initiatives/resources across the region and sub-region • The patient experience and feedback will commence in Wairarapa and Hutt in July 2014 • Reporting of the serious and adverse events in November 2014 through the HQSC • Improved compliance to risk assessment process and reduced hospital acquired pressure injuries. • Improvement in performance in the Balanced Set of Clinical and Quality Measures discussed at SCGC, HHS & ELT (CCDHB) • Current QSM focuses on the use of all three parts of the surgical checklist • Work to develop measurement on aspects of teamwork and communication will be developed as part of the programme. This will assist teams in identifying areas for improvement, and how they have improved.

Area	Actions	Indicators of Success
	▪ CCDHB monitors progress of the implemented surgical safety checklist as good progress has already been made. o 95 per cent of hip and knee replacement patients receive cephazolin ≥ 2g as surgical prophylaxis ▪ This will be part of the regular audit schedule for the 14/15 years • 100 per cent of hip and knee replacement patients have appropriate skin preparation o In 14/15 we will be reviewing the effectiveness of the orthopaedic preoperative patient groups and reviewing the health literacy at Wairarapa o Taking consumer advice of the most effective way to message home skin preparation in both Hutt and Wairarapa • Support projects that make a difference to improving the quality of care, reducing patient harm and contribute to the national patient safety campaign 'Open for better care' o Wairarapa, Hutt and Capital & Coast are part of the regional patient safety/open for better care group producing updates and sharing initiatives/resources across the region and sub- region. **Regional Alignment:** Refer to Regional Services Plan 2014/15 o 14/15 monthly teleconferences to share patient safety ideas and produce a newsletter to communicate the innovation and ideas across the region and sub-region. o CCDHB will continue to refine use of the Global Trigger Tool to enable insight to service problems. Consideration to be given to expanding the scope of GTT to more services and greater levels of analysis o Continue to progress optimisation of Audit processes across CCDHB • Support improved patient experience through increased patient involvement in decision making (at all levels), and the introduction of national survey questions as part of DHB systems for capturing consumer feedback o Wairarapa and Hutt have moved away from the paper based patient survey in preparation for commencing the electronic patient experience feedback o 13/14 the 3DHB have started to develop a strategy for improved consumer engagement across the sub-region and how we begin to include the consumers at all levels of health care planning, delivery and review. 14/15 will see this embedded into the 3 DHB culture with consumers from a wide range of interests included. o CCDHB implemented an electronic patient survey process in late 2013, have been analysing the feedback and improving service as a result. CC will be adopting the national survey in addition to the local one so that complete data is available	• Results of the SSI data collected on orthopaedic patients • Actions implemented from the monthly reports of consumer feedback from electronic survey • Consumer Council established in 2014/15

Area	Actions	Indicators of Success
	nationally. In addition CC will be trialling full detailed consumer analysis down to ward level in 2014/15 o CCDHB will be coordinating and managing the implementation of a Consumer Council for the 3 DHBs in the sub region to enable full engagement of consumers in some of the non-clinical decisions at the DHBs. • Support continued implementation of quality accounts o Wairarapa and Hutt have a development plan for the next set of quality accounts based on the feedback received from the first 13/14 set of accounts. • Improving patient safety and reducing healthcare harm o Wairarapa and Hutt continuing to report through all serious and adverse events to the HQSC o Reducing the incidence of pressure injuries over the 14/15 through enhanced skin integrity assessments and early identification and intervention to reduce harm. o 14/15 Wairarapa and Hutt are moving towards a common shared workspace to allow better audit and monitoring capabilities and greater visibility. o 14/15 the shared workspace between Wairarapa and Hutt will also centralise clinical risk registers allowing more joined work on shared issues, reducing duplication and making better use of limited resources. o 14/15 will see the development of more 3DHB clinical policies and protocols resulting in increased patient safety, mitigating the risk of staff working across three sites and trying to work to different policies. o Serious and Adverse events continue to be captured in the CCDHB system, analysed and reported monthly to SCGC and HHS. Progress to be made in 2014/15 to combine the systems across the sub-region so that a 3D perspective can be provided. CCDHB to design and implement a service review process (to include service credentialing) for implementation during 2014/15 that will supersede the service health-check process that has been running for some years. Design/implement Continuous Improvement framework, training, coaching and delivery of further benefits across sub-region from reduction in waste/optimisation of process and tools. Progress development and implementation of shared workspaces across the sub-region where appropriate. For example risk management, reportable events, service management and continuous improvement 2013/14 Quality Accounts will be produced during 2014/15 in accordance with guidance from HQSC	• 2013/14 Quality Accounts published for each DHB

2.5.3 Actions to Support Regional Priorities

Regional Alignment: Refer to Regional Services Plan 2014/15. Further activities can be found in the related section areas, such as 2.3.3 Mental Health and Addiction Service Development Plan, 2.3.8 Increased Access to Diagnostics, 2.3.13 Health of Older People.

Major Trauma

- Identify sub-regional clinical lead for Major Trauma
- Establish sub-regional co-ordinator role for Major Trauma to identify patients who meet criteria and capture relevant data
- Align local trauma definitions to those used in the New Zealand Major Trauma Dataset (NZMTMD), and establish processes to collect and report required data

Workforce

Refer 2.5.1 National Entity Priority Initiatives, Health Workforce NZ; Module 5 – Stewardship 5.3 Strengthening Our Workforce; and to Regional Services Plan 2014/15 for regional activity

IT

Refer 2.5.1 National Entity Priority Initiatives, National Health IT Board; Module 5 – Stewardship 5.2.3 Information Technology; and to Regional Services Plan 2014/15 for regional activity

Module 3: Statement of Performance Expectations

3.1 Measuring our performance

As the major funder and provider of health and disability services in the Hutt Valley, 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 of the Hutt Valley health system.

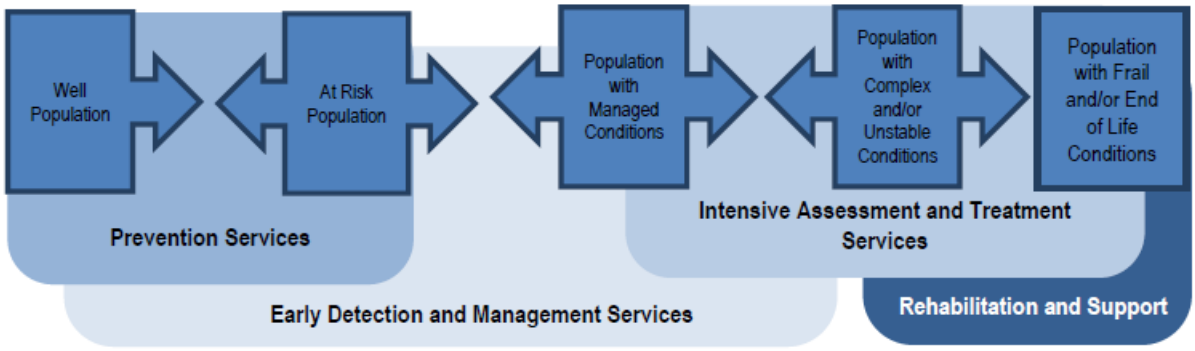


Figure 5: Scope of DHB Operations - Output Classes against the Continuum of Care

Continuum of Care

In the Statement of Performance Expectations, the DHB links outputs to the desired medium-term impacts, which in turn influence achievement of long-term outcomes (outlined in Module 1.4). 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

Output class definitions are in Module 1.2.3. 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

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 maintaining 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 2012/13 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. Wherever possible measures will be monitored with a focus on reducing inequalities, and targets are the same across total population and other population groups.

3.2 Output Classes and Measures of DHB Performance

3.2.1 Prevention 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. Maori 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. 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/Whanau, 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.

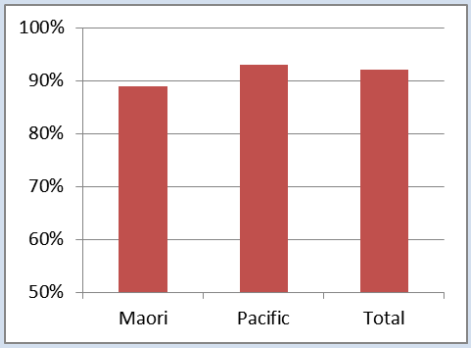
In 2014/15 Hutt Valley DHB will increase its work with primary health care providers to reduce the risk of chronic diseases and cancer, reduce the burden of preventable hospitalisations and increase immunisation and cancer screening rates. Hutt Valley DHB will continue to work with the district's communities and local government to ensure healthier environments (e.g. clean air, safe water, healthy housing).

Historical Performance

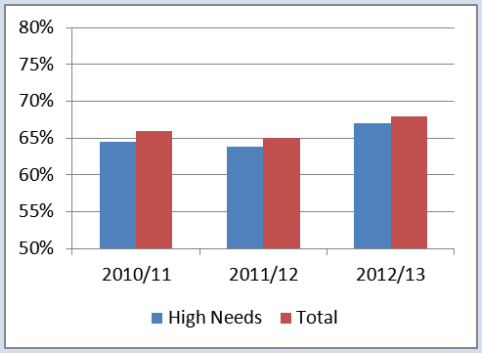
The DHB has attained the following results for priority measures, which provide background on why targets have been set at current levels.

Immunisation

The percentage of eight month olds fully vaccinated

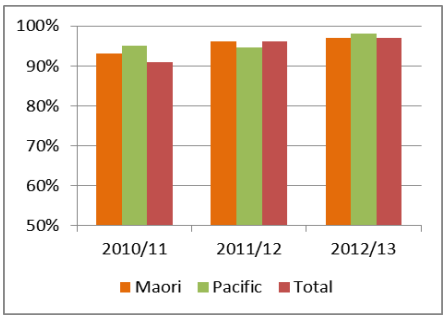


The percentage of enrolled people over 65 years vaccinated against flu

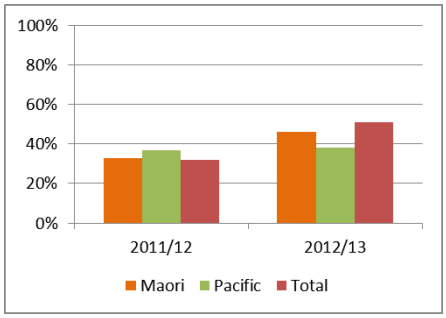


Smoking Cessation

The percentage of hospitalised smokers receiving advice and help to quit



The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking



Performance Measures

The DHB will monitor performance for 2014/15 with the following outputs:

Measure	Type of Measure	Baseline 2012/13	Target 2014/15	National Baseline
Immunisation Services				
Health Target: The percentage of eight month olds fully vaccinated	C	92%	**95%**	90%
The percentage of Yr 7 children provided Boosterix vaccination in schools [9]	C	70%	**70%**	
The percentage of Yr 8 girls vaccinated against HPV (final dose)	C	69%	**≥60%**[10]	
The percentage of enrolled people over 65 years vaccinated against flu	C	68%	**70%**	
High Needs		67%		
Smoking Cessation				
Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	97%	**95%**	96%
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	51%	**90%**	57%
Screening Services				
The percentage of eligible children receiving a Before School Check	C	83%	**90%**	80%
High Need		83%		80%
The percentage of eligible women (25-69) having cervical screening in the last 3 years[11]	C	80%	**≥80%**	77%

[9] Baselines (2013) and targets (2014) for Yr 7 Boosterix and Yr 8 HPV immunisations are for the calendar year to align with school year.
[10] Target aligned to national target
[11] Data from National Screening Unit for breast and cervical screening. Baseline for Cervical screening for 3 yrs to 30 June 2013.

