Hutt Valley District Health Board

Annual Report 2020-2021

E84 Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004.

HUTT VALLEY DHB

Contents

Glossary of acronyms:
HVDHB – Hutt Valley District Health Board
CCDHB – Capital & Coast District Health Board
2DHB – Hutt Valley and Capital & Coast District Health Boards
3DHB – Wairarapa, Hutt Valley and Capital & Coast District Health Boards
MHAIDS - Mental Health, Addictions and Intellectual Disability Service

Cover photo: *Rose Nimarota and Otila Tefono. Read their story on page 9.*

Chair and Chief Executive's Foreword

We are pleased to present Hutt Valley DHB's Annual Report for 2021. This report outlines the progress we have made towards putting our community at the heart of the health system in our region.

Together with Capital & Coast DHB, we have been working to bring our 2DHB partnership to fruition with a shared focus on providing safe, quality health services, and striving to achieve equitable health outcomes for everyone in our region.

Our people have adapted well to change over the past 12 months including the establishment of a single Executive Leadership Team across Hutt Valley and Capital & Coast DHBs and a strategic focus on unified healthcare delivery. As a result we are improving service coordination across the region, with people and place-centric service planning and delivery focused on the specific needs of each community.

The unprecedented challenges COVID-19 presented during the past year have underscored the importance of work underway to address health inequities. Our Boards have confirmed a set of equity goals and principles which will inform and guide our service improvements.

We know outbreaks of infections such as COVID-19 disproportionately impact people and populations already facing the challenge of poorer health outcomes. This is why we have made it a priority to ensure key health messages, services and support reach Māori, Pacific and Disability communities.

We have worked closely with mana whenua partners, and Māori providers, Pacific providers and organisations providing support to disabled people. Te Upoko O Te Ika Māori Council was established to ensure hauora Māori is at the forefront of planning, funding and service delivery activities across the region.

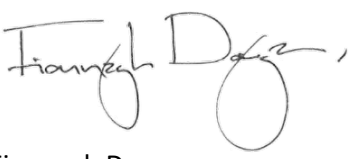
Together our DHBs commenced rollout of the COVID-19 vaccination programme, seeking to vaccinate over 400,000 eligible people in our region, the largest ever vaccination effort we have seen. The priority has been our equity populations and we are proud of what we have achieved by working together with our primary health providers, community organisations and health sector partners. This shift to working in partnership and more intensively with communities has been a defining feature of the past year.

During 2021 we commenced planning for one of the largest changes the New Zealand health and disability system will experience. As we work towards the new entities, Health NZ and the Māori Health Authority which come into effect in mid 2022, our DHBs have set 11 strategic priorities and 5 enablers which we will focus on. These strategic priorities and work programmes are aligned with and will support this reform.

Our Board remain committed to ensuring we are in a sustainable financial position, and work continues to ensure we optimise our resources to deliver quality care.

In closing, we would like to thank all our staff for their exceptional contribution over the past year. Ehara taku toa i te toa takitahi, engari he toa takitini.

David Smol
Manukura I Board Chair



Fionnagh Dougan
Āpiha Whakahaere Mātāmua | Chief Executive

Introduction

This annual report outlines HVDHB's progress toward meeting the intentions and priorities as outlined in 'Our Vision for Change – How We Will Transform the Health System 2017-2027' and the New Zealand Health Strategy, while ensuring we are well-positioned to support the new Health NZ and Māori Health Authority entities which that come into effective in mid 2022.

Our Vision for Change outlines our vision and strategy to transform the health system to ensure equity amongst our populations and support better health and wellbeing throughout the lives of the people in our communities. Achieving equity and providing an integrated seamless service is embedded throughout these strategic goals. Our Vision for Change is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

We are committed to improving health outcomes and achieving equity for our communities. We know that we need to do better for Māori, Pacific Peoples, disabled people, those who have fewer resources available to them and those with enduring mental illness. We can see this in our measurement of health system performance, impacts, and outcomes.

The boards and joint leadership team take a community-focussed approach to planning. The specific needs of each community in the region are considered, and we take a patient-centric approach to service planning that ensures services are well joined-up and seamless.

At the core of the strategic work programme across HVDHB and CCDHB is the "five communities" vision. This is an approach that focuses on the communities [that make up the communities] with our 2DHB boundaries - Kāpiti, Upper and Lower Hutt, Porirua and Wellington. Each of these communities has its own specific set of needs and challenges, and our vision is that by planning more effectively across the whole region, we can better serve our patients and clients and improve the equitability of our system.

Achieving equitable health outcomes for our communities requires a broader approach that breaks down traditional health sector boundaries. To respond to inequality, partnerships are required with local councils, government agencies, non-governmental organisations, and community organisations. We support these partnerships through local approaches with our communities.

Work to date on implementing Te Pae Amorangi, our Māori Health Strategy 2018-2027, has included identifying five key measures of equity common to HVDHB and CCDHB Māori health goals. These five key measures are: amenable mortality, avoidable hospital admissions, accessible appointments, primary care utilisation, and community-based services. These five overall measures of equity are adopted as a framework for identifying indicators of progress toward Māori health equity.

An important development this year was the establishment of Te Upoko O Te Ika Māori Council, which has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi. We now collaborate with Te Upoko O Te Ika Māori Council, Sub-Regional Pacific Strategic Health Group and the Sub-Regional Disability Advisory Group who provide advice on how we can improve these indicators.

The changes that feature in this annual report are about making sure healthcare is easy to access and effective for all people in our five communities. We know the most effective change will happen when we listen to and learn from feedback. We continue to work closely with a broad range of stakeholders, providers, sector and community groups and people in our five communities.

Our Vision and Strategic Direction

Hutt Valley District Health Board (HVDHB) is committed to meeting the Minister of Health's expectations and delivering our vision of:

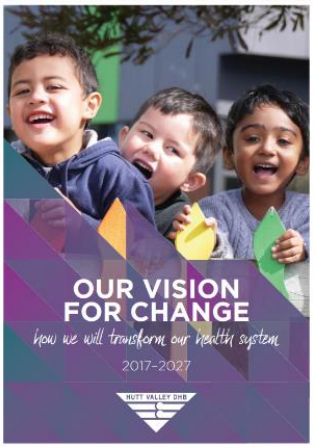
Healthy People, Healthy Families, Healthy Communities (Whānau Ora ki te Awakairangi)

To deliver on this vision, we are developing and implementing a health system that best meets the needs of our region's people and communities. This means applying our resources in the most effective manner to achieve equitable health outcomes and to advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate setting for our people and communities.

We recognise the role of many people in our success: our communities, our families, our workforce, our provider partners, our Ministry and our social service partners. Enabling people and their whānau to take the lead in their own health and wellbeing is at the heart of this approach.

Our Vision for Change

In 2017, we introduced 'Our Vision for Change – How We Will Transform the Health System 2017-2027'. Our people, whānau and communities have told us what is needed from the Hutt Valley health system in order to achieve 'Our Vision for Change'. These strategic objectives include services being organised and delivered equitably, whānau being owners of their care, a focus on prevention and early intervention, care delivered closer to home, coordinated health and social services, and a health system that is clinically and financially sustainable.



Our Vision for Change includes a focus on the following key strategic goals:

- Support people to live well
- Shift care closer to home
- Deliver shorter, safer, smoother care.

Our focus on achieving equity and providing an integrated seamless service is embedded in the work we do toward these strategic goals. Our Vision for Change is designed to support people and whānau-led wellbeing with the system organised around the two elements. People and Place.

People

We are committed to developing people-focussed service delivery models. There are three broad service delivery models for the main users of our health services:

- Core health care service users. Those who require any form of urgent and planned care. The health system will be acting early to prevent illness and disability and save lives.
- Maternity services users and children, young people, and their families and whānau. The health system will be providing support in these key life transitions, with a strong focus on children and young people where early action has benefits across the life course.

- People who require system coordination – including those who have long-term conditions, are becoming frail or are at the end of their life. These people have multiple needs from the health system and require the system to be easily and effectively navigated to enable them to lead their own health care.

This means recognising those who may need more help including Māori and Pacific peoples in our region, people with disabilities, people with an enduring mental illness and/or addiction, refugees and socially or economically vulnerable people.

Place

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths. It makes it easier to recognise and value community diversity, while organising a consistent system across many groups.

Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Health care has always been delivered in a variety of settings. The places where care is organised and delivered, together with increased access to better and cheaper technologies, provide the platform for a comprehensive system of care.

The plan centres on the following three core care settings:

- People's homes and residential care facilities.
- Community Health Networks, including Health Care Home and the Kāpiti Health Centre.
- Wellington Regional and Kenepuru Community hospitals providing specialist care for the CCDHB region.

Strategic framework

We are guided by a series of strategies and plans to improve the performance of our health care system and encourage better health and wellbeing and more equitable health outcomes for all our communities. These plans keep us focused on people and places, and providing care in the appropriate settings.

Read the strategies on our website: www.huttvalleydhb.org.nz

Health Equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Achieving equity in health and wellness is a focus for HVDHB. We know that we do not do as well for Māori, Pasifika People, disabled people, those who have fewer resources available to them, and those with enduring mental illness. We are committed to improving their health outcomes and achieving equity for them. We will continue to deliver against:

- Te Pae Amorangi, HVDHB's Māori Health Strategy 2018-2027
- the Sub Regional Pacific Health And Wellbeing Strategic Plan 2020-2025
- the Sub-Regional Disability Strategy 2017-2022
- Living Life Well – A Strategy for Mental Health and Addiction 2019-2025.

Our focus is on improving performance, ensuring we make the best use of our available resources, and achieving equity amongst our populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we will intensify resources and support for those who need us the most, and simplify for those who need us the least.

HVDHB has a fundamental role in enabling and facilitating the health system to achieve equitable health outcomes. Partnership is key to success in achieving equitable health outcomes. We collaborate with our Māori Council, the Sub-Regional Pacific Strategic Health Group, and the Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We measure and report on our progress regularly.

Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities to Māori through Te Tiriti o Waitangi, the founding document of Aotearoa. The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal, underpin the DHB's commitment to Te Tiriti, and guide the actions outlined in this annual plan. The 2019 Hauora report recommends a series of principles be applied to the primary health care system. These principles are applicable to the wider health and disability system as a whole. HVDHB values Te Tiriti and applies these the principles to our work across the health and disability system:

- **Tino rangatiratanga**: Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity**: Being committed to achieving equitable health outcomes for Māori.
- **Active protection**: Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

In planning and providing health services, we pay particular attention to the health needs and aspirations of our Māori population. There are well-documented and preventable inequities in the determinants of health between Māori and non-Māori, and these flow through to inequities in health outcomes. We aim to address this through targeting and driving our health services to create equity of health care for Māori, while developing partnerships with the wider social sector to support whole of system change.

Māori representation has been provided on all advisory committees and our Alliance Leadership Team, the Integrated Care Collaborative. We also have a 2DHB (HVDHB and CCDHB) Māori Council to formalise the relationship between local iwi and the DHB, build on relationships, and share aspirations and strategic directions.

Te Upoko O Te Ika Māori Council

Te Upoko O Te Ika Māori Council (TUI MC) was established in 2021 to represent hauora Māori across both CCDHB and HVDHB. TUI MC replaces the both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). The purpose of TUI MC is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within CCDHB, HVDHB, and the wider community. TUI MC has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi.

TUI MC comprises up to two representatives each of the following iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. The Chair is appointed by TUI MC members.

Māori Health

Historical disadvantage and alienation, poverty and poor living environments lead to sustained poor health outcomes. This applies to many Māori individuals and whānau. Life expectancy for Māori males and females living in the HVDHB area continues to lag about five years behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas. Disability is a significant issue for Māori. Nationally, approximately 200,000 Māori (26%) report having a disability.[1]

[1] Ministry of Health. 2018. Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan. Wellington: Ministry of Health.

In July 2019 HVDHB launched Te Pae Amorangi, HVDHB's Māori Health Strategy to 2027. Te Pae Amorangi is supported by this tūruapō (vision):

Mauri Ora – Whānau Ora – Wai Ora (Healthy People – Healthy Families – Healthy Communities)

Te Pae Amorangi is centred on achieving Māori health equity, and advancing Tiriti relationships and Māori participation across the health system.

Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is most cohesively described in the Ministry of Health's *He Korowai Oranga: Māori Health Strategy*. This overarching framework and its underlying themes of Pae Ora (healthy futures) founded on Whānau Ora (healthy families), Mauri Ora (Healthy individuals) and Wai Ora (healthy environments) guide our activity.

Te Pae Amorangi is consistent with He Korowai Oranga and has been developed to transform our health and disability services over the next nine years to achieve Māori health equity and outcomes.

We need to be bold and implement actions that will make a significant impact towards achieving our vision. However, we also need to be flexible enough to change direction if something is not working. There is a need to work across our communities to address the underlying causes of poor health and build a health system that achieves equitable Māori health outcomes. Progressing implementation of Te Pae Amorangi is a focus for 2021/22. We will measure and report on our progress regularly to the Māori Council on behalf of all Māori in our district.

Protecting our Pacific People from COVID-19

Rose Nimarota, left, and Otila Tefono are Speciality Clinical Nurses, working in the 3DHB Pacific Health Unit and helping to protect communities from COVID-19.

They are leading the way when it comes to protecting our Pacific community by getting their first COVID-19 vaccination doses and training to vaccinate others. Otila has extensive experience working mainly in general and obstetric nursing in hospitals in Samoa and New Zealand while Rose is experienced in dialysis, aged care and supporting GP services

Based at Hutt Hospital, the pair completed an Influenza, MMR and Pandemic Vaccinator Foundation Course then went on to complete a COVID-19 education course. They are now trained vaccinators, able to support our staff and Community Vaccination Centres. They will help other staff to get vaccinated and people in our community. All in all, the online training took about eight hours, which they fitted in part-time around their regular work.

"As a Speciality Clinical Nurse and working frontline, it's important that we get the COVID-19 vaccination because as nurses we have a duty of care to our patients.

As a Pacific mother, this duty of care extends to my family and the Pacific community. We acknowledge that Pacific people may have some fears and doubt about the vaccination and this is normal. We encourage them to talk to a health professional, ring their GP clinic and speak to a nurses, ring HealthLine on 0800 611116 or they can even ring through to the Pacific Health Units at Hutt Valley or Wellington hospitals. We can help with information so Pacific people can feel safe in making the right choices." Rose said.

3DHB Pacific Health director Dr Avataeao Junior Ulu said the team were "very proud" of Otila and Rose and their efforts to be trained vaccinators within their substantive roles.

"Otila and Rose will work with other Pacific nurses with a view of strengthening the collective Pacific capability in the Greater Wellington region."

About Hutt Valley DHB

Hutt Valley DHB is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services for people in the Hutt Valley.

Who we are

Hutt Valley DHB covers the Te Awakairangi area – the Hutt Valley and serves approximately 156,790 people. Our District Health Board covers both Upper Hutt City and Hutt City. People under 25 years of age account for 31% of the Hutt Valley population and those aged 65 years of age account for approximately 15%. Overall, the Hutt Valley area has similar proportions of those living in the highest and lowest deprivation areas. However, these overall figures mask the extremes in deprivation seen in the Lower Hutt area, where there is a greater proportion of the population living in the most deprived areas.

The Hutt Valley's population is ethnically diverse; 18% of our population identify as Māori (28,700), 8% as Pacific peoples (12,500) and 74% as New Zealand European, Asian and Other (118,300).

Disabilities

There are 35,000 people with a disability living in our district. More than half of the disabled population have a physical disability (58%), 20,200 people. With age, the prevalence of disability increases, and the type of impairment changes.

Our development and delivery of Planned Care takes into account the diversity in ethnicity, age, and ability of our population.

A changing population

As our population ages, we are seeing more people with long-term health conditions and multi-morbidities. People are living longer than previous generations, but are living longer in poorer health. This is particularly so for Māori, Pacific people, refugees, disabled people and those living with a mental illness.

Our total population is expected to grow over the next 10 years (6% or 10,000 people), although there are both short- and long-term plans for housing development in Lower Hutt and Upper Hutt cities. However, there will be a significant increase in the number of older people, with current projections suggesting that in 2030/31 almost one in five people will be aged over 65 years. The population aged over 80 will grow by almost 50%. The overall number of children is expected to decline.

As a consequence of our changing population, increased demand will occur across our health system in community care, primary care, aged residential care and in the hospital at the same time as our working-age population decreases. We have a significant challenge ahead to achieve the best and fairest outcomes for our population whilst responding to demographic change and other demand pressures.

The health of our population

Compared to New Zealand as a whole, we are relatively 'healthy and wealthy'. We have a high life expectancy at 81 years, rates of premature deaths from conditions amenable to healthcare have declined by 45% between 2000 and 2018, and more than half of our population (51%) live in areas of low deprivation.

However, we also have groups who experience inequitable health outcomes; in particular, Māori, Pacific peoples, those experiencing disabilities and those who live in highly deprived areas, concentrated in Wainuiomata, Naenae and Taita.

What we do

HVDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- Improve, promote, and protect the health of communities;
- Reduce inequalities in health status;
- Integrate health services, especially primary and hospital services; and,
- Promote effective care or support of people needing personal health services or disability support. DHBs act as planners, funders and providers of health services as well as owners of Crown assets.

Local services

Hutt Valley DHB provides community and hospital services throughout the region. We have a range of contracts with community providers, such as primary health organisations, pharmacies, laboratory, and community NGOs.

Hutt Valley DHB operates one hospital: Hutt Hospital in Lower Hutt. We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services. Hutt Valley DHB also provides sub-regional and regional services for other DHBs.

Hutt Valley DHB employs 1,733 FTE and has an annual budget of $642 million.

Sub-Regional services

HVDHB provides services to the people of Capital & Coast District Health Board (CCDHB) and Wairarapa District Health Board (WrDHB) under 2DHB (HVDHB and CCDHB) and 3DHB (WrDHB, HVDHB and CCDHB) models.

HVDHB and CCDHB serve populations that are geographically co-located. CCDHB provides more services to the HVDHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at HVDHB.

An estimated 321,000 people live in CCDHB. This is projected to grow by 21,610 people by 2029/30; a 7% increase. CCDHB's population has less ethnic diversity compared to HVDHB. In contrast to HVDHB, CCDHB has relatively low proportions of people who live in the most deprived neighbourhoods.

A further 48,500 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 1,700 people (4%) by 2029/30.

Response to COVID-19

In response to community cases identified with the Delta variant of COVID-19, on 17 August 2021 all of New Zealand entered into Alert Level 4. This was the second time New Zealand had entered into Alert Level 4 since the first lockdown in March 2020. We had learnt many new ways of working and responding to COVID since the first lockdown. Our COVID-19 resurgence plans were activated and our planning was quickly put into action. We again stood up our Incident Management Team and began to coordinate our response to the pandemic in partnership with HVDHB, WrDHB, and the Wellington Regional Emergency Management Office.

Regional Public Health managed the positive cases and contacts in the Wellington region and throughout New Zealand. It also provided significant support to Auckland and helped manage some of their cases.

Eleven Community Testing Centres (CTCs) were quickly established across the Wellington region to accelerate testing for COVID-19 and support general practice. As with the first lockdown, general practices continued to operate safely and effectively using telehealth and virtual tools, and general practice staff were supported by increased access to specialist advice.

