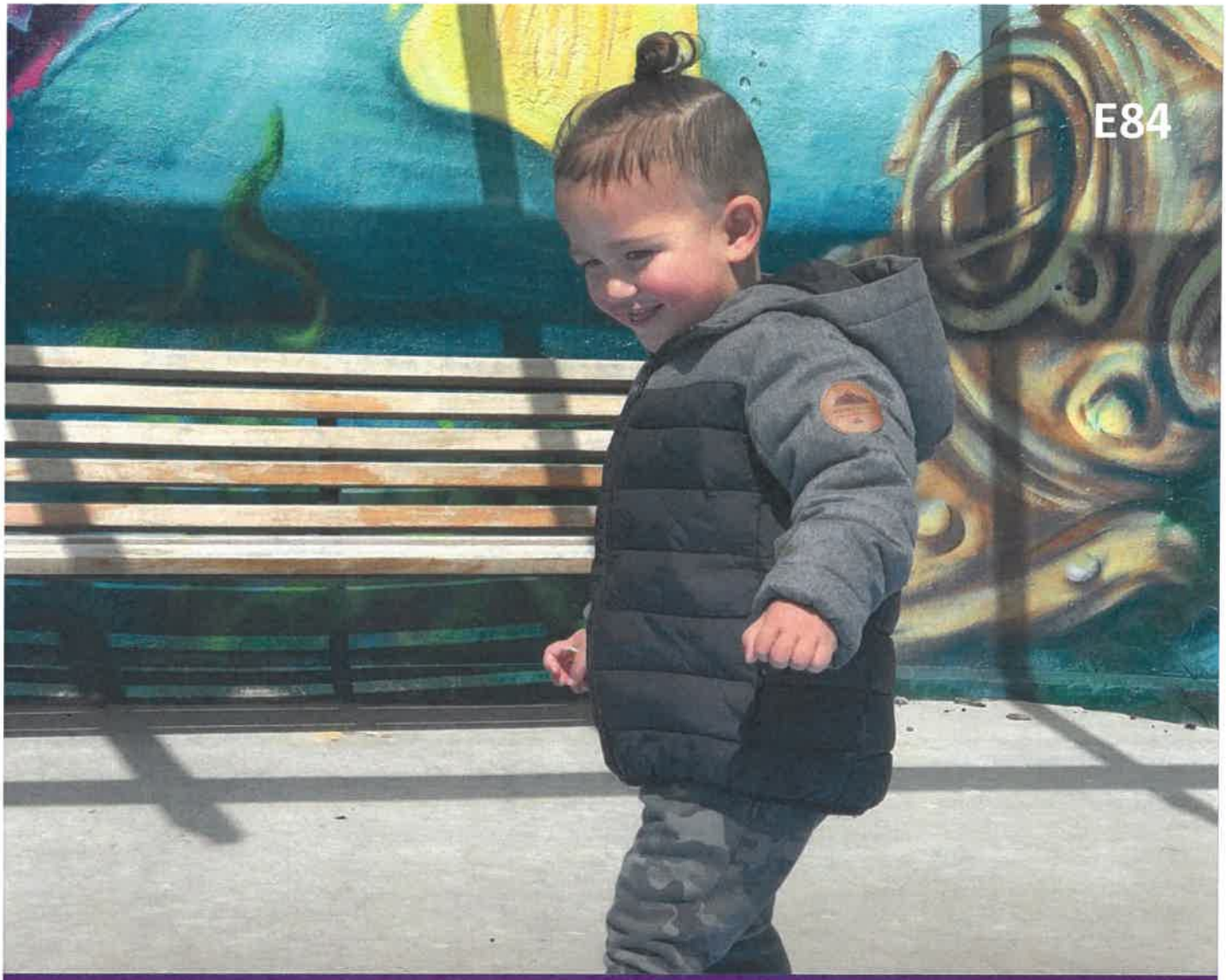


Hutt Valley District Health Board

Annual Report 2018-2019

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

HUTT VALLEY DHB

Contents

Chair & Chief Executive's Foreword

We are very pleased to present Hutt Valley District Health Board's annual report for the year ended June 2019. The Government has directed all DHBs to focus on achieving equity across our populations, the wellbeing of children, mental health and primary health care.

This report indicates our progress in relation to these priority areas. We are strongly committed to building a thriving and sustainable organisation – putting patients at the centre of all that we do, while prudently and strategically managing our resources.

The appointment of a joint Chief Executive across Hutt Valley and Capital & Coast DHBs will assist both Boards to drive a joint strategic vision and will result in improved services and health outcomes for both populations. CCDHB and Hutt Valley DHB have already entered into a collaborative sub-regional clinical planning process, and a wider joint planning work programme, which will inform our collaborative long-term investment plan.

Our Vision for Change describes the future direction for our DHB, and the following six priority areas indicate the approach we will take towards delivering on the Government's over-arching priorities for New Zealanders:

- Supporting people to live well
- Shifting care closer to home
- Delivering shorter, safer, smoother care
- Creating an adaptable workforce
- Effective commissioning, and
- Smart infrastructure.

We are making real progress in many of these areas.

Being People Focussed

Our Choosing Wisely campaign has been heavily promoted throughout the hospital community. It is a way of thinking –that empowers our patients to ask the right questions and be informed consumers of our services. We are very proud of the way this is being championed by our clinicians, because it leads to better outcomes for patients.

We have reshaped our organisational values based on staff and patient feedback. We are now implementing values-based recruitment and have developed a welcome programme for new staff to attend and understand from the beginning of their journey what our values in action mean.