Measure	Type of Measure	Baseline 2012/13	Target 2014/15	National Baseline
Maori		64%		63%
Pacific		67%		69%
The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	67%	**70%**	
Maori		58%		
Pacific		60%		

Health Promotion and Public Health Services			
Measure	**Type of Measure**	**Baseline**	**Target 2014/15**
The percentage of infants breastfed at 6 months[12]	C	63%	**59%**[13]
Number of new referrals to Public Health Nurses in primary/intermediate schools [14] – Hutt Valley DHB only	V	446	**786**
The number of disease notifications investigated[15]	V	2541	**2500**
The number of environmental health investigations	V	684	**680**
The number of premises visited for alcohol controlled purchase operations	V	280	**280**
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming	V	28	**28**

3.2.2 Early Detection and Management

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 24 practices in the Hutt Valley district and the best estimate is that approximately 96%[16] 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.

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 30 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.

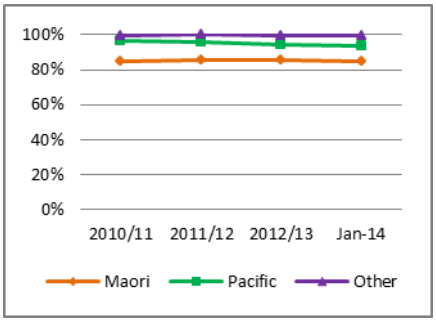
[12] Plunket data only, for exclusive, full and partial breastfeeding.
[13] National target
[14] Baseline for the six months July to December 2013. This measure will be aligned with the school (calendar) year rather than financial year. Target is estimated volumes, rather than a true 'target'.
[15] This and the following measures are part of RPH's statutory activity and cover the three DHBs.
[16] As at 1 January 2014

Historical Performance

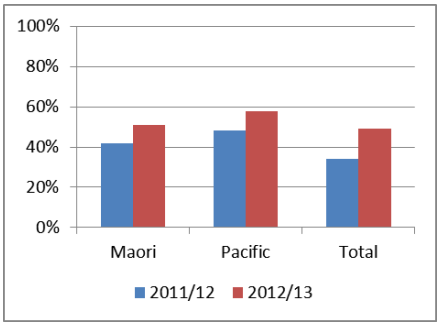
The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.

Screening

The percentage of the Hutt Valley DHB domiciled population enrolled in a PHO

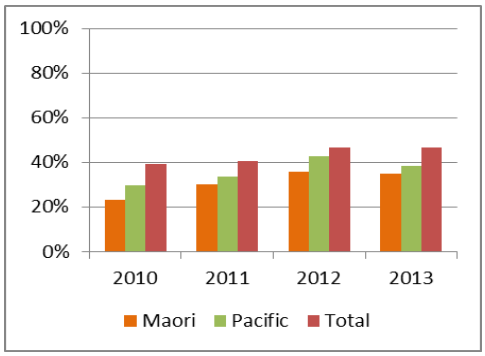


The percentage of eligible people assessed for CVD risk within the last five years

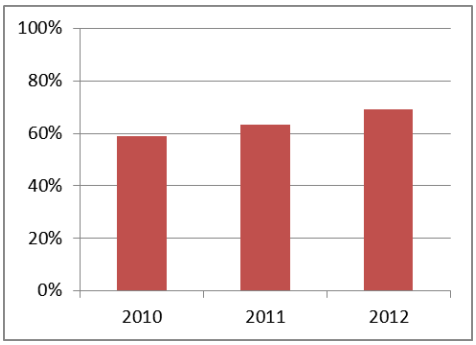


Oral Health

The percentage of children under 5 years enrolled in DHB funded dental services



The percentage of adolescents accessing DHB funded dental services



Performance Measures

The DHB will monitor performance for 2014/15 with the following outputs:

Measure	Type of Measure	Baseline	Target 2014/15	National Baseline
Primary Care Services				
The number of DHB domiciled population enrolled in a PHO[17]	V	140,529	**140,367**	
Maori		21,665	**22,045**	
Pacific		11,385	**11,394**	
The percentage of the PHO enrolled population enrolled in Care Plus[18]	C	5%	**5%**	
The ratio of nurse and GP visits by high need	V	1.05	**≥1.05**	

[17] Baselines April to June 2013 quarter

[18] Ibid

Measure	Type of Measure	Baseline	Target 2014/15	National Baseline
patients versus non high need patients [19]				
Health Target: The percentage of eligible people assessed for CVD risk within the last five years	C	49%	**90%**	67%

Oral Health Services					
Measure	**Type of Measure**	**Baseline 2013**	**Target**		**National Baseline**
As oral health measures are reported on a calendar year the Ministry of Health requests targets be specified for each year.			**2014**	**2015**	
The percentage of children under 5 years enrolled in DHB funded dental services	C	47%	**85%**	**85%**	
The percentage of adolescents accessing DHB funded dental services	C	69%[20]	**85%**	**85%**	70%

3.2.3 Intensive Assessment and Treatment Services

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 & Coast District Health Board for tertiary cancer treatment services, mainly chemotherapy and radiotherapy services. Hutt Valley DHB is 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.

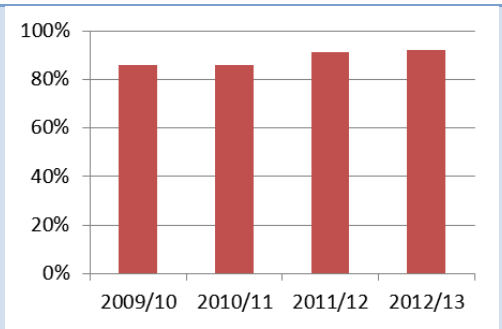
The Ministry of Health estimates that those in highest need of mental health services represent around 3% of the population. Hutt Valley DHB currently funds Mental Health and Addiction Services provided by Hutt Hospital and NGO providers, including a range of regional specialty services primarily delivered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

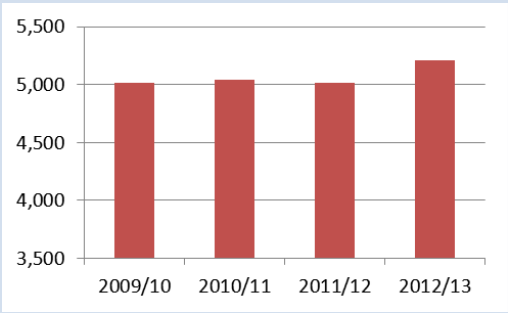
Historical Performance

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

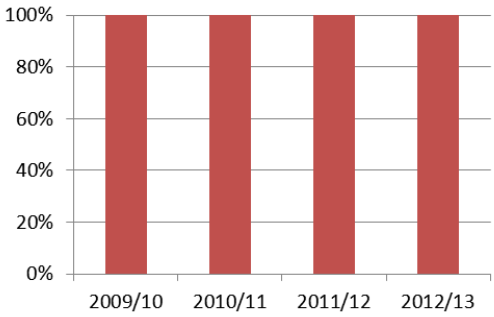
The percentage of patients admitted, discharged or transferred from ED within six hours	The number of surgical elective discharges delivered by any DHB for the Hutt Valley domiciled population

[19] The ratio (high need: non high need) of standardised GP and nurse utilisation rate. This measures equity of access, as those with high needs are likely to require more visits.
[20] 2012 calendar year baseline

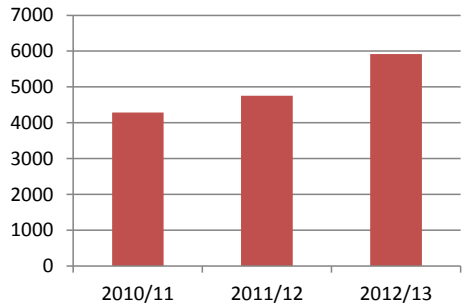




The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy



The number of people accessing secondary mental health services



Performance Measures

The DHB will monitor performance for 2014/15 with the following outputs:

Measure	Type of Measure	Baseline	Target 2014/15	National Baseline
Medical and Surgical Services				
Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	92%	**95%**	93%
Health Target: The number of surgical elective discharges delivered by any DHB for the Hutt Valley domiciled population	V	5,208	**5,014**	
The average length of stay for inpatients (days) – Acute	T	3.88	**3.88**	3.99
Elective		3.15	**3.15**	3.36
Quality Measures				
The percentage of "DNA" (did not attend) appointments for outpatient first specialist assessments	Q	7%	**6%**[21]	
Maori		15%		
Pacific		16%		
The number of hospital acquired pressure sores	Q	23	**0**	

[21] This is a long-term target

Measure	Type of Measure	Baseline	Target 2014/15	National Baseline
The number of central line acquired bacteraemia infections in ICU	Q	0	**0**	
The rate of falls per 1000 bed days	Q	3.93	**<3.93**	
The rate of medication errors per 1000 bed days	Q	1.9	**<1.9**	
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 number of people accessing secondary mental health services	V	5,920	**6,300**	
Maori		1,642	**1,747**	
Pacific		338	**360**	
Percentage of people admitted to an acute mental health inpatient service who were seen by mental health community team in the 7 days prior to the day of admission	Q	46%	**75%**	58%
Percentage of people discharged from an acute mental health inpatient service who were seen by mental health community team in the 7 days following the day of discharge	Q	51%	**90%**	62%
The percentage of patients 0-19 referred to non-urgent mental health services who are seen within eight weeks	T	78%	**95%**	88%
The percentage of patients 0-19 referred to non-urgent addictions services who are seen within eight weeks	T	97%	**95%**	89%

3.2.4 Rehabilitation and Support

Local Environment

The population of older people (65 years and over) in the district is 20,495[22] or 14% of the Hutt Valley total population compared with 15% for New Zealand. The Hutt Valley 65 plus population is projected to increase by 44% between 2014 and 2026. Contracted providers include 15 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.

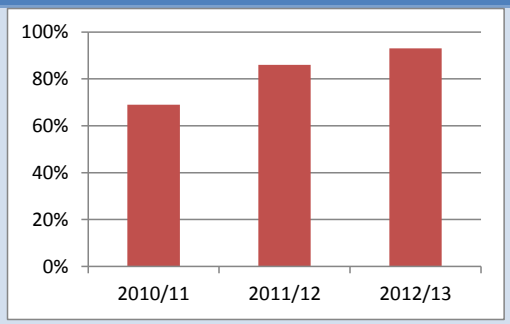
[22] Based on Statistics New Zealand projections for 2014/15

The three DHBs seek to improve accessibility, responsiveness and health outcomes for people with disabilities. Disability relates to the interaction between the person with the impairment and the environment. Planned actions are outlined in the Wairarapa, Hutt Valley and CCDHB NZ Disability Strategy and UN Convention on the Rights of Persons with Disabilities Implementation Plan: Valued Lives, Full Participation 2013-2018.
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.

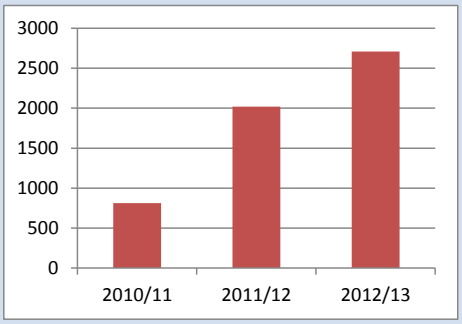
Historical Performance

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

The percentage of residential care providers meeting three year certification standards



The number of InterRAI assessments



Performance Measures

The DHB will monitor performance for 2014/15 with the following outputs:

Measure	Type of Measure	Baseline	Target 2014/15
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	Q	100%	**≥95%**
The number of InterRAI assessments	V	2,709	**≥2,709**
The number of people receiving home and community support services[23]	V	1,917	**1,936**
The number of days of Short-term Care (respite bed days, day respite, and community day activity support)[24]	V	9,383	**9,852**
The number of subsidised aged residential care bed days	V	309,225	**309,225**
The percentage of residential care providers meeting three year certification standards[25]	Q	**93%**	**≥93%**
The number of Disability Forum meetings (sub-regional and local)	V		**2**

[23] This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status
[24] Only includes volume paid as fee for service and excludes bulk-funded dedicated respite beds (3 Beds in Hutt Valley)
[25] Excluding new providers and facilities as these are required to have a one year certification

Module 4: Financials

4.1 Financial Assumptions

The assumptions are the best estimates of future factors which affect the predicted financial results. As such there is necessarily a degree of uncertainty about the accuracy of the predicted result, which is unable to be quantified.

