HUTT VALLEY DHB

Annual Report 2010

HUTT VALLEY DISTRICT HEALTH BOARD

Healthy People | Healthy Families | Healthy Communities

Welcome Mihi

Tihei Mauriora

He honore he kororia ki te Atua

He maungarongo ki te whenua

He whakaaro pai ki ngā tāngata katoa

E mihi ana tēnei ki a Te Atiawa ōtira ki ngā iwi o te motu e noho mai nei i roto i te rohe o Awakairangi arā Te Upoko o te Ika.

Tēnei te karanga, te wero, te whakapā atu ki a tātou katoa kia hōrapa, kia whakakōtahi o tātou nei kaha ki te whakatikatika o tātou māuiui. Hei aha Hei oranga mō te tangata.

Welcome

All honour and glory to our maker

Let there be peace and tranquillity on Earth

Goodwill to Mankind

The Hutt Valley District Health Board respects Te Atiawa and acknowledges the community of the Hutt Valley.

This is the cry, the challenge to all concerned to collectively unite our efforts in addressing and improving the health needs of the community.

contents

Chair's Foreword

I am pleased to present Hutt Valley District Health Board's annual report for the 12 months to 30 June 2010.

This has been a real year of achievement for Hutt Valley DHB that has seen resolution of some long-term issues, effective management of our budget under difficult circumstances and some significant planning for the future.

We have continued to focus on improving the health of our population by reducing health inequalities and improving access to services, reshaping services to meet emerging trends and working together with our neighbouring DHBs for better patient outcomes.

At the same time we have served the greater regional population with increasing efficiency through planning and delivery of our five regional services – the Wellington Regional Plastic, Maxillofacial and Burns service, Regional Rheumatology service, Regional Breast-screening service, Regional Public Health and the Oral Health Service (formerly School Dental Service).

Financial Result

The 09/10 year was one of the most challenging in recent years from a financial perspective. We started the year with an ambitious goal of achieving a $4.6million deficit and ended with a result of $4.5million deficit. This pleasing result is the outcome of strong clinical leadership and collaboration between disciplines, with our colleagues in our neighbouring DHBs and across the sector.

The Minister has signed off on our 2010/11 District Annual Plan which has a projected deficit of $3million. To achieve this result will require further savings plans of around $7million.

In order to achieve this budget result, changes were made in DHB provided services to reduce spending there by several million dollars. For example, restructuring of Regional Public Health has led to a net reduction in staff of around 10 without reduction in frontline services.

Early in the year a team of clinicians and managers developed a plan to reduce our discretionary spending with other providers. We reviewed all contracts with community providers and identified efficiencies that would have the least impact on front line services. Good engagement practices have meant we have managed to maintain a good working relationship with organisations that will receive reductions in funding next year. As a result of our conversations, many changes were made. We have also committed to working on a national proposal for new funding patterns for services to our highest need populations.

While we have worked hard this year to be in a good position to achieve next year's financial targets there is no room for complacency. The reality is that the perennial pressures of rising workforce costs, aging population pressures, new technology, and increasing expectations continue to mount.

Maori Partnership Board

Our Maori Partnership Board maintains an active governance relationship with the DHB and, this year, has agreed a Memorandum of Understanding with the Board that formalises that relationship. This important relationship assists in reducing health inequalities and improving the health outcomes of Maori people within the Hutt Valley. We are delighted that the re-vitalised Partnership Board got underway this year. Nominees of the Board are also serving on each of the DHB's advisory committees.

Emergency Department/ Operating Theatre development

The commissioning of the 'clip-on' operating theatres in late 2009 was a first for New Zealand, demonstrating the innovative 'can-do' attitude of our Hutt Valley staff. These two theatres have not only increased capacity, but have allowed better management of acute and elective surgery, including an impressive increase in day surgery and day of surgery admission. They also helped us exceed our elective surgery targets.

Completion of the new car-parking building at the end of last year made way for construction of the new $82 million Emergency Department and Operating Theatre complex. The construction is progressing on time and on budget, and despite resource consent conditions that limited the hours of work on site to defined time periods, is on track for completion in 2011.

This development has secured Hutt Hospital's future service to the community. The emergency department will finally be the right size for the number of people using it each day, the intensive care unit will fully support the complexity of both surgery and high-needs accident and medical patients, the medical day stay facility and an acute assessment unit will enable staff to fully implement new models of care, and the number of permanent operating theatres will increase from four to eight, enabling more services to be provided.

A hallmark of this development is the outstanding clinical leadership in the planning processes demonstrated by the staff that will be using these new facilities, alongside the expert contribution of our management team.

Our regional services

Our **BreastScreen Central** breast screening team continue to increase the number of screening mammograms provided to women in the greater Wellington region and finished the year at 72.3% against a target of 70%, screening 23,509 women. This wonderful result is due to a combination of factors, including streamlining service delivery, and a major drive to strengthen relationships with primary care and community partners, including the Mana Wahine collective and the 3 DHB's BreastScreen Central serves.

We look forward to further increases in the number of Maori and Pacific women screened, with the opening of the new satellite screening unit in Kenepuru in the 2010/11 year.

Our **Regional Rheumatology Service** sees around 1,000 new patients every year but the nature of their condition means they stay 'on the books' for many years. Several innovative initiatives have enabled the service to keep seeing this number of new patients. These include a nurse/physiotherapist led assessment clinic for people with ankylosing spondylitis that links to a multi-centre research project, a chronic pain management course, a prioritisation process for follow-up appointments and a custom designed long-term monitoring system that allows patients' treatment to be safely supervised without frequent clinic visits.

Our **Oral Health Service** serves over 55,000 children in the Wellington region and this year the service both increased enrolments and achieved an annual review rate of 93.2% (up from 63% two years ago). Most pleasingly, we are beginning to see a small but very significant drop in the amount of treatment required in children as a result of earlier intervention and education. We expect this trend to continue as we roll out the new clinics and screening mobiles over the next year. We have also secured the contract for dental health in the region's prisons.

At the beginning of the financial year, we were still in the middle of the H1N1 influenza pandemic. The World Health Organisation held up New Zealand's response as an example of a very sound process. Hutt Valley DHB's response was amongst the best. All staff involved, but particularly those in **Emergency Management** and our **Regional Public Health** service, did an excellent job, well beyond the call of duty. This exercise leaves us much better placed to deal with any future pandemic.

The **Wellington Regional Plastic**, Maxillofacial and Burns Unit continue to see more than 12,000 people each year. A charitable Trust has been established to support the development of the Gillies McIndoe Research Institute at Hutt Hospital, headed by Professor Swee Tan who continues to attract national and international acclaim for his innovative research and practice.

Capacity issues meant we have been unable to offer delayed breast reconstruction services since 2006. The new clip-on theatres have enabled us to recommence services, with operations starting from October 2009. Since March 2010 we have received 64 new referrals, in addition to the historical referrals, 26 of who have been given certainty of operation. We expect to offer 100 delayed breast reconstructions each year (as well as around 50 immediate reconstructions) for three years to treat the women who have not been able to access this service. We were delighted that in this year's Budget specific provision has been made for funding of this service.

Primary Care

Access to a GP for a number in our community has been difficult for many years. Most general practices had either closed books for new enrolments or limited access. This year, with support from the DHB, a new general practice has been established, enrolling around 1,700 patients so far. This has enabled several other practices to open their books, making GP access significantly easier, particularly for those who could not previously enrol with a GP in the Valley.

The DHB has also started a screening programme for people who present at ED with no one designated as their GP. Assistance is given to find a place of enrolment for them.

The process of re-shaping our Primary Health Organisations has begun, with the challenge of reducing the number from five to either one or two. As part of this process, Ropata PHO and Karori PHO have already announced a cross-DHB merger and formed Cosine Primary Health Network. We met the Ministry requirement of having a plan submitted by 30 June 2010. This reshaping is not a reflection on PHO performance – our PHOs have achieved most of their targets well, especially in immunisation rates. Rather, it is about meeting government expectations of primary services that are 'better, sooner and more convenient', partly through a national reduction in the number of PHOs. Another real challenge going forward for the DHB is the government's desire for integrated family health services that provide a wider range of services. Only a few of the Hutt Valley practices provide this, as we have a very high proportion of one or two GP practices.

Healthy Eating, Healthy Action, Healthy Homes

Our DHB's healthy eating, healthy action programme has played an important role in forging community partnerships during the year. We have funded and coordinated a range of projects designed to emphasise good eating and exercise. These include initiatives like garden projects in communities with high levels of ill-health, and in low-decile schools.

These initiatives will have long term benefits for our community and there has been very good feedback from groups who have received assistance to advance better health programmes. Between our two Healthy Housing Programmes, 530 Health and Safety assessments were undertaken, 450 in the Housing New Zealand programme and 80 in our local programme. This work links people with health services appropriate to their needs at the same time as their houses are made healthier through retro-fitted insulation.

Workforce Development

We are particularly proud of the innovative and successful workforce development programmes undertaken in the Hutt Valley DHB. The Manu Tipuranga Programme was established for courses focussed on primary mental health service delivery for Maori applicants. This year 24 bursaries were granted. Since its inception in 2004 the programme has accelerated the number of current and future Maori health workers' entry and graduation in a health or mental health related qualification.

Three students are currently enrolled in the Tu Tangata Maori Student programme which fosters and develops their talents in their chosen health career.

This year Hutt Valley DHB offered eight second and third year Otago University medical students a four-week opportunity to observe in a 'work experience' setting a variety of medical disciplines in both the hospital and the community. The studentships are highly sought-after and feedback placed Hutt Valley DHB in the most positive light possible and as a desired future place of work.

For the second consecutive year presentations by our Deputy Chief Medical Officer Dr Iwona Stolarek and Liz Fitzmaurice were part of our sponsorship of the Medical Students Association annual conference. The 150 student delegates are seen as the cream of the medical schools, and their response to our input has been very positive. In Primary Care, our Primary Care Liaison Dr Liz Fitzmaurice runs a programme supporting the careers of new GP Registrars. One Registrar has recently bought into a local Hutt Valley practice while the other three plan to stay in their existing Valley practices for the foreseeable future.

Our nursing workforce continues to develop innovative ways of improving both efficiency and the patient journey, successfully running nurse-led respiratory, cardiac, rheumatology and minor injuries clinics. We are proud to acknowledge our first 'Doctor Nurse' Doug King, who will be awarded his PhD in the 10/11 year.

The Allied Health service has developed a Rapid Response Team which works with both the Emergency Department and inpatient services to assist with timely admission and discharge for patients. The introduction of a physiotherapist working alongside general practice in Pomare has increased access for Maori and Pacific people and the Single Assessment Process developed by Occupational Therapists and Social workers has made services more streamlined for both patients and staff.

Health Targets

Hutt Valley DHB has performed extremely well against national health targets, increasing the elective operations we provide to our community and delivering around 172 operations above the target (103%). This tremendous result is attributable to a huge effort from theatre staff, and those who support them, as well as much better joint planning with Capital and Coast DHB and Boulcott Hospital.

86% of people were seen in our ED within 6 hours. All Hutt Valley domiciled patients receive radiation treatment within the 6-week target. Hutt Valley DHB performs very well in immunisation coverage, and cardiovascular/diabetes targets.

We also did a tremendous job ensuring all our hospital patients who smoke are given advice to quit and by the end of June we exceeded the national target of 80%.

Working with Our Neighbours

The long-term viability of sustainable health services in the Hutt Valley relies not just on our own staff but also on our clinical relationships with our neighbouring Wairarapa and Capital and Coast DHBs.

A very significant development has been the formation of a leadership group of senior clinical leaders (medical, nursing and allied health) from across the three DHBs, along with the three CEOs.

This group identified four initial areas where we can build better collaboration across the DHBs – mental health, ear, nose and throat, healthcare of the elderly, and paediatrics. These areas have been prioritised because they can achieve most benefit through collaboration in the short term. It has been pleasing to see clinicians feeling confident enough to really challenge the progress their colleagues have made in some areas.