Planning for the Future

We have spent a lot of time this year looking ahead and are proud to have created Our Wellbeing Plan to guide our decision makers, our work and our investment as a DHB. This plan signals to our partners, providers and our community our intention to champion wellbeing in our community. We want to make a collective impact, doing so with our partners, and we are committed to playing a key role in driving this way of working to achieve wellbeing in the community.

We completed Our Clinical Services Plan in the last financial year. This plan defines the changes we need in our model of care over the next five to ten years and was developed through extensive engagement across the health system involving clinicians, managers, community stakeholders, NGOs and consumers. The plan is now being implemented.

Over 2018/19 we developed and launched Te Pou Amorangi, Hutt Valley DHB's Māori Health Strategy to 2027, which details our commitment to improving the health of Māori and eliminating inequity for Māori. We also developed and launched Future Pharmacist Services 2018–2023, a five year pharmacy services strategy for the Hutt Valley. Living Life Well, our 3DHB Mental Health and Addictions Strategy 2019-2025, was also launched in 2019.

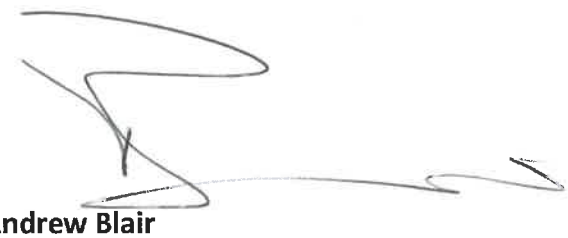
During the last year we have started the work to update our Pacific Health Action Plan. This is a key strategic document that aims to define the pathway to improvement in the health status of Pacific people and reduce health inequities through a focus on addressing the underlying social determinants of health, including income, employment, housing, and education.

Very good progress was made towards contributing to a health literate and enabled population. The Health Care Home is a patient-centred model of care being rolled out across the Hutt Valley. Nine general practices have adopted the model, representing approximately 54 percent of Hutt Valley DHB's 'enrolled population' (those enrolled with a general practice). This is the future model of care for general practice and we are pleased to see the roll out progressing.

We are also working closely with Central Region DHBs – and Capital & Coast DHB in particular - to plan and coordinate our services across Wellington, Kenepuru and Hutt Hospital. Joint hospital network planning will ensure the effective use of our combined facilities and workforce. This work is also contributing to a bigger programme of work – a joint 2DHB Long Term Investment Plan – to identify the investments needed to ensure both organisations have the assets needed in the future to manage growing demand and achieve our strategic objectives.

Our Financial Performance

Our financial performance showed a $1.4 million deterioration on the previous year, with a $8.3 million deficit (excluding one off exceptional items) affected by the additional costs of delivering care to more people. This was a reasonable result considering the cost of industrial action and other cost pressures. However, we are committed to improving our financial position so we can invest in the services our population will need in future.



Andrew Blair
Chair, Hutt Valley DHB

Fionnagh Dougan
Chief Executive, Hutt Valley DHB

About Hutt Valley District Health Board

What we do

The Hutt Valley District Health Board (DHB) is one of twenty DHBs in New Zealand charged by the Crown with improving, promoting and protecting the health and independence of their resident populations. Like all DHBs, we receive funding from the Government to purchase and provide the services required to meet the health needs of our population and we are expected to operate within allocated funding.

In accordance with legislation and government objectives, we use that funding to:

- *Plan* the strategic direction of our health system and, in collaboration with clinical leaders and alliance partners, determine the services required to meet the needs of our population.
- *Fund* the health services required to meet the needs of our population and, through collaborative partnerships and performance monitoring, ensure these services are safe, equitable, and effective.
- *Provide* a significant share of the specialist health and disability services delivered to our population, and to the population of other DHBs, where more specialised or higher-level services are not available.
- *Promote* and protect our population's health and wellbeing through investment in health protection, promotion and education services and delivery of evidence-based public health initiatives.

While Hutt Valley DHB is the lead provider of health services for the people of the Hutt Valley, it shares this responsibility with Primary Healthcare Organisations (PHOs), the Accident Compensation Corporation (ACC), and Non-Government Organisations (NGOs). This means there are health services provided in the Hutt Valley that are not commissioned by the DHB and this creates a requirement to build local partnerships and an integrated health system response by working with all of these partners, including local Māori, social sector agencies, and councils.

Our vision and values

Our vision for the Hutt Valley is: *Healthy people, healthy families and healthy communities (Whānau Ora ki te Awakairangi).*

Our values at Hutt Valley DHB are:

- *Always caring* – We are respectful, kind and helpful.
- *Can do* – We are positive, continually learning and growing, and appreciative.
- *In partnership* – We are welcoming, we listen, we communicate clearly, and we involve others
- *Being our best* – We are innovative, professional, and provide a safe environment for staff and patients.

The Treaty of Waitangi

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. Our intention is that we will target, plan and drive our health services to create equity of health care for Māori to attain good health and well-being, while developing partnerships with the wider social sector to support whole of system change.

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through the founding document of Aotearoa, The Treaty of Waitangi. Hutt Valley DHB values the Treaty and the principles of:

- *Partnership* – working together with iwi, hapū, whānau and Māori communities to develop strategies and services to improve Māori health and wellbeing
- *Participation* – involving Māori at all levels of decision-making, planning, development and service delivery
- *Protection* – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Māori representation has been provided on Hutt Valley DHB's advisory committees and its Alliance Leadership Team. Hutt Valley DHB has also established an Iwi Relationship Board to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

Our population

Hutt Valley DHB covers the Te Awakairangi area – the Hutt Valley – and serves approximately 150,000 people. Our District Health Board covers both Upper Hutt City and Hutt City. People under 25 years of age account for 32 percent of the Hutt Valley population and those aged 65 years of age account for approximately 15 percent. The Hutt Valley's population is ethnically diverse; 17 percent of our population identify as Māori, 8 percent as Pacific peoples and 75 percent as New Zealand European, Asian and Other. 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.