Factors which may cause a material difference between these prospective financial statements and the actual financial results would be a change in the type and volume of services provided, significant movement in staff levels and remuneration, plus unexpected changes in the cost of goods and services required to provide the planned services.

4.1.1 Revenue

- PBFF Increase of $6.5M as per Funding Envelope.
- IDF levels based on Funding Envelope or agreed changes within the sub-region.

4.1.2 Expenditure

- Personnel expenditure increase in line with sub-regionally agreed financial assumptions of 1%
- Supplies and expenses based on current contract prices where applicable
- Provider Arm 2013/14 achieved baseline savings targets are included in 2014/15 where these are on-going
- Depreciation to include base, plus work in progress, plus new purchases
- Capital Charge at 8% payable half yearly
- Debt renewals based on DMO quoted future rate projections
- Total Capital Expenditure of up to $12 million p.a. is planned from 2014/15

4.2 Capital Plan

The operational capital funding requirements for the Provider Arm will be met from cash flow from depreciation expense and prioritised with the clinical leaders both within the Directorates and across the Provider Arm. Only items of a legal & safety nature, or essential to support the District Annual and Strategic Plans have been included in the CAPEX budget. The baseline CAPEX for 2014/15 of $6.95 million and $5.03 million for strategic capex is required to be funded internally.

4.3 Debt & Equity

4.3.1 Equity drawing

No additional deficit support is required for the 2014/15 financial year.

4.3.2 Core Debt

The net interest cost on the Core CHFA debt of $79 million is currently between 2.75% and 6.54%, and the plan assumes roll-over of maturing debt in 2014/15 of $8 million in April 2015 at 3.55% ($4 million) and 4.5% ($4 million).

4.4 Working capital

The Board has a working capital facility with the Westpac bank, which is part of the national DHB collective banking arrangement negotiated by HBL. This facility is limited to one month's provider's revenue, to manage fluctuating cash flow needs for the DHB.

4.5 Gearing and Financial Covenants

No gearing or financial covenants are in place.

4.6 Asset Revaluation

Current policy is for land and buildings to be revalued every 3 – 5 years. A full revaluation was last completed in the year ended 30 June 2010 with desktop valuations done each yearend since. HVDHB are planning a full asset revaluation in 2014/15).

4.7 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.

4.8 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 Maori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi. No land has been identified as surplus to requirements within this plan.

4.9 Prospective Financial Statements

Financial Performance

DHB Provider

Forecast of Statement of Comprehensive Income

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
Operating Income	220,079	225,332	224,747	225,075	226,448	227,829
Interest	1,041	1,138	1,100	1,107	1,113	1,120
Total Income	**221,120**	**226,470**	**225,847**	**226,182**	**227,561**	**228,949**
Expenditure						
Personnel Costs	153,214	156,510	159,320	158,941	159,944	160,916
Depreciation	11,450	10,983	11,108	12,111	12,589	13,097
Outsourced Services	9,194	11,019	8,794	9,199	8,736	8,143
Clinical Supplies	24,829	27,919	25,608	25,002	25,572	26,398
Infrastructure & Non-Clinical Expenses	26,272	24,989	29,308	28,188	27,884	27,743
Internal Allocations	(585)	(637)	(623)	(627)	(630)	(634)
Total Expenditure	**224,374**	**230,783**	**233,515**	**232,814**	**234,094**	**235,663**
Net Surplus/(Deficit)	**(3,254)**	**(4,313)**	**(7,668)**	**(6,633)**	**(6,533)**	**(6,713)**
Other Comprehensive Income						
Revaluation of Land and Buildings	-	-	-	-	-	-
Total Comprehensive Income	**(3,254)**	**(4,313)**	**(7,668)**	**(6,633)**	**(6,533)**	**(6,713)**

Governance and Administration

Forecast of Statement of Comprehensive Income

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
Operating Income	3,143	3,270	3,270	3,205	3,224	3,244
Interest	-	-	-	-	-	-
Total Income	**3,143**	**3,270**	**3,270**	**3,205**	**3,224**	**3,244**
Expenditure						
Personnel Costs	941	61	85	85	86	86
Depreciation	2	1	1	1	1	1
Outsourced Services	933	2,013	2,050	2,062	2,075	2,087
Clinical Supplies	5	10	0	0	0	0
Infrastructure & Non-Clinical Expenses	412	482	427	429	572	434
Internal Allocations	585	637	623	627	630	634
Total Expenditure	**2,878**	**3,204**	**3,184**	**3,205**	**3,364**	**3,244**
Total Comprehensive Income	**265**	**66**	**86**	**0**	**(140)**	**0**

DHB Funder

Forecast of Statement of Comprehensive Income

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
Operating Income	407,708	418,128	424,090	427,363	429,970	432,593
Total Income	**407,708**	**418,128**	**424,090**	**427,363**	**429,970**	**432,593**
Expenditure						
Hutt Provider Arm and Governance	189,047	194,220	191,653	192,136	193,308	194,488
Other District Health Boards	80,163	81,506	80,988	81,463	81,960	82,460
Non Health Board Providers	138,470	139,976	143,867	147,131	148,029	148,932
Total Expenditure	**407,680**	**415,702**	**416,508**	**420,731**	**423,297**	**425,879**
Total Comprehensive Income	**28**	**2,426**	**7,582**	**6,633**	**6,673**	**6,714**
Expenditure Breakdown						
Personal Health	325,281	331,137	334,064	337,699	339,759	341,832
Mental Health	40,153	38,368	38,721	39,074	39,312	39,552
DSS	53,278	54,838	54,519	55,592	55,931	56,272
Public Health	642	897	1,407	729	733	738
Maori Health	1,229	1,237	1,274	1,282	1,290	1,298
Hutt Governance	3,012	5,633	3,151	3,085	3,103	3,122
Total Expenditure	**423,595**	**432,110**	**433,136**	**437,460**	**440,129**	**442,814**

Hutt Valley District Health Board

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

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
Operating Income	441,883	452,509	460,454	463,507	466,334	469,179
Interest	1,041	1,138	1,100	1,107	1,113	1,120
Total Income	**442,924**	**453,647**	**461,554**	**464,613**	**467,447**	**470,299**
Expenditure						
Personnel Costs	154,155	156,571	159,404	159,026	160,029	161,002
Depreciation	11,452	10,985	11,109	12,112	12,590	13,098
Outsourced Services	10,127	13,031	10,843	11,261	10,811	10,230
Clinical Supplies	24,834	23,886	25,608	25,002	25,572	26,398
Infrastructure & Non-Clinical Expenses	26,684	29,516	29,735	28,617	28,456	28,178
Other District Health Boards	80,163	81,506	80,988	81,463	81,960	82,460
Non Health Board Providers	138,470	139,976	143,867	147,131	148,029	148,932
Total Expenditure	**445,885**	**455,471**	**461,554**	**464,614**	**467,448**	**470,298**
Net Surplus/(Deficit)	**(2,961)**	**(1,824)**	**(0)**	**(0)**	**(0)**	**0**
Other Comprehensive Income						
Revaluation of Land and Buildings	-	-	-	-	-	-
Total Comprehensive Income	**(2,961)**	**(1,824)**	**(0)**	**(0)**	**(0)**	**0**

Movements in Equity

Hutt Valley District Health Board

Forecast of Statement of Changes in Equity
For the Year Ended 30 June

$000s	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Equity as at 1July	**68,308**	**94,579**	**93,038**	**93,038**	**93,038**	**93,038**
Capital Contributions from the Crown	-	1,066	2,067	2,067	2,067	2,067
Repayment of Equity to the Crown	(207)	(207)	-	-	-	-
Revaluation Surplus	29,439	-	-	-	-	-
Total Comprehensive Income for the Year	(2,961)	(1,824)	(0)	(0)	(0)	0
Equity as at 30June	**94,579**	**93,614**	**95,105**	**95,104**	**95,104**	**95,106**

Financial Position

Hutt Valley District Health Board

Forecast of Statement of Financial Position

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Assets						
Current Assets						
Cash and Cash Equivalents	24,650	23,623	22,576	25,980	29,960	34,435
Debtors and Other Receivables	11,860	15,641	13,408	13,293	13,293	13,293
Inventories	1,435	1,466	1,492	1,492	1,492	1,492
Total Current Assets	**37,945**	**40,730**	**37,476**	**40,766**	**44,746**	**49,221**
Non Current Assets						
Property, Plant and Equipment	205,014	197,639	199,115	194,802	190,079	185,801
Intangible Assets	3,302	8,823	11,316	11,604	11,526	11,329
Investment in Joint Ventures	1,280	2,744	1,350	2,130	2,737	2,737
Trust and Bequest Funds	1,099	1,288	1,187	1,187	1,187	1,187
Total Non Current Assets	**210,695**	**210,494**	**212,968**	**209,722**	**205,528**	**201,054**
Total Assets	**248,640**	**251,224**	**250,444**	**250,488**	**250,274**	**250,274**
Liabilities						
Current Liabilities						
Creditors and Other Payables	39,035	40,970	38,616	39,143	39,143	39,143
Employee Entitlements and Provisions	25,452	26,996	28,281	28,281	28,281	28,281
Borrowings	11,208	8,991	15,328	15,245	15,031	19,581
Total Current Liabilities	**75,695**	**76,957**	**82,225**	**82,668**	**82,454**	**87,004**
Non Current Liabilities						
Employee Entitlements and Provisions	6,978	6,440	6,978	6,978	6,978	6,978
Borrowings	70,291	72,925	64,949	64,550	64,550	60,000
Trust and Bequest Funds	1,099	1,288	1,187	1,187	1,187	1,187
Total Non Current Liabilities	**78,368**	**80,653**	**73,114**	**72,715**	**72,715**	**68,165**
Total Liabilities	**154,063**	**157,610**	**155,339**	**155,383**	**155,169**	**155,169**
Equity						
Crown Equity	44,078	44,937	46,530	46,530	46,530	46,530
Revaluation Reserves	79,805	79,807	79,805	79,805	79,805	79,805
Retained Earnings	(29,306)	(31,130)	(31,230)	(31,230)	(31,230)	(31,230)
Total Equity	**94,577**	**93,614**	**95,105**	**95,105**	**95,105**	**95,105**
Total Equity and Liabilities	**248,640**	**251,224**	**250,444**	**250,488**	**250,274**	**250,274**