We established daily meetings with a Pacific taskforce consisting of local Pacific sector experts, providers and community leaders. This enabled us to work with the Pacific community, supporting those Pacific people who had contracted COVID and their families. Our Whānau Care Service helped patients stay connected to their whānau while visiting restrictions were in place. Our 3DHB Disability Strategy team worked closely with the Ministry of Health to ensure disabled people have ready access to information, including sign language and easy-read documents. Emergency packages of care and support were delivered to those who needed it, and we worked across agencies to look after our most vulnerable populations, including homeless people.

We intensified our vaccination programme across the region. This included pop-up vaccination events, and mass vaccination drive-through sites; targeted at communities with higher risk of contracting COVID. These were highly successful with over 67,000 vaccinations delivered over the two weeks ending 29 August and 5 September respectively throughout the Wellington region against a plan of 28,000 for each week. For example, over a three day period 1,047 people were vaccinated at our Porirua drive-through site, and 59% were Pacific and 19% Māori. We organised pop-up event at ASB Stadium (Kilburnie) where 593 people (58% Pacific and 9% Māori) were vaccinated in one day. Our Māori and Pacific providers supported us to increase vaccination activity, including the use of outreach clinics.

HVDHB vaccination coverage data at 30 June 2021 is provided on page 58.

Our mental health and addiction services are leading the psychosocial response to the pandemic. This includes a comprehensive programme of work delivering our 3DHB Mental Health and Addictions Strategy: Living Life Well – A Strategy for Mental Health and Addiction 2019 – 2025, which aligns with the recommendations in He Ara Oranga - Report of the Government Inquiry into Mental Health and Addiction.

Read the latest updates on www.VaccinateGreaterWellington.nz

A resident at one of our Aged Residential Care homes with the nurse after her vaccination.

ARC vaccinations complete in our region

More than 5000 residents and staff at 46 Aged Residential Care (ARC) facilities across Wellington, Porirua, the Hutt Valley, and Kāpiti Coast have now received both doses of the COVID-19 vaccine, with the last vaccinations delivered in Lower Hutt.

Hutt Valley and Capital & Coast DHBs worked closely with pharmacy vaccinators to roll out vaccinations on site to this important priority population. Pharmacists Duncan Sutherland and James Westbury led teams that delivered vaccinations to the vast majority of residents and staff.

“Partnering with Pharmacy has enabled our successful programme to work well and provide a warm and welcoming vaccination service to our older generation,” said Rachel Haggerty, Director Strategy, Planning and Performance at Hutt Valley and Capital & Coast DHBs.

“We have seen both locally and overseas the devastating effect that COVID-19 can have on aged residential care communities. With two doses of protection now across our region, residents and their whānau can rest more easily.”

Pharmacist Duncan Sutherland of Unichem Upper Hutt led the team delivering the last doses in Lower Hutt, and said it was a real honour to be involved in the programme.

“It was easy to get our team motivated and set up to deliver such an important task. We have experience working in a mobile fashion and access to experienced vaccinators,” said Duncan Sutherland.

“I thank the DHB for having the trust in pharmacists, it’s been awesome working with them.”

A year at Hutt Valley DHB

2020-2021

1,625

Babies were born in our units

46,196

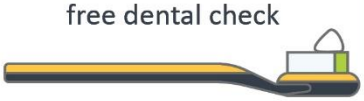
People presented to the emergency department at Hutt Hospital

2.9million

Items dispensed by community pharmacies

21,615

Children had a free dental check

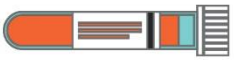


149,673

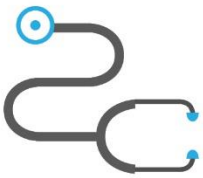
Primary health nurse visits

330,432

Laboratory tests were completed for ED/inpatients*



40,777

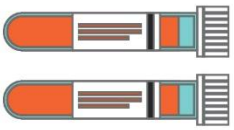


399,512

GP visits

855,256

Laboratory tests were completed for community and outpatients*



150,380

Outpatient appointments, outpatient clinics only excluding community home visits

*WSCL is the lab for all tests in Hutt Valley and Capital & Coast DHBs.

Figures cover July 2020 - June 2021

Governance of Hutt Valley DHB

Role of the Board

The Hutt Valley District Health Board is responsible for the governance of the organisation and is accountable to the Minister of Health. The DHB's governance structure is set out in the New Zealand Public Health and Disability Act 2000.

The Board has eleven members. Six are elected. Four are appointed by the Minister of Health (including the Chair and Deputy Chair). The Board currently has one position vacant following the resignation of one of the appointed members in February 2020.

Role of the Chief Executive

The board delegates to the chief executive on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the board's agreed strategic direction as set out in the Annual Plan. It endorses the chief executive, assigning defined levels of authority to other specified levels of management within Hutt Valley DHB's structure.

Governance Philosophy

Over the past few years, the Wairarapa, Hutt Valley and Capital & Coast DHBs boards have taken a whole-of-health-system approach, including integrating clinical and support services where this provides benefits across the health system. Each board provides governance of local services and all three boards provide collective governance over services that are shared or integrated, ensuring local accountability.

Integrated service approaches are intended to provide:

- preventative health and empowered self-care
- relevant services close to home
- quality hospital care, including highly complex care, for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design.

Our People

Being a good employer

Hutt Valley DHB is committed to being a good employer that provides equal employment opportunities and creates an environment where employees feel valued and respected, and where difference is celebrated and diversity encouraged.

Hutt Valley DHB aspires to create a thriving culture for our people that values who they are, nurtures skill development and provides an environment for them to do their best in every way, every day.

The heart of the health system is its people. A safe and supportive environment enables the delivery of high quality, compassionate and safe care to our communities.

Living our values across the 2DHB

Hutt Valley DHB values:

Capital & Coast DHB values:

Work continues by the 2DHB to further embed the values. With more employees working in a 2DHB capacity, the synergies of each DHBs values have been revealed to promote connectedness, unity and the feeling of one team.

Our values promote respect and kindness, partnership and connectedness, and doing our best to achieve excellence:

- **Manaakitanga/te atawhai tonu:** Caring for each other's mana is at the heart of this value. We do this by being kind, respectful, caring and helpful. We always ask ourselves – "is my behaviour mana-enhancing?"
- **Mahi tahi/kotahitanga:** We work collaboratively, constructively and fairly together. Communicating and listening are at the core of being able to work in partnership and unity.
- **Rangatiratanga/mahi rangatira:** We strive to be our best and bring out the best in others recognising that each of us has personal power. This value challenges us to use that with integrity to do the best work we can.

- **Mahi pai/can do:** We approach work with a positive and appreciative mind-set that fosters learning and growing.

2DHB People & Culture

The 2DHB vision identifies greater cooperation in a number of key areas across the Hutt Valley and Capital & Coast DHBs to improve the health outcomes of their communities in ways that they could not achieve alone.

The Hutt Valley DHB is a large organisation in its own right, and is expected to work closely as one team. It is vital that the DHB works in ways that enable, facilitate and promote greater collaboration with Capital & Coast DHB.

This includes a new approach for People and Culture.

A 2DHB operating model focussing on service improvement and delivery was established on 1 June 2021 following an extensive consultation process. While structural change will take the DHB part of the way in achieving its goals, good organisational structures with well-defined roles that are underpinned by clear accountability will facilitate and support high performance.

People and Culture are applying a 2DHB lens to thinking strategically about our needs, to more effectively support and develop our most important assets – our people – and, as a consequence, improve the care provided to our communities.

Workforce

The majority of staff employed at the DHB are covered by national Multi-Union Collective Agreements that set out the terms and conditions of employment.

Over the last year, a number of national Collective Agreements covering the work undertaken by Sonographers, Resident Medical Officers (Junior Doctors), Psychologists, Anaesthetic Technicians and Clinical Physiologists have been settled.

Collective Agreements covering the work undertaken by our senior doctors, nurses, midwives, allied health and administration staff continue to be negotiated.

A single employer Collective Agreement covering the work undertaken by Pharmacy, Stores and trades staff is also currently being negotiated.

A number of national pay equity claims covering the work undertaken by Administration, Nursing, Midwifery and Allied Health staff continue to be negotiated.

The pay equity claim covering the work undertaken by Administration staff is the most advanced of these claims, with work underway to develop new national pay and band structures.

A new 2DHB salary framework was developed to ensure a consistency of approach to remuneration decisions across the Hutt Valley and Capital & Coast DHBs. The first stage of the salary framework was applied in the 2020/2021 fiscal year for staff employed on Individual Employment Agreements in line with the Government's Public Service Pay Guidance in relation to pay restraint following the economic impact of the COVID-19 pandemic.

A union-DHB partnership approach to workforce concerns continues to be supported by regular Bipartite meetings with the unions and the quarterly Joint Consultative Committee meetings with the Association of Salaried Medical Specialists (ASMS).

Work is also underway to develop a strategic approach to the attraction and retention of critical staff, with a focus on fast tracking the on-boarding process, and local and national (working with other DHBs) recruitment campaigns.

Wellbeing

Over the last year it became apparent that COVID-19 is going to be part of our lives for the foreseeable future. Balancing business-as-usual activities with maintaining a COVID-ready health system and managing the impacts on personal lives, requires a focus on supporting staff to maintain their wellbeing.

Therefore, the focus on wellbeing over the last year has been to support leaders and employees to sustain their wellbeing over the longer term.

Kotahi – Be one.

"Ki te kotahi te kākaho ka whati, ki te kāpuia, e kore e whati.

If there is but one toetoe stem it will break, but if they are together in a bundle they will never break."

Kotahi

Since the initial phases of COVID-19, the Kotahi network, a group of 28 skilled professionals from across the 2DHBs, has walked alongside leaders and teams to support them in identifying welfare and wellbeing strategies.

More than 30 teams have accessed coaching support, wellbeing information and resources, and/or had the Kotahi team facilitate discussions to help defuse and debrief.

Given the success of this model, plans are now underway to explore options of embedding the Kotahi team sustainably into business as usual as one of the 2DHB internal wellbeing support options.

Supporting our leaders to create a thriving team

Fundamental to creating a thriving environment is the wellbeing of staff and people leaders play an important role in role modelling and cultivating this.

To support leaders to sustain their own wellbeing and to help their team(s) to flourish, the 'Looking after the team' eLearning programme was introduced. This 30 minutes programme is split into interactive modules and covers:

- The holistic models of wellbeing: Te whare tapa whā and Fonofale,
- The definition of what thriving means in a work environment
- The DHB values.
- Tips on being a compassionate leader by recognising emotions, moderating how to respond to others, and how to look after their own wellbeing.

- Ways to create a positive and safe work environment by valuing diversity, and how psychological safety helps create an environment where people feel comfortable to be themselves, and linking positive communication strategies to support this.

Streamlining our Employee Assistance Programme (EAP)

The employee assistance programme provides quality support to people in times of need. This year the EAP service transitioned to a joint 2DHB service provider ensuring a consistent and sustainable wellbeing service was accessible to all staff.

Working in partnership for wellbeing

To support employees with sustaining their wellbeing, in August a 'Mauri Ora Staff Wellbeing Expo' was run. Staff were able to discover a range of free wellbeing and lifestyle programmes and resources to support them and their whānau.

Second year nursing students from Whitireia's Bachelor of Nursing Pacific Programme also performed basic wellness checks, so were able to put their learning into real-life practice. 12 other community partners also provided their services and support. With a constant stream of over 300 staff attending throughout the day, the expo was a resounding success and a real demonstration of the value of 'mahi tahi – in partnership' .

Employees provided positive feedback on the expo:

- "Really awesome to know about some of the programmes on offer in the community which I haven't heard of before."
- "Loved this! Thank you for organising, educating and helping us to look after ourselves!"
- "Great stuff! Really valuable thanks. Helps us, to help ourselves, so we can help others."

Creating a positive and safe workplace

2DHBs strive to create a positive and safe workplace where everyone is treated with respect and that is reflective of our communities and where all of our people feel they belong.

Creating a positive and safe workplace policy

A collaborative approach with staff, key stakeholders and union partners was used to review and revise the "Preventing and Responding to Bullying, Harassment, Discrimination and Victimisation" policy.

The resultant "2DHB Creating a Positive and Safe Workplace" policy ensured the diverse range of perspectives and views were captured, as well as alignment with relevant national and sector guidance.

A set of principles guide the 2DHB response to incidents or complaints of bullying, harassment, victimisation or discrimination. In particular, emphasis has been placed on cultivating a 'just culture' and a 'restorative approach'. There is also an assumption that everyone involved needs access to support to minimise secondary harm and, where possible, to restore relationships.

Further workshops have been held this year and work continues to explore options to further embed the policy and support the organisation to embrace and carry out the key principles.

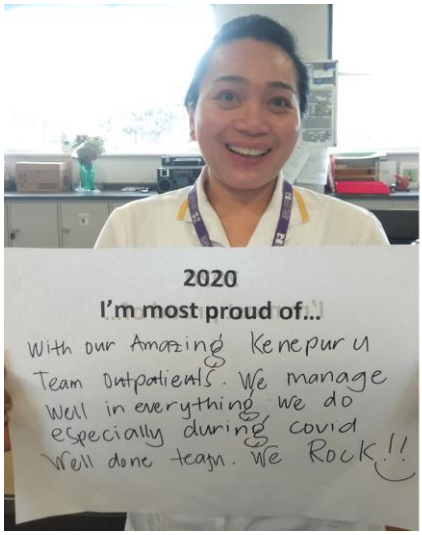
Pink Shirt Day

Both DHBs again turned into a sea of māwhero/pink on Pink Shirt Day to show their commitment to creating a positive workplace environment that is safe, welcoming and inclusive of everyone. A few Hutt staff below.

Celebrating Success Week

Celebrating Success Week 2020 provided an opportunity to acknowledge, take pride in, celebrate, appreciate and reflect on individual and group achievements.

One of the key activities as part of this week was the "I'm proud of..." campaign which encouraged our people to show what they were most proud of during 2020. Appreciation of colleagues and pride in work achievements that made a difference for our patients were key themes.



Growing great leaders

In celebration of the International Year of the Nurse and Midwife, a special edition of the Emerging Leaders Programme was run. A 3DHB collaboration between Capability Development and the Nursing Leadership team allowed 2DHB to provide an innovative and tailored development experience for 90 emerging leaders in nursing and midwifery.

The programme took a strengths-based approach to build a growth mind-set and propel these upcoming leaders to take on greater responsibilities and demonstrate visible leadership on the job. 98% of participants felt inspired for their careers in nursing or midwifery as a result of the programme.

The Frontline Leaders programme continues as a bastion of leadership development across 2DHB. Recent changes to content have strengthened alignment with the strategic priorities of equity and inclusion, and leading for wellbeing and engagement. A new selection criteria has been introduced to provide transparency and build a more rigorous and robust talent pipeline.

A 2DHB Clinical Leadership Programme was developed in preparation to be delivered from November 2021. Targeted at all leaders in clinical roles, the programme aims to build collaborative and compassionate leaders who are able to work across traditional boundaries and innovate to find new ways of delivering care. The syllabus includes formal learning, coaching and partnership workshops.

Leveraging technology to build our capability

Continuing the response to COVID-19, Capability Development have focused on making the best use of technology in orientation, on-boarding and learning programmes:

- The orientation and learning of IT-based systems is now increasingly being done through online guides complemented by drop-in coaching sessions
- Virtual reality learning is being used for more clinical teaching and the scope has been widened to include research. This tool has made accessible to 10 educators across both DHBs.

Keeping employees safe at work, and free from violence and aggression requires a whole of system approach. In response to this, a one-stop 'Keeping Everyone Safe' portal was developed. The portal provides quick and easy access to information on processes, procedures, learning, and where to go for help, all in one place. The portal is available at Capital & Coast DHB with refinements underway to tailor it for Hutt Valley DHB.

A people leader orientation designed to give leaders focus and a clear plan for their first few months is available across the 2DHBs. It enables them and their leader to work through a process to get up to speed quickly and effectively.

Participation in national collaboration initiatives ensures consistent learning packages continue to be delivered across the 20 DHBs. This year Hutt Valley DHB contributed to Safe Medication and a National IV learning package.

Te Puna Huihuinga Kaimahi - Employee Led Networks

"We value having a workforce that is diverse and inclusive. This means that we will be better positioned to understand, collaborate with and serve our community. We want all of our people to be able to bring their whole selves to work so that they can enjoy their work, do their best work and are proud to work here."

– Fionnagh Dougan, Āpiha Whakahaere Mātāmua, Chief Executive

Our employee-led networks provide a means for staff to connect, share ideas, and support each other. Over the last year the employee networks have steadily grown.

'Out & About' Rainbow Network

2DHB have strong rainbow employee networks with members and their allies connecting on a monthly basis. In February 2021, both DHB Out & About networks joined together in a show of unity to help launch the Wellington Pride Festival and took part in the Pride Hīkoi.

Out & About members were also integral in introducing eLearning to help grow employees' knowledge of the rainbow and transgender communities. The short module provided an overview of sexuality, gender and the best language to use, so people could create a safer and more welcoming environment for everyone.

The Out and About members at the Pride Hikoi

Manawa Ora 2DHB Orchestra

Musicians and singers from Hutt Valley and Capital & Coast DHBs have come together again to perform as Manawa Ora – the 2DHB orchestra.

Staff rehearse together and perform two concerts each year. This year they were also joined by a newly created staff choir.

"Music is a simple way to connect people – patients, whānau and staff appreciate the music and are grateful for a moment of joy. It feels like we're welcoming people to a place where we want them to feel safe."

- Dr Manjula Ricciardi; 2DHB Manawa Ora Orchestra organiser

Manawa Ora is supported by Wellington Hospitals Foundation, and its name was gifted by 2DHB director of Māori Health, Arawhetu Gray. Arawhetu felt that Manawa Ora was the right name as it encompasses a sense of joy, hope, and acknowledgement that music can lighten the heart.

Manawa Ora performing in the atrium at Wellington Regional Hospital

Employee Occupational Health & Safety

2DHB Occupational Health & Safety have sought to strengthen the COVID-19 response and planning preparation utilising learnings from the initial outbreak and national guidance.

Work has been completed to streamline procedures within the dedicated 2DHB COVID Response Centre, providing more timely responses to both employees and managers and improvements to the database have provided more relevant and useful information to managers.

COVID-19 Swabbing clinics have been broadened to include weekends at times of increased transmission, and the fast-tracking of urgent results to ensure limited drain on DHB service delivery. 2DHB also progressed from a contracted service to in-house delivery of Mask Fit Testing with trained internal testers on both sites to increase access to this service both during an outbreak and on an ongoing basis.

Beginning March 2021, both DHBs have focussed on the delivery of in-house COVID-19 vaccination clinics for all employees. The 2DHB set an initial target of 80% employee vaccination, and have exceeded that total with current total vaccinated with both doses at 83%. Whilst an Influenza campaign targeting employees commenced in April, this was superseded by COVID outbreaks – and the clinical focus has been to support COVID-19 vaccination first and foremost.