There has been an increasing recognition of the extensive collaboration already occurring. There is a range of tangible results – a joint Director of Allied Health appointment with Wairarapa, Hutt Valley doing MRIs for Capital and Coast DHB, a proposed joint general surgery department with Wairarapa, gynaecologist support from Wairarapa, anaesthetist support for Wairarapa, and the Planning and Funding units of the three DHBs working collaboratively on a range of initiatives.

Safer Hutt Valley

Hutt Valley DHB Planning and Funding, Regional Public Health, Hutt City and Upper Hutt City Councils have put together an application to become a World Health Organisation Safer Community.

There are six criteria to achieve World Health Organisation accreditation, involving multi-agency collaboration and shared processes and aims. Criteria include an infrastructure based on partnership and collaborations, long-term, sustainable programmes covering genders and all ages, environments and situations and programmes that target high-risk groups and environments, promote safety for vulnerable groups and document the frequency and causes of injuries.

Acknowledgements

This year marks the end of the triennium for the current Board. My warm thanks are due to each Board member, both elected and appointed, for the way we have worked together as a real team, in good times and bad. Each Board member makes a valuable contribution, and the leadership and passion shown by the Board is reflected in the excellent results achieved by the whole DHB. The Board cannot operate without our capable and hardworking Executive Management Team, led for much of the year by Acting CEO, Michael Hundleby. We owe you all a huge debt of thanks. And thanks, too, to our re-formed Maori Partnership Board. Together we can do great things.

During the year we received with regret the resignation of our Chief Executive, Chai Chuah after seven years of superb service to our DHB and community. Chai has served as a key member of the Government's Ministerial Review Group – looking at a re-shaping of the central health sector agencies – and has subsequently been appointed as Director of the new National Health Board – a tribute to his leadership and organisational skills. Chai has led from the front, exemplifying the values our DHB seeks to demonstrate – openness, honesty, good communication, a thirst for excellence, and compassion for people. On behalf of the whole Hutt Valley community I thank Chai for his service to our community.

As always, I want to thank the thousands of clinical, administrative, and management staff who work for the DHB, and for the many community-based health providers in our district. Hutt Valley DHB relies entirely on you for your skill, your caring, and your dedication.

We move into another year with confidence.

Peter Glensor

Our Key Priorities for 2009/10

Our 2006/2011 District Strategic Plan described the following goals, which informed the priorities we set for the 09/10 year:

- Improved health equity.
- Healthier communities.
- A focus on prevention, early treatment and easy access.
- Effective, efficient and high quality services.
- Seamless integration.
- An inclusive district.

Our District Annual Plan described the following priorities for the 2009/10 year:

1 **Clinical Leadership – Fostering clinical leadership within the DHB is a key aspect of our culture and key to our commitment to improve hospital services.**

2 **Financial Management – In order for the DHB to achieve its financial targets we will focus on four major change management programmes. These are:**

- *Electives*: Delivering increased electives that include successfully commissioning the clip on operating theatres on time, in October 2009.
- *Acute Medical Costs*: Managing change that will improve both clinical delivery and cost structures within the acute medical area of the hospital.
- *Mental Health*: Building on changes in our inpatient and community services in order to provide both improved service delivery and improved financial outcomes.
- *Community Pharmaceutical Costs*: Ensuring pharmaceutical costs continue to be appropriate.

3 **Emergency Department/Theatre Redevelopment – The delivery of the Emergency Department/Operating Theatre redevelopment on time and within budget.**

4 **Primary Care – Better, sooner, more convenient access to primary care.**

5 **Elective Surgery – Achieving increased government elective surgery targets.**

Statement of Purpose

Vision Mission and Values

The vision, mission and values set out here are incorporated in the Hutt Valley District Health Board's 2006-2011 Strategic Plan. They lie at the heart of our organisation.

Vision

Whanau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities are so inter-linked that it is impossible to say one comes first and then leads to another – hence we have placed them in a circle.

Mission

Working together for health and wellbeing

Our mission shows the DHB's commitment to a co-operative way of working – that includes our staff working co-operatively; working together with the people and organisations we fund, organisations from other sectors, and with our community.

Values

'Can do' – leading, innovating and acting courageously

Hutt Valley DHB is already acknowledged in the New Zealand health sector as an organisation that will try new things in order to make a difference. We will continue to do that and to be ever more innovative, in order to improve the health of Hutt Valley people.

Working together with passion, energy and commitment

Hutt Valley DHB's people work with passion, energy and commitment to each other, to their clients and their community.

Trust through openness, honesty, respect and integrity

The trust of those we work with and those we work for is fundamental to achieving good results. To be trusted, we will be open, honest, respectful and act with integrity in everything we do.

Striving for excellence

Striving for excellence in everything we do is a key Hutt Valley DHB value – we look for excellence in ourselves as individuals and collectively as an organisation. We look for it in the services we provide, the way we treat each other, the systems we put in place and the achievements we make.

Hutt Valley DHB Profile

The Hutt Valley District Health Board (DHB) is responsible for planning, funding and providing government-funded health care and disability support services for the 141,400 people who live in the Hutt Valley. Of these 101,500 people live in Hutt City and 39,900 live in Upper Hutt City.

Approximately 17% of the people who live here are Maori and 8% are Pacific peoples. Fewer Maori and Pacific people (as a percentage of the population) live in Upper Hutt than Hutt City. More of the Maori and Pacific people who live here are younger than other ethnic groups - half of the Maori and Pacific people here are aged under 25.

We also have significant Asian and refugee populations.

The Hutt Valley DHB employs over 2200 people, most of whom work at Hutt Hospital and for our community and regional health services. This part of the DHB is often referred to as our 'provider' arm.

An 11 member Board has governance and strategic oversight of the Hutt Valley DHB. Following a resignation of an elected Board member our Board comprised six community elected members in addition to the five members who were appointed by the Minister of Health.

The Board has responsibility for delivering objectives in local and national health within a current annual budget of approximately $422 million.

The Hutt Valley DHB was established on 1 January 2001. Over the 2009/2010 year the DHB has provided a wide range of services and implemented a number of initiatives in order to meet its commitment to:

- Improve, promote and protect the health of communities within the Hutt Valley.
- Reduce health disparities by improving health outcomes for Maori and other population groups.
- Encourage community participation in health improvement, and in planning for the provision of health services and any significant changes to the provision of health services.
- Ensure effective care or support of those in need of personal health services or disability support in the community.
- Promote the inclusion and participation in society of people with disabilities.
- Better co-ordinate health services in the Hutt Valley, for example, General Practitioner and hospital-based services.

Providing the wide range of services involves buying services from a diverse range of health and disability service providers which includes:

- General Practitioners.
- Maori and Pacific Island health providers.
- Mental health providers.
- Rest homes.
- Pharmacies.
- Private laboratories and hospitals.

Hospital Service Indicators

	2005/2006	2006/2007	2007/2008	2008/2009	**2009/2010**
Inpatient Discharges	17,236	17,272	17,835	17,687	**17,678**
Daycase Discharges	9,397	9,079	9,365	10,114	**10,960**
Total Discharges (Inc Newborns)	26,633	26,351	27,200	27,801	**28,638**
Discharges per day	73.0	72.2	74.3	76.0	**78.2**
Available Bed Days	93,075	93,075	95,526	96,624	**96,624**
Occupied Bed Days	80,863	80,076	85,183	86,236	**82,115**
Average Occupancy	86.9%	86.0%	89.2%	89.2%	**85.0%**
Inpatient Operations	5,505	5,369	5,535	5,637	**5,621**
Daypatient Operations	2,379	2,274	2,549	2,642	**3,396**
Total operations (theatre cases)	7,884	7,643	8,084	8,279	**9,017**
Elective Operations	3,582	3,615	4,136	4,337	**5,096**
Acute Operations	4,302	4,028	3,948	3,942	**3,921**
Total operations (theatre cases)	7,884	7,643	8,084	8,279	**9,017**
Inpatient Waiting List total 30 June	1,322	1,279	1,312	1,585	**1,834**
Outpatient attendances					
- Surgical	46,204	43,245	43,687	47,461	**44,895**
- Medical	20,901	22,123	22,455	30,779	**32,663**
- Paediatric	5,032	5,706	5,718	9,226	**10,763**
Emergency Attendances					
- First attendances	35,219	37,039	39,099	39,744	**39,191**
- Total attendances	35,730	37,440	39,360	40,356	**40,331**
Community Contacts - District Nursing	35,706	37,489	42,616	45,406	**43,179**
Births - Hospital	1,954	2,035	2,182	2,208	**2,248**
Radiology examinations	49,787	47,375	52,833	61,156	**61,229**
Laboratory tests performed	836,034	864,759	901,154	934,346	**967,112**

Financial Report

For the year ended 30th June 2010

Statement of Accounting Policies

For the year ended 30th June 2010

Reporting Entity

Hutt Valley District Health Board (HVDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. HVDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. HVDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Public Finance Act 1989 and the Crown Entities Act 2004.

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

The financial statements of HVDHB are for the year ended 30 June 2010.

The financial statements were authorised for issue by the Board of HVDHB on 14th October 2010.

Basis of Preparation

Statement of Compliance

The financial statements have been prepared in accordance with the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Functional and Presentation Currency

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

Measurement Base

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

Changes in Accounting Policies

There has been one change in accounting policy during the year. HVDHB has capitalised the interest on borrowings for qualifying assets.

The DHB has adopted the following revisions to accounting standards during the financial year which have only a presentational or disclosure effect.

NZ IAS 1. Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a Statement of Comprehensive Income. The Statement of Comprehensive Income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The DHB has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the Statement of Comprehensive Income were previously recognised directly in the statement of changes in equity.

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

NZ IAS 24 Related Party Disclosures (Revised 2009) and is effective for reporting periods commencing on or after 1 January 2011. The revised standard clarifies that related party transactions include commitments with related parties. The DHB expects it will early adopt the revised standard for the year ended 30 June 2011.

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 Clarification and Measurement, Phase 2 Impairment Methodology and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets 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 many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. The DHB has not yet assessed the effect of the new standard and expects it will not be an early adopter.

Significant Accounting Policies

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

Budgets

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

Revenue

Crown Funding

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

Goods Sold and Services Rendered

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

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

Borrowing Costs

Borrowing costs are recognised as an expense in the statement of comprehensive income in the period in which they are incurred except to the extent they are directly attributable to the acquisition or construction of a qualifying asset in which case they are capitalised as part of the cost of that asset. Qualifying assets are capital projects spanning more than one year and require long-term funding.

Interest paid on borrowings from Crown Health Financing Agency directly attributable to the Theatre and Emergency Department building project has been capitalised to the project in accordance with IAS 23. This policy will apply until such time as the developments are ready for use. This capitalisation policy has been approved by HVDHB's Board. The amount capitalised during the period is $428,239 (2009: Nil) with an applicable capitalisation rate of 4.8-5.97% p.a.

Leases

Finance Leases

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset are transferred to HVDHB, are classified as finance leases. The assets acquired by way of finance leases are stated at an amount equal to the lower of the present value of the minimum lease payments (at the inception of the lease), less accumulated depreciation and impairment losses; and their fair value. The leased item is recognised as an asset at the beginning of the lease term and depreciated on the same basis as equivalent fixed assets. A corresponding liability is also established and each minimum lease payment is apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Operating Leases

Operating lease payments, where lessors effectively retain substantially all the risks and benefits of ownership of the leased items, are recognised in the statement of comprehensive income on a straight-line basis over the term of the lease.

Cash Equivalents

Cash and cash equivalents include cash in hand and deposits with original maturities of less than three months held with banks and are measured at its fair value.

Goods and Services Tax

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

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

Employee Entitlements

Short-term entitlements:

Employee entitlements that HVDHB expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

HVDHB recognises a liability for sick leave to the extent that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent HVDHB anticipates it will be used by staff to cover those absences.

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

Long-term employee entitlements:

Entitlements that are payable beyond 12 months, such as long service, retirement leave, continuing medical education and sabbatical leave have been calculated on an actuarial basis.