Cash Flow

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

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Cash Flows from Operating Activities						
Cash Receipts	442,377	463,954	459,635	463,528	466,334	469,179
Payments to Providers	(220,805)	(234,992)	(224,854)	(228,594)	(229,989)	(231,392)
Payments to Suppliers and Employees	(208,790)	(209,752)	(212,634)	(211,829)	(213,211)	(214,899)
Goods and Services Tax (Net)	130	(168)	(5)	-	-	-
Capital Charge Paid	(5,308)	(7,410)	(8,240)	(8,290)	(8,341)	(8,392)
Net Cash Flows from Operating Activity	**7,604**	**11,632**	**13,902**	**14,814**	**14,794**	**14,496**
Cash Flows from Investing Activities						
Interest Received	1,053	1,137	1,100	1,107	1,113	1,120
Proceeds from Sale of Property, Plant and Equipment	300	-	(7)	(7)	(8)	(8)
Purchase of Sale of Property, Plant and Equipment	(6,733)	(9,648)	(11,979)	(8,087)	(8,396)	(9,101)
Investments	(1,867)	(1,464)	(1,337)	(780)	(607)	-
Net Cash Flows from Investing Activity	**(7,247)**	**(9,975)**	**(12,223)**	**(7,768)**	**(7,897)**	**(7,988)**
Cash Flows from Financing Activities						
Equity Contribution	-	1,066	1,000	-	-	-
Loans Raised	(689)	1,312	(696)	(482)	(214)	-
Interest Paid	(4,029)	(3,960)	(3,490)	(3,159)	(2,703)	(2,033)
Payment of Finance Leases	-	(895)	-	-	-	-
Repayment of Equity	(207)	(207)	-	-	-	-
Net Cash Flows from Financing Activity	**(4,925)**	**(2,684)**	**(3,186)**	**(3,641)**	**(2,917)**	**(2,033)**
Net Increase / (Decrease) in Cash Held	(4,568)	(1,027)	(1,508)	3,404	3,980	4,475
Cash and Cash Equivalents at Beginning of Year	29,218	24,650	24,084	22,576	25,980	29,960
Cash and Cash Equivalents at End of Year	**24,650**	**23,623**	**22,576**	**25,980**	**29,960**	**34,435**

Capex

Hutt Valley District Health Board

Capital Expenditure

For the Year Ended 30 June

$000s	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Baseline Expenditure						
Property and Plant	624	642	3,000	3,000	3,000	3,000
Clinical Equipment	561	1,224	2,000	2,000	2,000	2,000
Computer Equipment	1,570	1,907	1,850	1,850	1,850	1,850
Other Equipment	8	5	100	100	100	100
Motor Vehicles	-	-	-	-	-	-
Total Baseline	**2,763**	**3,778**	**6,950**	**6,950**	**6,950**	**6,950**
Strategic Expenditure						
Property and Plant	1,844	61	-	-	-	-
Clinical Equipment	3,191	652	-	894	840	1,675
Computer Equipment	2,054	4,311	5,029	1,023	607	-
Other Equipment	-	-	-	-	-	-
Motor Vehicles	-		-	-	-	-
Total Strategic	**7,089**	**5,024**	**5,029**	**1,917**	**1,447**	**1,675**
Total Capital Expenditure	**9,852**	**8,803**	**11,979**	**8,867**	**8,397**	**8,625**
Financed By						
Internally Sourced Funding	(2,961)	(1,824)	(767)	(0)	(0)	0
Equity Injections for Deficit Support	-	-	-	-	-	-
Depreciation	11,452	10,985	926	12,112	12,590	13,098
Sale of Fixed Assets	300	-	(1)	(7)	(8)	(8)
Equity Injections for Capital Expenditure	(207)	860	1,000	-	-	-
Private Debt	(689)	1,312	(58)	(482)	(214)	-
CHFA Debt	-	-	-	-	-	-
Other (Includes Cash Reserves)	30,215	25,938	26,839	23,763	27,167	31,147
Total Finance	**38,110**	**37,271**	**27,939**	**35,386**	**39,536**	**44,239**

FTEs

DHB Provider

FTEs by Class

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Medical	233	232	235	235	235	235
Nursing	697	717	703	703	703	703
Allied Health	432	428	448	448	448	448
Non-Allied Health	137	135	128	128	128	128
Management/Clerical	300	298	286	286	286	286
Total FTEs	**1,800**	**1,811**	**1,801**	**1,801**	**1,801**	**1,801**

DHB Governance & Administration

FTEs by Class

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Medical	1	-	-	-	-	-
Nursing	-	-	-	-	-	-
Allied Health	-	-	-	-	-	-
Non-Allied Health	-	-	-	-	-	-
Management/Clerical	15	1	1	1	1	1
Total FTEs	**16**	**1**	**1**	**1**	**1**	**1**

Hutt Valley District Health Board

FTEs by Class

For the Year Ended 30 June

	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Medical	234	232	235	235	235	235
Nursing	697	717	703	703	703	703
Allied Health	432	428	448	448	448	448
Non-Allied Health	137	135	128	128	128	128
Management/Clerical	315	299	287	287	287	287
Total FTEs	**1,816**	**1,811**	**1,802**	**1,802**	**1,802**	**1,802**

Key Financial Information

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

$000s	2012/13 Audited	2013/14 Audited	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Revenue	442,924	453,647	461,554	464,613	467,447	470,299
Expenditure	(445,885)	(455,471)	(461,554)	(464,614)	(467,448)	(470,298)
Revaluation of Land and Buildings	-	-	-	-	-	-
Total Comprehensive Income	**(2,961)**	**(1,824)**	**(0)**	**(0)**	**(0)**	**0**
Total Property, Plant & Equipment	205,014	197,639	199,115	194,802	190,079	185,801
Total Equity	94,577	93,614	95,105	95,105	95,105	95,105
Term Borrowings	70,291	72,925	64,949	64,550	64,550	60,000

Expenditure Category

Expenditure Category	2012/13 Audited $m	2013/14 Audited $m	2014/15 Plan $m	2015/16 Plan $m	2016/17 Plan $m	2017/18 Plan $m
DHB Provider Arm	224.4	230.8	233.5	232.8	234.1	235.7
Funder Arm	138.5	140.0	143.9	147.1	148.0	148.9
Services Purchased from Other DHBs (IDF Outflows)	80.2	81.5	81.0	81.5	82.0	82.5
Governance Arm	2.9	3.2	3.2	3.2	3.4	3.2
Total Allocated	**445.9**	**455.5**	**461.6**	**464.6**	**467.4**	**470.3**
Funding (excluding IDF inflows below)	394.7	403.4	408.0	411.4	413.9	416.4
Services provided for Other DHBs (IDF Inflows)	48.2	50.3	53.6	53.2	53.6	53.9
Total Funding	**442.9**	**453.6**	**461.6**	**464.6**	**467.4**	**470.3**
Surplus / (Deficit)	**(3.0)**	**(1.8)**	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**

Financial Performance

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

$000s	2012\13 Audited	2013\14 Actual	2014\15 Plan	2015\16 Plan	2016\17 Plan	2017\18 Plan
Income						
Operating Income	236,851	256,382	248,929	249,721	251,247	252,783
Interest Income	1,010	1,042	1,007	1,013	1,019	1,025
Total Income	**237,861**	**257,424**	**249,936**	**250,734**	**252,266**	**253,808**
Expenditure						
Personnel Costs	122,857	136,154	132,293	131,702	132,546	133,344
Depreciation	10,546	10,014	10,123	11,164	11,642	12,151
Outsourced Services	8,264	10,393	7,932	8,410	7,941	7,344
Clinical Supplies	20,697	21,308	21,191	20,517	21,059	21,858
Infrastructure and Non Clinical Expenses	13,548	12,938	14,284	13,443	13,596	13,980
Other District Health Boards	63,417	63,117	62,187	62,566	62,948	63,332
Non Health Board Providers	4,565	5,993	3,705	3,728	3,751	3,774
Capital Charge	4,156	6,088	6,773	6,814	6,856	6,897
Interest Expense	3,753	3,863	3,384	3,053	2,597	1,927
Other	2,385	2,832	2,725	2,742	2,759	2,776
Internal Allocations	(7,289)	(5,314)	(6,396)	(6,435)	(6,474)	(6,513)
Total Expenditure	**246,899**	**267,386**	**258,201**	**257,704**	**259,222**	**260,871**
Net Surplus / (Deficit)	**(9,038)**	**(9,962)**	**(8,265)**	**(6,970)**	**(6,956)**	**(7,063)**

Financial Performance

Prevention

Forecast Statement of Financial Performance

For the Year Ended 30 June

$000s	2012\13 Audited	2013\14 Actual	2014\15 Plan	2015\16 Plan	2016\17 Plan	2017\18 Plan
Income						
Operating Income	20,723	22,039	21,568	21,515	21,644	21,773
Interest Income	19	57	55	56	56	56
Total Income	**20,742**	**22,096**	**21,623**	**21,571**	**21,700**	**21,830**
Expenditure						
Personnel Costs	12,441	12,773	13,259	13,387	13,462	13,550
Depreciation	223	254	145	221	221	221
Outsourced Services	1,063	1,133	1,389	1,320	1,329	1,337
Clinical Supplies	956	1,035	755	800	805	810
Infrastructure and Non Clinical Expenses	502	577	627	614	608	621
Other District Health Boards	-	62	59	59	60	60
Non Health Board Providers	1,712	1,281	1,317	1,325	1,333	1,341
Capital Charge	228	334	371	374	376	378
Interest Expense	62	62	62	62	62	62
Other	494	955	990	996	1,002	1,009
Internal Allocations	3,063	3,072	3,041	3,059	3,078	3,097
Total Expenditure	**20,744**	**21,538**	**22,016**	**22,218**	**22,336**	**22,487**
Net Surplus / (Deficit)	**(3)**	**558**	**(393)**	**(647)**	**(637)**	**(658)**

Financial Performance

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

$000s	2012\13 Audited	2013\14 Actual	2014\15 Plan	2015\16 Plan	2016\17 Plan	2017\18 Plan
Income						
Operating Income	126,408	114,541	128,255	129,396	130,186	130,980
Interest Income	12	37	36	36	37	37
Total Income	**126,420**	**114,578**	**128,291**	**129,432**	**130,222**	**131,017**
Expenditure						
Personnel Costs	15,509	4,267	10,363	10,427	10,490	10,554
Depreciation	672	704	828	716	716	716
Outsourced Services	586	1,083	1,093	1,100	1,107	1,113
Clinical Supplies	741	407	499	502	505	509
Infrastructure and Non Clinical Expenses	1,027	590	831	836	897	846
Other District Health Boards	11,946	14,666	15,158	15,232	15,325	15,419
Non Health Board Providers	83,595	82,059	87,009	88,977	89,520	90,065
Capital Charge	916	976	1,083	1,089	1,096	1,102
Interest Expense	41	41	41	41	41	41
Other	751	122	438	440	443	446
Internal Allocations	3,472	1,574	2,649	2,665	2,681	2,698
Total Expenditure	**119,256**	**106,489**	**119,992**	**122,025**	**122,821**	**123,510**
Net Surplus / (Deficit)	**7,164**	**8,089**	**8,299**	**7,407**	**7,402**	**7,507**

Financial Performance

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

$000s	2012\13 Audited	2013\14 Actual	2014\15 Plan	2015\16 Plan	2016\17 Plan	2017\18 Plan
Income						
Operating Income	57,910	59,548	61,702	62,873	63,256	63,643
Interest Income	-	2	2	2	2	2
Total Income	**57,909**	**59,550**	**61,704**	**62,875**	**63,258**	**63,645**
Expenditure						
Personnel Costs	3,348	3,378	3,489	3,510	3,532	3,553
Depreciation	11	14	13	11	11	11
Outsourced Services	215	423	429	431	434	437
Clinical Supplies	1,147	1,135	1,166	1,173	1,180	1,187
Infrastructure and Non Clinical Expenses	55	70	54	54	75	55
Other District Health Boards	4,800	3,661	3,583	3,605	3,627	3,649
Non Health Board Providers	48,600	50,644	51,835	53,101	53,424	53,750
Capital Charge	8	12	13	13	13	13
Interest Expense	2	2	2	2	2	2
Other	55	53	55	56	56	56
Internal Allocations	754	667	706	710	715	719
Total Expenditure	**58,995**	**60,059**	**61,345**	**62,666**	**63,070**	**63,432**
Net Surplus / (Deficit)	**(1,085)**	**(509)**	**359**	**209**	**189**	**213**

Module 5: Stewardship

5.1 Managing our business

This section details how the 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.