Non-COVID related work has also continued with the progression of:

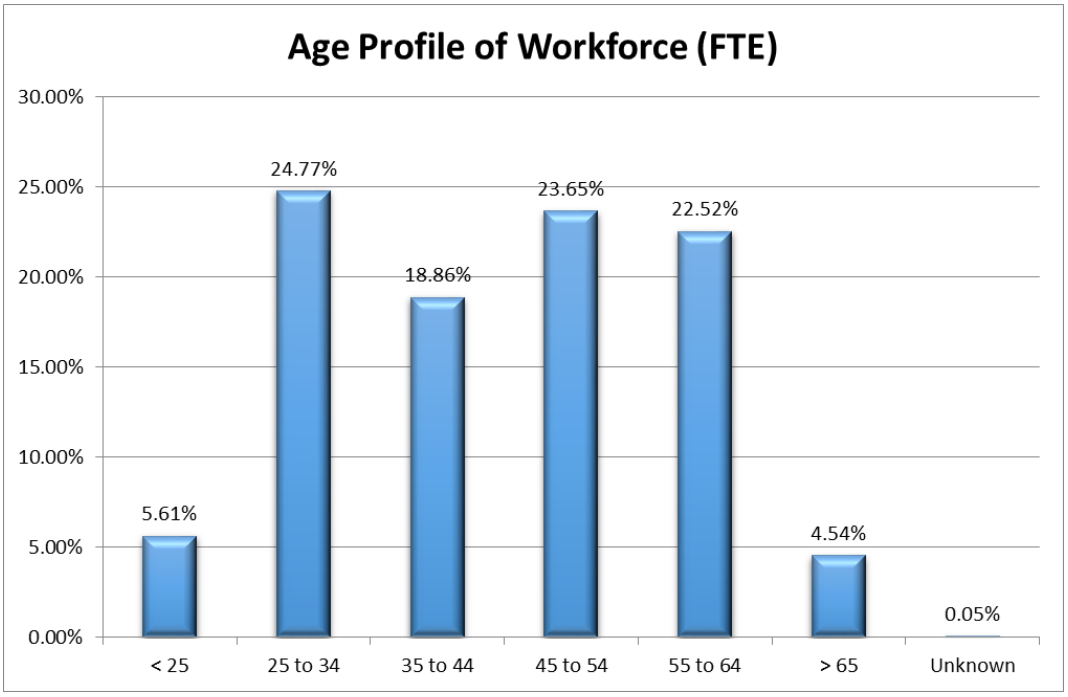
- Security for Safety project – a collaboration project across 2DHB with a focus on Hutt Valley DHB site to improve the safety experience of employees, staff and those visiting DHB premises.
- High Performance, High Engagement trial collaboration with ACC and MHAIDS to improve understanding and application of health and safety within 2DHB against three identified key projects.
- Collaboration with 20DHB Health and Safety Teams on key national projects – Contractor Management, Lone Workers, Occupational Health Services and Hazardous Substances.
- A full Health and Safety Review. This was undertaken to ensure a 2DHB model of application for all occupational health and safety resource.

Workforce profile

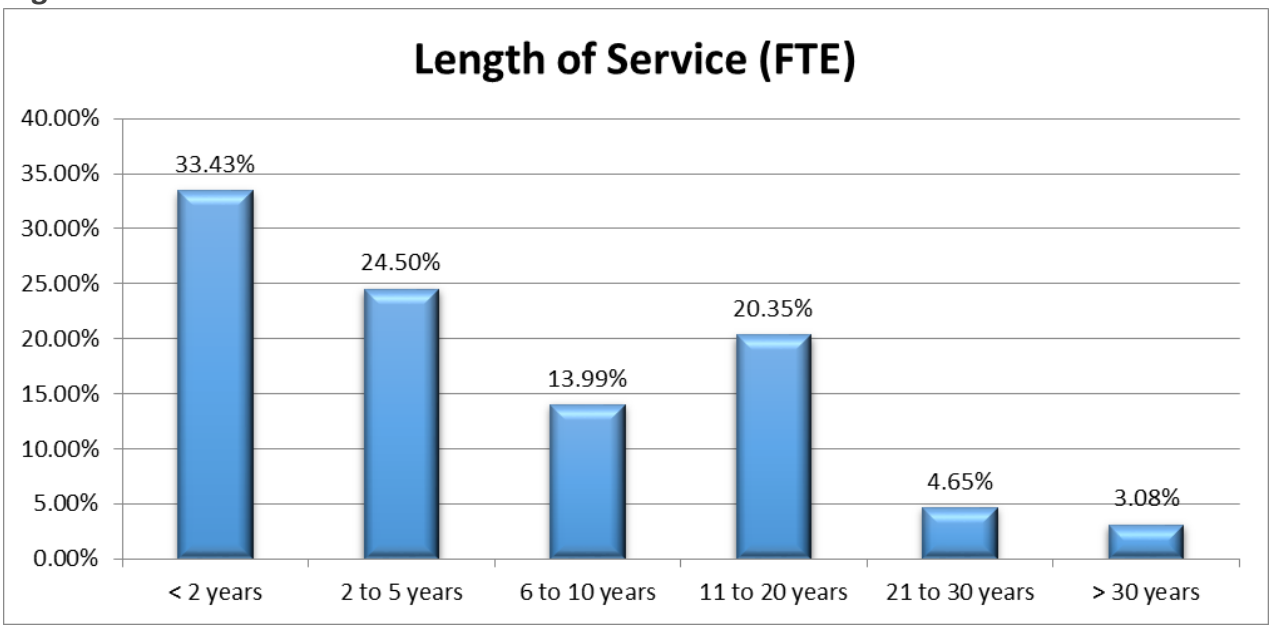
Full Time Equivalent Staff Numbers

	2021	2020	2019	2018	2017	2016	2015	2014
Medical	259	297	253	268	244	236	246	232
Nursing	683	735	707	709	696	696	755	717
Allied Health	370	398	409	410	395	401	440	428
Other	421	461	457	450	427	410	442	434
Total	1,733	1,891	1,826	1,837	1,762	1,743	1,883	1,811

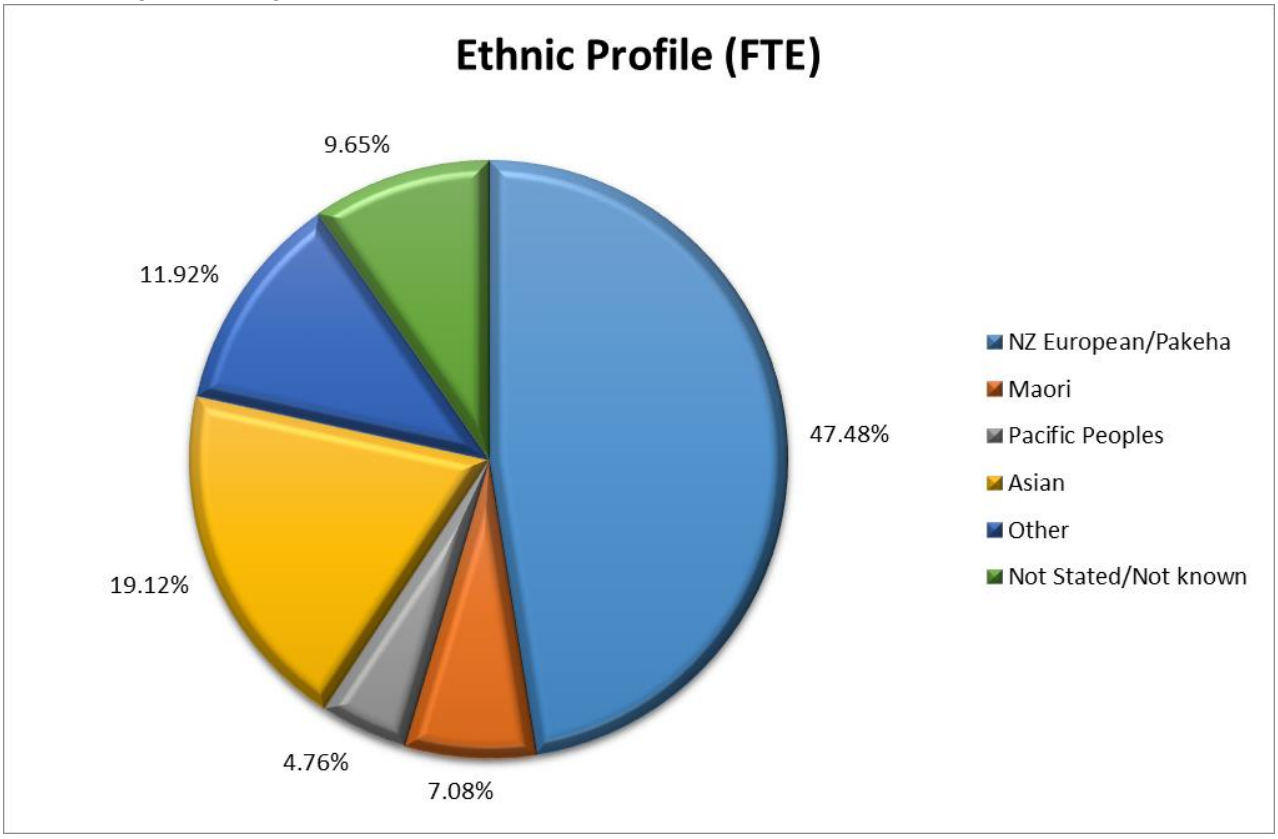
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2021	2020	2019	2018	2017	2016	2015	2014
Female	81.66%	79.63%	81.31%	82.51%	80.56%	81.05%	81.65%	81.89%
Male	18.34%	20.37%	18.69%	18.48%	19.44%	18.95%	18.35%	18.11%

Staff Compliments

"A big thank you to all the medical staff at Lower Hutt Hospital – especially the hard working nurses. I can't give them enough praise for the tireless work that they do. I was always made to feel comfortable as they went about their work in a caring and professional manner."

"Unfortunately I've experienced multiple services from and at Hutt Hospital. My experience is nothing but excellent professional friendly and accurate care. Never waiting for long, or had any cancellations. I feel blessed with such these good services that I depend on."

"10/10 for my recent day surgery at Hutt Hospital. Everyone was so friendly and I felt totally at ease. I was looked after so well from when I went in the door until I went home. The nurses and doctors doing my surgery were absolutely wonderful. In fact, I'll give you 15/10 if that's possible!"

"The doctor, nurses and receptionists at the breast clinic are wonderful. The day I had my surgery I was made to feel that I was the most important person there. Thank you to all of them."

"Recently I was admitted for a full hip replacement surgery in Hutt Hospital. To say I was nervous was an understatement, I am relatively young (47) and didn't know what to expect. The treatment I received from pre-assessment through to discharge was nothing but A+. Everything was so smooth and my concerns were put at ease. Please pass on my utmost gratitude to your wonderful staff for making my journey so easy."

"My family and I applaud the nursing team and we are incredibly grateful for their knowledgeable and empathetic service." - Patient

Our Progress

This section outlines our activities and progress under the three key strategic directions in *Our Vision for Change*.

Support People Living Well

Supporting people living well means:

- We invest in helping people and whānau to help themselves and each other keep well
- We invest in the first three years of life
- We intensify our services for individuals and whānau most at risk of poor life outcomes
- We have shared goals for improving physical and mental health and wellbeing, and eliminating health inequalities across the health and social sector

Māori Health Strategy - Te Pae Amorangi

In July 2019 we launched *Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy 2018-2027. Te Pae Amorangi* is closely aligned to He Korowai Oranga, the national Māori Health Strategy, which aims to achieve Pae Ora (healthy futures for Māori), Wai Ora (healthy environments), Whānau Ora (healthy families), and Mauri Ora (healthy individuals).

Te Pae Amorangi details our commitment to improving the health of Māori in our district through five priority areas: workforce, organisational development and cultural safety, commissioning, mental health and addictions, and the first 1,000 days of life. The strategy also seeks to address systemic issues and unconscious bias that can affect decision making and contribute towards the health inequities Māori experience. We want to transform the Hutt Valley health system to eliminate inequities and accelerate improvements in Māori health outcomes. Work to date on implementing Te Pae Amorangi is outlined below.

Tāngata Whaikaha Community Engagement Programme

We have contracted the Foundation for Equity and Research (FERNZ) to undertake research with the tāngata whaikaha community to identify the gaps and barriers in disability supports for tāngata whaikaha Māori and their whānau. The research will help 2DHB planning for service for tāngata whaikaha so that we focus on achieving equitable outcomes.

Te Kawa Whakaruruhau – Māori Cultural Safety Training

We have developed Te Kawa Whakaruruhau, Hutt Valley DHB's Māori cultural safety training programme. The first module, Te Tiriti o Waitangi, was launched at a powhiri in July 2020 and provides an opportunity for staff to learn more about New Zealand from a Māori perspective through the lens of Te Tiriti o Waitangi (the Treaty of Waitangi). The training will help us improve health outcomes for Māori patients by empowering staff with cultural knowledge. Staff learn about pre- and post-colonial New Zealand history including a breakdown of Te Tiriti articles, themes of racism, and bi-cultural themes for active partnership. All Hutt Valley DHB staff are required to attend at least one two-hour session in the Hutt Hospital Learning Centre, which can be accredited to professional development.

Staff are also invited to attend Te Pumaomao workshops, which is an immersive and holistic experience, allowing staff members to gain a new depth of insight into the Māori world. Te Pumaomao is a cultural conscientisation (consciousness raising) programme that deepens understanding of Māori world views, laws and philosophies.

2DHB Māori Health Dashboard: Measures of Equity

We have identified five key measures of equity that are common to CCDHB amd HVDHB Māori health strategies. These five key measures are:

Amenable mortality	Avoidable hospital admissions	Accessible appointments	Primary care utilisation	Community-based services

These five overall measures of equity are adopted as a framework for identifying indicators of progress toward Māori health equity in both the Capital and Coast and Hutt Valley regions. These measures are also aligned with the four key objectives of Whakamaua: Māori Health Action Plan, 2020-2025, which are:

1. Accelerate and spread the delivery of kaupapa Māori and whānau-centred services
2. Shift cultural and social norms
3. Reduce health inequities and health loss for Māori, and
4. Strengthen system accountability settings.

A sustained multi-pronged approach is required to make progress across these measures of equity. We have developed a 2DHB Māori Health Dashboard to measure our progress against these five measures of Māori health equity.

Increasing our Māori Workforce

Māori and Pacific workforce development and recruitment is a national priority for all DHBs. We aim to actively grow a Māori workforce that reflects our population. We have developed a Māori Workforce Recruitment Policy that operates across HVDHB and CCDHB. This has improved the way we recruit by making the process culturally appropriate. The policy ensures that all advertisements are designed to attract Māori applicants and include an organisation diversity statement, a Māori welcome, a whakataukī and a DHB kowhaiwhai. New guidelines and policies are being developed to enhance both DHBs' ability to attract, appoint and retain Māori staff.

Mothers, babies, children and young people

We are focused on improving health outcomes for mothers, babies, children and young people, alongside strengthening the quality of the overall system of care available to keep families well.

While many mothers, babies, children and young people across our DHBs enjoy better health outcomes than those people in other parts of New Zealand, there are some groups, in some localities, who experience persistent inequitable outcomes. We actively prioritise initiatives that redress these inequities. This involves adopting a range of approaches, including consumer-led procurement; co-design of services; pro-equity approaches to resource allocation; and using person-centred insights, analytics and evaluations to inform future commissioning decisions.

We have seen improvements in the percentage of pregnant women who have a Lead Maternity Carer (LMC) in the first trimester for both DHBs. There has also been improvement in the rates of newborn enrolment in primary care services for babies of Māori and Pacific descent, improvements in avoidable hospital readmissions for 0 to 4 year olds for both DHBs, especially for Pacific children.

We recognise the need to lift our childhood immunisation rates, particularly for tamariki Māori. We are investigating ways to support health professionals to have more meaningful dialogue with whānau regarding

the importance of childhood immunisations, recognising that the reasons for vaccine uptake are complex and include a wide range of influences.

Mental Health and Addictions Strategy

In May 2019 we launched Living Life Well – A Strategy for Mental Health and Addiction 2019-2025 Mental Health and Addictions Strategy for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards. The direction set out in Living Life Well is strongly aligned with the Government's future direction for mental health and addiction services and provides a strong platform to respond to new national priorities.

Living Life Well supports the complete continuum of care, from primary and community care through to intensive inpatient services. The strategy recognises the need to sustain specialist mental health and addiction services, while improving our early response and intervention when things start to go wrong. The strategy also focuses attention on those with inequitable health outcomes.

A work programme has been developed in partnership with lived-experience leaders, Māori, Pacific, primary care, NGOs, and specialist mental health and addiction providers. Through this co-design process, we aim to create a transformational approach to shared leadership, decision making, design, delivery and funding of services over the next five years. This work includes a new sub-regional Integrated Primary Mental Health and Addiction Service, and a GP Liaison Consultant Psychiatrist Service, which began operating in July 2020.

Smokefree Action Plan

We have developed a Smokefree Action Plan with key providers and community partners, focussing on target populations, cessation, and strengthening smokefree environments. This has already refocussed some of the DHB's tobacco funding to new areas. For example, the DHB is supporting the continued development and expansion of our smoke-free workforce within the Hutt Valley health system with the appointment of a Smokefree role for Upper Hutt City Council in partnership with Healthy Families Hutt Valley. Hutt Valley DHB has also invited two staff from the Regional Stop Smoking Service provider, Takiri Mai te Ata, to work in Hutt Hospital to help Māori and Pacific patients who smoke to consider quitting and to support them in their cessation journey.

Bowel, breast, and cervical screening

Screening and early detection of cancer gives people the best chance of successful treatment. We have rolled out and embedded the Bowel Screening Programme to detect bowel cancer at an early stage. Eligible residents (aged between 60 and 74) have been screened and, when necessary, accessed preventative treatment for bowel cancer. We are focused on lifting our breast and cervical screening rates for Māori and Pacific women. Breast screening is provided at Hutt Hospital's Breast Centre and we run five cervical screening sites across Hutt Valley DHB. We also fund general practices to provide free cervical screening in the Hutt Valley.

We have been data matching with general practices to identify women who have not been screened, and then following-up with them to offer screening and support. This includes booking clinic appointments, arranging transport and support, and referral to support services. We're continuing to open weekend and after-hours clinics to improve accessibility. Combined breast and cervical screening days on Saturdays at Hutt Valley DHB have been well attended and helped women access screening.

We are also providing more smear services in the home. After-hours smear clinics have been provided at Kokiri Puketapu Hauora Clinic, Waiwhetu Marae in Lower Hutt, and Orongomai Marae and Timberlea Community Centre in Upper Hutt. These clinics have been very successful with a good uptake from unscreened and under-screened women.

Well Homes - Healthy Housing

We are continuing to support and enhance the Well Homes service, which supports whānau to make their homes warmer, safer and drier. Housing assessors visit a home to conduct healthy housing assessments and provide education. They link whānau to appropriate services such as insulation, heating, curtain banks, beds, bedding, carpets, rugs, financial assistance and social housing providers. We have an automated referral system, so people admitted to hospital with respiratory problems are automatically offered the service. We have also partnered with more agencies to offer further support. For instance, Rimutaka/Arohata Prison, Department of Corrections, provides families in need with bedding, blankets, fire bricks, kindling and draught stoppers to help keep their homes warm and dry. This is a tangible way for offenders to give back to their communities and contributes to the Department of Corrections strategy to reduce re-offending by developing work and living skills.

Building healthy environments and promoting healthy choices

Our Regional Public Health service works with a variety of stakeholders such as early childhood centres, schools, workplaces, social support agencies, and local councils to encourage and support the development of health-focused policy and healthy environments. For example, Regional Public Health represents Hutt Valley DHB at council working group meetings to support collaborative activities that strengthen safe water delivery. Health promotional activities and initiatives are also undertaken by contracted providers such as primary care and Māori and Pacific providers, collaborative partners such as Healthy Families Lower Hutt, and Regional Public Health. These activities raise awareness and promote healthy choices across a range of topics.