The calculations are based on likely future entitlements accruing to staff, based on years of service, years to entitlement etc, the likelihood that staff will reach the point of retirement and contractual entitlements information, and the present value of the estimated future cash flows.

The discount rate is based on the weighted average of interest rates for government stock with terms to maturity similar to those of the relevant liabilities. The inflation factor is based on the expected long-term increase in remuneration for employees.

Defined Contribution Schemes

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Defined Benefit Contribution Scheme

HVDHB is a participating employer in the NPF Superannuation Scheme ("the Scheme") that is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the employer could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, the employer could be responsible for an increased share of the deficit.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the Scheme, the extent to which the deficit will affect future contributions by employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Debtors and Other Receivables

Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

Impairment of a receivable is established when there is objective evidence that HVDHB will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the statement of comprehensive income. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (i.e. not past due).

Inventories

Inventories are stated at the lower of cost, determined on a weighted average basis, and current replacement cost. This valuation includes allowances for slow-moving inventories.

Obsolete inventories are written off.

Property, Plant and Equipment

Property, plant and equipment asset classes consist of land, buildings, site improvements, plant and equipment, fit-outs and motor vehicles.

Property, plant and equipment are shown at cost or valuation, less any accumulated depreciation and impairment losses.

Revaluations:

Land and buildings are revalued with sufficient regularity to ensure that the carrying value amount does not differ materially from fair value and at least every five years. Fair value is determined from market-based evidence by an independent valuer. All other asset classes are carried at depreciated historical cost.

The carrying values of revalued assets are reviewed at each balance date to ensure that those values are not materially different from fair value. If there is a material difference then the off-cycle asset classes are carried at depreciated historical cost. Additions between revaluations are recorded at cost.

Accounting for revaluations:

HVDHB accounts for revaluations of land and buildings on a class of asset basis.

The results of revaluing are credited or debited to an asset revaluation reserve for that class of asset. Where this results in a debit balance in the asset revaluation reserve, this balance is expensed in the statement of comprehensive income. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the statement of comprehensive income will be recognised first in the statement of comprehensive income up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

Additions

The cost of an item of property, plant and equipment is recognised as an asset if and only if it is probable that future economic benefits or service potential associated with the item will flow to HVDHB and the cost can be measured reliably.

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

Disposal of Property, Plant and Equipment

Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive income is calculated as the difference between the net disposal proceeds and the carrying amount of the asset. When revalued assets are sold the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Subsequent Costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to HVDHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the statement of comprehensive income as they are incurred.

Depreciation of Property, Plant and Equipment

Depreciation is provided on a straight-line basis on all tangible property, plant and equipment, other than freehold land, at rates which will write off the cost (or valuation) of the assets, less their estimated residual value, over their useful lives.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Asset Class	Useful Life	Associated Depreciation Rates
Building structure	4 – 80 years	1.25% - 25%
Building fit-out and Services	2 – 36 years	2.8% - 50%
Plant and equipment	2 – 19 years	5.3% - 50%
Motor vehicles	5.5 – 12.5 years	8% - 18%
Computer equipment	3 – 5.5 years	18% - 33%
Leased assets	3 – 8 years	12.5% - 33%

Capital work in progress is not depreciated. The total cost of a project is transferred to a fixed asset category on its completion and then is depreciated.

Intangible Assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring into use the specific software.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs that are directly associated with the development of software for internal use by HVDHB are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

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

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each period is recognised in the statement of comprehensive income. The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Computer software – useful life 5 years, amortisation rate 20%.

Taxation

HVDHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 2004.

Creditors and other Payables

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

Trust and Bequest Funds

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

Cost of Services Statements (Statement of Objectives and Service Performance)

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

Cost Allocations

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

Cost drivers for allocation of indirect costs

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

Statement of Cash Flows

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

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

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

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

Impairment of Property, Plant, Equipment and Intangible Assets

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

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

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

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

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

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

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

Financial Instruments

HVDHB is risk averse and seeks to minimise exposure arising from its treasury activity. The Board is not authorised by its treasury policy to enter into any transaction that is speculative in nature.

Financial instruments reflected in the statement of financial position include cash and bank balances, receivables, trade creditors and borrowings. These instruments are, generally, carried at their estimated fair value. For example, receivables are carried net of the estimated doubtful receivables. The particular recognition methods adopted are disclosed in the individual policy statements associated with each item.

Provisions

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

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

ACC Partnership Programme

HVDHB belongs to the ACC Partnership Programme whereby HVDHB accepts the management and financial responsibility of work related illnesses and accidents of employees that are generally the result of an isolated event to an individual employee. Under the ACC Partnership Programme HVDHB is effectively providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which HVDHB has responsibility under the terms of the Partnership Programme. HVDHB has chosen a stop loss limit of 250% of the standard levy.

Statement of Comprehensive Income

For the year ended 30 June 2010

	Note	2010 Actual $'000	2010 Budget $'000	2009 Audited $'000
Government & Crown Agency sourced		419,053	419,302	392,822
Patient & Consumer sourced		1,009	964	985
Other		2,950	2,203	3,145
Operating Income	**1**	**423,012**	**422,469**	**396,952**
Operating Expenses	1	(413,135)	(411,839)	(392,170)
Depreciation & Amortisation expense	1	(8,593)	(9,387)	(7,745)
Operating Expenditure		**(421,728)**	**(421,226)**	**(399,915)**
Results from Operating Activities		**1,284**	**1,243**	**(2,963)**
Interest		345	504	714
Financing Costs	1	(1,259)	(1,566)	(1,255)
Capital Charge		(4,532)	(4,788)	(5,483)
Net finance expenses		**(5,446)**	**(5,850)**	**(6,024)**
Gain/(Loss) on Sale of Assets		(376)	(0)	(9)
Surplus/(Deficit) for the Year		**(4,538)**	**(4,607)**	**(8,996)**
Total Comprehensive Income for the Year		**(4,538)**	**(4,607)**	**(8,996)**

Statement of Changes in Equity

For the year ended 30 June 2010

	2,010 Actual $'000	2,010 Budget $'000	2,009 Audited $'000
Equity as at 1 July	**59,110**	**59,912**	**68,313**
Total Comprehensive Income for the Year:			
Operating Result	(4,538)	(4,607)	(8,996)
Contributions from the Crown	10,952	0	0
Repayments to the Crown	(207)	(207)	(207)
Equity as at 30 June	**65,317**	**55,098**	**59,110**

Supplementary Information

The following table shows the consolidation of service statements for each output class including the elimination of internal transactions.

	June 2010 Provider $000	June 2010 Governance $000	June 2010 Funder $000	June 2010 Elimination $000	June 2010 Consolidated $000
Operating income	204,616	3,089	384,880	(169,228)	423,357
Operating expenses	(193,684)	(2,871)	(385,808)	169,228	(413,135)
Operating Surplus before Depreciation, Capital Charge and Interest	**10,932**	**218**	**(928)**	**0**	**10,222**
Gain / (loss) on sale of assets	(376)	0	0	0	(376)
Depreciation	(8,593)	0	0	0	(8,593)
Capital charge	(4,532)	0	0	0	(4,532)
Interest expense	(1,259)	0	0	0	(1,259)
Net Operating (Deficit) / Surplus	**(3,828)**	**218**	**(928)**	**0**	**(4,538)**
Reconciliation to Retained Earnings					
Opening Balance	(28,750)	752	8,927	0	(19,071)
Net operating (deficit) / surplus for the year	(3,828)	218	(928)	0	(4,538)
Closing Balance	**(32,578)**	**970**	**7,999**	**0**	**(23,609)**

Mental Health Ring Fence for the year ended 30 June 2010

Hutt Valley District Health Board is required by its Crown Funding Agreement to ensure Mental Health funding is used to provide Mental Health Services. Included in the Funder accumulated funds of $8 million is $928,000 that is required to be used for future mental health service provision (2009: $61,000).

Statement of Financial Position

As at 30 June 2010

	Note	Year to 2010 Actual $'000	Year to 2010 Budget $'000	Year to 2009 Audited $'000
Equity				
Crown equity		38,558	27,606	27,813
Revaluation reserves		50,368	50,368	50,368
Retained earnings		(23,609)	(22,876)	(19,071)
Total Equity		**65,317**	**55,098**	**59,110**
Represented by:				
Current Assets				
Cash and cash equivalents		8,493	6	6,226
Receivables and prepayments	2	12,828	18,429	12,165
Inventories	3	1,355	1,517	1,202
Total Current Assets		**22,676**	**19,952**	**19,593**
Current Liabilities				
Payables and accruals	4	(35,222)	(63,874)	(37,562)
Employee entitlements and provisions	5	(21,807)	0	(21,484)
Borrowings	6	0	(904)	0
Total Current Liabilities		(57,029)	(64,778)	(59,046)
Net Working Capital Deficit		**(34,353)**	**(44,826)**	**(39,453)**
Non Current Assets				
Property, Plant and Equipment	8	133,020	139,629	117,839
Intangible Assets	9	2,362	0	1,854
Trust and bequest funds	11	778	798	665
Total Non Current Assets		**136,160**	**140,427**	**120,358**
Non Current Liabilities				
Employee entitlements and provisions	5	(3,712)	0	(2,130)
Borrowings	6	(32,000)	(39,705)	(19,000)
Trust and bequest funds	11	(778)	(798)	(665)
Total Non Current Liabilties		**(36,490)**	**(40,503)**	**(21,795)**
Net Assets		**65,317**	**55,098**	**59,110**

For, and on behalf of, the Board

Peter Glenson

Board Member | Board Member | 14th October 2010

Statement of Cash Flows

For the year ended 30 June 2010

	Note	Year to 2010 Actual $'000	Year to 2010 Budget $'000	Year to 2009 Audited $'000
Cashflows from Operating Activities				
Cash was provided from:				
Cash receipts		422,185	422,973	402,946
		422,185	**422,973**	**402,946**
Cash was disbursed to:				
Payments to providers		(221,322)	(266,719)	(198,477)
Payments to suppliers & employees		(194,456)	(141,840)	(189,669)
Net goods and services tax paid		285	0	556
Capital charge paid		(5,510)	(4,788)	(5,646)
		(421,003)	**(413,347)**	**(393,236)**
Net cash Inflow from Operating Activities	7	**1,182**	**9,626**	**9,710**
Cashflows from Investing Activities				
Cash was provided from:				
Interest Received		345	504	0
Proceeds from sale of property, plant and equipment		1,338	0	0
		1,683	**504**	**0**
Cash was applied to:				
Interest paid		(1,581)	(1,380)	(1,255)
Purchase of property,plant and equipment		(22,762)	(27,935)	(10,508)
		(24,343)	**(29,315)**	**(11,763)**
Net cash Outflow from Investing Activities		**(22,660)**	**(28,811)**	**(11,763)**

continued over...

Statement of Cash Flows continued...

For the year ended 30 June 2010

	Note	Year to 2010 Actual $'000	Year to 2010 Budget $'000	Year to 2009 Audited $'000
Cashflows from Financing Activities				
Cash was provided from:				
Equity Contribution		10,952	0	0
Loans raised		13,000	15,700	0
		23,952	**15,700**	**0**
Cash was applied to:				
Repayment of Equity		(207)	(207)	(207)
		(207)	**(207)**	**(207)**
Net Cash Inflow / (Outflow) from Financing Activities		**23,745**	**15,493**	**(207)**
Net Increase / (Decrease) in Cash Held		**(2,267)**	**(3,692)**	**(2,260)**
Add opening cash and cash equivalents		6,226	2,794	8,486
Ending Cash and Cash Equivalents Carried Forward		**8,493**	**(898)**	**6,226**
Cash and Cash equivalent balances in the Statement of Financial Position:				
Cash and Cash Equivalents		8,493	(898)	6,226
Ending Cash and Cash Equivalents carried Forward		**8,493**	**(898)**	**6,226**

The GST (net) component of operating activities reflects the the net GST paid and received with the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statement purposes.