5.1.1 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 sub-regional CPHAC and DSAC, comprised of members from the Wairarapa, Hutt Valley and Capital & Coast Boards. This is to allow greater sub-regional 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 & Coast DHBs have maintained a 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. As part of the changes to the Maori Health directorate, the DHBs are looking toward a sub-regional iwi relationship model to commence in 2014/15, to continue to the existing DHB level relationships. There is also a joint Hutt Valley and Capital & Coast Sub-regional Pacific Health Strategy Group to ensure Pacific participation in service planning and service delivery for the protection and improvement of the health status of Pacific people.

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 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.

5.1.2 Performance Reporting

In the three DHBs, performance against Government targets, annual planning obligations and financial performance is monitored by the Chief Executive, Chief Operating Officer, SIDU, Executive Leadership Team and the Board (including through the Board's Committees).

As part of the closer working relationships between the Wairarapa, Hutt Valley and Capital & Coast DHBs, consideration is being given to what a sub-regional performance framework might look like.

5.1.3 Funder (SIDU) 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 & Coast DHBs. SIDU is responsible for:

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

The 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. SIDU 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 Funding and Provider funding details for the DHB for 2014/15 can be found in Module 4 - Financials.

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 on-going 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 Price Volume Schedule (PVS) 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 people).

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 any 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 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 three 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 for the DHBs.

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.

5.1.4 Provider Interests

3DHB Production Plan

For 2014/15 the three DHB provider arms have worked collaboratively on a 3DHB production plan, based on a consistent set of assumptions. As part of this, there is a view for each DHB and a combined view across the three. The providers have formulated this joint production plan to consider volume demands and from these derive theatre planning with a view to maximise use of existing resources. As part of the 3DHB production plan, the three DHBs have proactively considered initiatives such as length of stay reduction based on average complexity and worked towards an average length of stay that allows patients to get home more quickly without compromising quality of care. From this, the DHBs have determined the total expected bed days across the three DHBs to allow the teams to get individual DHB and a 3DHB view of bed demands.

Wairarapa DHB

The Wairarapa DHB's Provider Arm, which provides secondary care services, is based at Wairarapa Hospital.

The resources required to deliver these services include:

- $48m of land, buildings, clinical and other equipment mostly located on the Hospital campus
- $60m of revenue mainly provided by the Crown

Hutt Valley DHB

The Hutt Valley DHB's Provider Arm, which provides secondary and tertiary care services, is based at Hutt Hospital.

The resources required to deliver these services include:

- $213m of land, buildings, clinical and other equipment mostly located on the Hospital campus

- $226m of revenue mainly provided by the Crown

Capital & Coast DHB

Capital & 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:

- $517 million of land, buildings, clinical and other equipment mostly located on the hospital campus
- $627 million of revenue mainly provided by the Crown

A comprehensive plan is in place to address issues along the health continuum and establish sustainable clinical and financial outcomes. This 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 organisational change where required
- 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 include:

- Improvements to efficiencies from working collaboratively across 3DHB
- HealthPathways
- Supplies management
- Personnel costs
- Revenue

A performance management framework is in place within the Capital & Coast Provider Arm to monitor performance against initiatives and to mitigate risks as they arise.

5.1.5 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 Technical Advisory Service Ltd (CTAS) coordinates this Routine Audit Programme. In addition to the Routine Audit Programmes, 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 meets acceptable standards.

Wherever possible, all three DHBs endeavour to coordinate audit activity with other DHBs, in particular the sub-regional DHBs.
Independent IQA occurs on all large procurement, construction and ICT programmes of work.

5.2 Building Capability

5.2.1 National Entities Priorities and Regional Work

There are national entities which drive work that is most efficiently done nationally to achieve the best gains for the health sector, such as PHARMAC. As part of the national entities' work, DHBs contribute to ensure plans are suitable and able to be implemented nationally, as well as to rationalise expenditure on planning in these areas. Nationally, this includes work undertaken by Health Benefits Limited, National Health IT Board, Health Quality and Safety Commission, Health Workforce NZ, National Health Committee, Health Promotion Agency and PHARMAC. Annual detail on activities can be found in (Annual Plan text: 2.5.1 National Entity Priority Initiatives/ SOI text: the activities module of the Annual Plan).

DHBs also work together regionally to deliver the best services for their populations. Wairarapa, Hutt Valley and Capital & Coast DHBs are part of the Central Region. Detail on regional work can be found in the Central Region's Regional Services Plan, developed by Central Technical Advisory Services in conjunction with DHBs.

5.2.2 Workforce

It is recognised at a national, regional, sub-regional and local level that sustainable services rely on a stable, fit-for-purpose, clinical and non-clinical workforce. The three DHBs are committed to supporting the initiatives of HWNZ and partnering with our regional, sub-regional neighbours and local partners in developing a workforce that is fit-for-purpose for the coming years. This will require both a planned approach (focus on vulnerable services at a regional level and service initiatives via the 2D and 3D 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. As good employers and responsible health care providers we 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, 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 three DHBs actively involve staff and union partners in the development and renewal of policies and procedures on a regular basis to support consistent practice across the three DHBs.

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

The 2D and 3D programmes both have a workforce development and training component. As services transition to a sub-regional focus tailored workforce plans will need to be developed to support and enable the transition. This will consider new roles, alternative rostering arrangements, training, systems support and non-clinical support requirements. Change management support for our workforce will be key during the transition to 3 DHB services.

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

A key priority will be supporting our workforce through changes associated with national initiatives such as Health Benefits Limited activities.

5.2.3 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).

Work is underway across the sub-region to implement a 3DHB ICT function to deliver on the broader ICT enablement over the next three years. This will require prioritisation and pooling of the limited resources and expertise across the sub-region while also ensuring that ICT infrastructure, systems and services swiftly enable the sub-regional and regional outcomes. To support the new 3DHB ICT function, a 3DHB ICT Governance Group has recently been established. The group's representation includes executive level representation from Operations, Clinical, SIDU, Legal, and ICT. It will provide direction and oversight to the 3DHB ICT function to ensure alignment of ICT strategic plans, appropriate allocation and prioritise of resources, harmonisation of ICT policies and compliance with ICT privacy and security standards. Membership of this group may extend to cover Primary Care in the near future to ensure alignment of Primary-Secondary integration initiatives across the 3DHBs.

In tandem to this development, shared care records for Wairarapa, Hutt Valley, and Capital & Coast 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.

5.2.4 Infrastructure

The three DHBs have Asset Management Plans (AMP) which are prepared to assist in determining the on-going capital requirements to meet the DHBs' service objectives (**Refer** to Module 4 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.

Wairarapa DHB

As part of Tihei Wairarapa the Wairarapa DHB considered a range of options for the development of an integrated family health network (IFHN). These conversations with Primary Care and General Practice have recently been reinvigorated and will continue to be progressed through the 2014/15 Tihei Wairarapa work programme.

A number of other infrastructure projects will be progressed in 2014/15. 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.

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.

Capital & Coast DHB

Infrastructure and support is seen as a key enabler for 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 2014/15 include:

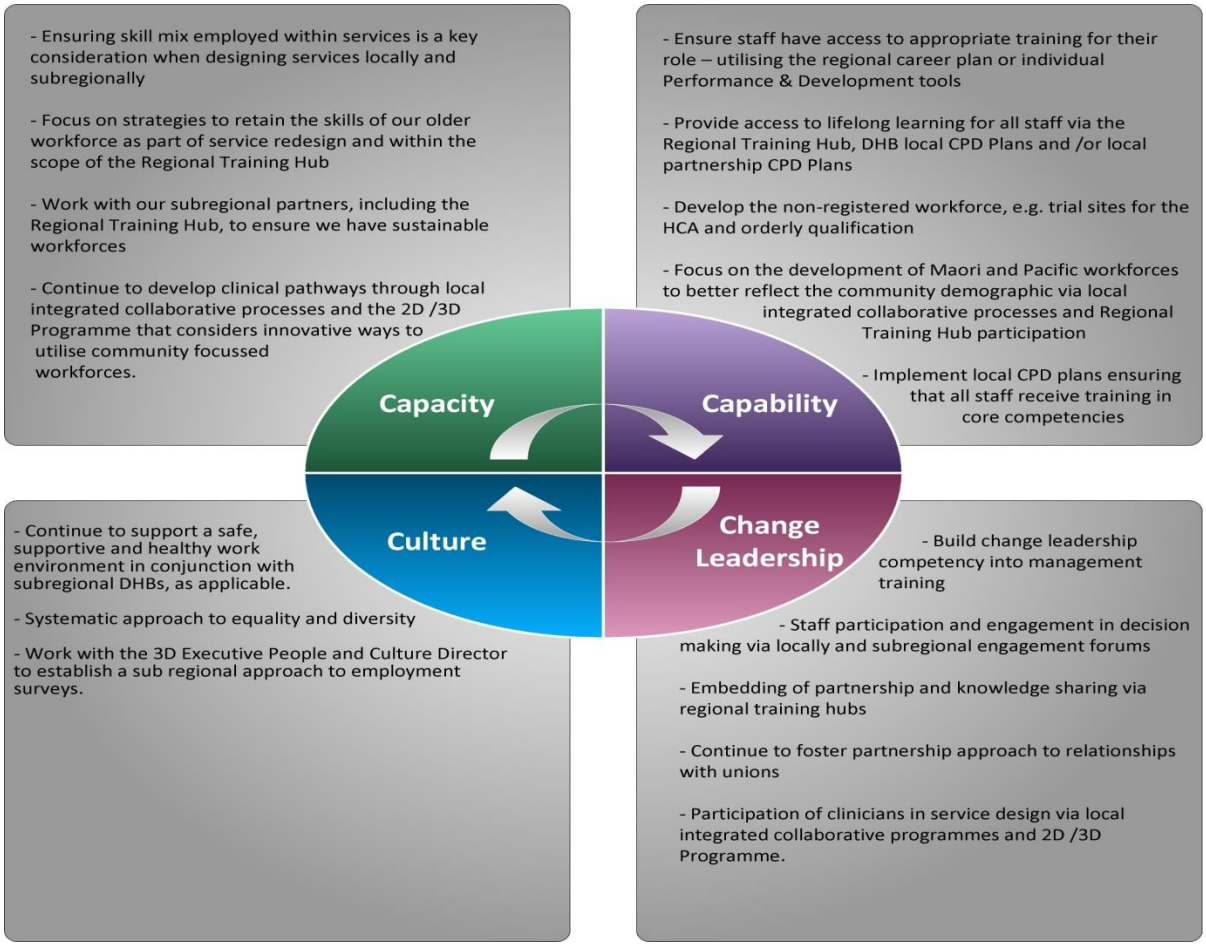
- Continued IT/IM developments following the implementation of EHR2 (Electronic Health Record) in 2010/11 and the development of the Central Region Information Services Plan (CRISP) over the next three years
- Corporate system development and enhancement including Payroll system improvements
- Disaster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

5.3 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 sub-region, 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 sub-regional 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 sub-regional Workforce Plan focuses on capacity, capability, culture and change leadership as depicted below:

Figure 6: Sub-regional Workforce Plan



The intent of the sub-regional Workforce Development Plan is to:

- identify the main workforce demands, and the potential challenges, that the 3 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 sub-region 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 sub-regional DHBs' workforce were determined to be:

- The ageing workforce
- The increasing health gap between Maori 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 will focus on the impact that local and regional strategies will have on the workforce of the sub-region requiring the 3 DHBs to have a comprehensive and integrated workforce strategy that will encompass the primary and NGO sectors. This plan will focus on the priority areas and support sustainable outcomes that strengthen the workforce of the 3 DHBs, both as independent DHBs, and DHBs within a sub-regional and regional context.

Continued collaboration in the area of human resources and workforce development across the sub-region is a focus for the 3DHB Executive Director of People and Culture (ED P&C) across the three DHBs. The focus is to ensure that our workforce plans and organisational requirements are aligned. This focus is further supported

by the appointment of a 3 DHB Director of Human Resources who will take responsibility for the completion of a Workforce Development Plan, which will factor in the requirements of HWNZ, the 3DHB sub-regional plans and the workforce sections of the Regional Services Plan (RSP).