An average day in Hutt Valley health

On average five babies are born in the Hutt Valley each day, 18 breast cancer screenings are carried out, 32 children are immunised, 1,870 laboratory tests are done and 284 children visit the school dental service.

In addition to this, 2,030 people are seen by a GP or primary care nurse, and 126 by a community nurse. 286 people attend outpatient clinics, 705 hours of home support are carried out, 13 people receive their annual diabetes review and 54 people get the flu vaccination.

At the hospital 131 people visit the Emergency Department and 75 patients are discharged. Each day thirteen new people access mental health support and 775 people reside in aged residential care.

The needs of an ageing population

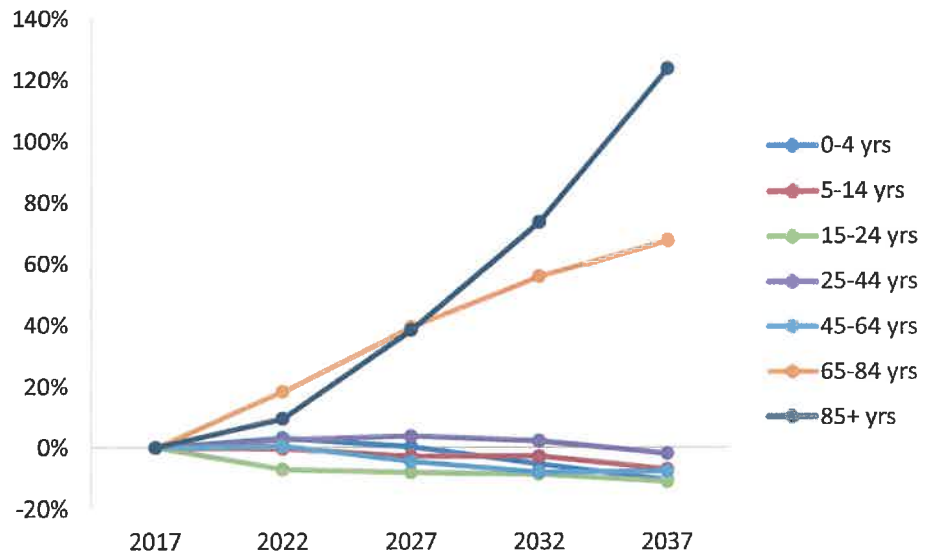
As our population ages, we are seeing more people with long-term health conditions and multi-morbidities. People are living longer than previous generations, but are living longer in poorer health.[1] This is particularly so for Māori, Pacific people, refugees, disabled people and those living with a mental illness:

> *Māori males aged 65 can expect the shortest remaining time of living without disability or long-term illness (5.5. years on average) and the highest proportion of remaining time lived with disability requiring support.*[2]

Ageing leads to a gradual decrease in physical and mental capacity and an increasing risk of age-related health conditions (often several at the same time). Old age can also be characterised by the emergence of syndromes such as frailty, delirium and urinary incontinence. Older people are not a homogeneous group and many people over the age of 65 years will continue to be active and independent members of their communities. However, as a result of increasing health and social care needs, older people generally require a far greater share of health care resources than younger people.

Our total population is not expected to grow substantially over the next 20 years (just under 5% or around 7,000 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 2038 almost one in four people will be aged over 65 years. The population aged over 80 will double. The overall number of children and working-age adults is expected to decline.

Figure 1 Hutt Valley growth by age group



Source: Statistics New Zealand population projections prepared for the Ministry of Health.

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.

[1] http://www.who.int/news-room/fact-sheets/detail/ageing-and-health Ministry of Health. 2018. *Health and Independence Report 2017. The Director-General's Annual Report on the State of Public Health.* Wellington: Ministry of Health.

[2] Associate Minister of Health 2016. *Health Ageing Strategy.* Wellington: Ministry of Health.

Persistent inequities

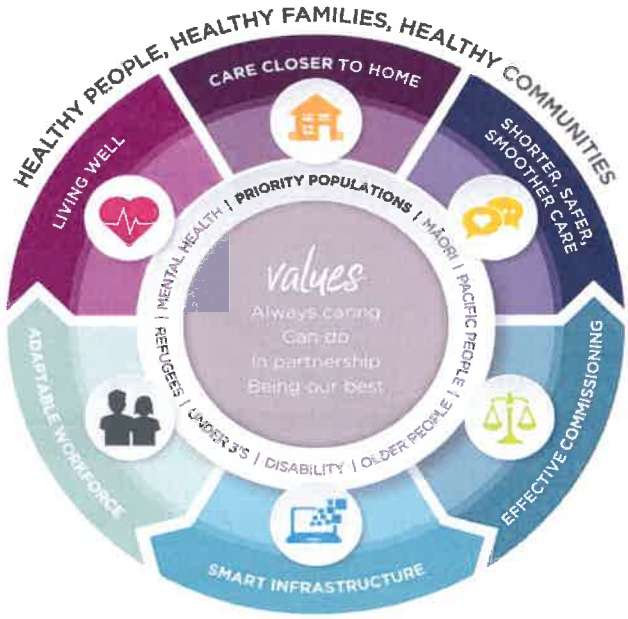
We have a significant challenge ahead to achieve the best and fairest outcomes for our population whilst responding to demographic change and other demand pressures. Some groups in our population experience unacceptable inequities in health outcomes, including Māori, Pacific people, people with disabilities or experience of mental illness and addictions, those living in socioeconomic deprivation and our refugee community.