Notes to the Financial Statements

For the year ended 30 June 2010

		Year to June 2010 $'000	Year to June 2009 $'000
1	**Operating surplus**		
	After crediting revenue:		
	Interest income	345	714
	Other income	3,959	4,130
	Total Government & Crown Agency Sourced Revenue	419,053	392,822
	After charging expenses:		
	Fees paid to external auditors:		
	Audit fees - year end financial statements	104	99
	Fees paid to AuditNZ for other assurance services	9	0
	Board and Committee member fees:		
	Board Member Fees	237	280
	Committee Member Fees	113	14
	Rental and operating lease costs	2,396	1,836
	Bad debts - movement in provision	103	78
	Bad debts written off	55	33
	Net loss on sale of assets	376	9
	Personnel costs	145,739	136,477
	Depreciation:		
	Building Structure	1,992	1,511
	Building Services & Fitout	2,533	2,375
	Site Improvements	68	66
	Plant & Equipment	2,127	2,125
	Motor Vehicles	17	22
	Computer Equipment	859	715
	Computer Software	994	927
	Leased Plant & Equipment	3	4
	Total depreciation	**8,593**	**7,745**
	Interest expense:		
	Crown Health Financing Agency	1,242	1,242
	BNZ	17	13
	Total interest expense	**1,259**	**1,255**

Notes to the Financial Statements

For the year ended 30 June 2010

	Year to June 2010 $'000	Year to June 2009 $'000
2 Receivables and Prepayments		
Trade debtors - Ministry of Health	3,156	4,836
Trade debtors - other	9,768	7,153
Provision for doubtful debts	(484)	(381)
	12,440	**11,608**
Prepayments	388	557
	12,828	**12,165**
3 Inventories		
Pharmaceuticals	156	172
Surgical and medical supplies	1,209	1,040
	1,365	**1,212**
Provision for obsolescence	(10)	(10)
	1,355	**1,202**

Certain inventories are subject to retention of title (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to inherent difficulties in identifying the specific inventories affected at year-end.

4 Payables and Accruals		
Trade creditors	1,439	2,770
Accrued expenses	24,625	24,244
Income in advance	5,023	7,026
Other payables	1,765	0
GST and other taxes payable	1,535	1,261
	34,387	**35,301**
Capital charge payable to shareholders	399	1,377
Fixed assets payable	436	884
	35,222	**37,562**

Notes to the Financial Statements

For the year ended 30 June 2010

	Year to June 2010 $'000	Year to June 2009 $'000
5 Personnel Costs		
Increase/(decrease) in employee entitlements (see below)	1,905	1,353
	1,905	**1,353**
Employee Entitlements & Provisions		
Annual Leave	12,833	11,977
Long Service Leave	3,362	2,103
Retirement Gratuities	1,247	997
Other Employee Provisions	8,077	8,537
	25,519	**23,614**
Made up of:		
Current		
Annual leave	12,833	11,977
Long Service Leave	1,080	1,042
Retirement Gratuities	171	220
Other Entiltlements	7,723	8,245
	21,807	**21,484**
Non-current		
Long Service leave	2,282	1,061
Retirement gratuities	1,076	777
Other entitlements and provisions	354	292
	3,712	**2,130**

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will impact on the carrying amount of the liability.

In determining the appropriate discount rate HVDHB considered the risk free rates as calculated from the yields on NZ Government bonds that have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 3.44% (2009: 3.79%) and an inflation factor of 2.75% were used.

If the discount rate were to differ by 1% from HVDHB's estimates, with all other factors constant, the carrying amount of the liability would be an estimated $178/$160 higher/lower. If the inflation factor were to differ by 1% from HVDHB's estimates, with all other factors constant, the carrying amount of the liability would be an estimated $ 178/$160 higher/lower.

Notes to the Financial Statements

For the year ended 30 June 2010

	Year to June 2010 $'000	Year to June 2009 $'000
6 Borrowings		
Crown Health Financing Agency	32,000	19,000
	32,000	**19,000**
Crown Health Funding Agency Loans are repayable as follows:		
Current (*payable to 30 June 2011*)	0	0
One to two years (*payable to 30 June 2012*)	0	0
Two to five years (*payable subsequent to 30 June 2012*)	32,000	19,000
	32,000	**19,000**
Total current portion of loans	0	0
Total non-current portion of loans	32,000	19,000
Total Loans	**32,000**	**19,000**
Interest rates per annum:	%	%
Crown Health Financing Agency Loan	4.88 - 6.535	6.535
Line of credit restricted access		
Bank loan facilities	6,000	6,000
Used at balance date:	0	0
Unused at Balance Date	**6,000**	**6,000**

Notes to the Financial Statements

For the year ended 30 June 2010

		Year to 2010 Actual $'000	Year to 2010 Budget $'000	Year to 2009 Audited $'000
7	**Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities**			
	Net operating surplus	(4,538)	0	(8,996)
	Add back non-cash items:			
	Depreciation	8,593	9,387	7,745
	Increase/(decrease) in Employee entitlements	1,905	0	1,353
	Total Non-cash Items	**10,498**	**9,387**	**9,098**
	Add/(subtract) items classified as investment activity:			
	Net gain/(loss) on sale of property, plant and equipment	(376)	0	(9)
	Total Investing Activity	**(376)**	**0**	**(9)**
	Add/(subtract) items classified as financing activity:	(914)	0	0
		(914)	**0**	**0**
	Movements in working capital:			
	Decrease/(increase) in receivables and prepayments	(208)		1,359
	(Increase)/decrease in inventories	(153)		(8)
	(Decrease)/increase in capital charge payable	(978)		(163)
	Increase/(decrease) in payables and accruals	(2,149)	239	7,174
	Total Net Working Capital Movement	**(3,488)**	**239**	**8,362**
	Net Cash Inflow from Operating Activities	**1,182**	**9,626**	**8,455**

Notes to the Financial Statements

For the year ended 30 June 2010

8 Property, Plant and Equipment

Movements for each class of property plant and equipment are as follows:

	Land	Site Improve-ments	Buildings Services Fitout	Plant & Equip.	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance at 1 July 2008	10,570	1,100	98,115	37,444	98	552	147,879
Additions	0	19	2,094	3,299	0	0	5,412
Work in Progress	0	0	4,435	461	0	0	4,896
Revaluations	0	0	0	0	0	0	0
Disposals	0	0	(5)	(991)	0	0	(996)
Balance 30 June 2009	**10,570**	**1,119**	**104,639**	**40,213**	**98**	**552**	**157,191**
Balance 1 July 2009	10,570	1,119	104,639	40,213	98	552	157,191
Additions	2,450	76	6,062	4,185	0	22	12,795
Work in Progress	0	0	10,198	1,451	0	59	11,708
Revaluations	0	0	0	0	0	0	0
Disposals	0	0	(141)	(3,097)	0	(24)	(3,262)
Balance 30 June 2010	**13,020**	**1,195**	**120,758**	**42,752**	**98**	**609**	**178,432**
Accumulated depreciation							
Balance at 1 July 2009	0	117	7,734	25,104	94	471	33,520
Depreciation expense	0	66	3,887	2,840	4	22	6,819
Depreciation on disposals	0	0	(5)	(982)	0	0	(987)
Balance 30 June 2009	**0**	**183**	**11,616**	**26,962**	**98**	**493**	**39,352**
Balance at 1 July 2010	0	183	11,616	26,962	98	493	39,352
Depreciation expense	0	68	4,530	2,987	0	17	7,602
Depreciation on disposals	0	0	(39)	(1,479)	0	(24)	(1,542)
Balance 30 June 2010	**0**	**251**	**16,107**	**28,470**	**98**	**486**	**45,412**
Carrying Amounts							
At 30 June 2009	10,570	936	93,023	13,251	0	59	117,839
At 30 June 2010	13,020	944	104,651	14,282	0	123	133,020

Restrictions

Land is not subject to any restrictions or claims under the Treaty of Waitangi.

Valuation

The most recent valuation of land and buildings was performed by independently contracted registered valuer, Paul Butchers, BBS, FPINZ of CB Richard Ellis. The valuation is effective as at 30 June 2004.

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Buildings are valued at fair value using maket based evidence.

Notes to the Financial Statements

For the year ended 30 June 2010

9 Intangible Assets

Movements for each class of intangible asset are as follows:

	Computer Software $'000
Cost	
Balance 1 July 2008	7,164
Additions	2,190
Work in progress	(1,232)
Disposals	0
Balance 30 June 2009	**8,122**
Balance 1 July 2009	8,122
Additions	1,529
Work in Progress	0
Disposals	(27)
Balance 30 June 2010	**9,624**
Accumulated Amortisation	
Balance 1 July 2008	5,342
Amortisation expense	926
Disposals	0
Balance 30 June 2009	**6,268**
Balance 1 July 2009	6,268
Amortisation expense	994
Disposals	0
Balance 30 June 2010	**7,262**
Carrying amounts	
At 30 June 2009	1,854
At 30 June 2010	2,362

10 Other Investments

Other investments comprise the 16.7% shareholding in Central Region's Technical Advisory Services Limited (CRTAS). CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region.

CRTAS has a total share capital of $600 of which Hutt Valley DHB's share is $100. At balance date all share capital remains uncalled.

Notes to the Financial Statements

For the year ended 30 June 2010

11 Trust and Bequest Funds

Hutt Valley DHB receives donations and bequests for specific purposes. If for any reason Hutt Valley DHB is not able to use the funds as specified, then Hutt Valley DHB is obligated to return the donation to the donor. Funds are held in a separate bank account and any interest earned is allocated to the individual trust balances.

	Year to June 2010 $'000	Year to June 2009 $'000
Opening balance	665	848
Funds received	285	257
Interest received	26	39
Funds disbursed	(198)	(479)
Closing Balance	**778**	**665**

Notes to the Financial Statements

For the year ended 30 June 2010

	Year to June 2010 $'000	Year to June 2009 $'000
12 Statement of Commitments		
Operating lease commitments		
Less than one year	1,486	1,275
One to two years	961	841
Two to five years	1,285	1,143
Over five years	0	0
	3,732	**3,259**
Provider funding commitments		
Less than one year	37,114	32,412
One to two years	13,385	26,988
Two to five years	728	11,866
Over five years	0	0
	51,227	**71,266**
Capital commitments		
Less than one year	36,598	19,314
One to two years	17,024	0
	53,622	**19,314**
Total Commitments	**108,581**	**93,839**

The District Health Board is also obligated to funding significant streams of "demand driven" health purchasing expenditure. Commitments of this nature are in place for the purchase of pharmacy and GP services. Since this expenditure is "demand driven" it is not possible to quantify the obligation in this note.
Actual costs are as follows:

Health of Older Persons	35,148	35,089
Primary Care	60,917	56,231
	96,065	**91,320**

Leases contained no renewal, purchase option, escalation or restrictive clauses.

Notes to the Financial Statements

For the year ended 30 June 2010

13 Statement of Contingencies

There are no contingent assets and liabilities as at 30 June 2010 (Nil: 30 June 2009).

14 Segmental Reporting

Hutt Valley DHB provides health and disability support services to the Wellington region. It also provides some specialist health and plastic surgery/ burns services for the lower half of the North Island as well as the Nelson and Marlborough region.

Segmental reporting is not applicable.

15 Financial Instruments

Hutt Valley DHB is risk averse and seeks to minimise exposure arising from its treasury activity. Hutt Valley DHB does not enter into any transaction that is speculative in nature.

Hutt Valley DHB has a series of policies providing risk management for interest and currency rates and the concentration of credit.

Interest Rate Risk

Interest risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates.

Hutt Valley DHB has fixed rate borrowings from the Crown Health Funding Agency and other sources that are used to fund ongoing activities. Hutt Valley DHB policy is to monitor the interest rate exposure with a view to refinancing if appropriate. The interest rates on borrowings as at 30 June 2010 are disclosed in Note 6.

There are no interest rate options or swap agreements in place as at 30 June 2010.

Currency Risk

Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. Hutt Valley DHB has no exposure to currency risk.

Concentration of Credit Risk

Credit risk is the risk that a third party will default on its obligation to Hutt Valley DHB thereby causing Hutt Valley DHB to incur a loss.