The three DHBs are working within 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 achieved.

The suggested prioritisation to vulnerable or critical specialities will require on-going 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 sub-regional approach to training will be explored.

The three DHBs will actively engage with the medical workforce taskforce to develop action plans as a result of the national recommendations.

The three DHBs will develop opportunities for GP registrars to meet their training requirements as outlined by the medical council

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. **Regional Alignment:** Refer to Regional Services Plan 2014/15

The workforce plans for DHBs will be increasingly linked to sub-regional work around integrated services. 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 approach, which puts the patient at the centre, ensuring patient needs are best served when we provide the services which make the most difference to the population health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost.

5.3.1 Health Workforce New Zealand

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 sub-regional 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 while maximising the quality of the product delivered.

The focus for the Central Region Training Hub services plan for 2014/15 is to:

- Implement innovative clinical placements and projects, new and extended roles
- Further develop regional collaboration around education and development sharing good practice and link to national initiatives
- Support all clinical networks to make best use of all skills and resources.
- Develop plans and processes to retain older workers in the workforce
- Increase Maori and Pasifika participation into the workforce
- Improve recruitment to hard-to-staff clinical specialties, geographical areas and communities

- Identify and make best use of all possible training settings for entry to practice, in particular for the most vulnerable workforces
- Develop the unregulated workforce in the disability support, aged care, mental health and addiction service sectors
- Support all DHBs to meet the funding criteria of post entry training in medical disciplines as per 70/20/10 requirements

5.3.2 Child Protection Policies and Children's Worker Safety Checks

The Vulnerable Children's Bill is expected to receive Royal assent in June 2014 which will see a further strengthening of the DHBs' recruitment process.

Post the introduction of the legislation, the DHBs will engage with employees and their representative unions to implement a process to provide for appropriate checks in line with the Act requirements and to retrospectively undertake comprehensive police checks for all staff working with a child or young person. The Human Resources Information System (HRIS) will be the vehicle which identifies staff required to undertake further three-yearly police checks.

The DHBs' recruitment process currently requires all new staff to produce appropriate identification (including identification and police checks for overseas sourced employees to maintain its accredited employer status with New Zealand Immigration). Reference checks are comprehensive in nature and will be further revised to include specific questions on working with children and young people where appropriate.

The DHBs will take appropriate action to build on existing recruitment processes to date to ensure the organisation meets its obligations under the Act. The DHBs will ensure that safety checking information is available for provision to the Director General to meet the requirements in the Vulnerable Children's legislation.

The DHBs will adopt, as soon as is practicable, a child protection policy; report in the annual report (under the New CE Act 2004 s150) on whether, or on the extent to which, its operations have implemented the policy; ensure that a copy of the policy is made available on an Internet site maintained by or on behalf of the board; ensure that every contract, or funding arrangement, that after that commencement the board enters into with an independent person requires the person as soon as practicable to adopt a child protection policy; and review the policy within 3 years.

5.3.3 Sub-regional workforce plans

Table 3: Workforce Plans – Service, Directorate, Hospital and Sub-regional

Activity	Intention	Measured by:
Develop baseline workforce plans for each directorate which reflect service need, workforce requirements. Work with sub-region 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.	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	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 specific to the needs of each DHB Leadership development programme in place and achieving outcomes PGY1 and 2 training continues to be standardised across the region Career Planning process, career

Active participation in the Central Region Training Hubs planning and initiative development.	scopes of practice could improve service delivery (by Directorate service planning and wider Integrated Collaborative Care activity). Develop targeted and organisation wide mechanisms to maintain and further develop an engaged and motivated workforce.	guidance, and resources are implemented as per HWNZ requirements Improved flow of career planning information for the RMO population across the sub-region. Extended GPEP training (GP vocational training) is supported across the sub-region. Learning and Development strategy is implemented Strategic Objectives for Learning, Development and Research are progressed against milestones. 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 4: Recruitment and Retention

Activity	Intention	Measured by:
Explore opportunities for joint appointments across the region as vacancies arise in line with the RSP and sub-regional work programme Enhance recruitment and candidate management tools and functions Collaborate with sub-region to improve recruitment processes. Senior clinical and non-clinical vacancies are reviewed to assess value of a joint appointment approach or region/sub-regional approach. Improved recruitment and retention data collection Increasing access to training and development activities across the sub-region 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 sub-region is aligned and supported by consistent systems and processes. 2DHB/3DHB 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 sub-regional/regional DHBs on recruitment processes.	Systems, policies and procedures are aligned across the sub-region (region). Evidence of joint appointments where value added is demonstrated Regular recruitment and retention reporting Applicants and candidates indicate they found the process for sourcing and applying for 2DHB and 3DHB roles clear and transparent

Table 5: Leadership Capability and 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. This will align with the national activities. 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 opportunities to develop their leadership capabilities	Leadership capability framework is in place aligned with the national framework We are able to successfully fill leadership roles internally Evidence of collaborative operational and clinical leadership and decision making

Table 6: Staff Engagement

Activity	Intention	Measured by:
Undertake biannual staff culture and safety surveys Implement specific staff engagement activities, at a Team, Service Directorate and/or organisational level as indicated. Develop activities to support 'positive workplace culture' Design and implement a consistent approach to change management focusing on meaningful and early engagement with employees and union partners.	Staff Engagement strategy implemented including development of steering group to support the strategy and staff engagement activity. To use the work on Values based behaviours to inform workforce strategies 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 surveys to be implemented where there is not current activity, and to continue in the DHBs who have a process for this There is evidence the organisations have communicated the survey results and organisational changes and /or targeted activity programmes to address results of survey and other metrics/information are in place There is trend data to show improvement in the results of the survey and metrics over time There is evidence to show that employees are engaged directly, and via the union, effectively and early within a change process.

Table 7: Learning and Development

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 Select and implement a learning management system	Align the Three year Learning and Development Strategy launched in early 2012 across the sub-region. The strategy outlines five key principles that will ensure that CCDHB becomes a learning organisation. The strategy is operationalised	Presence of Learning and Development strategy Achievement of four high level objectives delivered through detailed plan (refer plan) include • Develop Learning and Development Culture across

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	through Learning and Development Strategic objectives. These will continue to be implemented in 2014/15 Maximise use of expertise, resources and systems through collaboration with other DHBs and stakeholders in the sub-regional, region and national activity.	the sub-region • 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 sub-region MOU is in place for the region re Skills and Simulations

Table 8: Clinical Leadership and Career Planning

What we are doing in 2014/2015	What we will achieve by 2016
• Engagement of our clinical workforce in regional service planning and development. Effort is focused on releasing senior clinicians so they can participate in sub-regional discussions. • Implementation of a regional approach for the allocation of placements and funding for the HWNZ Nursing programmes, i.e. Nursing Entry to Practice and Post Graduate Education. • Development of a nursing workforce plan for the sub-region of Wairarapa, Hutt and Capital & Coast • Support the continued implementation of local, sub-regional and regional workforce innovations that arise out of local collaborative programmes and the 3D programme, e.g. regional ENT Specialists.	• Service Models will be designed and endorsed by clinicians. The view of the workplace will be broader and the services will focus on a regional population. • There will be a regional picture of skill set and career pathways of our nurses. The region will be in a better place to encourage career pathways into priority areas. • Supporting the development of non-registered workforces, specifically HCA, via pilot development programme

Table 9: Working Sub-regionally to Sustain our Clinical Workforce

What we are doing in 2014/2015	What we will achieve by 2016
• Continue to work with sub-regional DHBs and PHOs to obtain commitment to work collaboratively when developing and implementing new Models of Care. This will include the need to consider current practices and processes operating within other DHBs/primary practices and where appropriate how DHBs will implement the model of care consistently, e.g. communications, change management, professional development and education • Continue the implementation of clinical pathways that take into account cultural, ethnic, gender and age specific needs. • Participate in regional information sharing. e.g. regional leadership initiatives. • When a role becomes vacant consideration will be given to whether the role can be filled as a sub-regional role. Sharing of information and entering new projects with the consideration and engagement of the other two DHBs. • Where possible taking the opportunities to develop 3 DHB roles through robust change programmes	• Clinicians, supported by managers, leading the development, design and implementation of services, systems and processes. • Strategies that promote a flexible and mobile workforce, with the workforce moving to where the people need to best receive the services and where it is best to deliver services. • Develop our recruitment and retention strategies across the sub-region to grow the sub-regional brand and provide consistent standards and expectations for future employees.

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

Wairarapa DHB has a consumers' 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.
Hutt Valley and Capital Coast maintain a list of consumers who are willing to engage to improve services or provide insight. In 2014/15, CCDHB will establish a Consumer Council and the scope is proposed to be across the three DHBs. This will be coordinated across each of the DHBs and with Central TAS which has a similar initiative for the region.

All 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

5.4.1 Other improvement projects

Wairarapa DHB

The DHB is continuing to work with the HQSC on other initiatives, and is actively participating in both the 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.

Hutt Valley DHB

The Hutt Integrated Network of Care (Hutt INC) 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 2014/15.

Capital & Coast DHB

Capital & 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 2014/15 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
- CCDHB has established a role for Continuous Improvement which will provide training and coaching across the sub-region to support more effective delivery of projects using lean and six sigma process improvement methodologies.

Primary Secondary Clinical Governance

Capital & 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

5.5 Organisational Health

The Wairarapa, Hutt Valley and Capital & Coast DHBs (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 Executive and Senior Leadership Teams and high performing clinical workforces and supporting infrastructures 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.

The three DHBs will follow 'good employer' practices and EEO principles.
The three will continue to develop the Provider Arms' workforce 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.

Having the right workforce to deliver high quality, effective services is critical if we are to realise our high level outcomes: preventative health and empowered self-care, the provision of relevant services close to home, and quality hospital care, including highly complex care, for those who need it.

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

As a 'good employers', the three DHBs 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 three DHBs will work with the relevant unions in partnership.

The three DHBs believe that they will benefit from a diverse workforce and are committed to recognising and valuing different skills, talents, experiences and perspectives of employees. 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, the DHBs endeavour to promote equity, fairness and a safe and healthy work environment.

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 Sub-regional and Regional collaboration and co-operation.

In 2014/15 the three DHBs will continue to:

- Further develop the recruitment strategy and processes to ensure compliance with the DHBs' 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 sub-regional 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 the three DHBs live within their 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.

5.6 Reporting and Consultation

The three DHBs provide regular reporting to the Minister of Health as outlined in the table below. In accordance with s141 (1)(g) Crown Entities Act 2004 each DHB will consult with the Minister via the Ministry of Health on any significant developments not covered in this plan.

Table 10: 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

5.7 Shares, Interests or Subsidiaries

Wairarapa, Hutt Valley and Capital & Coast DHBs, with other Central Region DHBs, have joint ownership of the Central Technical Advisory Service (CTAS). CTAS 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. CTAS is funded by the DHBs on an annual budget basis to provide services.

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.

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

Module 6: Service Configuration

6.1 Overview

In early 2014, the Boards of Wairarapa, Hutt Valley, and Capital & Coast District Health Boards agreed the goals of the three DHBs are to develop integrated service approaches to improve preventative health and empowered self-care; the provision of relevant services closer to home and quality hospital care, including highly complex care, for those who need it.

The three DHBs continue to advance their collaboration to deliver patient centred care that improves the patient journey. This work is primarily clinically led and is occurring in the hospitals, community and across the lower North Island health system. The DHBs will be developing HealthPathways in 2014/15, based on those from Canterbury DHB. Professor Ian Sturgess has visited and provided recommendations for Capital & Coast DHB; he will be visiting Hutt Valley DHB in early 2014 and potentially Wairarapa as well.