Despite improvements in amenable mortality rates (avoidable, premature deaths), Māori and Pacific rates in Hutt Valley are still more than twice that of non-Māori and non-Pacific. In the New Zealand Health Survey, Māori and Pacific in Hutt Valley were significantly more likely than others to report an unmet need for primary health care in the last year, and we know they have higher rates of hospital admission for avoidable conditions. Hutt Valley DHB is committed to investing in services that are designed in meaningful partnership with people and whānau, so that we achieve equitable access, experience and outcomes for all people in Hutt Valley,

Our strategic framework

The growing demands and persistent inequities are challenges for us to address now and in the future. Changes are needed for us to appropriately manage and respond to the inequities and growing demand on health services. To support these changes and guide our approach over the next five to ten years, we have developed Our Vision For Change – How We Will Transform The Health System 2017-2027. This high-level strategy will help us achieve our vision of 'healthy people, healthy families, and healthy communities'. To achieve *Our Vision For Change*, our people, whānau and communities have told us the Hutt Valley health system needs to incorporate the following components.

- Care and services are organised and delivered equitably so everyone has the opportunity to achieve the same level of good health.
- Individuals and whānau are owners of their care and we involve them fully in decision-making about their care.
- Most health services focus on prevention, and health care is provided earlier and closer to people's homes.
- Urgent and complex care is readily available for episodes of ill health but most health care will be planned.
- Individuals and whānau experiences of health care is optimal, throughout their life span.
- Services are planned and delivered in partnership with local government, the wider health, social and education sectors.
- There is a clinically and financially sustainable future for our health system.



Key strategic directions and enablers have been identified to guide and support us towards creating the future health system we want. Our key strategic directions are: support living well, shift care closer to home, and deliver shorter, safer, smoother care. Our key strategic enablers are: adaptable workforce, smart infrastructure and effective commissioning.

Figure 2 on the following page shows the relationship between the Government's priorities for the health system, our vision for change and strategic objectives, how we will measure our progress and performance, and how we work to achieve our vision (our core values).

Figure 2: Hutt Valley District Health Board – Achieving Our Vision for Change

Whole of Government	**Improving the wellbeing of New Zealanders and their families**					
Health contribution	**Live longer in good health**		**Improved quality of life**		**Equity for Māori and other groups**	
Government Priorities	Strong fiscal management	Child wellbeing	Primary health care	Public health & environment	Mental health and addictions	Equitable system
Our Vision	**Healthy People** (Mauri ora)		**Healthy Families** (Whānau ora)		**Healthy Communities** (Wai ora)	
Strategic Objectives	• Services are organised to ensure everyone has the opportunity to achieve the same level of good health • Individuals and whānau are owners of their care and we involve them fully in decision-making about their care • Most health services focus on prevention, and health care is provided earlier and closer to people's homes • Urgent and complex care is readily available for episodes of ill health but most health care will be planned • Individuals and whānau experiences of health care is optimal, throughout their life span • Services are planned and delivered in partnership with local government and the wider social and education sectors • There is a clinically and financially sustainable future for our health system					
Key Progress measures[3]	- **Equity of service access and outcomes for Māori, Pacific, and low income people (across all areas)** - Financial performance - Amenable mortality rates (deaths of people under 75 years old that could be avoided)					
	- Babies breastfed at 3 months - Children fully immunized - Oral health at age five - Screening for breast and cervical cancer (& eventually bowel cancer) - Adults offered help to quit smoking		- Ambulatory Sensitive Hospital (ASH) admissions - Diabetes management - ED presentation rates per capita - Acute hospital bed days per capita - Acute readmission to hospital		- Length of inpatient stay in hospital - Time patient spend in ED - Waiting time to access mental health and addiction services - Falls in hospital - Access to electives - Patient experience in hospital	
What we're doing to achieve our vision	**Support people living well** We will work collaboratively with partners to create healthy environments, eliminate health inequities, and support people to adopt healthy lifestyles and keep well.		**Shift care closer to home** We will shift services so they are delivered closer to the people using them, so people can receive most of their (non-complex) care within their community or homes.		**Deliver shorter, safer, smoother care** We will coordinate and streamline patient care, so that individuals and whānau experience a shorter, safer and smoother journey through our services.	
	Adaptable Workforce We will create a work environment for staff that values what they do, nurtures skill development and provides the culture for them to be their best and provide quality care. We will have a well-trained and engaged workforce that is adaptable with a diverse skill mix.					
	Effective Commissioning We will ensure our commissioning is informed by evidence to achieve the best health outcomes for individuals and the population, support the elimination of health inequities, and improve people's experience of care.					
	Smart infrastructure We will create a digitally-enabled health system that supports people to stay well, and shares information and care plans for better tracking of care. We will use data to understand people's needs and drive people-focused services. Our hospital facilities will be designed for complex care, and networked with other hospitals.					
How we work	Always Caring	Can Do	**Our Values**	In Partnership	Being Our Best	

[3] We have chosen some key progress measures to closely monitor the progress we are making towards *Our Vision for Change*. However, it should be noted that we use a number of additional measures to monitor the quality of our service, which cover service access, safety, equity, efficiency, timeliness, outcomes, and patient experience.

We have developed a number of plans to support us to meet the challenges ahead and achieve Our Vision for Change. Together these plans reflect our Hutt Valley DHB's strategic framework (see below).

Figure 2 Hutt Valley DHB's Strategic Framework

- Our Clinical Services Plan 2018-2028 provides an outline of how we will need to reconfigure our clinical services over the next 5-10 years to address growing health demands.
- Our Wellbeing Plan: A Thriving Hutt Valley focusses on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that impact our physical and mental wellbeing.
- Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy to 2027, 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.
- Our Pacific Health Action Plan aims to improve Pacific health and reduce health inequities through four priorities focus areas: child health, health literacy, access to care, and workforce capacity.
- Living Life Well, our 3DHB Mental Health and Addictions Strategy 2019-2015, sets the direction for mental health and addiction care to improve outcomes for our people, their whānau, and our wider communities.