Nutrition and physical activity programmes

There are a number of nutrition and physical activity programmes in the Hutt Valley targeted to priority populations. We fund a free healthy eating and exercise programme, Pre-School Active Families, through Sport Wellington that incentivises whānau with obese pre-school children (identified through the B4 School Check) to enrol in and complete the programme. We also fund Sport Wellington to deliver a Maternal Green Prescription programme and the Active Families programme. The Maternal Green Prescription programme supports pregnant women to maintain healthy weight gain in pregnancy and promotes healthy eating, exercise, breastfeeding and the introduction of solids in the postpartum period. The Active Families programme helps children and their whānau create a healthier lifestyle by becoming more active and learning about healthy eating. These programmes are successfully engaging with Māori and Pacific families.

Te Awakairangi Health provides a Healthy Families Coach Service, where a team of dietitians and exercise specialists provide advice, ongoing support, and encouragement around nutrition, physical activity, and other healthy lifestyle changes. Wesley Community Action, community groups and organisations work with Regional Public Health to enable locally run fruit and vegetable cooperatives to provide fresh fruit and vegetables at affordable prices. Bags of fresh fruit and vegetables are delivered each week through 14 distribution centres across Hutt Valley.

Oral health services to children

The Bee Healthy Regional Dental Service provides free community-based dental services to children across the Wellington Region. The service operates from 13 fixed sites in the community and 12 mobile clinics that travel to primary and intermediate schools across the region. While the service has good coverage, it continues to use new approaches to increase examination numbers, prevention opportunities, and access to care year-on-year.

The Regional Dental Service has an Early Intervention and Prevention (EIP) Team that manages equity driven outreach programmes supplemental to the standard model of care that include oral health checks being provided to pre-school children onsite at Kohanga Reo, Pacific Language Nests, and other early childhood centres in high need areas. It also provides health education and information to teachers, support staff, students, and families to raise awareness of the importance of teeth and key prevention messages. Since 2020, a supported supervised tooth brushing programme is also being offered to some early childhood centres and primary schools.

Other initiatives include drop-in dental check-ups to children in community settings during school holidays, and working with Māori and Pacific providers and local councils to promote the service and increase coverage. The Bee Healthy Service is continuing to increase the number of children seen each year, and the service now reaches around 74,000 primary and intermediate school children every year.

Improving sustainability and reducing carbon emissions

We continue to make positive changes that reduce carbon emissions and improve recycling. We purchase biodegradable paper medication cups and drinking cups, instead of polystyrene cups. Medical staff are provided with re-usable water bottles to reduce our use of plastic water bottles. A water fountain has been installed in the Hutt Hospital cafeteria, which complements our healthy food and drink (water only) policy. We are cutting back on the use of disposable coffee cups with donated reusable coffee cups. The meals we provide in the hospital are now being served on crockery plates instead of plastic. We have also moved to reusable Personal Protective Equipment (PPE) gowns rather than disposable gowns. All these changes mean we will be sending 94,000 fewer plastic containers to landfill each year.

We are steam-cleaning all clinical areas of the hospital and eliminating chemical cleaners. We have replaced thirty hospital fleet petrol vehicles which equates to 21% of the fleet, with more environmentally friendly hybrids. This progression to Hybrid will continue as the lease agreements come up for renewal. Additionally we now have 12 Electric Bikes for staff use, reducing the need to use cars even further. Finally, Hutt Valley DHB applied and to become a member of the Certified Emissions Measurement and Reduction Scheme and is committed to lowering its greenhouse gas emissions.

In July 2020 HVDHB entered into a Collaboration Partnership with EECA and set an estimated target of energy savings or renewable energy conversion in the order of 2 gigawatt hours per year. As part of this Collaboration Partnership, EECA is assisting with part funding of the investigation and implementation of opportunities, such as completing the replacement of fluorescent lights with LED lights, improving building management system control of heating and cooling plant, and ground source heat pumps and electric heat pumps to replace gas fired equipment.

Measuring our Progress: Supporting People to Live Well

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not achieved, but progress made	≤10% of target	●
Not achieved	≥10.1% of target	●
Demand-driven Measure	No rating applied	●
Data not available by ethnicity	No rating applied	○

Progress Measure	Baseline	Target 2020/21	Actual 2020/21	Trends – including equity gap	
[2]Amenable mortality rates (rate per 100,000)	2017: Māori: 195.6 Pacific: *[3] Total: 98.2	Reducing Trend (Māori and Pacific)	2018: Māori: 144.3 Pacific: [4] Total: 80.1	Māori	●
				Pacific	○
Babies breastfed at 3 months	2018/19 *[5] Māori: 46% Pacific: 43% Total: 54%	≥70%	Māori: 47% Pacific: 45% Total: 58%	Māori	●
				Pacific	●
				Total	●
Children fully immunized at 2 years	2019/20: Māori 89% Pacific 92% Total 93%	≥95%	Māori: 81% Pacific: 90% Total: 89%	Māori	●
				Pacific	●
				Total	●
Children with no cavities at five years of age	2019: Māori 52% Pacific 48% Total 65%	≥65%	2020: Māori 46% Pacific 27% Total: 60%	Māori	●
				Pacific	●
				Total	●
Average number Diseased Missing and Filled Teeth (DMFT) at age 5	2019: Māori: 1.89 Pacific: 2.60 Total: 1.37	Reducing trend	2020: Māori: 2.43 Pacific: 4.50 Total: 0.64	Māori	●
				Pacific	●
				Total	●
Reduced burden of tooth decay at year 8 (DMFT	2019: Māori: 0.81 Pacific: 0.69 Total: 0.63	Reducing trend	2020: Māori: 0.88 Pacific: 1.10 Total: 0.67	Māori	●
				Pacific	●
				Total	●
Women screened for cervical cancer	2019/20: Māori 63% Pacific 64% Total 69%	>80%	Māori 65% Pacific 67% Total : 71%	Māori	●
				Pacific	●
				Other	●
Women screened for breast cancer	2019/20: Māori: 63% Pacific: 61% Total : 64%	>70%	Māori 66% Pacific 68% Total 72%	Māori	●
				Pacific	●
				Total	●

[2] Note: There is a time lag in the reporting of Mortality data so the rates for 2017-2021 will not be published until 2023/24

*[3] Suppressed due to actual volume being below 30

[4] Suppressed due to actual volume being below 30

*[5] 2019/20 Data unavailable as Ministry of Health were unhappy with data quality

Progress Measure	Baseline	Target 2020/21	Actual 2020/21	Trends – including equity gap	
PHO enrolled patients who smoke and are offered help to quit	2019/20: Māori: 86% Pacific: 87% Total: 89%	≥90%	Māori: 86% Pacific: 88% Total: 87%	Māori	
				Pacific	
				Total	
Hospital patients who smoke and are offered help to quit	2019/20 Māori: 97% Pacific: 95% Total: 97%	≥95%	Māori: 97% Pacific: 95% Total: 96%	Māori	
				Pacific	
				Total	
% of babies living in Smokefree homes at 6 week check	2019 Māori: 52% Pacific: 40% Total: 64%	Improved performance	2020 Māori: 42% Pacific: 38% Total: 58%	Māori	
				Pacific	
				Total	
% of eligible population having CVD risk assessment in last five (ten) years[6]	2019/20 Māori: 57% Pacific: 55% Total: 75%	≥90%	Māori: 79% Pacific: 80% Total: 80%	Māori	
				Pacific	
				Total	

[6] Prior to 2019/20, CVD risk assessments have been for the previous five years. From 2019/20 on, they are for the previous ten years.

Shift Care Closer to Home

Shifting care closer to home means:

- Care is community-based 'by default' - services are delivered closer to people and their whānau
- Enhanced primary care functions as the 'health care home' of people and their whānau
- Health professionals and community providers collaborate, and work as one team to support people in their communities
- A hospital facility footprint focused on complex care and designed for contemporary models of care.

Three Year Plan for Planned Care Services

We are implementing our Three Year Plan for Planned Care Services, which was developed in consultation with hospital services and community providers. Planned Care encompasses all non-acute (non-urgent) health care activity delivered in hospitals, primary care, and community settings. One of the key initiatives in this area is a renewed focus on care across the system, and removing financial disincentives for delivering planned care outside of the hospital setting.

The plan was developed in collaboration with HVDHB to ensure a coordinated approach to the development of planned care services across both DHBs. The plan outlines how the DHB intends to address five nationally-set strategic priorities: understanding health need, balancing national consistency and local context, simplifying pathways for service users, optimising sector capacity and capability, and delivering sustainable and 'fit for future' services. The changes that will be progressively enabled by the new approach to planned care include improvements in equity of access and outcomes of care, encouraging provision non–surgical care alternatives in community settings, creating incentives to implement innovative models of care, and increasing the volume and range of interventions to meet changing population health needs.

Health Care Homes

We have invested in the sustainability and enhancement of primary care through the Health Care Home (HCH) model of care across CCDHB and HVDHB. The HCH is a team-based health care delivery model, led by primary health clinicians. Although implementation of the HCH model is in its infancy in New Zealand, evaluation of the model is promising and suggests that acute need is being prevented or successfully dealt with out of hospital by HCH practices.

One of the key aims behind the Health Care Home is to support practices to create more capacity to better manage growing patient demand, and to more proactively manage those patients with complex needs alongside community services teams, who may also be high users of acute hospital services.

The HCH model includes a telephone triage service, where patients calling the practices may talk directly to a registered health professional, typically a general practitioner. Talking to a health professional means some issues may be resolved over the phone, saving people the time and effort of going to the practice. The HCH practices also offer extended opening hours, increasing the opportunity for patients to see their doctor outside normal working hours. They also use patient portals, so patients can go online to order repeat prescriptions, book appointments, check results and message their GP or nurse directly. HCH practices also offer telehealth

options as alternatives to face-to-face appointments where appropriate, making healthcare more affordable and accessible.

The investment in the HCH model meant that CCDHB and HVDHB general practices were well prepared to operate effectively using telehealth services and virtual tools during the COVID-19 lockdown (Alert Levels 3 and 4). Nineteen practices across HVDHB are HCH practices, covering approximately 84 percent of the enrolled population enrolled in HVDHB, and similar coverage for priority populations (Māori, Pacific and quintile 5).

Specialist support for general practice

Timely access to specialist advice assists with hospital avoidance, greater coordination of care for the patient - especially if a referral for an acute specialist assessment is required - and improved support and up-skilling for general practice staff. We have improved patient care in the community by setting up a process where general practice staff can phone a senior medical specialist for urgent (same day) advice. This is now available for general medicine, geriatrics, diabetes, respiratory, rheumatology, cardiology, mental health, palliative care and paediatrics. General Medicine, the specialty with the highest proportion of patients presenting acutely unwell (40%), now staff daily acute clinics where patients can receive referrals from Primary Care and a specialist review without needing an admission. The on call general medicine physician is based in our Medical Assessment and Planning Unit (MAPU) every weekday afternoon and can provide acute advice to general practice staff.

Falls prevention and management

We have partnered with ACC to establish and embed a falls prevention and management programme across Hutt Valley, Capital & Coast, and Wairarapa DHBs. The programme is delivered in the community and aims to reduce the incidence and impact of falls and fractures in older people. The programme includes risk-of- falling screening, assessment, triage and management of frail elderly delivered in primary care; a 10 week in- home strength and balance programme delivered by our community physiotherapy team; and group-based strength and balance classes, provided at various locations across the district, delivered by local providers and coordinated by Sports Wellington. We are working to improve access to strength and balance activities and programmes, particularly for Māori and Pacific older peoples.

Community-based support for people with mental health or addiction issues

In addition to providing our specialist mental health and addiction treatment services, we also fund a number of support services in community settings for people with mental health or addiction issues.

In July 2020 we began operating a new primary mental health and addiction service, under the ‘Access and Choice’ initiative, which is being rolled out nationally over five years. It aims to expand the access to, and choice of, primary mental health and addiction services in New Zealand. The investment in the Access and Choice model of care is designed to address the long-standing gap in the mental health and addiction continuum of service delivery by investing in primary mental health services, which is where most people initially present with mental health and addiction issues. So far 40 FTE have been established to the Access and Choice service across both CCDHB and HVDHB. There are plans to add another 20 FTE over the next two years. The investment in Access and Choice complements our investment in primary care addiction services.

Implementation of the Access and Choice initiative will be supported by the establishment of locality-based mental health and addiction networks. Current initiatives or smaller existing networks will be incorporated into more integrated 2DHB networks to ensure a range of connected services.

Community-based care for pregnant women

Lead Maternity Carers work in the community providing continuity of care and support to women throughout their pregnancy and labour, until the handover to a Well Child/Tamariki Ora provider at six weeks post-partum.

In addition to the great work that our Lead Maternity Carers do in the community, the DHB's Community Midwifery Team runs both an appointment based and midwifery drop-in service, called Hapū Ora, at Lower Hutt's Waiwhetu Marae. Hapū Ora is a collaborative Māori maternity service for whānau expecting a new baby. The free services are run by mana whenua Te Runanganui O Te Atiawa with support from Hutt Maternity and Hutt Valley DHB. The drop-in service provides a continuum of care covering everything from maternity to breastfeeding for new mothers and their whānau.

Hapū Ora was set up in partnership with Māori in an effort to reduce inequity for our Māori wāhine and whānau. The service provides wrap-around care for pregnant women – many of whom have complex social needs – in partnership with other relevant health and social services. By encouraging whānau to engage with health services, the Hapū Ora midwives can connect whānau with a wide range of support including scans and medical tests. The main priority of Hapū Ora is getting people access to the services they need.

Hutt Valley DHB also established a presence at the cultural festivals. This helped increase the visibility of maternity services and encouraged pregnant women to make contact with a Lead Maternity Carer. The team also promoted and encouraged pregnant women to get their free flu and whooping cough immunisations and contraception. To help improve the uptake, we set up outreach pop-up immunisation clinics throughout the Hutt Valley region, including clinics at supermarkets, malls, libraries, WINZ offices, and on local marae.

Measuring our progress: Shifting care closer to home

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not achieved, but progress made	≤10% of target	●
Not achieved	≥10.1% of target	●
Demand-driven Measure	No rating applied	●
Data not available by ethnicity	No rating applied	○

Progress Measure	Baseline 2019/20	Target 2020/21	Actual 2020/21	Trends – including equity gap	
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000	*Year to March 20* Māori 12,394 Pacific 15158 Total: 9,337	Māori ≤ 8,243 Pacific ≤ 8,243 Total ≤ 8,243	*Year to March 21* Māori 6,862 Pacific 9,381 Total: 5,951	Māori	●
				Pacific	●
				Total	●
ASH Rates (avoidable hospitalisations) for 45-64 years	*Year to March 20* Māori 7,654 Pacific 8,060 Total 4,512	Māori ≤ 4,340 Pacific ≤ 4,340 Total ≤ 4,340	*Year to March 21* Māori 6,887 Pacific 7,564 Total 4,179	Māori	●
				Pacific	●
				Total	●
Well Managed Diabetes in primary care	Māori 42% Pacific 41% Total 50%	≥70%	Māori 48% Pacific 47% Total 58%	Māori	●
				Pacific	●
				Total	●

Progress Measure	Baseline 2019/20	Target 2020/21	Actual 2020/21	Trends – including equity gap	
Acute hospital bed days per capita	Māori 323 Pacific 354 Total 361	Māori: ≤ 542 Pacific: ≤ 596 Total: ≤ 386	Māori 497 Pacific 495 Total 324	Māori	
				Pacific	
				Total	
Acute readmissions to hospital	*Year to June 20* Māori 13% Pacific: 11% Total 12%	Reduction in rate	*Year to March 21* Māori 14% Pacific 17% Total 15%	Māori	
				Pacific	
				Total	
Acute readmissions to hospital Age 0-4	Māori 14% Pacific 12% Total 14%	Reduction in rate	Māori 14% Pacific 17% Total 15%	Māori	
				Pacific	
				Total	
PHO Enrolment	Māori: 88% Pacific: 99% Total: 96%	≥98%	Māori: 84% Pacific: 94% Total: 91%	Māori	
				Pacific	
				Other	
Newborn PHO enrolment	93%	≥85%	91%	Total	
Proportion of dispensed Asthma medications that were a preventer rather than reliever	55%	Increasing trend	58%	Total	
Cancer Mortality	*2012-2016* 286	Decreasing trend	*2014-2018* 222	Total	
Decrease in hospitalisation for cardiovascular disease	Māori: 254 Pacific: 189 Total: 1,967	Decreasing trend	Māori: 346 Pacific: 225 Total: 2,468	Māori	
				Pacific	
				Total	
Decrease in hospitalization for Chronic Obstructive Respiratory Disease	Māori: 87 Pacific: 41 Total: 350	Decreasing trend	Māori: 95 Pacific: 24 Total: 373	Māori	
				Pacific	
				Total	

Deliver Shorter, Safer and Smoother Care

Shorter, safer and smoother care means:

- People and whānau can communicate with a wider range of health providers electronically
- Patients, their whānau and health professionals engage in informed conversations about treatments and interventions that add value to care
- Individualised shared care plans are built around what's important to people and whānau
- Primary and community services coordinate care across a wide range of health and social services based on a shared care plan
- All health professionals within the system engage and collaborate in training, leadership and quality improvement activities and opportunities.

2DHB Work Programme

2DHB is a joint programme of work currently underway between HVDHB and CCDHB. This work is focussed on 3 major themes:

1. Improving patient access to healthcare - including making the system more equitable for Māori and Pacific patients
2. Working together across the two DHBs and making the most of limited resources
3. Planning together for the region, with a joined-up leadership and vision for healthcare.

Five Communities, One Vision

At the core of this change is the "five communities" vision. This is an approach that focuses on the communities that make up the communities with our DHB boundaries - Kāpiti, Upper and Lower Hutt, Porirua and Wellington. Each of these communities has its own specific set of needs and challenges, and our vision is that by planning more effectively across the whole region, we can better serve our patients and clients and improve the equitability of our system.

In this vision, our patient pathway will be simplified, particularly for patients who would previously have had to cross DHB boundary lines to receive care. At the same time we hope to make life simpler for our clinical and administrative staff, by removing some red tape along the way.

Making the most of a limited resource

Both DHBs have been making the most of what they can with the resources available to them, but it is clear that this approach will not continue to be sustainable into the future. In order to maximise the resource available to our staff and patients, CCDHB and HVDHB will be looking at areas where it makes sense to work together. This may be in areas like human resources or communications, where having a common work approach will also help in other ways.

Planning together

One of the ways we will work towards a more sustainable and equitable service is through joined-up leadership and planning. The boards of HVDHB and CCDHB have appointed a single CEO, Fionnagh Dougan, to oversee both organisations. We also have a new 2DHB leadership team that has responsibility for healthcare in both DHBs and supports the CEO. The leadership team takes a community-focussed approach to planning. The

specific needs of each community in the region are considered, and we take a patient-centric approach to service planning that ensures services are well joined-up and seamless.

The changes we are making are about making sure healthcare is easy to access and effective for all people in our five communities. We will work with everyone involved as we design the new approach. This means not just doctors and nurses, but all hospital staff, the five communities, families, patients, and external experts. The most effective change will happen when we listen to and learn from feedback.

Improvements to our Women's Health Service

Our Women's Health Service is critical to the wellbeing of mothers - mama, babies-pepe and their whānau across our region. Over the last year we have strengthened our medical and midwifery workforce and leadership, embedded new monitoring and quality improvement mechanisms, and provided cultural safety training.