Financial instruments that potentially expose Hutt Valley DHB to concentrations of risk consist principally of cash, short-term investments and trade receivables.

Hutt Valley DHB places its cash and short-term investments with high credit quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance of Hutt Valley DHB's revenue from the Ministry of Health. The Ministry of Health is a high quality financial institution, being the Government purchaser of health services.

Liquidity Risk

Liquidity risk is the risk that Hutt Valley DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through adequate amounts of committed credit facilities and the ability to close out market positions. Hutt Valley DHB aims to maintain flexibility in funding by keeping committed credit lines available.

Notes to the Financial Statements

For the year ended 30 June 2010

In meeting its liquidity requirements, Hutt Valley DHB maintains a target level of investments that must mature within specified timeframes.

The following methods and assumptions were used to estimate fair value of each class of financial instrument for which it is practical to estimate that value:

Trade debtors, trade creditors and bank in funds – the carrying amount of these items is equivalent to their fair value.

Term loans and current portion of term loans – the fair value of term loans is approximated by the carrying amount disclosed in the Statement of Financial Position.

The table below analyses Hutt Valley DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flow

	Less than 6 months $'000	6 months to 1 year $'000	Greater than 1 year $'000
Financial liabilities measured at amortised cost			
2009			
Creditors & other payables (Note 5)	37,562	0	0
Borrowings (Note 6)	0	0	19,000
2010			
Creditors & other payables (Note 5)	35,222	0	0
Borrowings (Note 6)	0	0	32,000
Loans and Receivables			
2009			
Cash & cash equivalents	6,226	0	0
Debtors & other receivables	12,165	0	0
2010			
Cash & cash equivalents	8,493	0	0
Debtors & other receivables	12,828	0	0

Notes to the Financial Statements

For the year ended 30 June 2010

16 Transactions with Related Parties

Hutt Valley DHB is a wholly owned entity of the Crown. The Government influences the role of Hutt Valley DHB in the type and volume of services it purchases.

During the period Hutt Valley DHB received 84.09% (2009: 83.6%) of its revenue from the Government, through the Ministry of Health, to fund and provide health services. The amount outstanding at 30 June 2010 was $3.2 million (2009: $4.9 million).

Hutt Valley DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis where those parties are only acting in the course of their normal dealings with Hutt Valley DHB. These transactions are not considered to be related party transactions.

In addition the following members of the Board have related parties with DHB suppliers.

Peter Glensor: Member of capital investment committee, National Health Board; Chair District Health Boards New Zealand; member Wellington Regional Council.

Sharron Cole: member purchasing guidance advisory group Accident Compensation Corporation; assessor, Baby Friendly Hospital and Community Initiative; deputy chair Midwifery Council; board member Natural Fertility New Zealand.

Katy Austin: member Upper Hutt City Council.

Debbie Chin: crown monitor Capital and Coast District Health Board; chief executive Standards New Zealand.

Sandra Greig: member Greater Wellington Regional Council; president Grey Power Hutt City.

Wayne Guppy: trustee Orongomai Marae; mayor Upper Hutt City.

Keith Hindle: board member Capital and Coast District Health Board; director Metlife Care Palmerston North.

Ken Laban: trustee Te Omanga Hospice.

Catherine Love: Families Commission whanau reference group member; senior lecturer Department of Health and Development Massey University; director Metlife Care Palmerston North; council member Weltec; extended whanau, hapu and iwi members are involved in various health occupations in the Hutt Valley.

David Ogden: mayor Hutt City; director HMCT Holdings Ltd; member Hutt Mana Charitable Trust; trustee of two trusts relating to Waiwhetu Marae; involved with Gillies McIndoe Research Institute for reconstructive and plastic surgery.

The following members of the Executive Management Team have related parties with DHB suppliers:

Michael Hundleby: wife works for Buddle Findlay.

Jill Lane: son works for Fonterra which has contracts with HVDHB.

Peter Kennedy: trustee Hutt Hospital Foundation.

The following transactions were carried out on an arm's length basis with related parties other than those described above. They represent the aggregate value of transactions and outstanding balances relating to entities over which key management personnel have an influence.

Notes to the Financial Statements

For the year ended 30 June 2010

		Year to June 2010 $'000	Year to June 2009 $'000
Central Region Technical			
Advisory Services (Note 10)	Purchased	399	395
Provision of technical assistance	Received	24	24
	Outstanding at year-end		
	Payable	0	0
	Receivable	0	0
District Health Boards New Zealand	Purchased	388	170
Provision of advisory services	Received	3	7
	Outstanding at year-end		
	Payable	0	54
	Receivable	0	0
Provision of goods and services:			
Wellington Regional Council	Purchased	2	7
	Outstanding at year end	0	0
Midwifery Council	Purchased	12	1
	Outstanding at year end	0	0
Upper Hutt City Council	Purchased	66	20
	Outstanding at year end	0	0
Standards New Zealand	Purchased	17	35
	Outstanding at year end	0	0
Orongomai Marae	Purchased	23	21
	Outstanding at year end	0	0
Te Omanga Hospice	Purchased	5	1
	Outstanding at year end	0	0
Hutt City Council	Purchased	320	162
	Outstanding at year end	0	0
Buddle Findlay	Purchased	17	10
	Outstanding at year end	0	7
Fonterra	Purchased	93	21
	Outstanding at year end	2	3
Weltec	Purchased	0	2
	Outstanding at year end	0	0

There are family members of key management personnel employed by Hutt Valley DHB or suppliers to Hutt Valley DHB. The terms and conditions of those arrangements are no more favourable than Hutt Valley DHB would have adopted if there were no relationship to key management personnel.

17 Capital Charge

All DHBs are required to pay a capital charge monthly to the Crown based on the greater of their actual or budgeted closing equity balance for the month. The charge was set at 8% for the financial period (2009: 8%).

18 Post Balance Date Events

There are no significant events subsequent to balance date (2009: Nil)

Notes to the Financial Statements

For the year ended 30 June 2010

19 Major Variations from the Statement of Intent

Variations within each output class are disclosed following the cost of service statements, included within the Statement of Objectives and Service Performance on the following pages.

Key variations from the Statement of Intent within the Statement of Financial Position are as follows:

Category	Explanation
Cash and cash equivalents/ Receivables and Prepayments	The cash and cash equivalents have increased during the year following the capital injection, somewhat offset by increased payments to suppliers and providers.
Payables and Accruals	Payables and accruals have increased mainly due to the increase in accrued expenses caused by additional volumes.
Employee entitlements and Provisions	The increase in employee entitlements is due to increased actuarial valuations and also increased year-end annual accruals for annual leave liabilities.

20 Board Members Remuneration 2010

Board Members	Year to 30-Jun-10 Board Fees	Year to 30-Jun-10 Com. Fees	Year to 30-Jun-10 Total fees	Year to 30-Jun-09 Total fees
P Glensor (Chairman)	40,000	8,250	48,250	47,750
S Cole (Deputy Chairman)	25,000	5,625	30,625	29,500
K Austin	20,000	5,063	25,063	24,938
P Brosnan	20,000	2,250	22,250	22,750
S Greig	20,000	3,000	23,000	23,250
W.Guppy	20,000	4,813	24,813	23,000
K Hindle	20,000	5,063	25,063	24,813
K Laban	20,000	4,500	24,500	24,000
C Love	20,000	750	20,750	22,000
D Ogden	20,000	4,250	24,250	23,250
D Chin	11,667	1,500	13,167	0
P McCardle	0	0	0	14,667
Total	**236,667**	**45,064**	**281,731**	**279,918**

Notes to the Financial Statements

For the year ended 30 June 2010

20 Board Members Remuneration 2010 continued...

Co-opted Committee Members	Year to 30-Jun-10 Total fees	Year to 30-Jun-09 Total fees
G Alcorn	1,750	2,250
A Bain	0	500
N Cutelli	0	500
W Dunn	1,000	750
D Graig	0	200
L Hawkins	0	500
D Judd	0	400
J Paton	0	600
V Puketapu	0	100

Co-opted Committee Members	Year to 30-Jun-10 Total fees	Year to 30-Jun-09 Total fees
S Reid	1,000	1,750
J Ryall	0	444
K Stuart	3,350	500
M Tunoho	1,750	1,500
P Umanga	0	1,850
I Vaofusi	2,000	1,500
D Wilson	0	400
Total	10,850	13,744

21 Employees Remuneration 2010

Range	Year to 30 June 2010	Year to 30 June 2009	Med/Dent. Year to 30 June 2010
100,000 - 109,999	33	27	12
110,000 - 119,999	16	11	4
120,000 - 129,999	11	8	7
130,000 - 139,999	9	7	7
140,000 - 149,999	11	10	8
150,000 - 159,999	16	7	14
160,000 - 169,999	8	5	7
170,000 - 179,999	4	10	4
180,000 - 189,999	6	9	4
190,000 - 199,999	5	9	5
200,000 - 209,999	8	6	7
210,000 - 219,999	8	6	7
220,000 - 229,999	7	5	7
230,000 - 239,999	4	5	4
240,000 - 249,999	5	4	5
250,000 - 259,999	2	5	1
260,000 - 269,999	4	2	4

Range	Year to 30 June 2010	Year to 30 June 2009	Med/Dent. Year to 30 June 2010
270,000 - 279,999	3	0	3
280,000 - 289,999	1	2	1
290,000 - 299,999	4	0	4
300,000 - 309,999	1	0	1
310,000 - 319,999	1	0	1
320,000 - 329,999	1	0	0
330,000 - 339,999	0	1	0
340,000 - 349,999	0	0	0
350,000 - 359,999	1	0	1
360,000 - 369,999	0	1	0
370,000 - 379,999	1	0	1
380,000 - 389,999	0	0	0
390,000 - 399,999	0	0	0
430,000 - 439,999	1	0	1
500,000 - 509,999	0	1	0
590,000 - 599,999	1	0	1
Grand Total	**172**	**141**	**121**

Notes to the Financial Statements

For the year ended 30 June 2010

Key Personnel Remuneration

Key personnel comprise Chief Executive Officer, Chief Financial Officer, Director Planning and Funding, Chief Operating Officer, General Counsel, General Manager Communications, Director of Medicine and Director of Nursing. A total of $1,743,786 (2009: $1,607,661) was paid in short term benefits. Long-term benefits amounted to $16,179 (2009: $16,637). Termination benefits totalled $104,824 (2009: $70,757).
Total: $1,864,789 (2009: $1,695,055).

Board members were also paid an annual fee and expenses totalling $281,731 (2009: $279,918); see Note 20.

Employee Benefits

Retirement gratuities, in lieu and special leave and other employment settlement payments of $659,680 were paid to 75 staff in the year ended 30 June 2010 (2009: $321,542 to 67 staff)

Human Resources

Hutt Valley DHB's fundamental employment philosophy is to recruit the best person for the role based on professional and general competencies, and best fit with team and operational needs. Our HR policies and systems are subject to constant review to ensure both best practice and legal compliance.

Employee Management

The DHB has both a moral and legal requirement to be a good employer. To these ends our HR policies and systems reinforce consistency and fairness in applying these requirements. Current recruitment and employment processes are fair and equitable. There is a commitment to offering equal opportunity and removal of barriers by way of discrimination.

Performance Management

Hutt Valley DHB has fair and equitable performance management systems in place that are supported by policy. The need to maintain strong relationships with employees and unions are reinforced by the Employment Relations Act and Health and Safety in Employment Amendment Act 2002, and considerable effort is put into these relationships.

Employee Training and Professional Development

The DHB employs a highly qualified and often highly specialized workforce in a diverse range of occupations. The training and development offered reflects this diversity and the DHB is committed to supporting all staff to access ongoing training appropriate to their needs.

Health and Safety

HVDHB promotes and provides opportunities for employees to contribute to the ongoing management and improvement of health and safety in the workplace via representatives from each service. The entry into the ACC partnership programme at tertiary level recognizes that systems in place support a safe environment and are implemented throughout the organization.