The work of implementing our strategic plans has begun, on top of the business as usual work, and we are developing and progressing work programmes to drive the changes we need to make. As well as changes to our own services, we are also working closely with Central Region DHBs – and Capital & Coast DHB in particular - to plan and coordinate our services across Wellington, Kenepuru and Hutt Hospital. This work is contributing to a bigger programme of work – a Long Term Investment Plan – to identify the investments needed to ensure these hospitals have the assets needed in the future to manage growing demand and achieve our strategic objectives.

Activities & Outcomes

Our progress

This section outlines what we've done under the three key strategic directions in *Our Vision for Change*. It also outlines what we're doing in terms of building our three key strategic enablers.

SUPPORT PEOPLE LIVING WELL

Supporting people living well means:

- We invest in helping people and whanau 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
- We work collaboratively with partners and other sectors to create healthy environments for all.

Māori Health Strategy - Te Pae Amorangi

We've developed and launched Te Pae Amorangi, Hutt Valley's Māori Health Strategy to 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.

There is considerable goodwill and knowledge around equity and Māori health across the system. Te Pae Amorangi will help us turn the goodwill into practical changes that make a difference. We know, for instance, there is a need to grow our Māori workforce and continue initiatives to address institutional racism and develop a workforce that is responsive to Māori. We also need better data to underpin our decision making for commissioning services, and to monitor the purchase of services so they support equity and contribute to the achievement of better health outcomes for Māori. We will work in partnership with the community, including Iwi, Whānau Ora providers, Māori communities, primary health organisations and NGOs to develop shared goals and work together to achieve equity and Māori health outcomes.

Mental Health and Addictions Strategy

To support a planned approach to the delivery of mental health and addiction services over the next five years, in May 2019 we launched 'Living Life Well', the 2019-2025 Mental Health and Addictions Strategy for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards. This strategy was developed after a significant amount of planning, consultation and discussion with stakeholders across the three DHBs. The strategy was also produced with the 2018 Government Inquiry into mental health and addiction in mind, and

its strategic direction and focus areas were reviewed to ensure that they were in line with the Inquiry recommendations.

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 co-design approach is being applied to implement the strategy. A work programme is being 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.

In May 2019 the Government released its response to the recommendations made in He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. The Government has accepted, accepted in principle, or agreed to further consideration of 38 of the 40 recommendations of the Inquiry Panel. 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.

Our Wellbeing Plan

In August 2018 we launched Our Wellbeing Plan for the Hutt Valley. This plan focusses on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that affect wellbeing in the Hutt Valley. Key focus areas of the plan are: wellbeing at work, housing, healthy lifestyles and physical activity, alcohol and other drugs, tobacco, and tamariki and whānau with complex social needs. Initiatives will be targeted to Māori and Pacific, as these populations are disproportionately represented in wellness statistics.

We've began to progress implementation of the plan. The initial focus has been on building relationships with internal and external partners, ensuring a collaborative approach to the development and implementation of the Wellbeing Plan work programme.

Tobacco Control Action Plan

We've developed a two year Tobacco Control 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 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.

Sudden Unexpected Death in Infancy (SUDI)

We contract with local Māori health providers to deliver safe sleep devices to at-risk whānau across the Hutt Valley. Our providers use locally woven wahakura (flax bassinets for infants) where possible rather than purchase plastic pods. Kokiri Marae has also been contracted to provide a safe sleep coordination service, working with midwives, general practices and other key stakeholders to support safe sleep education across the Hutt Valley.

Reduced the cost barrier for medications

To reduce the cost barrier of medications, we've implemented a new service in community pharmacies for people with long term conditions on multiple medications. Some people were avoiding picking up all of their prescription items due to the high cost of collecting multiple medications. To help address this situation, we've worked with pharmacists to establish a more flexible weekly payment system, so that people with

long term conditions on multiple medications can now receive their medications straight away. The service has been targeted in a way that is consistent with findings from the New Zealand Health Survey, which shows that unfilled prescriptions due to cost particularly affect Māori and Pacifica, and those living in the most deprived neighbourhoods.

Ageing Well Programme

We've contracted with Wesley Community Action to provide an Ageing Well Programme. This is a 10-week programme for groups of older people experiencing loneliness and isolation and who may also be experiencing some cognitive decline. The Ageing Well programme has been developed to be inclusive of older Māori and Pacific people. The groups do activities like making crafts for others in the community, going on outings, doing gardening, and hearing from visiting guest speakers. As well as a focus on older people, part of the. The course has a real focus on helping people to build new friendships. After the course is over, the group moves to join the Ageing Well coffee group from which they can continue to build on their friendships they have made.

Bowel, breast, and cervical screening

Screening and early detection of cancer gives people the best chance of successful treatment. We've 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're continuing to focus the programme on improving participation for priority populations.

We're 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.

We've been data matching with general practices to identify women who haven't 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're 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're 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 draft 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.

Tu Kotahi Māori Asthma Trust PJs initiative

Hutt Valley DHB and Tu Kotahi Māori Asthma and Research Trust worked together to collect and distribute warm pajamas to tamariki, pepi and whānau during the winter period. Tu Kotahi are leaders in respiratory services and are well-respected across the community and with whānau. They also provide Well Homes services and have a wide reach into the community.

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 Child Oral Health Service provides free community-based dental services to children across the Wellington region. The service operates from 13 fixed sites in the community, and it also has 12 mobile clinics that travel to the majority of primary schools across the region. While the service has good coverage, it continues to use new approaches to increase access so that all children receive dental care. This year the service was provided with an additional mobile dental van, which means an additional 3600 children will be seen in the school environment each year.