Hutt Hospital's maternity services and facilities are also being upgraded and refurnished to improve patient outcomes, privacy, and comfort. The Maternity Assessment Unit, Maternity Ward (birthing and postnatal) and the Special Care Baby Unit will be redeveloped over the next two years. Concept plans have been completed and we are confident that the redevelopment will create a new, inclusive, modern environment to better meet the needs of pregnant women, babies and their whānau.

Care Capacity Demand Management

We have advanced the Care Capacity Demand Management (CCDM) programme in partnership with the New Zealand Nurses Organisation, the Public Service Association and the Safe Staffing Healthy Workplaces Unit. The CCDM programme helps the DHB match the capacity to care with patient demand, and supports staff to provide high-quality and safe care to our patients, while improving the work environment and organisational efficiency. CCDM enables the DHB to invest effectively by getting an accurate forecast of patient demand, removing as much variability as possible from the system, and matching the required resources as closely as possible (in staff numbers and skill mix).

Capacity at a Glance screens are used to monitor current capacity (the staff) against demand (the patients in the ward), visualise the performance of the ward at a glance, and identify opportunities for improvement. Variance Response Management processes and tools enable the DHB to quickly respond to workforce demands and therefore improve patient flow. The CCDM programme helps the hospital run more effectively, improves our patients' experience and outcomes, and makes working at Hutt Valley DHB more satisfying for our staff.

New Kaupapa Māori Forensic Mental Health Service for Wellington Region

CCDHB has contracted Te Waka Whaiora Trust to develop and implement a forensic step-down service for Tangata Motuhake — those who identify as Māori experiencing mental illness. Te Waka Whaiora is a current provider of Kaupapa Māori community mental health and addiction services in the greater Wellington region and specialises in the delivery and design of services for Māori.

The four-six bed service will be managed by Te Waka Whaiora in partnership with CCDHB's Te Korowai Whāriki — Regional Forensic Service. The new service will provide forensic transitional care for Tangata Motuhake as they begin their integration journey back into their community and reconnect with their culture and whānau. Kaupapa Māori concepts using Te Whare Tapa Wha will be combined with expertise in community residential rehabilitation in a safe and secure home-like accommodation. Tangata Motuhake will be supported by Kaitautoko using whānaungatanga principles to gain skills and functional independence through structure, supervision and holistic assistance.

Forensic mental health services are a highly specialised component of New Zealand's mental health assessment, treatment and rehabilitation services. They exist at the interface between the mental health and criminal justice sectors and focus on managing and providing expert advice in a variety of settings including prisons, courts, specialised inpatient units, and the community.

New procedure suite to increase surgical capacity

We have began planning for a new purpose-built procedure suite at Hutt Hospital. The new facility will increase the capacity of the hospital's surgical services by freeing up space in the main operating theatres. The development will include five procedure rooms (one of which is larger for laser use), dedicated patient change facilities for each procedure room, a central three lazi-boy chair recovery room with a beverage bay, and a main waiting room.

The purpose-built facility will improve patient experiences when undergoing surgical procedures under local anaesthetic. It is expected that approximately 500 surgical procedures will be undertaken in the procedure suite per year—increasing the capacity for minor surgery across the region. The new procedure suite will improve outcomes for people across the wider region and ensure that services are accessible and delivered in the most appropriate setting. The additional capacity created will address the increased demand from an ageing and growing population and improve elective surgery and cancer treatment timeframes.

Measuring our progress: Shorter, Safer, Smoother Care

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not achieved, but progress made	≤10% of target	●
Not achieved	≥10.1% of target	●
Demand-driven Measure	No rating applied	●
Data not available by ethnicity	No rating applied	○

Progress Measure	Baseline 2019/20	Target 2020/21	Actual 2020/21	Trends – including equity gap	
Length of inpatient stay in hospital (average days)	Acute 2.23 Elective 0.71	Acute ≤2.4 Elective ≤1.5	Acute 2.23 Elective 1.69	Acute	●
				Elective	●
Time patient is in ED (6 hour discharge or transfer)	86%	≥95%	84%	Total	●
Waiting time to access Mental Health/ Addiction Services. (Referred and seen within 3 and 8 weeks)	*Mental Health* 34% < 3 wks 81% <8 weeks *Addiction services* 68% < 3 wks 88% < 8wks	*Targets* 80% < 3 wks 95% < 8 wks	*Mental Health* 70% < 3 wks 90% < 8 wks *Addiction services* 25% < 3 wks 89% < 8 wks	Total	● ● ● ●
Readmission to Mental Health services within 28 days	8%	<9%	8%	Total	●

Access to Electives	98%	100%	101%	Total	
Percentage of patients receiving their first cancer treatment within 31 days of decision to treat	91%	≥85%	90%	Total	
Age of Entry into Age Residential Care	81.8	Increasing trend	83.8	Total	

Quality Safety Innovation & Improvement

The Quality Safety Innovation & Improvement group leads and supports the quality improvement and patient safety work across the DHB using quantitative and qualitative measures to support evidence-based decision making and practice change, as well as streamlining systems and data reporting mechanisms.

Hospital Surveillance

In March 2021 HVDHB underwent Ministry of Health Surveillance audit, against NZS 8134:2008 Health and Disability Services Standard. The three-day surveillance audit included a review of quality and risk management systems, staffing requirements, aspects of clinical care, infection prevention and control, and restraint minimisations and safe practice. Work has progressed in most of the previous areas identified for improvement and five previous corrective actions were closed (consent, adverse events, audit, corrective actions, storage of food and two aspects of restraint management).

The auditors noted that there was increased 2DHB integration, with some services working well together, and processes starting to align. The quality and risk management system was developing well between the 2DHBs with a consistent quality and risk framework and a developing clinical governance model. Improvement activity was evident at both DHBs, from large projects across the continuum of care, to smaller ward-based initiatives. Patient tracer methodology was used across services at both DHBs and is being used to bring about change. The audit activity was noted as 'a real strength' to the 2DHBs.

Patient and System Tracer Audits

Patient tracer methodology was commenced across services in March and is being used to bring about change and effective monitoring of the patient journey. The audit activity was noted as 'a real strength' to the DHB and has expanded to focus on risk assessment such as medication and Know your IV lines. Tracer audits provide an accurate assessment of the systems and processes for the delivery of care, treatment, and services. Tracer audits are recorded in real-time and paint a powerful 'snap-shot' of the challenges and successes experienced within a ward.

In March 2021, the auditing team followed the experience of a sample of patients, as they interacted with the health care system. Feedback was provided to the Manager in real-time, so that identified safety issues and risks were acted upon quickly. Further development is underway to support the same approach in monitoring Pathways to Wellbeing, Patient-Centred and Safe Environment, and Infection Prevention and Anti-Microbial Stewardship; and aligning current process with the new 'Ngā Paerewa Health and Disability Services Standard' 2021. A tracer audit schedule was implemented across the inpatient areas, with development of training, tools to online solutions and policy to guide and support practice.

Open Communication

Open Communication is an integral part of ensuring we deliver safe, quality health care to our patients and whānau. It refers to open and transparent discussion between patients and staff, and is particularly important when things do not go as expected in the health care setting. Both patients and staff can be adversely affected in many ways. The aim of the Open Communication

programme is to help staff respond effectively to minimise harm to all parties involved in situations where there has been an upsetting outcome or expectations have not been met.

Over the past year, QIPS has worked with Capability Development and other experts to refresh Open Communication training across 2DHB. Open Communication facilitators from both CCDHB and HVDHB were trained by an external expert who delivered theory-based sessions over a 6 month period. Using a train-the-trainer model, facilitators then went on to learn how to train other staff in Open Communication in practical workshops. A new model has been established whereby any staff member can now undertake an online learning module, followed by a practical workshop led by an Open Communication facilitator, to hone their skills. The refreshed Open Communication course was officially launched by the Executive Leadership Team in July 2021. It is now available via ConnectMe to staff across 2DHB.

Serious Adverse Events

At HVDHB improving the quality and safety of care we provide to our patients and whānau is a key priority. Early detection and review of adverse events that are the result of a health care system or process failure is therefore essential. By learning from these reviews we can reduce the risk of similar adverse events recurring and causing avoidable harm to our patients.

A formal review is conducted for each adverse event to better understand what happened and why, and to establish improvements in our systems of care to prevent harm occurring again. Families have input into the reviews and are provided copies of the final report.

Since last year, the Serious Event Review Committee (SERC), which forms part of the wider clinical governance structure has become an integral part of the Adverse Event review process. SERC's purpose is to monitor and improve clinical safety for patients across the organisation focusing on learning from events to prevent harm. This means improved oversight of serious adverse events and the completion of recommendations to improve systems and processes. A strength of SERC has been its membership, which includes senior clinicians, quality teams and consumers.

Statement of Performance

The Statement of Performance Expectations (SPE) presents a snapshot of the services provided for our population and how these services perform. The SPE is grouped into four output classes: prevention services; detection and management; intensive assessment and treatment; and rehabilitation and support services. Each output class includes measures that help to evaluate our performance over time, recognising the funding received, government priorities, national decision-making and board priorities.

We have a particular focus on improving health outcomes and improving health equity for Māori and Pacific peoples. Therefore, a range of measures are used to monitor progress in improving the health and wellbeing of our Māori and Pacific populations. Equity is a priority and the targets set for Māori and Pacific reflect a pathway to achieving equity, or are universal and apply to all population groups. In some cases, data is not available by ethnicity. We are in the process of developing a programme of work to monitor and report our performance by ethnicity, and understand our performance for our Māori and Pacific populations.

Output Classes contributing to desired outcomes

We evaluate measures across four output classes that provide an indication of the volume and coverage of services funded and delivered by the HVDHB, alongside service quality indicators. These Output Classes follow the classification established by the Ministry of Health for use by all DHBs as a logical fit with stages spanning the continuum of care.

The four Output Classes and their related services are:

Prevention Services
- Health protection and monitoring services
- Health promotion services
- Immunisation services
- Smoking cessation services
- Screening services

Early Detection and Management services
- Primary care (GP) services
- Oral health services
- Pharmacy services

Intensive Treatment and Assessment Services
- Medical and surgical services
- Cancer services
- Mental Health and Addiction services

Rehabilitation and Support services
- Disability services
- Health of older people services

Within these Output Classes, the measures we have chosen reflect activity across the whole of the HVDHB health system and help us to monitor that we are on track to achieve positive long-term outcomes.

Interpreting our performance

Types of measures

Evaluating performance is more than measuring the volume of services delivered or the number of patients cared for. In monitoring our progress we want to be sure that the people who most need services are getting those services in a timely way, and that these services are delivered to the right quality standard. In the tables below we note the types of output measure, and where appropriate the results are detailed for different ethnicities.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T
DHB of Domicile	DoD
DHB of Service	DoS

Ethnicity	Abbreviation
Māori	M
Pacific	P
Total (all ethnicities)	T

Standardisation, Targets and Estimates

In some cases the results are standardized for population characteristics, such as age, to allow meaningful comparison between different populations, for example, to compare between two or more districts that may have different age group profiles.

Some measures reflect our pursuit of a target, such as aiming to screen 70% or more eligible women for breast cancer in the last two years. Other measures are more simply an estimate of the volume of a service rather than a target and are included to provide an indication of the extent of services funded or undertaken by the DHB, such as the number of prescription items filled in one year. We report on these measures by commenting if the volume is in line with our estimate, lower or higher than estimated.

Appropriation Reporting

	Budget 2021 $000	**Actual 2021 $000**	**Actual 2020 $000**
Appropriation revenue	455,669	455,083	416,835

The Appropriation revenue received by Hutt Valley DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

Output Class: Financial Performance ($000s)

Revenue	**2020/21 Actual**	**2020/21 Budget**	**2019/20 Audited**
Prevention	22,683	55,249	21,885
Early detection and management	309,137	174,242	289,678
Intensive assessment and treatment	259,478	327,889	225,147
Rehabilitation and support	59,249	74,380	56,711
Total	**650,547**	**631,760**	**593,421**
Expenses	**2020/21 Actual**	**2020/21 Budget**	**2019/20 Audited**
Prevention	23,824	56,914	21,703
Early detection and management	301,767	175,793	292,317
Intensive assessment and treatment	283,126	336,242	261,571
Rehabilitation and support	54,057	73,456	56,613
Total	**662,774**	**642,404**	**632,204**

Output Class 1: Prevention Services

'Preventative' health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

Immunisation Services					
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21[7]	Achievement
% of eight month olds fully vaccinated	Māori	86%	≥95%	81%	
	Pacific	94%		86%	
	Non-Māori, Non-Pacific	93%		95%	
	Total	92%		90%	
% of two year olds fully immunised	Māori	89%	≥95%	81%	
	Pacific	92%		90%	
	Non-Māori, Non-Pacific	77%		92%	
	Total	93%		89%	
% of five year olds fully immunised	Māori	85%	≥95%	85%	
	Pacific	84%		86%	
	Non-Māori, Non-Pacific	80%[8]		88%	
	Total	89%		87%	
% of children aged 11 years provided Boostrix vaccination[9]	Māori	72%	≥70%	70%	
	Pacific	65%		66%	
	Non-Māori, Non-Pacific	67%		93%	
	Total	68%		73%	
% of children (girls and boys aged 12 years) provided HPV vaccination (*one dose)[10]	Māori	70%	≥75%	54%	
	Pacific	66%		66%	
	Non-Māori, Non-Pacific	74%		67%	
	Total	70%		64%	
% of population aged 65 years and over immunised against influenza[11]	Māori	60%	≥75%	62%	
	Pacific	58%		71%	
	Non-Māori, Non-Pacific	66%		62%	
	Total	55%		62%	

Health Promotion Services					
These services inform people about risk, and support them to make healthy choices. Success is	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement

[7] Data from Q4 2020/21 unless stated otherwise
[8] Result not included in 2019/20 report
[9] Results not available in time for 2019/20 annual report due to COVID
[10] Results not available in time for 2019/20 annual report due to COVID
[11] Results not available at time of publication of previous annual report

evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.					
% of infants fully or exclusively breastfed at 3 months [12]	Māori	50%	≥70%	47%	
	Pacific	40%		45%	
	Non-Māori, Non-Pacific	56%		60%	
	Total	53%		58%	
% of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention[13]	Māori	82%	≥95%	95%	
	Pacific	61%		95%	
	Non-Māori, Non-Pacific	89%		90%	
	Total	87%		92%	
% of PHO-enrolled patients who smoke and have been offered help to quit by a health practitioner in the last 15 months	Māori	86%	≥90%	86%	
	Pacific	87%		88%	
	Non-Māori, Non-Pacific[14]	89%		87%	
	Total	89%		87%	
% Hospitalised smokers offered advice to help quit	Māori	97%	≥95%	97%	
	Pacific	95%		97%	
	Non-Māori, Non-Pacific	97%		95%	
	Total	96%		96%	
% of pregnant women who identify as smokers upon registration with a DHB midwife or Lead Maternity Carer offered advice to quit[15]	Māori	100%	≥90%	65%	
	Total	100%		64%	

Population-based Screening Services					
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
% of eligible children receiving a B4 School Check [16]	Māori	62%	≥90%	70%	
	Pacific	67%		80%	
	Non-Māori, Non-Pacific	71%		92%	
	Total	68%		86%	
	Māori	63%	≥80%	65%	
	Pacific	64%		67%	
	Non-Māori, Non-Pacific	73%		73%	

[12] Results not available at time of publication of 2019/20 annual report as MOH concerned with Data quality issues
[13] Results not available in time for 2019/20 annual report due to COVID
[14] Not included in 2019/20 annual report
[15] Results not available in time for 2019/20 annual report due to COVID
[16] Results not available in time for 2019/20 annual report due to COVID

% of eligible women (25-69 years old) having cervical screening in the last 3 years[17]	Total	69%		71%	
% of eligible women (50-69 years old) having breast cancer screening in the last 2 years [18]	Māori	63%	≥70%	66%	
	Pacific	61%		68%	
	Non-Māori, Non-Pacific	64%		74%	
	Total	64%		72%	

Oral Health Services					
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
% of children under 5 years enrolled in DHB-funded dental services [19] *	Māori	95%	≥95%	94%	
	Pacific	91%		93%	
	Non-Māori, Non-Pacific	99%		97%	
	Total	98%		96%	
% of children caries free at 5 years *	Māori	52%	≥65%	46%	
	Pacific	48%		27%	
	Non-Māori, Non-Pacific	72%		71%	
	Total	65%		60%	
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 *	Māori	0.81	≤0.59	0.88	
	Pacific	0.69		1.10	
	Non-Māori, Non-Pacific[20]	0.56		0.53	
	Total	0.63		0.67	
% of children (0-12) enrolled in DHB oral health services overdue for their scheduled examinations [22] **	Māori	6%	≤5%	19%	
	Pacific	5%		18%	
	Non-Māori, Non-Pacific	4%		24%	
	Total	5%		22%	
% of adolescents accessing DHB-funded dental services[23]	Māori	47%	≥85%	53%	
	Pacific	54%		65%	
	Non-Māori, Non-Pacific	89%		79%	
	Total	73%		71%	

* Data from 2020 calendar year, as this was the latest data available at the time of writing this report

** Data from Q3 2020/21, as this was the latest data available at the time of writing this report

[17] Results not available in time for 2019/20 annual report due to COVID
[18] Results not available in time for 2019/20 annual report due to COVID
[19] Results not available in time for 2019/20 annual report due to COVID
[20] Result not included in 2019/20 Annual report

[22] Results not available in time for 2019/20 annual report due to COVID
[23] Results not available in time for 2019/20 annual report due to COVID

Output Class 2: Early Detection and Management

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations.

Primary Care Services					
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
% of new born enrolment with general practice by three months of age	Māori	88%	≥85%	74%	
	Pacific	93%		87%	
	Non-Māori, Non-Pacific[24]	93%		101%	
	Total	93%		91%	
% of the DHB-domiciled population that is enrolled in a PHO	Māori	88%	≥98%	84%	
	Pacific	99%		94%	
	Non-Māori, Non-Pacific[25]	98%		97%	
	Total	96%		94%	
% of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol	Māori	46%	≥60%	48%	
	Pacific	43%		46%	
	Non-Māori, Non-Pacific	55%		62%	
	Total	55%		58%	
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people) [1]	Māori	12,394	≤8,243	6,862	
	Pacific	15,158		9,381	
	Non-Māori, Non-Pacific[27]	6,487		5,008	
	Total	9,337		5,951	
Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people) [1]	Māori	7,654	≤4,340	6,887	
	Pacific	8,060		7,564	
	Non-Māori, Non-Pacific[28]	3,748		3,488	
	Total	4,512		4,179	
Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years age	Māori	N/A	≤11.9	7.23	
	Pacific	N/A		7.29	
	Non-Māori, Non-Pacific	N/A		3.58	
	Total	358		4.99	
Primary Care Patient Experience scores	Communication				

[24] Result not included in 2019/20 Annual report
[25] Result not included in 2019/20 Annual report

[27] Result not included in 2019/20 Annual report
[28] Result not included in 2019/20 Annual report

	Partnership	National patient experience survey has changed dimensions so data is no longer comparable
	Physical and Emotional Needs	
	Coordination	

Pharmacy Services					
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	2020/21 actual	Achievement
% of the DHB-domiciled population that were dispensed at least one prescription item	Māori	75%	≥80%	68%	●
	Pacific	80%		73%	●
	Non-Māori, Non-Pacific	82%		78%	●
	Total	81%		76%	●
% of people aged 65+ years receiving five or more long-term medications	Māori	49%	≥47%	45%	●
	Pacific	55%	≥51%	49%	●
	Non-Māori, Non-Pacific	38%	≥37%	40%	●
	Total	39%	≥38%	41%	●
Number of people registered with a Long Term Conditions programme in a pharmacy	Total	5759	≥5800	5,997	●
Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Total	191	≥195	184	●

Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals mostly in a hospital setting where clinical expertise (across a range of areas) and specialist equipment are located in the same place. These services include inpatient, outpatient, emergency and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population. Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals, and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Acute and Urgent Services					
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
Number of POACs delivered in community settings across 2DHB[29]	Total	455	≥529	529	
Number of zero-fee consultations at after-hours services by children under 13 years[30]	Māori	1,053	≥1,053	2,340	
	Pacific	409	≥409	1,903	
	Non-Māori, Non-Pacific	4,768	≥4,768	7,768	
	Total	6,230	≥15,706	12,011	
Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals[31]	Māori	320	≤285	343	
	Pacific	337		359	
	Non-Māori, Non-Pacific	238		259	
	Total	257		280	
% of patients admitted, discharged or transferred from ED within 6 hours[32]	Māori	87%	≥95%	85%	
	Pacific	87%		86%	
	Non-Māori, Non-Pacific	86%		84%	
	Total	86%		84%	
Standardised acute readmission rate within 28 days *	Total	12%	12%	12%	

* Data from Q3 2020/21, as this was the latest data available at the time of writing this report.