Productivity

Hutt Valley DHB takes a "wellness" approach to managing sick leave and offers occupational health support in managed return-to-work programmes.

Capital Management

The DHB's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure the DHB effectively achieves its objectives and purpose, whilst remaining a going concern.

Hospital Services

Statement of Financial Performance **For the year ended 30 June 2010**

	Actual $'000	Budget $'000	Variance $'000
Revenue			
Revenue	217,228	217,203	24
Interest Revenue	345	500	(154)
Total Revenue	**217,573**	**217,703**	**(130**
Operating Expenditure	(219,561)	(216,350)	(3,211)
Depreciation	(8,044)	(8,905)	861
Interest Expense	(1,259)	(1,386)	127
Capital Charge	(4,532)	(4,782)	250
Internal Allocations	7,316	7,466	(150)
Total Expenditure	**(226,079)**	**(223,956)**	**(2,122)**
Net Surplus / (Deficit)	**(8,506)**	**(6,253)**	**(2,253)**
Gain / (Loss) on Sale of Assets	(370)	-	(370)
Net Surplus / (Deficit)	**(8,876)**	**(6,253)**	**(2,622**
Expenditure Breakdown:			
Personnel Costs	(115,395)	(112,757)	(2,639)
Outsourced Services	(5,357)	(3,551)	(1,806)
Clinical Supplies	(22,246)	(21,370)	(876)
Infrastructure and Non-Clinical Supplies	(29,017)	(31,844)	2,827
IDF Outflows	(57,054)	(55,197)	(1,856)
External Contract Payments	(4,326)	(6,704)	2,378
Internal Allocations	7,316	7,466	(150)
Total Expenditure	**(226,079)**	**(223,956)**	**(2,123)**

Public Health Services

Statement of Financial Performance **For the year ended 30 June 2010**

	Actual $'000	Budget $'000	Variance $'000
Revenue			
Revenue	24,655	24,767	(112)
Interest Revenue	-	-	-
Total Revenue	**24,655**	**24,767**	**(112**
Operating Expenditure	(19,981)	(19,869)	(112)
Depreciation	(390)	(329)	(62)
Interest Expense	-	-	-
Capital Charge	-	-	-
Internal Allocations	(3,572)	(3,716)	143
Total Expenditure	**(23,943)**	**(23,913)**	**(30)**
Net Surplus / (Deficit)	**712**	**854**	**(142)**
Gain / (Loss) on Sale of Assets	(2)	-	(2)
Net Surplus / (Deficit)	**710**	**854**	**(143)**
Expenditure Breakdown:			
Personnel Costs	(13,817)	(14,148)	331
Outsourced Services	(1,017)	(883)	(134)
Clinical Supplies	(2,239)	(1,864)	(375)
Infrastructure and Non-Clinical Supplies	(1,597)	(1,879)	281
IDF Outflows	-	-	-
External Contract Payments	(1,701)	(1,424)	(277)
Internal Allocations	(3,572)	(3,716)	143
Total Expenditure	**(23,943)**	**(23,913)**	**(30)**

Primary & Community Services

Statement of Financial Performance **For the year ended 30 June 2010**

	Actual $'000	Budget $'000	Variance $'000
Revenue			
Revenue	123,792	124,847	(1,055)
Interest Revenue	-	-	-
Total Revenue	**123,792**	**124,847**	**(1,055)**
Operating Expenditure	(119,023)	(121,195)	2,172
Depreciation	(157)	(149)	(8)
Interest Expense	-	-	-
Capital Charge	-	-	-
Internal Allocations	(3,134)	(3,132)	(2)
Total Expenditure	**(122,314)**	**(124,476)**	**2,162**
Net Surplus / (Deficit)	**1,478**	**371**	**1,107**
Gain / (Loss) on Sale of Assets	(4)	-	(4)
Net Surplus / (Deficit)	**1,474**	**371**	**1,104**
Expenditure Breakdown:			
Personnel Costs	(13,070)	(13,476)	406
Outsourced Services	(456)	(629)	173
Clinical Supplies	(639)	(612)	(27)
Infrastructure and Non-Clinical Supplies	(1,154)	(1,260)	106
IDF Outflows	(6,552)	(6,766)	214
External Contract Payments	(97,310)	(98,601)	1,291
Internal Allocations	(3,134)	(3,132)	(2)
Total Expenditure	**(122,314)**	**(124,476)**	**2,162**

Support Services

Statement of Financial Performance **For the year ended 30 June 2010**

	Actual $'000	Budget $'000	Variance $'000
Revenue			
Revenue	57,343	55,655	1,687
Interest Revenue	-	-	-
Total Revenue	**57,343**	**55,655**	**1,687**
Operating Expenditure	(54,573)	(54,609)	36
Depreciation	(5)	(6)	1
Interest Expense	-	-	-
Capital Charge	-	-	-
Internal Allocations	(609)	(618)	9
Total Expenditure	**(55,187)**	**(55,234)**	**47**
Net Surplus / (Deficit)	**2,156**	**421**	**1,735**
Gain / (Loss) on Sale of Assets	-	-	-
Net Surplus / (Deficit)	**2,156**	**421**	**1,735**
Expenditure Breakdown:			
Personnel Costs	(3,458)	(3,509)	51
Outsourced Services	(82)	(103)	20
Clinical Supplies	(1,266)	(1,116)	(150)
Infrastructure and Non-Clinical Supplies	(130)	(127)	(3)
IDF Outflows	(5,335)	(5,335)	-
External Contract Payments	(44,307)	(44,425)	118
Internal Allocations	(609)	(618)	9
Total Expenditure	**(55,187)**	**(55,234)**	**47**

Statement of Objectives & Service Performance

For the year ended 30 June 2010

Introduction

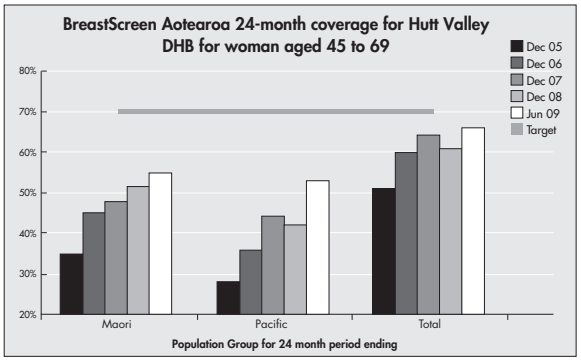
As a crown entity, Hutt Valley DHB is required by the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 to report on its service performance. In this section the actual performance of Hutt Valley DHB for the year ended 30 June 2010 is measured against the undertakings made in the DHB's Statement of Intent 2009/10-2010/12. Audit NZ on behalf of the Auditor-General has audited this performance report for accuracy and reasonableness.

Public Health Services Output Class - Keeping Our People Well

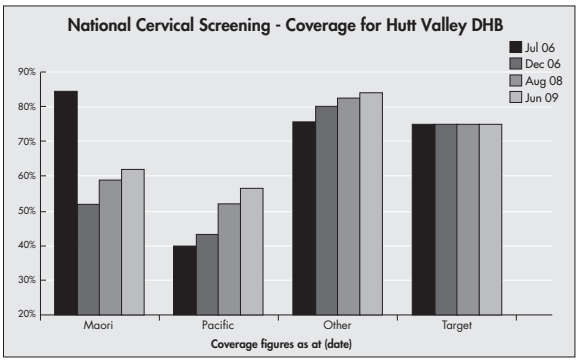
Keeping our people well is a priority for Hutt Valley DHB and key to ensuring we achieve our District Strategic Plan goals. A focus on keeping our people well as a priority contributes to enhanced health protection, reduced health risk, earlier intervention, improved infrastructure and regional collaboration and positive partnerships.

Output	Measure	Target	Achievement
Health Protection Services	*Control of infectious diseases* The number of outbreaks of infectious diseases managed in accordance with public health service specifications and statutory and regulatory requirements.	100%	Achieved 100% - 28 actual outbreaks notified and contained
		RPH staff developed health promotion strategies, aimed at various age groups, to increase pertussis (Whooping Cough) awareness as a result of an increase in the number of pertussis notifications within the HVDHB area. Regional Public Health was recognized nationally for the quality and timeliness of their management of the first wave of the H1N1 pandemic in the winter of 2009. The unit is currently revising its preparedness for a pandemic following the experience of managing the H1N1 pandemic.	
Health Promotion Services	*Better help for smokers to quit – Government Health Target* Smoking is a major contributor to poor health outcomes and health inequalities. The number of hospitalised people who are smokers who are given advice and helped to quit. Government has set a health target of 80% of hospitalised smokers are provided with advice and help to quit.	Total 80% Maori 80% Pacific 80%	83% 83% 88%
		We have increased training (based on effective brief intervention model) for our staff. In the coming year this will also be a priority for primary care.	
	Increasing the number of homes with adequate insulation and adequate heating The number of homes assessed for healthy environment installations – insulation, ventilation and heating. Insulating homes is a cost effective way to reduce the incidence of respiratory and other related illnesses and reduce the use of health services.	150 homes assessed	530 homes assessed
		Additional funding was provided by Housing New Zealand to increase the number of household assessments. We were able to meet the increased target, and assessed 530 homes between the Housing New Zealand and DHB funded programmes.	

Public Health Services Output Class - Keeping Our People Well continued...

<table>
<tr><th>Output</th><th>Measure</th><th>Target</th><th>Achievement</th></tr>
<tr><td>School Health Services</td><td>Number of Year 7 children (cohort) vaccinated in Schools in the Hutt District
Number of students fully vaccinated in the school year by Regional Public Health (RPH).</td><td>77.2% of total Year 7 School roll vaccinated
97.5% of those eligible consent to be vaccinated</td><td>Not Achieved
77.7% of the total roll vaccinated
97.2% of those eligible consented to vaccination</td></tr>
<tr><td>DHB Primary and Community Services</td><td>Cancer Screening Services
The Ministry of Health sets breast and cervical screening coverage target rates based on targets for reduced mortality (breast and cervical cancer) and reduced incidence (cervical cancer). For example if 70% of eligible women are screened for breast cancer then we can expect a 30% reduction in mortality amongst the screened population.
 
</td><td>Breastscreening
Age Ethni. Target 09 / 10
45-49 All 70%
50-54 All 70%
55-59 All 70%
60-64 All 70%
65-69 All 70%
45-69 All 70%
45-69 Māori 70%
45-69 Pacific 70%</td><td>Partial Achievement - Breastscreening
Actual 09 / 10
01/07/2008 – 30/06/2010 (For 24 month period)
63.8%
73.3%
73.8%
78%
79.5%
72.3%
63.8%
67.2%</td></tr>
<tr><td colspan="4">The increased coverage is due to improved access, with increased use of the Mobile service across the region.
The increase in Maori & Pacific coverage is due to BSC Health promotion initiatives and increased collaboration with primary care & and community providers (refer to graph 1 opposite).</td></tr>
</table>

Public Health Services Output Class - Keeping Our People Well continued...