The Regional Child Oral Health Service has an Early Intervention Team that provides oral health checks to pre-school children at 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. During the last year, the team introduced a pre-visit to early childhood centres to familiarise and socialise the children to its staff and provide information to teachers and parents. This is designed to build understanding and increase the effectiveness of the free oral health checks.

Other initiatives include the introduction of digital radiography (which enables point-of-care diagnosis and care planning for all our children), 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 its 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

Our Sustainability Committee continues to support the organisation to make positive changes that reduce carbon emissions and improve recycling.

Changes already made include purchasing 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 hospital cafeteria, which complements our healthy food and drink (water only) policy. We're 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). All these changes mean we will be sending 94,000 fewer plastic containers to landfill each year.

We're steam-cleaning all clinical areas of the hospital and eliminating chemical cleaners. We've replaced thirty hospital fleet petrol vehicles with more environmentally friendly hybrids. Finally, Hutt Valley DHB applied and to become a member of CEMARS (Certified Emissions Measurement and Reduction Scheme) and is committed to lowering its greenhouse gas emissions.

Progress Measure	Baseline	Target 2018/19	Actual 2018/19	Trends – including equity gap [4]
Amenable mortality rates (rate per 100,000)	Deaths in 2011-2015:[5] Total: 97 Māori: 167 Pacific: 136	Māori: 162 Pacific: 132	Deaths in 2012-2016: Total: 94 Māori: 175 Pacific: 147	Exceeded targets significant ethnicity equity gap remains.
Babies breastfed at 3 months	2017/18: Total : 55% Maori: 46% Pacific: 56%	≥70%	Total : 54% Maori: 46% Pacific: 43%	Total performance has decreased, but Māori static. Large decrease for Pacific
Children fully immunized at 2 years	2017/18: Total: 91% Māori: 90% Pacific: 94%	≥95%	Total: 92% Māori: 88% Pacific: 91%	Target not met. Our rates are consistent with a national trend of reducing rates, which is in part due to immunisation receiving negative publicity.
Children with no cavities at five years of age	2017: Total: 66% Māori: 50% Pacific: 52%	68%	2018: Total: 63% Māori: 47% Pacific: 47%	Target not met. Performance deteriorated in this measure over the last year.
Average number Diseased Missing and Filled Teeth (DMFT) at age 5	2017 Total: 1.29 Māori: 1.97 Pacific: 2.38	Reducing trend	2018 Total: 1.04 Māori: 2.09 Pacific: 2.55	There has been an overall improvement in this measure however scores for Maori and Pacific children have deteriorated.
Reduced burden of tooth decay at year 8 (DMFT	2017 Total: 0.67 Māori: 0.99	Reducing trend	2018 Total: 0.65 Māori: 1.01	Although there is an improvement for the total population the position for Maori and Pacific children has deteriorated.

[4] This is an assessment on whether the overall trend is improving, declining, or static, and whether the gap between Māori, Pacific, and other ethnicities is reducing, growing, or static. Red background represents a concerning trend, orange a trend we need to monitor closely, and a green represents a positive trend.

[5] Note: baseline rate is calculated from data available for 2018 (deaths in 5 year period 2011-2015), and actual 2018/19 rate is from the most recent report of 2016 data (deaths in 5 year period 2012-2016). There is currently a time lag for reporting of mortality data so the mortality rate for deaths in 2017-2021 will not be reported until financial year 2023/24.

Progress Measure	Baseline	Target 2018/19	Actual 2018/19	Trends – including equity gap [4]
	Pacific: 0.97		Pacific: 1.02	
Women screened for cervical cancer	2017/18: Total : 67% Māori: 70% Pacific: 75%	>80%	Total : 76% Māori: 68% Pacific: 69%	Did not meet target, Total rates increased but Māori and Pacific reduced.
Women screened for breast cancer	2017/18: Total : 72% Maori: 69% Pacific: 68%	>70%	Total : 75% Maori: 69% Pacific: 69%	Total improved but Maori static with some improvement for Pacific.
PHO enrolled patients who smoke and are offered help to quit	2016/17: Total: 94% Māori: 92% Pacific: 92%	≥90%	Total: 91% Māori: 91% Pacific: 90%	Rates have reduced slightly but remain above target.
Hospital patients who smoke and are offered help to quit	2017/18: Total: 83% Māori: 81% Pacific: 91%	≥95%	Total: 91% Māori: 91% Pacific: 89%	Target not met. Following concerted efforts rates are on the rise except for Pacific
% of babies living in Smokefree homes at 6 week check[6]	Dec 17 Total:79% Māori: 59% Pacific: 68%	Improved performance	Dec 18 Total: 64% Māori: 44% Pacific: 56%	The ministry has revised how they collect this measure which accounts for the change in rates.
% of eligible population having CVD risk assessment in last 5 years	2017/18: Total: 85% Māori: 82% Pacific: 85%	≥90%	Total: 82% Māori: 80% Pacific: 83%	Not meeting target and performance reducing across all ethnic groups especially Pacific

In our SOI measures we had included staff and patient satisfaction with the health passport this survey is no longer collected. We also included an aim to reduce the burden of obesity for adults and children data at a DHB level for this is not available.

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.

[6] This measure replaces Mothers smokefree at 2 weeks postnatal which is no longer provided by the ministry of health

Improved access to general practice

All general practices in the Hutt Valley district have adopted the Government's new primary care initiatives. These initiatives include extending free general practice visits, along with exemption from the standard $5 charge per prescription item, for children under 14. The changes also include free visits to after-hours clinics and injury-related visits covered by the Accident Compensation Corporation.