Through this work the DHBs are committed to delivering services in a more seamless way, while following the principles of the Triple Aim. While the items identified in this document may not necessarily be service changes as defined by the Operational Policy Framework, they are significant changes undertaken with the aim to improve the patient journey and experience.

Any future configuration of services will seek to deliver on the following outcomes:

- improved health outcomes for our populations;
- on-going clinically-led service development to strengthen integration and service quality;
- equitable access;
- clear referral pathways to support good practice and help manage demand;
- workforce development and sustainability;
- assisting the 3 DHBs to live within their financial means and deliver good value for money.

6.2 Changes and Potential Changes

As part of the ongoing 3D HSD programme, a number of services are developing clinically-led single service models which will alter the way services are delivered across the three DHBs. There are also a number of developments as integrated improves across the whole of the health system through the Alliance Leadership Teams. Due to these, the following changes and potential changes are presently identified.

Service Area	Health Improvement Outcome	Potential Change(s)
Frail Elderly	Care Closer to Home Equitable access to services Improve preventative care and empowered self-care Supporting older people to stay at home Quality hospital care, including complex care, for those who need it	In response to a report from Professor Ian Sturgess, CCDHB is implementing a programme to improve the Frail Elderly Pathway. This will improve outcomes for older people and result in reductions in length of stay and a reduction in transfer to supported care in the community. These changes will be accompanied by strengthening of other services to support earlier discharge. Hutt Valley DHB is looking at a similar initiative, with a visit planned by Prof Sturgess in early 2014, and potential for this to occur for Wairarapa DHB as well. Other work streams such as those included in the sub-regional service integration programme and clinical pathways e.g. supported discharge are likely to impact on health of older people services, but at this stage actual service changes are unknown. The context for all these service changes will be on creating shorter, safer patient journeys through the system with more care available closer to home.
Home and Community Services	Equitable access to services Supporting older people to stay at home	The three DHBs are implementing a review of Home and Community Services, which will be completed during 2014/15. It is expected that this review will inform potential configuration and procurement options.

Service Area	Health Improvement Outcome	Potential Change(s)
Needs Assessment and Service Coordination (NASC) services	Equitable access to services Supporting older people to stay at home	Because of the intrinsic connection of NASC services to Home and Community Services, these services will also be included in the above review and may be subject to service change.
Laboratory Services	Care closer to home Equitable access to services Clinical sustainability Financial sustainability	The three DHBs are implementing the Laboratory Services Strategy (the Strategy) developed in 2013 with a range of key stakeholders. The Strategy identifies potential configuration and procurement options for laboratory services across the 3DHBs. The procurement project started in 2013 will ensure ongoing contractual arrangements are in place at the end of current contracts in October 2015. Both the Strategy and procurement project focus on integrated services, both across the three DHBs and across community and hospital laboratory services to provide a more seamless service for referrers and patients across the health system.
Maori Health – Hutt Valley DHB only	Reducing Inequalities Improved patient journey	An initial review of these services by SIDU has identified opportunities for improving value for money and reducing duplication of investment. Options are being presented to the Board in Q1 14/15 and implementation of approved options will change the way that these services are delivered and potentially the number of service providers.
Mental Health	Quality hospital care, including complex care, for those who need it Improved patient journey Clinical Sustainability	The Wairarapa, Hutt Valley and Capital & Coast DHB provider arms are working towards having a single management structure for Mental Health by 1 July 2014. A strategic framework has been developed for the three DHBs. An implementation plan is being developed. It is expected that there will be reconfiguration of services within the implementation plan and in particular General Mental Health Services.
Mental Health – Hutt Valley only		Acute unit rebuild planned for Hutt Valley DHB. As redesign of services is planned this may impact on other services particularly general adult mental health services, however the progress of 3DHB work may influence decision on rebuild.
Mental Health – Capital & Coast DHB only	Care closer to home Improved patient journey More seamless health system	Te Ara Pai implementation will continue. An RFP was run in 13/14 for a further stage of Te Ara Pai looking at day activity programmes, drop in centre, occupational activities etc. New services from this stage will be implemented in 2014. This is expected to impact on some current providers. The services have been co-designed with people who use services, providers and other stakeholders. The next stage of this implementation is the closure of extended care and rehabilitation beds. This will see service users from the service moved into community settings with additional supports wrapped around individual service users as required.
Pharmacy	Services closer to home Improved patient journey	The three DHBs will continue to work with Community Pharmacy on the implementation of stage four of the CPSA (Community Pharmacy Services Agreement). The DHBs will also contribute to the national discussions with the Pharmacy sector on the next phase of the CPSA from July 2015.

Service Area	Health Improvement Outcome	Potential Change(s)
Pharmacy – CCDHB only	Equitable services	Capital & Coast DHB is currently reviewing an after hours payment made annually to Kenepuru After Hours Pharmacy to be completed by 30 September 2014. This payment allows patients to avoid an additional co-payment cost ($1/item) that is usually applied when a pharmacy operates outside of normal business hours. More work is required to determine the implications of withdrawing this payment on the local population.
Laboratory Services	Care closer to home Equitable access to services Clinical sustainability Financial sustainability	The three DHBs are implementing the Laboratory Services Strategy (the Strategy) developed in 2013 with a range of key stakeholders. The Strategy identifies potential configuration and procurement options for laboratory services across the 3DHBs. The procurement project started in 2013 will ensure ongoing contractual arrangements for an outsourced integrated hospital and community laboratory are in place at the end of current contracts in October 2015. Both the Strategy and procurement project focus on integrated services, both across the three DHBs and across community and hospital laboratory services to provide a more seamless service for referrers and patients across the health system.
Primary Care	Services closer to home Improve preventative care and empowered self-care Improved patient journey	All three DHBs continue to develop and implement their integrated work programmes with the relevant local primary care and community partners. There may be possible future impacts on primary care services from these programmes. Review contracts for immunisation, smoking cessation, and long term conditions to ensure there is the right mix for target attainment & sustainable achievement.
Primary Care – Hutt Valley DHB only	Equitable access to services Improve empowered self-care	The current mix of after-hours services will change in the 2014/15 year. Currently the DHB funds HML nursing triage service 24/7 as well as a range of other services. Whilst the total investment is not planned to decrease in 2014/15 the investment in the nurse triage service will be reduced by the DHB. Discussions are underway in order to establish either joint funding for this service or a different solution.
Primary Care – Capital & Coast DHB only	Equitable access to services Care closer to home Increased patient access	WFA proposes transitioning the Kapiti UCC from a 24hr provision to a 12hr (7am/8am – 7pm/8pm) service by 1 July 2014. WFA proposes transferring extended care paramedic resource to staff a UCC service in Porirua from 10am/11am to 10pm/11pm, commencing 1 July 2014. A draft proposal has been provided to the NHB. SIDU has recently reviewed its discretionary investment in services to ensure good access to primary care for high needs populations. In some cases, there are opportunities to get better value for this spend. A number of options are being developed to be presented to the Board in March that may result in service changes, and these will be discussed through the Alliance Leadership Team.
Radiology	Improved patient journey	Diagnostic imaging services have previously been identified as a

Service Area	Health Improvement Outcome	Potential Change(s)
	Improved timeliness of services Clinical Sustainability Financial sustainability	vulnerable service by the Central Region DHBs. As a result, the three sub-regional DHBs have been working together to explore opportunities to improve the quality and sustainability of diagnostic imaging services. This work will continue in 2014/15 and involve exploring how hospital radiology services across the three DHBs can work together as one sub-regional hospital radiology service. This will build off earlier consultation with hospital radiology staff about a proposal to establish a single sub-regional hospital radiology service and how this might work across the three DHBs based on a two department model operating across multiple sites. The three DHBs will also be progressively implementing common community referred access criteria for radiology services. In 2014/15, the three DHBs will also be exploring the optimal balance between public and private provision of radiology services. Our vision is to develop a patient focused radiology service that is high quality, timely, affordable and sustainable.
Youth	Services that are better designed for youth patients Equitable access to services Financial Sustainability	There are options/opportunities for improving both efficiency and effectiveness of youth focussed health care services across the sub-region. SIDU will be reviewing youth current services (locally and across the sub-region) and funding in terms of known performance and outcomes, value for money, and alignment to DHB priorities. SIDU will consider potential opportunities for realigning services, disinvestment and/or explore reprioritisation of funding for DHBs, over the short and longer terms. Implications of change are high. DHBs have been asked by the Ministry of Health to maintain current investment in Youth One Stop Shops (YOSS) while a sustainability review is undertaken. Any change would need to be consistent with the Prime Ministers Primary Youth Mental Health Project Objectives. DHBs are required to have a Service Level Agreement for youth in 2014/15 and so this is likely to significantly reduce the potential risks identified with any change undertaken in the youth health space.

National – Health Benefits Limited

The DHBs will be implementing the national Finance, Procurement and Supply Chain (FPSC), including the Financial Management Information System in 2014/15. Essentially, the FPSC will result in a national process for the way DHBs order, deliver, store and pay for goods and services (including medical equipment and pharmaceuticals).

The Food Services and Linen and Laundry Services streams are also being progressed.

Module 7: Performance Measures

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy priorities'
- meeting service coverage requirements and Supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

Each performance measure has a nomenclature to assist with classification as follows:

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

Performance measure	2014/15 Performance expectation/ target	Wairarapa	Hutt Valley	Capital & Coast
PP6: Improving the health status of people with severe mental illness through improved access	0-19	5.49%	4.22%	3.74%
	20-64	5.56%	4.53%	3.36%
	65+	1.02%	1.97%	1.3%
PP7: Improving mental health services using transition (discharge) planning and employment	Long term clients	Provide a report as specified		
	Child and Youth with a Transition (discharge) plan	At least 95% of clients discharged will have a transition (discharge) plan.		
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm			
	<= 3 weeks	80%	80%	80%
	<=8 weeks	95%	95%	95%
	Addictions (Provider Arm and NGO)			
	<= 3 weeks	80%	80%	80%
	<=8 weeks	95%	95%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1 (2014)	1.15	0.81	0.67
	Ratio year 2 (2015)	1.05	0.81	0.67
PP11: Children caries-free at five years of age	% year 1 (2014)	64%	70%	67%
	% year 2 (2015)	68%	70%	69%

Performance measure	2014/15 Performance expectation/ target	Wairarapa	Hutt Valley	Capital & Coast
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1 (2014)	85%	85%	85%
	% year 2 (2015)	85%	85%	85%
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1 (2014)	85%	85%	85%
	% year 2 (2015)	87%	85%	85%
	Children not examined 0-12 years % year 1 (2014)	5%	15%	15%
	% year 2 (2015)	5%	10%	10%
PP18: Improving community support to maintain the independence of older people	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan	≥95%	≥95%	≥95%
PP20: improved management for long term conditions (CVD, diabetes and Stroke) Focus area 1: Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.			
Focus area 2: Diabetes Management (HbA1c)	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control			
Focus area 3: Acute coronary syndrome services	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')			
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.			
Focus area 4: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed			
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway			
PP21: Immunisation coverage (previous health target)	Percentage of two year olds fully immunised	95%	95%	95%
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.			