<table>
<tr><th>Output</th><th>Measure</th><th>Target</th><th>Achievement</th></tr>
<tr><td>DHB Primary and Community Services continued...</td><td></td><td>Cervical Screening
Age Ethni. Target 09 / 10
20-24 All 78%
25-29 All 78%
30-34 All 78%
35-39 All 78%
40-44 All 78%
45-49 All 78%
50-54 All 78%
55-59 All 78%
60-64 All 78%
65-69 All 78%
20-69 All 78%
20-69 Māori 78%
20-69 Pacific 78%
20-69 Asian 78%
20-69 Other 78%</td><td>Partial Achievement - Cervical Screening
Actual 09 / 10
65.9%
80.3%
80.1%
83.2%
80.3%
79.1%
82.9%
81.4%
80.1%
65.6%
79%
63%
60%
72%</td></tr>
<tr><td colspan="2"> 
</td><td colspan="2">Increased awareness of the importance of having cervical smears and accessibility to screening services has attributed to the improved coverage rates for all women, as well as reducing inequality for women in all population groups (refer to graph 2 opposite).</td></tr>
<tr><td>DHB Primary and Community Services continued...</td><td>Primary Care Services
Hutt Valley DHB seeks to improve access to primary care for high needs populations to improve health equity and reduce avoidable admissions to hospital. We aim to increase the number of GP consultations per high need person (decile 9 or 10 or Māori/Pacific) when compared to non-high need person (a ratio of high need to low need).</td><td>Ratio of High Need to Low Need GP Consults
> 1.15
The number of General Practitioners and Practice Nurses (PN) providing services in the Hutt Valley
Population per GP <1,850
Population per PN <2,775</td><td>Partial Achievement
1.04
1,988
2,038</td></tr>
<tr><td colspan="2"></td><td colspan="2">Target was not met although High Needs patients have a greater number of visits per person than Low Needs patients. The lower GP consults rate has been partially addressed by the establishment of well patronised nurse-led clinics.
The Hutt Valley has a relatively low number of GPs for its population and is addressing this through a variety of workplace initiatives.</td></tr>
</table>

Public Health Services Output Class - Keeping Our People Well continued...

Output	Measure	Target	Achievement
DHB Primary and Community Services continued...	*Human Papilloma Virus Immunisation* The HPV programme aims to reduce cervical cancer in New Zealand by protecting girls against HPV infection. Currently, each year around 160 New Zealand women are diagnosed with cervical cancer and 60 women die from cervical cancer. Since September 2008 family doctors, practice nurses and health clinics have been offering HPV vaccine to young women born in 1990 and 1991 and younger girls who have left school. During 2009 and 2010, HPV vaccine was offered through school based programmes for girls in Years 8 to 13, and to girls aged 12 to 18 from their family doctor, practice nurse or health clinic.	7,125 Girls will receive the vaccine in 2009 school year	Not Achieved 2009 School year 3,916 girls were vaccinated.
		There have been issues with the public perception of this vaccine. We continue to work on strategies for this.	
	Before School Checks The B4 School Check aims to identify and address any health, behavioural, social, or developmental concerns which could affect a child's ability to get the most benefit from school, such as a hearing problem or communication difficulty. It is the eighth core contact of the Well Child Tamariki Ora Schedule of services, and replaces the New Entrant Check that was offered in some areas.	2,000 Checks completed for eligible children	Achieved 1406 checks completed another 501 screens are awaiting closure, that is they have been carried out but are awaiting the actioning of resulting referrals and thus not closed.
		After the SOI was completed, the ministry and we agreed to revise the target to 1,176 and this revised target was exceeded.	
	Breastfeeding Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy and childhood. The Ministry of Health has identified targets for the proportion of infants exclusively and fully breastfed: 85% at discharge from maternity unit, 74+% at six weeks; 57+% at three months; 27+% at six	numbers of infants exclusively and fully breastfed as a % of the total population of infants *Breastfed on discharge* 09/10 Target - 85% *Breastfed at 6 weeks* 09/10 Target - 63.7% *Breastfed at 3 months* 09/10 Target - 57% *Breastfed at 6 months* 09/10 Target - 27%	Not Achieved Actual - 95% Actual - 58% Actual - 50% Actual - 19%
		Although high on discharge our breastfeeding rates drop below the national average (65%) at six weeks, which is of continuing concern. We have developed a programme where Maori and Pacific Health Workers will provide additional support to women and their families for breastfeeding. These services will be delivered to support the HVDHB Health Eating Health Action (HEHA) Breastfeeding Plan commencing in Q1 of the 2010/11 year.	

Primary and Community Services Output Class

Primary Health Care

Primary Health Care is a key priority area for Hutt Valley DHB, and one of the strategies identified within our District Strategic Plan for achieving our strategic goals. A focus on primary health care as a priority contributes to achievement of the key outcomes of reduced health risk, improved access to services, earlier intervention, better service integration, more efficient and effective services, higher quality and safe services, improved infrastructure and regional collaboration and positive partnerships.

Output	Measure	Target	Achievement
DHB Primary and Community Services	*Reducing ambulatory sensitive (avoidable) admissions.* 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.	**Age** **Ethni.** **Target 09 / 10** 0-74 Māori <=105 0-74 Pacific <=103 0-74 Other <=109 0-4 Māori <=115 0-4 Pacific <=128 0-4 Other <=133 45-64 Māori <95 45-64 Pacific <95 45-64 Other <=104	Not Achieved **Actual 09 / 10** 117.1 117.6 118.4 116.7 146.7 149.6 118.0 96.9 122.7
		Hutt Valley DHB continues to have high rates of ambulatory sensitive hospitalisations (ASH). We are working with clinical teams to identify clinical champions to lead work in this area. In June we funded two primary care nursing innovations (Family Care and Tu Kotahi) focussed on respiratory conditions. We are also working with Piki Te Ora PHO on a cellulitis initiative. These will provide models to build on to reduce our ASH in the future.	

Maternity, Child and Youth Health

Maternity, child and youth health is a priority for Hutt Valley DHB. A focus on maternity, child and youth health as a priority contributes to achievement of the key outcomes of reduced health risk, improved access to services, earlier intervention, more efficient and effective services, improved infrastructure and sustainable services, and regional collaboration and positive partnerships.

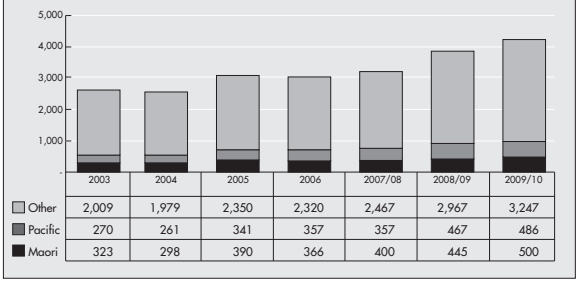
Output	Measure	Target	Achievement
Maternity, Child and Youth Services	*Improving immunisation coverage – Government Health Target* Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. The Government's health target is that 85% of two year olds are fully immunised by July 2010.	The number of two year olds fully immunised **Target 09/10** Total 87% Māori 87% Pacific 87%	Achieved **Actual 09/10** 88% 88% 89%

Primary and Community Services Output Class continued...

Output	Measure	Target	Achievement
DHB Primary and Community Services continued...	*Improving diabetes and cardiovascular disease – Government Health Target* Chronic disease comprises the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly. Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need. The Government's health target is that there will be an: • Increase in the percentage of eligible adult population that have had their CVD risk assessed in the last five years. • Increase in the percentage of people with diabetes who attend free annual checks • Increase in the percentage of people with diabetes who have satisfactory or better diabetes management.	*% of eligible people having CVD risk assessed in last 5 years* Maori 67% Pacific 70% Other 78% **Total 76%** *% Diabetics having Annual Free Check* Maori 55% Pacific 63% Other 64% **Total 63%** *% Diabetics well managed* Maori 59% Pacific 52% Other 81% **Total 74%**	Partial Achievement The DHBs overall achievement against this target was ranked as 4th best of the 20 DHBs *Achieved* *CVD Risk Assessment* 69.5% 68.8% 78.3% **76.4%** *Achieved* *Diabetes Annual Free Check* 55% 67% 68% **66%** *Not Achieved* *Diabetics Well Managed* 61% 54% 78% **73%**

Levels have fluctuated throughout the year. However the number of diabetes annual reviews has increased by 12% for Maori and 9% overall.

Hutt Valley DHB number of Diabetes Annual Reviews (Get Checked)



	2003	2004	2005	2006	2007/08	2008/09	2009/10
Other	2,009	1,979	2,350	2,320	2,467	2,967	3,247
Pacific	270	261	341	357	357	467	486
Maori	323	298	390	366	400	445	500

Primary care has been working to improve access to diabetes checks. This has resulted in a 9% increase in the number of checks provided, 4,233 in 09/10 up from 3,879 the previous year. This continues to be an area of focus for the DHB with a funder review of diabetes services in the early part of 2010-11 planned (please refer to graph 3 opposite).

The services achieved the targets for Maori and Pacific people. Improving the overall care and management for people with diabetes remains a priority for the DHB.

Primary and Community Services Output Class continued...

Output	Measure	Target	Achievement
DHB Primary and Community Services continued...	*Improving oral health* Oral health is an important indicator of the overall state of child health. The indicators below look at access to services and the outcomes of those services.	The number of adolescents accessing DHB funded dental services – 68%	Not Achieved 59.2%
		The pilot at Wainuiomata High School increased utilisation from 129 students in 2008 to 353 students in 2009. We are seeking feedback from the dentists, students and school staff involved with a view to expanding the utilisation project in 2011.	
	For year 8 children examined the number of decayed, missing and filled teeth (DMFT)	**Target 2009** Māori 1.2 Pacific 1.2 Other 0.7 **Total 0.9**	Not Achieved 1.38 1.76 0.88 **1.09**
	% children at age 5 year are caries free	**Target 2009** Māori 53% Pacific 44% Other 75% **Total 67%**	Not Achieved 43% 25% 71% **59%**
		Number of children waiting for recall for over 12 months – 10%	Not Achieved 6.8%
		Two years ago, 37% of eligible children were waiting over 12 months for recall - that is, they we not being seen each year. Now, 93.2% of children are being seen each year. This significant improvement has meant we have identified more children with high needs, which partly explains why we have not achieved the DMFT, and % caries free targets. However, earlier intervention and education is beginning to show small but significant improvements in these statistics. Note that the Oral Health Service indicators are measured on the calendar year, to fit with the school year.	

Primary and Community Services Output Class continued...

Output	Measure	Target	Achievement
DHB Primary and Community Services continued...	*Primary Care Services* Hutt Valley DHB seeks to improve access to primary care for high needs populations to improve health equity and reduce avoidable admissions to hospital. We aim to increase the number of GP consultations per high need person (decile 9 or 10 or Māori/Pacific) when compared to non-high need person (a ratio of high need to low need).	Ratio of High Need to Low Need GP Consults > 1.15 The number of General Practitioners and Practice Nurses (PN) providing services in the Hutt Valley **Population per GP <1,850** **Population per PN <2,775**	Partial Achievement 1.04 **1,988** **2,038**
		Target was not met although High Needs patients have a greater number of visits per person than Low Needs patients. The lower GP consults rate has been partially addressed by the establishment of well patronised nurse-led clinics. The Hutt Valley has a relatively low number of GPs for its population and is addressing this through a variety of workplace initiatives.	

Hospital Services Output Class

Acute services

Acute Services encompass all services provided via the Hutt Hospital, other than Elective Services, Maternity, Child and Youth, and Mental Health Services including:

- Acute and Chronic Care services
- Plastic, ENT, Audiology and Dermatology services
- Gynaecology services
- Community Dental services

Acute Services are a key priority for Hutt Valley DHB. A focus on these services as a priority contributes to achievement of the key outcomes of improved access to services, better service integration, more efficient and effective services, high quality and safe services, improved infrastructure and sustainable services.

Elective Services

Elective services (booked surgery) are for patients who do not require immediate hospital treatment. Hutt Valley DHB is committed to meeting the government's expectations around elective services, particularly the key principles underlying the electives system:

- clarity – where patients know whether or not they will receive publicly funded services
- timeliness – where services can be delivered within the available capacity, patients receive them in a timely manner; and
- fairness – ensuring that the resources available are directed to those most in need.

Elective Services is a key priority for Hutt Valley. A focus on these services as a priority contributes to achievement of the key outcomes of improved access to services, more efficient & effective services, improved infrastructure and sustainable services.

Output	Measure	Target	Achievement
Elective Services	*Elective Surgical Discharges – Government Health Target* The number of elective surgical discharges. This is a measure of increasing access to planned services.	**PU Name** / **Target 09/10** General surgical 948 Cardiothoracic 74 Ear, nose, throat 662 Gynaecology 668 Neurosurgery 46 Ophthalmology 564 Orthopaedics 604 Paediatric surgical 99 Plastics 841 Urology 214 Vascular surgery 121 **4,841**	Achieved **Actual 09/10** 964 87 681 652 54 577 616 112 936 214 119 **5,013**
		Various strategies including implementing Clip-on theatres and outsourcing of services to private hospitals have achieved this year end result.	