The cost of GP visits for Community Services Card holders is now lower. People with a Community Services Card and their dependents aged 14 to 17 years who are enrolled with a general practice pay less for their visits to see a doctor or nurse. Patients with a Community Services Card who attend After Hours will be charged the normal co-payment (with the exception of children under 14 who will be free).

Health Care Homes

We've enhanced primary care by progressing the Health Care Home (HCH) patient-centered model of care across the Hutt Valley. 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, the evaluation of the model is promising and suggests that a significant proportion of acute need is being prevented or successfully dealt with out of hospital by HCH practices.[7]

Nine general practices have adopted the HCH model, representing approximately 54 percent of Hutt Valley DHB's 'enrolled population' (those enrolled with a general practice). These practices have a new triage service, where patients calling the practices first thing in the morning may talk directly to a general practitioner or nurse. Talking to a health professional means some issues may be resolved over the phone, saving people the time and hassle 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. Implementation planning is progressing with other practices expected to adopt the HCH model in 2020.

Specialist support for general practice

We've improved patient care in the community by setting up a standardised process where general practice staff can phone a senior medical specialist for urgent (same day) advice. This is now available for diabetes, respiratory, rheumatology, cardiology, palliative care and paediatrics. Work is progressing to expand this service to other fields. We've also developed and implemented a standardised process for general practice staff to access non-urgent advice from a medical specialist (within 1-3 days). This process has been established for diabetes and respiratory services. Work is underway to expand the model to cardiology, rheumatology, mental health and general medicine. 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.[8]

Better management of acute respiratory events in the community

A new model of care has been developed to better manage acute respiratory events in the community. Under the new model, patients with respiratory problems have a plan for accessing urgent (acute) medical services in the community when needed (via an ambulance and primary care pathway). The plan will include techniques and tools the patient can use to help manage an acute episode. The plan also records what is 'normal' for the patient, which has been proven to be extremely useful for ambulance staff when determining an appropriate response. The model has been incorporated into our planning for the winter period when hospital demand peaks. In autumn, general practices are sent a list of their patients who had two or more presentations to the emergency department for acute respiratory / breathing problems in

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[7] *Health Care Home evaluation - updated analysis, April-September 2017.* Auckland: Ernst & Young, 2018.

[8] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), *Shifting the balance of care: great expectations.* Research report. Nuffield Trust.

preceding 12 months. General practices can then work with these patients to develop a care plan for them. Emergency department presentations have been avoided because patients are able to manage their condition in partnership with their general practice, using back-pocket prescriptions and access to immediate advice and support.

Primary Options for Acute Care

Primary Options for Acute Care (POACs) are funded packages of care or interventions that enable acute conditions to be managed in the community rather than the hospital. We've expanded POACs to support more acute conditions to be managed in the community through clinical pathways. POACs are used for deep vein thrombosis, cellulitis, acute urinary retention, acute asthma, renal colic, headache/migraine and dehydration.

Pilot to improve the management of gout in primary care

We've started a pilot to reduce the impact of gout, which predominantly affects our Māori and Pacific communities. This is a joint effort between the Whai Oranga Health Centre in Wainuiomata and Arthritis New Zealand, with the support of community pharmacies and Hutt Valley DHB.

Whai Oranga Health Centre patients who have previously been prescribed but not collected a prescription for their gout prevention medication for more than 6 months are invited to an education session with supper provided. At the sessions, patients can have their uric acid tested and, where appropriate, on-the-spot prescriptions provided. Plans are being made to provide patients with more convenient access to their medications, ongoing monitoring and education by practice nurses and community pharmacy by using 'standing orders'.

The pilot is relatively low cost but has the potential to deliver significant benefits. By improving health literacy around the use of medications to manage gout, the pilot has the potential to avoid the disabilities associated with acute flares of gout and the potential co-morbidities associated with poorly controlled gout. It could also be highly cost-effective by avoiding presentations to ED and acute demand in primary care, and reducing admissions to hospital and length of hospital stay. It also provides an opportunity to screen these patients for diabetes and cardiovascular risk (with the potential for on-the-spot cholesterol and blood sugar tests). If the pilot proves successful, we will look to expand the model into other communities.

Home and Community Support Services

In April 2019, the DHB begun a new contract with Access and Nurse Maude for home and community support services. As a result, people over 65 years old now have a choice of two providers in the Wellington region (Capital & Coast and Hutt Valley DHBs) for home and community support services. Moving from one to two providers has been a significant transition with the division of almost 4,000 clients and 750 support workers amongst the two providers. Both providers and the two DHBs have worked collaboratively through this transition.

Falls prevention and management

We've 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.

Patient: "The medical staff, both occupational therapists and physiotherapists, all worked exceptionally well together. It was not until I got home that I found out how well prepared I was."

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. Our services are tailored to people across the life course, including maternal, child, youth, and family mental health services.

We fund Hutt Women's Centre to provide maternal mental health care to assist support women with mental health needs. We also fund Nāku Ēnei Tamariki to provide an intensive community-based maternal mental health and social support service targeting Māori, Pacific, and low income pregnant women, new mothers, and their whānau.

Through Atareira we provide and deliver an 8 week community based children's programme called 'Children Understanding Mental Health' for approximately six young people aged 8 to 12 years once a term. The programme is delivered by a trained counsellor who is able to see the children individually if needed. During the 8 week programme families are contacted weekly and if they identify they have their own support needs, they can be referred to Atareira's Hutt Valley family/whānau worker.

In 2019 the Piki pilot was launched. This initiative provides free mental health support to young people (aged 18-25 years old) with mild to moderate mental health needs across Hutt Valley, Capital & Coast, and Wairarapa DHBs. This initiative aims to intervene early to support good mental health and wellbeing. It is designed to strengthen other existing services and expand access options and the range of therapies available for young people.