[29] Result not included in 2019/20 Annual report
[30] Results not available in time for 2019/20 annual report due to COVID
[31] Result not included in 2019/20 Annual report
[32] Result not included in 2019/20 Annual report by ethnicity

Elective and Arranged Services					
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
Number of planned care interventions – inpatient surgical discharges	Total	4,962	5,807	5,845	
Number of planned care interventions – minor procedures	Total	3,163	2,677	3,951	
% of patients given a commitment to treatment but not treated within four months	Total	29%	0%	35%	
% of "DNA" (did not attend) appointments for FSA (first specialist appointments)	Māori	N/A	≤5%	15%	
	Pacific			14%	
	Non-Māori, Non-Pacific			4%	
	Total			7%	
% of patients waiting longer than four months for their first specialist assessment	Total	11%	0%	14%	
% of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Total	90%	≥90%	90%	
% of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat	Total	91%	≥85%	90%	

Mental Health, Addictions and Wellbeing Services						
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service.		Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
Access to mental health services: Number of mental health services[34]		Māori	1,800	1,896	1,877	
		Pacific	362	404	405	
		Non-Māori, Non-Pacific	4,437	4,269	4,663	
		Total	6,237	6,569	6,540	
% of population accessing community mental health	Mental health services	Māori	7.20%	7.20%	4.91%	
		Pacific	3.50%	3.50%	2.58%	
		Non-Māori, Non-Pacific	3.80%	3.80%	3.07%	

[34] Result not included in 2019/20 Annual report

services[35]		Total	4.40%	4.40%	3.36%	
	Addiction services	Māori	1.90%	1.90%	1.54%	
		Pacific	0.70%	0.70%	0.52%	
		Non-Māori, Non-Pacific	0.60%	0.60%	0.50%	
		Total	0.80%	0.80%	0.69%	
% of population accessing secondary:[36]	Mental health services	Māori	5.07%	5.07%	5.02%	
		Pacific	2.58%	2.58%	2.61%	
		Non-Māori, Non-Pacific	3.04%	3.04%	3.13%	
		Total	3.37%	3.37%	3.43%	
	Addiction services	Māori	1.74%	1.74%	1.60%	
		Pacific	0.56%	0.56%	0.53%	
		Non-Māori, Non-Pacific	0.52%	0.52%	0.51%	
		Total	0.74%	0.74%	0.71%	
% of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks: [32] *	Mental health services	Māori	88%	≥95%	90%	
		Pacific	88%		94%	
		Non-Māori, Non-Pacific	87%		81%	
		Total	87%		84%	
	Addiction services	Māori	91%		92%	
		Pacific	100%		83%	
		Non-Māori, Non-Pacific	100%		94%	
		Total	95%		91%	
% of people admitted to an acute mental health inpatient service that were seen by mental health community team: [38]	7 days prior to the day of admission	Māori	64%	≥75%	80%	
		Pacific	57%		68%	
		Non-Māori, Non-Pacific	80%		81%	
		Total	73%		79%	
	7 days following the day of discharge	Māori	69%	≥90%	78%	
		Pacific	80%		65%	
		Non-Māori, Non-Pacific	82%		80%	
		Total	77%		78%	
% of clients with a transition (discharge) plan		Community	48%	≥95%	51%	
		Inpatient	70%		79%	
% of clients with a wellness plan		Community	43%	≥95%	47%	
Rate of Māori under the Mental Health Act: Section 29 community treatment orders		Māori	316	286	316	

[35] Result not included in 2019/20 Annual report by ethnicity
[36] Results not available in time for 2019/20 annual report due to COVID
[32] Baseline was not available at time of writing 2019/20 annual report
[38] Result not included in 2019/20 Annual report

Quality, safety and patient experience					
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement.[39]	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
Rate of inpatient falls resulting in a fracture per 1,000 bed days	Total	0.16	≤0.07	0.15	
Rate of hospital acquired pressure injuries per 1,000 bed days	Total	0.24	≤0.5	0.53	
Rate of staphylococcus aureus bacteraemia, per 1,000 bed days *	Total	0.06	≤0.1	0.15	
Rate of surgical site infections for hip and knee operations, per 100 procedures **	Total	0	0	5.2	
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, per 1,000 admissions *	Total	1.62	≤1.4	2.08	
Rate of rapid response escalations, per 1000 admissions *	Total	43.6	≤43	52.4	
Rates of deep vein thrombosis/pulmonary embolus *	Total	19	≤22	22	
The weighted average score in the Inpatient Experience Survey by domain	Data no longer Reported HQSC have changed their reporting nationally				

*** Data from Q3 2020/21, as this was the latest data available at the time of writing this report**

**** Data from Q2 2020/21, as this was the latest data available at the time of writing this report**

[39] Result not included in 2019/20 Annual report

Output Class 4: Rehabilitation and Output Class 4: Rehabilitation and Support

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services may be provided at home, as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Disability Support Services					
These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
Number of sub-regional Disability Forums	Total	0	1	0	
% of hospital staff that have completed the Disability Responsiveness eLearning Module	Total	11%	80%	10%	
Number of people with a disability alert	Total	The current Disability Alerts system is very limited, and ineffective as both a data collection tool and communicating access needs. We are working on a standardised disability question and comprehensive data collection that will enable a more robust Disability Alerts tool.			
% of the HVDHB domiciled population with a disability alert who or Māori or Pacific	Māori				
	Pacific				

Home-based and Community Support Services					
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2020/21	HVDHB Result 2020/21	Achievement
% of people 75+ living in their own home	Total	88%	88%	92%	
Acute bed day rate per 1000 for people 75+ [41]	Māori	1,377	≤1,643	2,944	
	Pacific	1,515		1,857	
	Non-Māori,	1,643		1,943	

[41] Result not included in 2019/20 Annual report

	Non-Pacific				
	Total	1,628		1,981	
Standardised acute readmission rate for people 75+ [42]	Māori	11.6%	≤12%	14%	
	Pacific	14.4%		14%	
	Non-Māori, Non-Pacific	12.4%		12%	
	Total	12.4%		12%	
Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+	Total	0.53	≤2.2	1.2	

Aged Residential Care Services					
With an ageing population, demand for aged residential care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Target Group	HVDHB Baseline 2019/20	HVDHB Target 2021/22	HVDHB Result 2020/21	Achievement
% of residential care providers meeting three year certification standards[43]	Total	100%	100%	100%	

ICT Asset Performance Measures

Measure	Indicator	2020/21	2020/21
ICT asset portfolio		Target	Outcome
% availability of critical systems	Functionality	≥99.9%	99.59%
% of ICT hardware at a condition level of 'Acceptable' or better (a rating of 3 or lower)	Condition	≥80%	67%
% usage of storage data network (SAN)	Utilisation	≥75% peak	70%

[42] Result not included in 2019/20 Annual report

[43] Result not included in 2019/20 Annual report

HVDHB COVID-19 Vaccine Data at 30 June 2021

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 4) **DHB of residence**	**Proportion fully vaccinated (note 1)**
Hutt Valley	**10.73%**

Vaccine doses administered by DHB **DHB of service**	**Dose 1**	**Dose 2**	**Total**
Hutt Valley	**18,024**	**12,440**	**30,464**

Vaccine doses administered by sequencing group (note 4) **Sequencing group (note 3)**	**Dose 1**	**Dose 2**	**Total**
Group 1	533	539	1,072
Group 2	9,423	8,460	17,883
Group 3	7,084	3,279	10,363
Group 4	984	162	1,146
Total	**18,024**	**12,440**	**30,464**

Vaccine doses administered by ethnicity (note 4) **Ethnicity**	**Dose 1**	**Dose 2**	**Total**
Asian	2,166	1,693	3,859
European or other	11,689	8,548	20,237
Māori	2,371	1,206	3,577
Pacific peoples	1,710	938	2,648
Unknown	88	55	143
Total	**18,024**	**12,440**	**30,464**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 155,442. This is 3,508 below the Stats NZ total projected population of 158,950 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total HVDHB population	HSU	Stats NZ	Difference
Māori	25,567	28,400	(2,833)
Pacific	12,410	12,450	(40)
Asian	21,365	23,400	(2,035)
Other	96,100	94,700	1,400
Total	155,442	158,950	(3,508)

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions

and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Financial Statements

Statement of comprehensive revenue and expense

For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Revenue				
Operating revenue	2	650,262	631,457	593,152
Interest		285	250	157
Dividends		-	-	111
Total revenue		**650,547**	**631,707**	**593,420**
Expenditure				
Personnel costs	3	200,068	213,888	204,366
Depreciation and amortisation	10-11	15,028	16,022	14,917
Outsourced services		37,634	15,479	18,386
Clinical supplies		31,198	28,663	25,790
Infrastructure and non-clinical expenses		24,748	14,522	16,904
Other district Health Boards		108,813	109,807	101,298
Non-health board providers		223,654	227,536	218,583
Capital charge	4	8,482	12,423	10,257
Finance costs	5	13	71	12
Other expenses	6	10,408	3,944	3,521
Total expenditure excluding Holidays Act		**660,046**	**642,354**	**614,034**
Surplus/(deficit) excluding Holidays Act		**(9,499)**	**(10,647)**	**(20,614)**
Holidays Act Provision	15	2,727	-	18,170
Surplus/(deficit) for the year		**(12,226)**	**(10,647)**	**(38,784)**
Other comprehensive revenue and expense				
Gain/(loss) on property revaluations		-	-	(19,866)
Total comprehensive revenue and expense		**(12,226)**	**(10,647)**	**(18,918)**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of financial position

As at 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	28,126	1,359	-
Debtors and other receivables	8	34,698	28,393	28,393
Inventories	9	2,322	2,200	2,199
Total Current Assets		**65,146**	**31,952**	**30,592**
Non-Current Assets				
Property, plant and equipment	10	223,548	263,372	225,970
Intangible assets	11	9,410	8,862	17,820
Investments in joint ventures	12	1,150	1,150	1,150
Trust and bequest funds	13	1,221	1,347	1,347
Total Non-Current Assets		**235,329**	**274,731**	**246,287**
Total Assets		**300,475**	**306,683**	**276,879**
Liabilities				
Current Liabilities				
Cash and cash equivalents	7	-	-	6,059
Creditors and other payables	14	47,437	35,318	40,785
Employee entitlements and provisions	15	64,700	36,784	64,274
Borrowings	16	42	42	42
Total Current Liabilities		**112,179**	**72,144**	**111,160**
Non-Current Liabilities				
Employee entitlements and provisions	15	9,150	8,972	8,972
Borrowings	16	136	180	178
Trust and bequest funds	13	1,221	6,274	1,347
Total Non-Current Liabilities		**10,507**	**15,426**	**10,497**
Total Liabilities		**122,686**	**87,570**	**121,657**
Net Assets		**177,789**	**219,113**	**155,222**
Equity				
Crown equity	17	158,709	181,123	123,916
Revaluation reserves	17	146,289	146,289	146,289
Accumulated deficit	17	(127,209)	(108,298)	(114,983)
Total Equity	17	**177,789**	**219,113**	**155,222**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of changes in equity

For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Equity as at 1 July		155,222	172,760	174,347
Repayment of equity to the Crown		(207)		(207)
Contribution of equity from the Crown		35,000	57,000	
Revaluation reserves		-	-	19,866
Total comprehensive revenue and expense for the year		(12,226)	(10,647)	(38,784)
Equity as at 30 June	17	**177,789**	**219,113**	**155,222**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of cash flows

For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Cash flows from Operating Activities				
Cash receipts		644,562	637,207	592,673
Payments to providers		(334,684)	(337,339)	(319,709)
Payments to suppliers & employees		(291,072)	(275,517)	(264,789)
Goods and services tax (net)		(436)	(1,700)	832
Capital charge paid		(8,482)	(12,423)	(10,257)
Net cash flows from Operating Activities		**9,888**	**10,228**	**(1,250)**
Cash flows from Investing Activities				
Interest received		285	250	157
Dividends received		-	50	111
Purchase of property, plant and equipment and intangible assets		(10,717)	(50,265)	(8,649)
Net cash flows from Investing Activities		**(10,432)**	**(49,965)**	**(8,381)**
Cash flows from Financing Activities				
Contribution from the Crown		35,000	57,000	-
Repayment of equity to the Crown		(207)	-	(207)
Repayment of finance leases		(42)	-	(1)
Interest paid		(22)	(71)	(3)
Net cash flows from Financing Activities		**34,729**	**56,929**	**(211)**
Net (Decrease) / Increase in Cash and Cash Equivalents		**34,185**	**17,192**	**(9,842)**
Cash and cash equivalents at beginning of year	7	(6,059)	(6,059)	3,783
Cash and Cash Equivalents at end of year		**28,126**	**11,133**	**(6,059)**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Reconciliation of net deficit to net cash flows from operating activities

For the year ended 30 June 2021

	2021 Actual $000	2020 Actual $000
Reconciliation of net deficit to net cash flows from operating activities		
Net surplus/(deficit)	(12,226)	(38,784)
Add/(less) non-cash items:		
Depreciation and amortisation expense	15,028	14,917
Impairment on intangibles	6,520	-
Increase/(decrease) in Provisions	551	22,721
Loss on disposal of property, plant and equipment	2	-
Total non-cash items	**22,101**	**37,638**
Add/(less) items classified as investing or financing activity:		
Dividends received	-	(111)
Net interest received	(272)	(145)
Total items classified as investing or financing activity	**(272)**	**(256)**
Add/(less) movements in statement of financial position items:		
(Increase)/decrease in debtors and other receivables	(6,253)	(630)
(Increase)/decrease in inventories	(124)	(764)
Increase/(decrease) in creditors and other payables	6,352	1,835
Trust Movement	309	(289)
Net movements in Working Capital items	**285**	**152**
Net cash flow from Operating Activities	**9,888**	**(1,250)**

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

For the year ended 30 June 2021

1 Statement of accounting policies

REPORTING ENTITY

Hutt Valley District Health Board (Hutt Valley DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing Hutt Valley DHB includes the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. Hutt Valley DHB's ultimate parent is the New Zealand Crown.

Hutt Valley DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. Hutt Valley DHB does not operate to make a financial return.

Hutt Valley DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for Hutt Valley DHB are for the year ended 30 June 2021, and were approved by the Board on 25 February 2022.

BASIS OF PREPARATION

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 DHBs with a new Crown Entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Maori Health Authority will monitor the state of Maori health and commission services directly.

Legalisation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the Hutt Valley DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the Hutt Valley DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 15 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort, dated 13 October 2021, from the Ministers of Health and Finance stating that the Government is committed to working with the DHB over the medium term to maintain its financial viability. The Government also acknowledges that additional support may be required over the period up until Health New Zealand is established, and that if so, the Crown will provide equity support where necessary.

Statement of compliance

The financial statements of Hutt Valley DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 Public Benefit Entity (PBE) accounting standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Changes in accounting policy

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

Standards issued and not yet effective and not early adopted

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. Hutt Valley DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 *Financial Instruments* and is effective for the year ending 30 June 2023, with early adoption permitted. Hutt Valley DHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The DHB does not intend to early adopt the standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 *Presentation of Financial Statements* and is effective for the year ending 30 June 2023, with earlier adoption permitted. Hutt Valley DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate.
Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are in respect of:

- Estimating the fair value of land and buildings – refer to note 10.
- Impairment of intangible assets – refer to note 11.
- Measuring the liabilities for long service leave, retirement gratuities, sabbatical leave, sick leave and continuing medical education leave – refer to note 14.
- Measuring the liability for Holidays Act 2003 remediation – refer to note 15.

2 Operating income

Accounting policy
The specific accounting policies for significant revenue items are explained below.

Ministry of Health (MoH) revenue
Hutt Valley DHB is primarily funded through revenue received from the MoH. This funding is restricted in its use for the purpose of Hutt Valley DHB meeting its objectives specified in its founding legislation and the scope of the relevant appropriations from the Funder.
Hutt Valley DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.
The fair value of revenue from the MoH has been determined to be equivalent to the amounts due in the funding arrangements.

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

Revenue from other DHBs
Inter district patient inflow revenue occurs when a patient treated within the Hutt Valley DHB region is domiciled outside of Hutt Valley.

Interest revenue
Interest revenue is recognised using the effective interest method.

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

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

Donations and bequests
Donations and bequests which have restrictive conditions are recognised as liabilities of the DHB. They are recognised as revenue in the surplus or deficit when the funds are spent in accordance with the conditions.

	2021 Actual $000	2020 Actual $000
Ministry of Health contract funding	510,793	474,094
ACC contract revenue	7,129	6,457
Other Government	1,662	1,144
Revenue from other district health boards	125,142	106,795
Other patient care related revenue	3,931	4,070
Other revenue:		
Donations and bequests received	1,270	255
Rental revenue and services	336	337
Total Operating Income	**650,263**	**593,152**

Revenue from other DHBs includes inter district patient inflow revenue. The MoH credits Hutt Valley DHB with a monthly amount based on estimated patient treatment for non-Hutt Valley residents within Hutt Valley. An annual wash up occurs at year end to reflect the actual non-Hutt Valley patients treated at Hutt Valley DHB.

3 Personnel costs

Accounting policy

Salary and wages
Salary and wages are recognised as an expense as employees provide services.

Superannuation schemes
Defined contribution schemes
Employers contributions to KiwiSaver, the Government Superannuation Fund, and other State Sector Retirement Savings Schemes are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

	2021 Actual $000	2020 Actual $000
Salaries and wages	197,228	194,998
Defined contribution plan employer contributions	4,964	4,876
Increase/(decrease) in liability for employee entitlements	(2,124)	4,492
Total Personnel Costs	**200,068**	**204,366**

See note 22 for a breakdown of employee remuneration by salary band.

4 Capital charge

Accounting policy
The capital charge is recognised as an expense in the financial year to which the charge

Hutt Valley DHB pays a capital charge to the Crown every six months. The charge is based on the actual closing equity balance excluding the value of donated assets. The capital charge rate was 5% for the year ending 30 June 2021 (2020: 6%).