Performance measure	2014/15 Performance expectation/ target	Wairarapa	Hutt Valley	Capital & Coast
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP25: Prime Minister's youth mental health project	Provide quarterly narrative progress reports against the local alliance Service Level Agreement plan to implement named initiatives/actions to improve primary care responsiveness to youth. Include progress on named actions, milestones and measures.			
PP26: The Mental Health & Addiction Service Development Plan	Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2014/15 and for any actions which are in progress/on-going in 2014/15.			
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan			
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 40% lower than the average over the last 3 years	0	2.9	1.8
PP29: Improving waiting times for diagnostic services	Coronary angiography – 90% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)			
	CT and MRI – 90% of accepted referrals for CT scans, and 80% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)			
	<u>Diagnostic colonoscopy –</u> a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) and b. 60% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)			
	<u>Surveillance colonoscopy</u> 60% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date			
PP30: Faster cancer treatment (details of expectations to be confirmed)	Part A: Faster cancer treatment – 62 day indicator	85 percent of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) to be achieved by July 2016. *This indicator will be included within PP30 for quarter one 2014/15 only* *From quarter two 2014/15 this indicator will become a health target.*		
	Part B: Faster cancer	< 10 percent of the records submitted by		

Performance measure	2014/15 Performance expectation/ target	Wairarapa	Hutt Valley	Capital & Coast
	treatment – 31 day indicator	the DHB are declined. *This indicator will be included within PP30 for all quarters of 2014/15.*		
	Part C: Shorter waits for cancer treatment – radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat. *This indicator will be included within PP30 from quarter two 2014/15 (transitioning from health target).*		
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	95%	129%	95%
	Age 45-64	95%	104%	95%
	Age 0-74	103%	114%	95%
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives			
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage			
SI4: Standardised Intervention Rates (SIRs)	major joint replacement	21.0 per 10,000 of population		
	cataract procedures	27.0 per 10,000		
	cardiac surgery	6.5 per 10,000 of population		
	percutaneous revascularization	12.5 per 10,000 of population		
	coronary angiography services	34.7 per 10,000 of population		
SI5: Delivery of Whanau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers.			
OS3: Inpatient Length of Stay	Elective LOS	3.18	3.15	3.18
	Acute LOS	3.66	3.88	3.81
OS8: Reducing Acute Readmissions to Hospital (standardised)	total pop	6.5%	7%	7.2%
	75 plus	9.6%	9.3%	10%
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1: Improving the quality of identity data	**New NHI registration in error**			
	Greater than 1.5% and less than or equal to 6%	Greater than 1% and less than or equal to 3%	Greater than 2% and less than or equal to 4%	
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%			
	Update of specific ethnicity value in existing NHI record with a non-			

Performance measure	2014/15 Performance expectation/ target	Wairarapa	Hutt Valley	Capital & Coast
	specific value Greater than 0.5% and less than or equal to 2%			
	Validated addresses unknown Greater than 76% and less than or equal to 85%			
	Invalid NHI data updates causing identity confusion %tbc			
Focus area 2: Improving the quality of data submitted to National Collections	**NBRS links to NNPAC and NMDS** Greater than or equal to 97% and less than 99.5%			
	National collections file load success Greater than or equal to 98% and less than 99.5%			
	Standard vs. edited descriptors Greater than or equal to 75% and less than 90%			
	NNPAC timeliness Greater than or equal to 95% and less than 98%			
Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD File Success Rate- Greater than 95%			
	PRIMHD data quality	Routine audits undertaken with appropriate actions where required		
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan			
Developmental measure DV4: Improving patient experience	No performance target set			

Appendix I: Statement of Accounting Policies

Reporting Entity

The Hutt Valley District Health Board (Hutt Valley DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. Hutt Valley DHB's ultimate parent is the New Zealand Crown.

Hutt Valley DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, Hutt Valley 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 Valley 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.

The financial budgets for Hutt Valley DHB are for the year ended 30 June 2015, with forecasts to 30 June 2018, and were approved by the Board on 2 May 2014.

Basis of Preparation

Statement of Compliance

The financial statements of Hutt Valley 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 financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement Base

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

Changes in Accounting Policies

There have been no changes in accounting policies during the financial year.

There have been no revisions to accounting standards during the financial year which have had an effect on the DHB's financial statements.

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to Hutt Valley DHB, are:

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following three main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied to public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Hutt Valley DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Hutt Valley DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Hutt Valley DHB is unable to assess the implications of the new Accounting Standards Framework at this time

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Significant Accounting Policies

Revenue

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

Ministry of Health (MoH) revenue

Hutt Valley DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of Hutt Valley 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 Valley DHB region is domiciled outside of Hutt Valley. The MoH credits Hutt Valley 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 Valley 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 Valley 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

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.

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 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 Valley 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 straight line 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.

Foreign currency transactions

Foreign currency transactions are translated into NZ$ (the functional currency) using the exchange rates prevailing at the dates of the transactions.

Cash and cash equivalents

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

Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

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 Valley 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 Valley 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 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 Valley 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 Valley 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	6 to 33 years
Building Services Fitout	2 to 36 years
Plant and equipment	2 to 25 years
Computer equipment	2 to 10 years
Leased assets	3 to 6 years
Motor vehicles	5.5 to 10 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 Valley 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 3-10 years, amortisation rate 10- 33%

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 Valley 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 Valley DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where Hutt Valley 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 Valley 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 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 Valley 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, 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 Valley 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 Valley 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 Valley 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 Valley DHB has responsibility under the terms of the Partnership Programme. Hutt Valley 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, buildings and site improvements to fair value.

Goods and services tax

All items in the 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 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 Valley 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.

Budget figures

The budget figures are derived from the statement of intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

Hutt Valley 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.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these 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

Note 10 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

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 Valley 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 Valley 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 Valley 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 Valley 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 financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. Hutt Valley DHB has exercised its judgement on the appropriate classification of leases, and have determined two lease arrangements are finance leases.

Appendix II: Summary of Regional Public Health Plan 2014-15

During 2013-2015, the Ministry of Health is undertaking an assessment of public health services, including a review of the service specifications for public health services. A revised tier one service specification was released in February 2014. The review of tiers two and three are expected to be finalised for use in 2015-16. Within the context of this assessment, public health units have been asked to provide one year plans in 2012-13, 2013-14 and again in 2014-15.

In November 2013, we produced a new RPH Planning Framework that replaces the previous Keeping Well strategic framework that we have used in recent years. The new framework is informed by the New Zealand Public Health Clinical Network's report 'Core Public Health Functions for New Zealand' which is incorporated into the Ministry of Health's new Tier One Public Health Service Specification. The development of this framework has enabled us to trial the use of the core public health functions approach for this business plan.

Bold goal and priorities

Since 2012, we have had a deliberate focus on aligning all our activities to achieve our bold goal of 'halving the rate of avoidable hospital admissions for Maori, Pacific and children by 2021'. This is an aspirational outcome statement developed by staff to challenge and motivate us, and bring a collective purpose to our work. In 2014, our annual priorities are: working with Maori; engagement with primary care; focus on children.
The plan takes into account the Government's expectations as well as national, regional, sub-regional and district priorities. We contribute *indirectly* to many of the Government's and three DHB's health targets and priorities. For example, RPH activities to increase access to healthy food choices can over time, contribute to preventing diabetes and other long term conditions. Of the specified Government and DHB health priorities, our services *directly* contribute to:
Government health targets:

- better help for smokers to quit
- increased immunisation

Government priorities:

- reducing rheumatic fever
- children's action plan
- social sector trials (Porirua)

Central region population health priorities:

- 'Making Connections: Auahi Kore/Tupeka Kore Central Region', the Central Region Smokefree Plan
- consistent emergency management responses and surge capacity across the central region public health services
- reduced gastroenteritis ambulatory sensitive hospitalisation rates for zero to four year olds

Sub-regional DHB population health outcomes:

- Improved health equity
- Preventative care
- Preventative care: Improved child and youth health

Action Plans

The work that RPH delivers is broken up into 'action plans'. These incorporate work from one or more contracts. Each action plan contains a number of 'activities', typically 3-6 per action plan. Within each activity, there are a number of 'tasks' which break the work down further into manageable chunks. These tasks are not included in the business plan, as they are for operational planning and monitoring. An interactive on-line version of our business plan will be trialled by RPH this year. This will allow public access to our plan, and readers will be able to group, sort, order and filter the activities by a range of different criteria, including:

- core public health function
- contract lines
- activities expected to lead to Maori health gain
- activities expected to lead to Pacific peoples health gain
- activities expected to contribute to achieving our bold goal
- activities by geographical area of focus e.g. DHB, sub-region, region, national.

We expect to have this operational by 1 July 2014 and available on our website www.rph.org.nz.

Appendix III: Glossary of Terms

Term	Meaning
3DHB	The 3DHB HSDP, or 3DHB Health Services Development Programme, is the major programme of integration work across the three DHBs.
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	An asset Management Plan is a tactical plan for managing an organisation's infrastructure and other assets to deliver an agreed standard of service.
AOD	Alcohol and Other Drugs
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 impact 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, More Convenient –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
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.
CTAS	Central Technical Advisory Services supports the six District Health Boards that are part of the Central Region in the Lower North Island - Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui DHBs.
CVD	Cardiovascular 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.
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.
ED	Emergency Department
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 has been piloted at Waitemata, Lakes, Wairarapa and Canterbury DHBs and will be rolled-out nationally in stages, starting February 2013.
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.

Term	Meaning
FFP	A flexible funding pool (FFP) is a key enabler of the work of the Alliance Leadership Teams, facilitating development and implementation of new models of care or improved integration of care.
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
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.
Hutt INC	Hutt Integrated Network of Care (Hutt INC) is Hutt Valley DHB's Alliance Leadership Team, and was developed from PSSG.
HVDHB	Hutt Valley District Health Board, covering Lower and Upper Hutt Territorial Authorities.
HQSC	Health Quality & Safety Commission
ICC	Integrated Care Collaborative – a CCDHB programme aimed at promoting increased integration and cooperation between primary and specialist services. The leadership group of the ICC is CCDHB's Alliance Leadership Team.
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 model to deliver co-located, multi-disciplinary primary healthcare. Proposals are underway through the Wairarapa DHB Tihei Wairarapa programme.

Term	Meaning
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.
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	Maori Health Plans (MHPs) are fundamental planning, reporting and monitoring documents, which underpin the DHB's efforts to improve Maori health and reduce the disparities between Maori and non-Maori. An MHP provides a summary of a DHB's Maori 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.
NASC	The Needs Assessment and Service Coordination (NASC) services are organisations contracted by the Ministry of Health to work with disabled people to: • identify their strengths and support needs • outline what disability support services are available • determine their eligibility for Ministry-funded support services. NASCs allocate Ministry-funded disability support services and help with accessing other supports. These services are then delivered by their respective service providers.
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.

Term	Meaning
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 is 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 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.
POAC	Primary Options for Acute Care (POAC) is a patient centred service providing healthcare professionals access to investigations, care, or treatment for their patient, where the patient can be safely managed in the community.
PPP	The PHO Performance Programme (PPP) has been developed by District Health Boards, the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a Primary Health Organisation. 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. *See Hutt INC.*
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 & Coast District Health Boards to 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 '3DHB' or 3 DHB Health Services Development Programme.
SRDAG	The Sub-regional Disability Advisory Group. SRDAG was established in late 2013 to ensure people with disabilities have a forum to enable their voices to be heard across the Wairarapa, Hutt Valley and Capital & Coast DHBs. SRDAG advises the three Boards and their Board Advisory committees on public health matters and disability support, as the 3DHBs work in partnership to integrate their services, enabling people living within the sub-region to enjoy a seamless healthcare experience, regardless of their individual needs.
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.
Tihei	Tihei Wairarapa is the Alliance Leadership Team, working to promote and develop integration between primary/secondary care to better achieve the Triple Aim. Tihei Wairarapa was founded in 2010 as one of nine pilots, and the Alliance Leadership Team model has since been founded in each DHB.
Three DHBs	The three DHBs working in collaboration across the lower North Island: Wairarapa, Hutt Valley and Capital & Coast DHBs.

Term	Meaning
WCTO	Well Child/Tamariki Ora (WCTO) is a free service that is offered to all New Zealand children from birth to five years. - 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 - a free Well Child/Tamariki Ora Health Book, with information for parents on protecting and improving their child's health and development.
WDHB	Wairarapa District Health Board, covering Carterton, Masterton, and South 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.

Annual Plan 2014/15

incorporating Statement of Intent 2014/15-2017/18
and Statement of Performance Expectations 2014/15

Hutt Valley DHB