Hospital service Output Class continued...

<table>
<tr><th>Output</th><th>Measure</th><th>Target</th><th>Achievement</th></tr>
<tr><td rowspan="2">Acute Services</td><td rowspan="2">Emergency Department Waiting Times – Government Health Target
Overcrowding of Emergency Department (ED) is linked to poor outcomes for patients. This is a measure of system flow as long waits in ED can be impacted by the number of people coming to the department, and lack of supports or capacity to transfer them out to other services.
The percentage of patient presentations to ED with an ED length of stay less than six hours/total number of patient presentations to the ED.</td><td>Admit Service | Target 09/10
Admitted Total | 84%
Treated & Discharged | 92%
Treated & Referred | 91%
Total | 90%</td><td>Not Achieved
Actual 09/10
72%
91%
90%
86%</td></tr>
<tr><td colspan="2">We have made progress towards meeting the Emergency Department (ED) effectiveness measurement criteria (Health Target: 90% of people will be seen within less than 6 hours). Despite our cramped physical environment, we have gone from seeing 83 percent of people within 6 hours at the beginning of the year to 87 percent in the last month.
We have implemented a whole of system project to improve patient flow throughout the hospital. We are making practical changes to processes that improve patient flow, enhance the patient experience and make work better for staff. This work will continue to be a priority in 2010-11, with significant improvement expected when our new ED is commissioned, and as we explore ways we can work better with Primary Care providers and the new PHO structure.</td></tr>
<tr><td rowspan="4">Non- Admitted patient services</td><td rowspan="2">Day case rates
An important way to increase hospital throughput is through increasing the proportion of surgery carried out on a day surgery basis. For planned admissions (arranged and elective) it should be possible to improve the management of surgery in order to improve day surgery rates. Patient feedback around day surgery is positive, and day surgery therefore represents a quality experience for the patient.</td><td>36%
9,359 day cases</td><td>Achieved
47%
10,714 day cases</td></tr>
<tr><td colspan="2">The Clinical Lead, Day Surgery and the Clinical Nurse Manager are working with individual surgeons and departments to identify barriers to support them in carrying out procedures as day surgery. This work will continue into 2010-11.</td></tr>
<tr><td rowspan="2">Reducing cancer waiting times – Government Health Target
Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Development of indicators that mark quality cancer treatment is, however, restricted by the lack of routinely collected information on common treatment. In the interim, waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, and is an area with waiting time issues for patients.</td><td>100% of patients will be seen within 6 weeks</td><td>Achieved
100%</td></tr>
<tr><td colspan="2">This service is provided by Capital & Coast. Our cancer facilitator has worked with them to ensure Hutt Valley DHB patients are seen in a timely fashion.</td></tr>
</table>

Mental Health Services

Hutt Valley DHB provides mental health and addiction services on the basis of the national Mental Health Strategy, Te Tāhuhu - Improving Mental Health 2005-2015 The strategy sets out the leading challenges or action priorities that Hutt Valley DHB is working to achieve, to ensure continued improvement in mental health and addiction outcomes for our population. A focus on mental health services as a priority contributes to achievement of key outcomes of improved access to services, more efficient and effective services, and sustainable services.

<table>
<tr><th>Output</th><th>Measure</th><th>Target</th><th>Achievement</th></tr>
<tr><td>Mental Health Services</td><td>Access to services
Percentage of population accessing mental health services for different ethnic groups and by age group, compared to the 3% of the population that are estimated to have severe mental health disorders, provides a measure of access and availability of mental health services.</td><td>Ethni. Age Target 09 / 10
Māori 0-19 2.5%
Māori 20-64 4.8%
Māori 65+ 1.5%
Pacific 0-19 1.0%
Pacific 20-64 2.5%
Pacific 65+ 1.0%
Other 0-19 2.3%
Other 20-64 2.9%
Other 65+ 1.5%
Total 0-19 2.3%
Total 20-64 2.9%
Total 65+ 1.5%</td><td>Partial Achievement
Actual 09 / 10
1.8%
5.4%
1.6%
0.8%
2.7%
1.6%
2.5%
2.9%
1.4%
2.1%
3.3%
1.4%</td></tr>
<tr><td></td><td></td><td colspan="2">There has been a significant improvement in the % of patients accessing services since the beginning of the 2009/10 year. Targets remaining unmet include young Maori and Pacific, and the over 65 Other although these are close to target. Focus continues through a number of projects to address this.</td></tr>
<tr><td>Mental Health Services</td><td>Improving mental health services
All clients with enduring mental illness should have up to date crisis prevention/ resiliency plans (NMHSS criteria 16.4). Crisis prevention/resiliency planning has been shown to be a key component of service delivery that ensures the medium to longer impacts of a serious mental illness are to be minimised. Effective prevention planning can be expected to contribute materially to improved outcomes for clients.</td><td>Age Ethni. Target 09 / 10
20 years+ (exc. addictions only) Māori 90%
20 years + (addictions only) Maori 90%
Child and Youth Māori 90%
Total Māori 90%
20 years+ (exc. addictions only) Pacific 90%
20 years + (addictions only) Pacific 90%
Child and Youth Pacific 90%
Total Pacific 90%
20 years+ (exc. addictions only) Other 90%
20 years + (addictions only) Other 90%
Child and Youth Other 90%
Total Other 90%
20 years+ (exc. addictions only) Total 90%
20 years + (addictions only) Total 90%
Child and Youth Total 90%
Total Total 90%</td><td>Not Achieved
Actual
6%
9%
57%
26%
47%
0%
67%
38%
Not
Measured
Not
Measured
43%
11%
56%
58%</td></tr>
<tr><td></td><td></td><td colspan="2">The service has had IT issues all year which means they cannot report on Other Ethnicity. Targets were set at the Ministry of Health optimum rather than achievable level. There continue to be issues in reporting which are currently being addressed with an expectation that there will be significant improvement in this reporting in the coming year.</td></tr>
</table>

Support Services Output Class

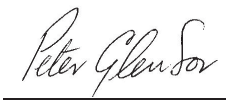
Older Peoples Health Services

Hutt Valley DHB is progressively implementing the national Health of Older People Strategy, which all DHBs are required to implement by 2010 to better meet the needs of older people now and in the future. Our local Health of Older People plans detail the development of more integrated health and disability services that are responsive to older people's varied and changing needs, with a focus on improving community-based services that enable older people to remain safely in their own homes.

Output	Measure	Target	Achievement
Older Peoples Health Services	*Home based support utilisation* In order to support older people to remain in their own homes for longer we aim to increase the range and availability of home support service.	329,006 – the number of home based support service hours provided for older people.	Not Achieved 230,745 – Home based support hours provided
		We have identified a need to improve the range of services in the community to support older people with low to medium support needs. We have reviewed many client's packages of care in 2009/10 and now have greater confidence that individuals are receiving the appropriate level of support. Although work has commenced with some existing providers, progress has been delayed due to an ownership change with one of our largest providers. We expect further progress in 2010-11. Continued work in this area is included in the DHBs Health of Older People Strategic Action Plan 2010-2016.	
	Utilisation of Aged Residential Care Beds Residential care is an expensive resource that should be well managed. We will utilise our enhanced NASC to manage use and ensure older people are placed in the correct level of care to meet their needs.	305,244 Targeted maximum – number of subsidised bed days provided for older people	Achieved 302,123
		The DHB has identified that our population has an unduly high rate of using aged residential care (ARC) beds, especially hospital level ARC beds. The strategy in 2009/10 was to reduce the number of ARC beddays that were used by older people, to be lower than the target level of 305,244 days. This was achieved by careful management of entry to these ARC services, working closely with the augmented Needs Assessment and Service Coordination (NASC) service and other agencies.	

Statement of Responsibility

1. The Board and management of Hutt Valley District Health Board accept responsibility for the preparation of the financial statements and statement of service performance and judgements used in them;
2. The Board and management of Hutt Valley District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting; and
3. In the opinion of the Board and Management of Hutt Valley District Health Board, the financial statements and statement of service performance for the year ended 30 June 2010 fairly reflect the financial position and operations of Hutt Valley District Health Board.



Board Member | Board Member | 14th October 2010

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit report

To the readers of Hutt District Health Board's financial statements and statement of service performance for the year ended 30 June 2010

The Auditor-General is the auditor of the Hutt District Health Board (the Health Board). The Auditor General has appointed me, Leon Pieterse, using the staff and resources of Audit New Zealand, to carry out the audit on her behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health Board for the year ended 30 June 2010.

Unqualified opinion

In our opinion:

- The financial statements of the Health Board on pages 20 to 40:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board's financial position as at 30 June 2010; and
    - the results of its operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board on pages 41 to 56:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 14 October 2010, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statements and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board as at 30 June 2010 and the results of its operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

Other than the audit and performing an independent assurance review over a tender, we have no relationship with or interests in the Health Board.

Leon Pieterse Audit New Zealand

On behalf of the Auditor-General, Wellington, New Zealand

HVDHB Directory

Head Office - Pilmuir House, Pilmuir Street, Lower Hutt. www.huttvalleydhb.org.nz.

Postal Address - Private Bag 31-907, Lower Hutt.

Bankers - Bank of New Zealand.

Auditor - Audit New Zealand Wellington, on behalf of the Controller and Auditor-General.

Hutt Valley DHB People

Board Members

The Board consists of eleven members, seven elected and four appointed by the Minister of Health including a chair and a deputy chair.

Peter Glensor, *Chair*
Sharron Cole, *Deputy Chair*
Katy Austin
Pat Brosnan
Debbie Chin - appointed November 2009
Sandra Greig
Wayne Guppy
Keith Hindle
Ken Laban
Catherine Love
David Ogden

Maori Partnership Board
Louise Windleborn, *Chair*
Shamia Shariff, *Deputy Chair*
Janis Awatere
Ihaia Biddle
Millie Hawiki
Lizzy Kepa-Henry
Mahara Okeroa
Keriata Stuart

Committee Members

The membership of the committees is as follows:

Community & Public Health Advisory Committee (CPHAC)
Katy Austin, *Chair*
Gil Alcorn
Peter Glensor
Wayne Guppy
Keith Hindle
Lizzy Kepa-Henry – Appointed April 2010
Ken Laban
Catherine Love
Stewart Reid
Shamia Shariff – Appointed April 2010
Muriel Tunoho
Iunita Vaofusi

Disability Support Advisory Committee (DSAC)
Ken Laban, *Chair*
Janis Awatere – Appointed February 2010
Pat Brosnan
Warick Dunn
Peter Glensor
Sandra Greig
Catherine Love
David Ogden
John Ryall – Resigned May 2010
Pati Umaga

Finance, Property and Audit Committee (FAC)
Keith Hindle, *Chair*
Katy Austin
Debbie Chin – joined November 2009
Sharron Cole
Peter Glensor
Wayne Guppy
Ken Laban
David Ogden

Hospital Advisory Committee (HAC)
Sharron Cole, *Chair*
Mena Aukuso
Pat Brosnan
Peter Glensor
Sandra Greig
David Ogden
Keriata Stuart

Executive Management Team

Chai Chuah
Chief Executive to February 2010
Bridget Allan
Director, Planning, Funding and Public Health
Stephanie Chapman
Project Manager
Tony Cooke
Chief Information Officer
Toni Dal Din
Director of Nursing to May 2010
Mark Davies
Interim Director of Nursing from June 2010
Liz Fitzmaurice
Primary Care Liaison
Cheryll Graham
Community Liaison
David Graham
GM Communications
Michael Hundleby
General Counsel & Acting Chief Executive
Peter Kennedy
Chief Financial Officer
Phil Kerslake
General Manager Human Resources
Jill Lane
Chief Operating Officer
Dr Robert Logan
Chief Medical Advisor
Siloma Masina
Pacific Peoples' Health Advisor
Kuini Puketapu
Maori Health Advisor
Russell Simpson
Director of Allied Health
Iwona Stolarek
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