5 Finance costs

Accounting policy
Borrowing costs are recognised as an expense in the financial year in which they are incurred

	2021 Actual $000	2020 Actual $000
Interest on overdraft facility	13	12
Total Finance Costs	**13**	**12**

6 Other expenses

Accounting policy

Operating leases

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

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

	2021 Actual $000	2020 Actual $000
Audit Fees for financial statement audit	177	173
Audit-related fees for internal audit services	52	146
Operating lease expense	3,290	2,841
Allowance for credit losses on receivables	66	60
Board member and committee fees	301	301
Loss on disposal of property, plant and equipment	2	-
Write-down on initial recognition of intangible assets	6,520	-
Total Other expenses	**10,408**	**3,521**

See note 21 for a breakdown of board member remuneration.
See note 11 for detail of the intangible asset write-down.

7 Cash and cash equivalents

Accounting policy

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

	2021 Actual $000	2020 Actual $000
Call deposits/(overdraft) with NZ Health Partnerships Ltd	22,874	(11,000)
Cash at bank and on hand	5,252	4,941
Total Cash and cash equivalents	**28,126**	**(6,059)**

Hutt Valley DHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility that is available to any DHB is the value of provider arm's planned monthly Crown revenue used in determining working capital limits, and is defined as one-twelve of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For the Hutt Valley DHB that equates to $24.2m (2020: 23.0m).

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirement of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

8 Debtors and other receivables

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. Hutt Valley DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been aggregated into groups of receivables that share similar credit risk characteristics. They have also been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments.

	2021 Actual $000	2020 Actual $000
Ministry of Health	12,635	10,333
Other DHBs	13,478	8,759
PHARMAC	5,937	6,225
Trade debtors - other	1,535	2,547
Other Departments	238	133
	33,823	**27,997**
Less: Allowance for credit losses	(366)	(419)
	33,457	**27,578**
Prepayments	1,241	815
Total Debtors and other receivables	**34,698**	**28,393**
Total Debtors and other receivables comprises:		
Revenue from the sale of goods and services (exchange transactions)	22,429	18,480
Revenue from grants (non-exchange transactions)	12,269	9,913
Total Debtors and other receivables	**34,698**	**28,393**

Trade receivables are reported at their face value, less an allowance for expected losses. Expected losses are assessed by aggregating debts into groups of receivables that share similar credit risk characteristics and historical patterns.

The movement in the allowance for credit losses is as follows:

	2021 Actual $000	2020 Actual $000
Opening allowance for credit losses as at 1 July	(419)	(359)
Increase in loss allowance made during the year	(45)	(125)
Receivables written off during the year	98	65
Balance as at 30 June	**(366)**	**(419)**

9 Inventories

Accounting policy

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

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

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

	2021 Actual $000	2020 Actual $000
Pharmaceuticals	213	196
Surgical and medical supplies	2,119	2,013
	2,332	**2,209**
Provision for obsolescence	(10)	(10)
Total Inventories	**2,322**	**2,199**

All inventories are distributed to operating areas in the normal course of business and recognised as an expense at the time of distribution.

No inventories are pledged as security for liabilities (2020: nil) however some inventories are subject to retention of title clauses.

10 Property, plant and equipment

Accounting policy

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

- land;
- building structure, services, fit out and site improvements;
- plant and equipment (includes computer equipment);
- leased assets; and
- motor vehicles.

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

Revaluations

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

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

Revaluation movements are accounted for on a class-of-asset basis. All other asset classes are carried at depreciated historical cost.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit

balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to Hutt Valley DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

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

Disposals

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

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to Hutt Valley DHB and the cost of the item can be measured reliably.
The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The estimated useful lives and associated depreciation of major classes of property, plant and Equipment were reviewed during the year and have been estimated as follows:

Site Improvements	10 to 100 years	1.0% to 10.0%
Building structure, services and fit out	5 to 50 years	2.0% to 20.0%
Plant and equipment	5 to 25 years	4.0% to 20.0%
Computer equipment	5 to 10 years	10.0% to 20.0%
Leased assets	7 years	14.3%
Motor vehicles	5 to 10 years	10.0% to 20.0%

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

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

Impairment of property, plant and equipment

Property, plant, and equipment are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other

comprehensive revenue and expense to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

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

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

Land and building valuations are done on a five year cycle. Desktop valuation updates are done in the interim years between full valuations. The most recent full valuation was as at 30 June 2020 and was performed by an independently contracted registered valuer, CBRE Limited. The land was valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. The hospital buildings were valued at fair value using optimised depreciated replacement cost because no reliable market data is available for such specialised buildings. Any expected effect on the value of the buildings due to COVID-19 were taken into account by the valuer.

Optimised depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

At 30 June 2021, the Hutt Valley DHB engaged CBRE Limited to undertake a 'desktop' valuation to determine potential materiality movement since 30 June 2020, the date of the last full and comprehensive valuation. The desktop valuation refers to the market at 30 June 2021 but is undertaken without inspection and excludes all capital expenditure since previous valuation date. CBRE Ltd have assessed that there has not been a material change in fair value and confirmed that the 30 June 2020 valuation remains an appropriate statement of fair value as at 30 June 2021.

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

	Land	Buildings	Plant & Equipment	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance 1 July 2019	28,050	177,660	47,326	2,284	2,486	257,806
Additions	-	4,528	5,995	293	214	11,030
Disposals	-	-	(10)	-	-	(10)
Revaluation increase/(decrease)	2,000	370	1,851	-	-	2,370
Work in progress adjustment		(3,284)	(4,135)	-	(195)	(7,614)
Work In progress closing balance	-	1,653	1,851	-	-	3,504
Balance at 30 June 2020	30,050	180,927	51,027	2,577	2,505	267,086
Balance 1 July 2020	30,050	180,927	51,027	2,577	2,505	267,086
Additions	-	2,189	5,132	-	-	7,321
Disposals	-	-	(4)	-	-	(4)
Revaluation increase/(decrease)	-	-	-	-	-	-
Work in progress adjustment		(1,653)	(1,851)	-	-	(3,504)
Work In progress closing balance	-	2,864	2,773	-	-	5,637
Balance at 30 June 2021	30,050	184,327	57,077	2,577	2,505	276,536

	Land	Buildings	Plant & Equipment	Lease	Motor	Total
	$000	$000	$000	$000	$000	$000
Accumulated depreciation and impairment losses						
Balance 1 July 2019	-	9,456	33,992	1,266	2,145	46,859
Depreciation expense	-	8,476	2,735	411	141	11,763
Depreciation on disposals	-	-	(10)	-	-	(10)
Adjustment	-	(44)	44	-	-	-
Elimination on revaluation	-	(17,496)	-	-	-	(17,496)
Balance at 30 June 2020	-	392	36,761	1,677	2,286	41,116
Balance 1 July 2020	-	392	36,761	1,677	2,286	41,116
Depreciation expense	-	8,328	3,130	366	50	11,874
Depreciation on disposals	-	-	(2)	-	-	(2)
Elimination on revaluation	-	-	-	-	-	-
Balance 30 June 2021	-	8,720	39,889	2,043	2,336	52,988
Carrying Amounts						
As at 1 July 2019	28,050	168,204	13,334	1,018	341	210,947
As at 30 June 2020	30,050	180,535	14,266	900	219	225,970
As at 30 June 2021	30,050	175,607	17,188	534	169	223,548

Finance leases

The net carrying amount of assets held under existing finance leases is $0.21m (2020: $0.25m) for plant and equipment. Note 16 provides further information about finance leases.

Restrictions on title

There are no restrictions over the titles of Hutt Valley DHB's property plant and equipment; neither have any of the DHB's property, plant and equipment been pledged as security for liabilities.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2021 was $nil (2020: $nil).

Seismic Status of Buildings

All Hutt Valley DHB's buildings have had detailed seismic assessments. All the assessed buildings meet the current minimum of 34% of the New Building Standard. There is uncertainty around the future of some of the buildings on site due to their relatively low NBS rating, assessed importance level (IL), age and fit for purpose such as the Heretaunga Building (IL3), Kitchen Building (IL2) and Care Building (IL3). Strengthening is on hold until the Master Plan is completed which will give direction as to the future of the buildings on site and what works (if any) are undertaken.

11 Intangible assets

Accounting policy

Software acquisitions and development

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

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

Costs associated with maintaining computer software and with the development and maintenance of Hutt Valley DHBs website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

Indefinite life intangible assets are not amortised.

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

Computer Software	5 to 43 years	2.3% to 20.0%

Impairment of intangible assets

Refer to the policy for impairment of property, plant and equipment in Note 10. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is an indication of impairment.

	Acquired Software $000	Investment In RHIP $000	Total $000
Cost or valuation			
Balance 1 July 2019	26,523	8,337	34,860
Additions	3,327	-	3,327
Impairment	-	-	-
Work in progress adjustment	(3,760)	(8,337)	(12,097)
Work In progress closing balance	1,432	9,066	10,498
Balance 30 June 2020	27,522	9,066	36,589
Balance 1 July 2020	27,522	9,066	36,589
Additions	1,661	-	1,661
Impairment	-	(6,520)	(6,520)
Work In progress adjustment	(1,432)	(9,066)	(10,498)
Work In progress closing balance	312	9,789	10,101
Balance 30 June 2021	28,063	3,269	31,333
Accumulated amortisation and impairment losses			
Balance at 1 July 2019	15,614	-	15,614
Amortisation expense	3,154	-	3,154
Balance 30 June 2020	18,768	-	18,768
Balance at 1 July 2020	18,768	-	18,768
Amortisation expense	3,154	-	3,154
Balance 30 June 2021	21,922	-	21,922
Carrying Amounts			
At 1 July 2019	10,909	8,337	19,246
At 30 June 2020	8,754	9,066	17,820
At 30 June 2021	6,141	3,269	9,410

There are no restrictions over the title of Hutt Valley DHBs intangible assets; nor are any intangible assets pledged as security for liabilities.

Regional Health Informatics Programme (RHIP)

RHIP is a programme to move the six central region District Health Boards from a current state of disparate and fragmented clinical and administrative information systems to a regional solution that would integrate patient administration and clinical functionality through single clinical applications. The intent being is to provide a single patient shared care record for clinicians across the central region at the right time and right place.

As at 30 June 2021, Hutt Valley DHB had contributed $9.789 million towards central region IT applications which has been recognised as work in progress in respect of intangible assets. This investment has been tested for impairment during the year by DHB management and $6.520 million was written off to correct the remaining useful life of the regional Clinical Portal, WebPAS and RADA IT applications.

12 Investments in companies and joint ventures

	2021 Actual $000	2020 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares – Allied Laundry Services Limited	1,150	1,150
Closing Balance	**1,150**	**1,150**

Allied Laundry Services has a total share capital of 6,900,000 of which the DHB's share is 1,150,000 (16.67%). The shares have been fully paid.

13 Special 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 restricted fund balances.

	2021 Actual $000	2020 Actual $000
Opening balance	1,347	1,409
Funds received	389	474
Interest received	1	9
Funds disbursed	(516)	(545)
Closing Balance	**1,221**	**1,347**

14 Creditors and other payables

Accounting policy
Short-term payables are measured at the amount payable.

	2021 Actual $000	2020 Actual $000
Payables under exchange transactions		
Creditors	3,168	2,974
Accrued expenses	31,596	26,948
Inter-district flows	(1,173)	(1,009)
Interest	-	9
Income in advance	5,880	3,770
Total payables under exchange transactions	39,471	32,692
Payables under non-exchange transactions		
Taxes	2,731	3,166
Trusts	5,236	4,927
Total payables under non-exchange transactions	7,967	8,093
Total Creditors and other payables	**47,438**	**40,785**

See note 24 for liquidity risk.

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their fair value.

15 Employee entitlements and provisions

Accounting policy

Provisions

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

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 an interest expense and is included in "finance costs".

ACC Partnership Programme

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

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, long service leave, retiring gratuities, continuing medical education leave and expenses, and other entitlements for example sick leave.

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

A liability and an expense are recognised for bonuses where the Hutt Valley DHB has a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as sabbatical leave, long service leave, retirement gratuities, continuing medical education and expenses, have been calculated on an actuarial basis.
The calculations are based on contractual entitlement information including likely future entitlements accruing to staff based on years of service, years to entitlement and the likelihood that staff will reach the point of entitlement.

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

Presentation of employee entitlements

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

Critical accounting estimates and assumptions

Sabbatical leave, long service leave, retirement gratuities and continuing medical education.

The present value of long service leave, retirement gratuities, sabbatical leave, sick leave and continuing medical education leave and expenses depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates have maturities that match, as closely as possible, the estimated future cash flows. 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 1.71% (2020: 1.4%) and a salary growth factor of 2.5% (2020: 2.5%) has been used.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the actuarial valuation would be an estimated $0.4m higher/lower.

Holiday Act 2003 remediation

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of all 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non- compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and the final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the Hutt Valley DHB recognises it has an obligation to address any historical non-compliance under the MOU and has engaged Ernst & Young (New Zealand) to estimate the value of this liability. This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year.

	2021 Actual $000	2020 Actual $000
Current provision		
Salary and Wages accrued	3,515	7,599
Annual leave	22,234	21,523
Holidays Act 2003 remediation	30,218	27,491
Long service leave	1,219	2,125
Retirement gratuities	253	300
Continuing medical education leave and expenses	1,937	1,165
Other Entitlements	5,324	4,071
Total Current provision	**64,700**	**64,274**
Non-current provision		
Long Service leave	1,949	2,422
Retirement Gratuities	718	751
Continuing Medical Education Leave and Expenses	4,205	3,212
Other Entitlements	2,278	2,587
Total Non-current provision	**9,150**	**8,972**
Total Employee Entitlements and Provisions	**73,850**	**73,246**

16 Borrowings

Accounting policy

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

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

Critical judgements in applying accounting policies

Classification of leases

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Hutt Valley DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

Hutt Valley DHB has exercised its judgement on the appropriate classification of leases, and has determined that there were no new arrangements during the year to June 2021 considered to be finance leases.

	2021 Actual $000	2020 Actual $000
Current portion		
Finance leases	42	42
	42	**42**
Non-current portion		
Finance leases	136	178
	136	**178**
Total borrowings	**178**	**220**

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment. The net carrying amount of assets held under finance lease is disclosed in note 10.

The fair value of finance leases is $0.178m (2020: $0.220m). Fair value is estimated at the present value of future cash flows.

Analysis of finance lease

	2021 Actual $000	2020 Actual $000
Minimum lease payments payable:		
Not later than one year	42	42
Later than one year and not later than five years	136	168
Later than five years	-	10
Total minimum lease payments	178	220
Future finance charges	-	-
Present value of minimum lease payments	178	220
Present value of minimum lease payable:		
Not later than one year	42	42
Later than one year and not later than five years	136	168
Later than five years	-	10
Total present value of minimum lease payments	178	220

Description of finance leasing arrangements

Hutt Valley DHB holds 1 (2020: 1) finance lease. The finance lease is for medical equipment. There are no restrictions placed on Hutt Valley DHB by this finance leasing arrangement.

17 Equity

Accounting policy

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

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

Revaluation reserves

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

	2021 Actual $000	2020 Actual $000
Contributed equity		
Balance at 1 July	123,916	124,123
Equity contributions from the Crown	35,000	-
Repayment of equity to the Crown	(207)	(207)
Balance at 30 June	158,709	123,916
Revaluation reserves		
Balance at 1 July	146,289	126,423
Revaluations	-	19,866
Balance at 30 June	146,289	146,289
Revaluation reserves consist of		
Land	25,689	25,689
Buildings	121,263	121,263
Equipment	(663)	(663)
Total revaluation reserves	146,289	146,289
Accumulated surplus/(deficit)		
Balance at 1 July	(114,983)	(76,199)
Deficit for the year	(12,226)	(38,784)
Balance at 30 June	(127,209)	(114,983)
Total equity	177,789	155,222

Capital management

The Hutt Valley DHB's capital is its equity, which comprises Crown equity, accumulated surpluses/deficits and revaluation reserves. Hutt Valley DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that the DHB effectively achieves its objectives and purposes, while remaining a going concern.

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

18 Capital commitments and operating leases

Accounting policy

Operating leases

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

	2021 Actual $000	2020 Actual $000
Capital commitments	10,366	8,430
Operating leases as lessee		
Not later than one year	2,540	2,061
Later than one year and not later than five years	4,110	3,657
Later than five years	-	-
Total Non-cancellable Commitments	**17,016**	**14,148**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

The DHB leases a number of premises, a fleet of motor vehicles, EFTPOS machines and a variety of medical equipment under operating leases. The major leases are outlined below:

- Regional Public Health premises in Porirua are leased for six years with a final expiry date of March 2025.
- Community Mental Health premises in Lower Hutt are leased for six years with two rights of renewal in September 2023 and September 2026 and a final expiry date of August 2029.
- CT scanner leased for five years with an expiry date of August 2022.
- Orthopaedic tools are leased for seven years with an expiry date of August 2023.
- Fluoroscopy Combi Diagnost is leased for five years with an expiry date of July 2024.
- Magnetic Resonance Imaging (MRI) leased for five years with an expiry date of August 2024.

19 Contingencies

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2021 (2020: Nil).

20 Related party transactions

Hutt Valley DHB is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other Government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel

Key management personnel include the Chief Executive, other members of the executive management team, and the Board.

	2021 Actual $000	2020 Actual $000
Leadership team		
Salaries and other short-term employee benefits	$2,595	$2,587
Less: Amount paid by Capital & Coast DHB	(452)	(241)
Amount paid by Hutt Valley DHB	$2,143	$2,346
Full-time equivalent members	*7.42*	*9.78*
Board members		
Remuneration	$300	$273
Full-time equivalent members	*1.19*	*1.18*
Total key management personnel remuneration	**$2,443**	**$2,619**
Total full-time equivalent personnel	***8.61***	***10.96***

The full-time equivalent for Board members has been determined based on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

An analysis of Board member remuneration is provided in note 21.

During the year, Hutt Valley DHB, Capital & Coast DHB and Wairarapa DHB share some leadership team members, and recharge or recover the remuneration between DHBs.

In addition the DHBs share some board members and committee members.

There are close 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. No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2020: nil).

21 Board member remuneration and meetings attended

The total value of remuneration for board and committee fees paid or payable to each Board member during the year was:

Board Member	Position	2020/21 actual ($000)	2019/20 actual ($000)
Board members as at 30 June 2021			
David Smol	Joint Chair HVDHB & CCDHB (from 1 December 2019)	50	27
Wayne Guppy	Deputy Chair	34	30
John Ryall	Current Member (from 1 December 2019)	27	14
Josh Briggs	Current Member (from 1 December 2019)	27	14
Ken Laban	Current Member	27	24
Keri Brown	Current Member (from 1 December 2019)	27	14
Naomi Shaw	Current Member (from 1 December 2019)	24	14
Prue Lamason	Current Member	26	24
Richard Stein	Current Member (from 1 December 2019)	27	14
Ria Earp	Current Member (from 16 April 2021)	4	-
Yvette Grace	Current Member	27	23
Board members who left during 2019/20			
Andrew Blair	Previous Chair (until 30 November 2019)	-	19
Lisa Bridson	Previous Member (until 30 November 2019)	-	9
Tim Ngan-Kee	Previous Member (until 30 November 2019)	-	11
David Ogden	Previous Member (until 30 November 2019)	-	10
John Terris	Previous Member (until 30 November 2019)	-	9
Kim von Lanthen	Previous Member HVDHB & CCDHB (until 29 February 2020)	-	17
Total Board member remuneration		300	273

Board and committee meeting attendances in the year to 30 June 2021:

Board Member	Position	Meetings Attended				
		Board	FRAC	HSC	DSAC	MCPAC
1 July 2020 to 30 June 2021						
David Smol	Joint Chair HVDHB & CCDHB	9/9	6/6	-	-	6/6
Wayne Guppy	Deputy Chair	9/9	6/6	-	-	6/6
John Ryall	Current Member	8/9	6/6	-	3/3	-
Josh Briggs	Current Member	7/9	-	6/6	-	-
Ken Laban	Current Member	9/9	-	5/6	-	-
Keri Brown	Current Member	7/9	-	5/6	-	-
Naomi Shaw	Current Member	9/9	-	-	3/3	-
Prue Lamason	Current Member	8/9	6/6	-	1/3	-
Richard Stein	Current Member	9/9	-	6/6	-	-
Ria Earp	Current Member (Appointed 16 April 2021)	*2/2	-	*1/1	-	-
Yvette Grace	Current Member	9/9	6/6	-	3/3	-

**Only meetings that occurred while the person was a Board member are included*

Key:

FRAC	Finance, Risk, Audit Committee
DSAC	Disability Services Advisory Committee
HSC	Health Systems Committee
MCPAC	Major Capital Projects Advisory Committee

The DHB has provided a deed of indemnity to Directors for certain activities undertaken in the performance of the DHBs functions.

The DHB has in effect Directors' and officers' liability and professional indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

22 Employee remuneration

Annual remuneration	2021	2020	2019	2018
100,000-109,999	99	92	77	48
110,000-119,999	60	43	37	29
120,000-129,999	34	27	25	19
130,000-139,999	15	19	13	13
140,000-149,999	17	19	10	10
150,000-159,999	16	11	12	12
160,000-169,999	11	12	7	13
170,000-179,999	5	12	15	13
180,000-189,999	11	15	9	8
190,000-199,999	13	14	10	11
200,000-209,999	10	5	9	6
210,000-219,999	7	9	4	10
220,000-229,999	6	15	8	6
230,000-239,999	8	9	13	6
240,000-249,999	10	5	10	8
250,000-259,999	7	11	4	7
260,000-269,999	6	0	9	4
270,000-279,999	4	8	4	7
280,000-289,999	7	1	4	4
290,000-299,999	7	4	6	2
300,000-309,999	2	8	5	3
310,000-319,999	10	3	3	
320,000-329,999	5	1		1
330,000-339,999	1	2	1	2
340,000-349,999	1	1	2	3
350,000-359,999	2	3	1	
360,000-369,999	1	1	2	
370,000-379,999		1		
380,000-389,999	2	2		1
390,000-399,999	2	1	1	
400,000-409,999		1	1	2
450,000-459,999				1
460,000-469,999				1
470,000-479,999				1
510,000-519,999	1			
520,000-529,999			1	
Grand Total	**380**	**355**	**303**	**251**

Termination payments

During the year ended 30 June 2021, 9 employees (2020: 12) received compensation and other benefits in relation to cessation totalling $318,138 (2020: $197,102). The payments were in the nature of redundancy or retirement gratuities.

23 Events after balance date

The Health Sector Reforms are scheduled to come into effect on 1 July 2022, refer to note 1 for more detail.

In response to COVID-19, on 17 August 2021, the Wellington region moved to Alert Level 4 for two weeks, then to Alert Level 3 for one week and then down to Alert Level 2.

On 3 December 2021 the alert levels were replaced with a traffic light system. Subsequently, New Zealand moved into the highest COVID-19 setting (red light) on 24 January 2022. At the time of publication, there has been no widespread community transmission in the Wellington region, and therefore no changes made to the DHB's services or visitor policy. The DHB continues to monitor the situation closely, and has the ability to extend testing hours or increase testing capacity in the community if required.

For details on the impact of COVID-19 during the year to June 2021, refer to note 27. The impact of COVID-19 is considered a non-adjusting event for the purposes of these financial statements.

There have no other material events subsequent to balance date.

24 Financial instruments

Fair Values

The fair values together with the carrying amounts shown in the statement of financial position are as follows:

	2021		2020	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	$000	$000	$000	$000
Cash and cash equivalents	28,126	28,126	(6,059)	(6,059)
Debtors and other receivables	34,698	34,698	28,393	28,393
Creditors and other payables	47,438	47,438	40,785	40,785
Borrowings	178	178	220	220
	110,440	**110,440**	**63,339**	**63,339**

Financial Instrument Risks

The activities of Hutt Valley DHB expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow the DHB to enter into any transactions that are speculative in nature.

Price Risk

Price risk is the risk that the fair value of a financial instrument will fluctuate as a result of changes in market prices. Hutt Valley DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. Hutt Valley DHBs exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the DHB, as investments and borrowings are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Hutt Valley DHBs exposure to cash flow interest rate risk is limited to on- call deposits. At 30 June 2021, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2020/21, only the net interest from cash holdings would be affected.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. Hutt Valley DHB purchases clinical equipment from overseas, which requires it to enter into transactions denominated in foreign currencies. As a result of these activities, exposure to currency risk arises. This exposure is not considered significant and is not actively managed.
The effect of a general increase of one percentage point on the value of the NZD against other foreign currencies would have had a minimal impact on earnings.

Credit risk

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

Due to the timing of its cash inflows and outflows, surplus cash is invested with registered banks or NZHPL.

In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in statement of financial position.

The DHB places its cash and short term deposits with high quality financial institutions and the DHB has a policy that limits the amounts of credit exposure to any one financial institution. Hutt Valley DHB has not experienced any defaults of interest or principal payments for term deposits.

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest debtor and it is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets

The gross carrying amount of financial assets, excluding receivables, by credit rating is provided below by reference to Standard & Poor's credit ratings (if available) or to historical information about counterparty default rates:

	2021 Actual $000	2020 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
AA	-	-
AA-	6,473	6,288
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	22,874	(11,000)
	29,347	**(4,712)**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	28,126	(6,059)
Trust and bequest funds	1,221	1,347
Debtors and other receivables	34,698	28,393

Debtors and other receivables mainly arise from Hutt Valley DHBs statutory functions, therefore there are no procedures in place to monitor or report the credit quality of debtors and other receivables to internal or external credit ratings.

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 mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the "DHB Treasury Services Agreement" with New Zealand Health Partnerships Limited (NZHPL) as described in Note 7.

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1 - 2 years $000	More than 2 years $000
2021					
Creditors and other payables	38,827	38,827	38,827	-	-
Finance leases	178	178	42	42	94
Total	**39,005**	**39,005**	**38,869**	**42**	**94**
2020					
Creditors and other payables	33,849	33,849	33,849		
Finance leases	220	220	42	42	136
Total	**34,069**	**34,069**	**33,891**	**42**	**136**

25 Explanation of major variances against budget

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2021 are provided below.

Statement of comprehensive revenue and expense

The Hutt Valley DHB recorded a deficit of $9.499m (excluding one off exceptional items) compared with a budget deficit of $10.647m.

Revenue was higher than budget by $18.840m (3.0%). This is largely due to recovery of costs from Capital & Coast DHB as part of a shared 3DHB Mental Health, Addictions and Intellectual Disability Service (MHAIDS). This increase in revenue was offset by an increase in expenditure.

Expenditure, excluding provision for Holidays Act remediation, was over budget by $17.692m (2.8%) largely due to the move to a 3DHB MHAID service, offset by an increase in recoveries. The main variances to budget include:

- Personnel costs were lower than budget due to DHB staff for MHAIDS and Information Services moving to a single employer, Capital & Coast DHB (as the 3DHB lead).
- Outsourced services were higher than budget largely representing the move to a single employer. This increase partly offsets the decrease in personnel Costs. Also included is an increased investment in information services.
- The increase to budget spend on infrastructure and non-clinical services was largely the result of the transfer of funding of the 3DHB MHAID service. This was offset by an increase in revenue.
- Other expenses were higher than budget due to the write down of intangible assets.

The exceptional item was the increase in the current year provision for the Holidays Act remediation of $2.727m.

Statement of financial position

- Cash and cash equivalents were over budget mainly due to the delay in commencing capital projects – specifically building and ICT projects.
- Debtors and other receivables were over budget mainly due to the recovery of costs from Capital & Coast DHB as part of the shared 2DHB MHAID service.
- Property, plant and equipment was below budget mainly due to the delay in commencing capital projects.
- Creditors and other payables were over budget mainly due to the transfer of internal DHB funding to Capital & Coast DHB as part of the shared 2DHB MHAID service, as well as increase in deferred contract revenue.
- Employee entitlements and provisions were over budget mainly due to the provision made to remediate non-compliance with the Holidays Act. (Estimated liability as at 30 June 2021 was $30.218m).
- Equity was under budget by $41.3m. The opening accumulated deficit at 30 June 2020 was $114.983m, compared with $97.653m in the budget model. Also, a capital injection of $22.0m was budgeted for, but as this was not required due to delay in planned capital projects, it was not received.

Statement of cash flows

The net cash position is over budget.

- Purchase of property, plant and equipment was below budget due to unspent capital projects.
- Financing cash flows were below budget mainly due to the capital injection not being received.

26 Cost of service statements for output classes

Accounting policy

Cost allocation

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

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

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

$000s	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
	2020\21 Actual	2020\21 Budget	2019\20 Audited	2020\21 Actual	2020\21 Budget	2019\20 Audited	2020\21 Actual	2020\21 Budget	2019\20 Audited	2020\21 Actual	2020\21 Budget	2019\20 Audited	2020\21 Actual	2020\21 Budget	2019\20 Audited
Income															
Operating Income	22,660	55,222	21,862	309,122	174,224	289,663	259,232	327,686	225,028	59,248	74,379	56,710	650,262	631,511	593,263
Interest Income	23	28	23	15	18	15	246	203	119	1	1	1	285	250	158
Total Income	**22,683**	**55,249**	**21,885**	**309,137**	**174,242**	**289,678**	**259,478**	**327,889**	**225,147**	**59,249**	**74,380**	**56,711**	**650,547**	**631,760**	**593,421**
Expenditure															
Personnel Costs	14,709	14,936	14,062	8,309	14,297	12,758	172,281	179,921	172,447	4,769	4,733	5,097	200,068	213,887	204,364
Depreciation	198	365	349	736	960	733	14,071	14,673	13,814	23	23	21	15,028	16,021	14,917
Outsourced Services	2,307	2,229	1,253	1,135	1,088	1,274	33,923	11,877	15,631	270	284	227	37,635	15,478	18,385
Clinical Supplies	1,059	1,233	505	779	581	378	27,649	23,533	23,288	1,711	1,325	1,619	31,198	26,672	25,790
Infrastructure and Non Clinical Expenses	473	575	618	562	969	761	23,638	12,415	31,123	75	128	120	24,748	14,087	32,622
Other District Health Boards	-	27,574	-	106,078	45,770	97,782	-	27,525	-	2,735	8,937	3,516	108,813	109,806	101,298
Non Health Board Providers	-	4,568	-	180,260	106,639	173,523	-	59,290	-	43,394	57,089	45,060	223,654	227,586	218,583
Capital Charge	486	525	486	884	1,067	901	7,095	10,813	8,854	17	18	17	8,482	12,423	10,258
Interest Expense	-	-	-	-	-	-	13	71	12	-	0	-	13	71	12
Other	390	556	488	188	587	566	12,509	5,165	4,873	47	61	46	13,134	6,370	5,973
Internal Allocations	4,202	4,352	3,942	2,836	3,834	3,641	(8,053)	(9,043)	(8,471)	1,016	857	890	1	1	2
Total Expenditure	**23,824**	**56,914**	**21,703**	**301,767**	**175,793**	**292,317**	**283,126**	**336,242**	**261,571**	**54,057**	**73,457**	**56,613**	**662,774**	**642,405**	**632,204**
Net Surplus / (Deficit)	**(1,141)**	**(1,665)**	**182**	**7,370**	**(1,551)**	**(2,639)**	**(23,648)**	**(8,353)**	**(36,424)**	**5,192**	**923**	**98**	**(12,227)**	**(10,645)**	**(38,783)**

27 Impact of COVID-19

During August and September 2020 and February and March 2021, the Auckland Region moved into Alert Levels 3 and 2 and other parts of the country, which includes the Hutt Valley DHB's service area, moved into Alert Level 2.

At Alert Level 2, the operating capacity of the DHB was reduced. At Alert Level 1, the DHB resumed to normal business activity and in some instances at a higher level than pre-COVID-19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels.

In the year to 30 June 2021, there were $7.3m additional costs from the COVID-19 response. These were mostly external provider costs as well as some additional hospital costs such as security services. These additional costs were largely offset by additional MoH revenue, resulting in a $0.025m net surplus.

28 Late signing of Annual Report

Hutt Valley District Health Board was required under section 156 (3) of the Crown Entities Act 2004 to adopt its audited financial statements and service performance information by 31 December 2021. This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of COVID-19, including lockdowns.

Statement of Responsibility

We are responsible for the preparation of Hutt Valley DHB's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end of year performance information provided by Hutt Valley DHB under section 19A of the Public Finance Act 1989.

We have responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of Hutt Valley DHB for the year ended 30 June 2021.

Signed on behalf of the Board:

David Smol,
Chair
25 February 2022

Wayne Guppy,
Chair Finance, Risk and Audit Committee
25 February 2022

Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of the Hutt Valley District Health Board's financial statements and performance information for the year ended 30 June 2021

The Auditor-General is the auditor of the Hutt Valley District Health Board (the Health Board). The Auditor-General has appointed me, Andrew Clark, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 61 to 95, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 45 to 60.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 61 to 95, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 45 to 60:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2021, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed late

Our audit was completed on 25 February 2022. This is the date at which our opinion is expressed. We acknowledge that our audit was completed later than required by the Crown Entities Act 2004, section 156(3)(a). This was due to an auditor shortage in New Zealand and the consequential effects of COVID-19, including lockdowns.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 66 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 15 on page 82 outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board has estimated a provision of $30.218 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The Health Board is reliant on financial support from the Crown

Note 1 on page 66 outlines the Health Board's financial performance difficulties. There is uncertainty whether the Health Board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with financial support, where necessary.

HSU population information was used in reporting COVID-19 vaccine strategy performance results

Pages 58 to 60 outline the information used by the Health Board to report on its COVID-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 59. This outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of COVID-19

Note 23 on page 90 and note 27 on page 95 of the financial statements which outlines the impact of COVID-19 on the Health Board.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 44 and page 96, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the Health Board.

Andrew Clark
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Ministerial Directions

Hutt Valley District Health Board complies with the following Ministerial Directions:

- The 2011 Eligibility Direction issues under s.32 of the NZ Public Health and Disability Act 2000
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of Government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. Procurement and ICT apply to Hutt Valley DHB
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizable ICT business transactions and investment specifically listed within the 2014 direction.

Directory

Head Office Postal Address: Hutt Valley District Health Board Private Bag 31-907, Lower Hutt 5040 **Website:** www.huttvalleydhb.org.nz **Facebook:** www.facebook.com/HuttValleyDHB	**Head Office Physical Address:** Executive Reception, Pilmuir House, Pilmuir Street Hutt Hospital Campus, Lower Hutt 5010 **Phone:** (04) 566 6999
Bankers: Bank of New Zealand	**Auditor:** Audit New Zealand Wellington, on behalf of the Controller and Auditor-General

HVDHB Board Members as at 30 June 2021	
The Board has eleven members. Seven are elected. Four are appointed by the Minister of Health *(marked*).*	
David Smol, Chair Hutt Valley and Capital & Coast DHB*	
Wayne Guppy, Deputy Chair	Ken Laban
Josh Briggs	Prue Lamason
Keri Brown	John Ryall*
Ria Earp*	Naomi Shaw
Yvette Grace*	Richard Stein

Executive Leadership Team for Hutt Valley and Capital Coast DHBs as at 30 June 2021			
Fionnagh Dougan	2DHB Chief Executive Officer	**Rosalie Percival**	2DHB Chief Financial Officer
Joy Farley	2DHB Director Provider Services	**Sarah Jackson**	2DHB Acting Director Clinical Excellence
Chris Kerr	2DHB Director of Nursing	**Arawhetu Gray**	2DHB Director of Māori Health
John Tait	2DHB Chief Medical Officer	**Junior Ulu**	2DHB Director of Pacific People's Health
Christine King	2DHB Director of Allied Health	**Rachel Haggerty**	2DHB Director Strategy Planning and Performance
Declan Walsh	2DHB Director People, Culture and Capability	**Steve Earnshaw**	Acting Chief Digital Officer, 3DHB
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disabilities, 3DHB	**Sally Dossor**	2DHB Director of the Office of the Chief Executive
Helen Mexted	2DHB Director, Communications and Engagement		

3DHB Disability Support Advisory Committee as at 30 June 2021			
'Ana Coffey (Chair)	Capital & Coast DHB	**Yvette Grace**	Hutt Valley DHB
Sue Kedgley	Capital & Coast DHB	**John Ryall**	Hutt Valley DHB
Tristram Ingham	Capital & Coast DHB	**Naomi Shaw**	Hutt Valley DHB
Vanessa Simpson	Capital & Coast DHB	**Ryan Soriano**	Wairarapa
Jill Pettis	Wairarapa DHB	**Jill Stringer**	Wairarapa
Sue Emirali	Chair, Sub-regional Disability Advisory Group	**Jack Rikihana**	Te Upoko o te Ika A Maui Māori Council
Bernadette Jones	Chair, Sub-regional Disability Advisory Group	**Marama Tuuta**	Chair of Kaunihera Whaikaha, Wairarapa

Combined Health System Committee as at 30 June 2021			
Sue Kedgley	Chair, Capital & Coast DHB	**Ken Laban**	(Deputy), Hutt Valley DHB
Josh Briggs	Hutt Valley DHB	**Keri Brown**	Hutt Valley DHB
'Ana Coffey	Capital & Coast DHB	**Chris Kalderimis**	Capital & Coast DHB
Vanessa Simpson	Capital & Coast DHB	**Richard Stein**	Hutt Valley DHB
Ria Earp	Hutt Valley DHB	**Roger Blakeley**	Capital & Coast DHB
Paula King	Te Upoko o te Ika A Maui Māori Council	**Fa'amatuainu Tino Pereira**	Sub-regional Pacific Strategic Health Group
Sue Emirali	Sub-regional Disability Advisory Group	**Bernadette Jones**	Sub-regional Disability Advisory Group
Teresea Olsen	Community Māori Representative, Hutt Valley DHB		

Chief Executive Employment Committee (CEEC) as at 30 June 2021.	
David Smol – Chair, Hutt Valley and Capital & Coast District Health Boards	
Wayne Guppy – Deputy Chair, Hutt Valley DHB)	Stacey Shortal – Deputy Chair, Capital & Coast DHB)

Finance Risk and Audit Committee as at 30 June 2021 - HVDHB	
Wayne Guppy – Chair, Hutt Valley DHB	John Ryall – Hutt Valley DHB
Yvette Grace – Hutt Valley DHB	David Smol – Hutt Valley DHB
Prue Lamason – Hutt Valley DHB	

Major Capital Projects Advisory Committee as at 30 June 2021	
Brendan Boyle – Chair, Capital & Coast DHB	Wayne Guppy – Hutt Valley DHB
Hamiora Bowkett – Capital & Coast DHB	David Smol – Hutt Valley DHB
Tony Lloyd – Ministry of Health	Bruce McLean – appointed independent expert