Our Occupational Service assists people with mental health or addiction needs to find and keep employment. The road to recovery for a person affected by mental health illness or addictions can be hindered by long-term unemployment. The Occupation Service works with housing and recovery services, and inpatient and rehabilitation care services, to assist mental health service users attain their vocational goals. We also fund a dedicated housing co-ordination service to assist people with mental health or addiction needs overcome housing issues and sustain secure housing.

Over the last year, we've also worked with local council to deliver 'mental health 101' training sessions for key stakeholders around suicide prevention and supporting first symptoms of mental health. These training sessions better equip community-based workers and volunteers to engage with people experiencing mental health difficulties.

Rheumatic Fever Prevention Programme

We're continuing to implement the Rheumatic Fever Prevention Programme to reduce cases of rheumatic fever in the Hutt Valley. Rheumatic fever can develop after a 'strep throat' – a throat infection caused by a Group A Streptococcus bacteria. Most strep throats get better and do not lead to rheumatic fever. However, in a small group of people an untreated strep throat leads to rheumatic fever one to five weeks after a sore throat. This can cause the heart, joints, brain and skin to become inflamed and swollen.

Hutt Valley is one of ten regions in New Zealand with a high incidence of rheumatic fever, and Māori and Pacific children and young adults have the highest rates. It is highly likely that a combination of crowded housing conditions and socio-economic deprivation, barriers to primary healthcare access, and the

subsequent higher burden of untreated strep sore throat infections, are important factors leading to higher rates of rheumatic fever among Māori and Pacific people.

Under the Rheumatic Fever Prevention Programme, children with sore throats are assessed and treated, as appropriate, on the day they present. There are eight general practices and 16 pharmacies actively engaged in the programme. Targeted resource material has been developed and distributed, with support from community providers, to promote sore throat and rheumatic fever awareness – causes and prevention. There are strong links between the Rheumatic Fever Prevention Programme and the Well Homes programme. A combined Well Homes and Rheumatic Fever Governance Group meets quarterly to oversee implementation of the programme.

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 Midwives Team runs a midwifery drop-in service, called Hapū Ora, at Tamariki Ora/Waiwhetu Medical Centre. This was set up in partnership with Māori in an effort to reduce inequity for our Māori wāhine and whānau. Hapū Ora provides wrap-around care for pregnant women - many of whom have complex social needs - in partnership with other relevant health and social services.

Hutt Valley DHB also established a presence at the local Te Rā o Te Raukura cultural festival in February 2019. 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. 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.

Progress Measure	Baseline	Target 2018/19	Actual 2018/19	Trend – including equity gap
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	12 Months to June 2018: Total: 9,106 Māori: 10,451 Pacific: 12,692	Total: ≤ 8,650 Māori: ≤ 10,091 Pacific: ≤10,899	12 Months to June 19: Total: 8,354 Māori: 10,517 Pacific: 14,369	Target achieved for total, but significant equity gap remains. Māori and Pacific rates have increased.
ASH Rates (avoidable hospitalisations) for 45-64 years	12 Months to June 2018: Total: 4,758 Māori: 8,408 Pacific: 7,117	Total: ≤3,948 Maori: ≤6,080 Pacific: ≤7,104	12 Months to June 19: Total: 4,840 Māori: 7,928 Pacific: 9,561	Not Achieved. Total and Pacific rate increasing but Maori rate has decreased
Well managed diabetes in primary care	2017/18: Total: 55% Māori: 50% Pacific: 48%	≥70%	Total: 57% Māori: 46% Pacific: 44%	Not Achieved. Total rates have increased. Māori and Pacific have dropped.
Acute hospital bed days per capita	2017/18: Total: 347 Maori: 566 Pacific: 566	Total: 386 Māori: 542 Pacific: 596	Total: 351 Maori: 584 Pacific: 577	Target met for total and Pacific. Total acute hospital bed days per capita increased for all ethnicities

Progress Measure	Baseline	Target 2018/19	Actual 2018/19	Trend – including equity gap
Acute readmission to hospital	Year to June 2018 Total: 12% Māori: 14% Pacific: 12%	Not applicable	Year to June 2019 Total: 13% Māori: 14% Pacific: 13%	Acute readmissions to hospital have been relatively static over last year three years. The national average standardised rate is 12%.
Acute readmission to hospital Age 0-4	Year to June 2018 Total: 15% Māori: 15% Pacific: 12%	Not applicable	Year to June 2019 Total: 15% Māori: 14% Pacific: 15%	Acute readmissions to hospital have been relatively static over last year three years. The national average standardised rate is 13%.
PHO Enrolment	July 2018 Total: 98% Māori: 89% Pacific: 98%	Increased enrolment	July 2019 Total: 98% Māori: 91% Pacific: 98%	Enrolment rates are static with an improvement for Maori
Newborn PHO enrolment	June 18 67.9%	Increased enrolment	June 19[9] 75.2%	The Newborn enrolment rate has improved
Proportion of dispensed Asthma medications that were preventer rather than reliever	2017/18 55%	Increasing trend	2018/19 55%	There has been no change in the proportion of preventers
Cancer Mortality	2015 277	Decreasing trend	2016[10] 286	The number of deaths from cancer has not changed significantly in the last 5 years
Decrease in hospitalisation for cardiovascular disease	2017/18 Total: 1,694 Maori: 257 Pacific: 123	Decreasing trend	Total: 1,738 Maori: 212 Pacific: 156	Hospitalisations for the total population and Pacific have increased whilst they have fallen for Maori however these changes are not significant
Decrease in hospitalisations for Chronic Obstructive Respiratory Disease	2017/18 Total: 370 Maori: 86 Pacific: 36	Decreasing trend	Total: 364 Maori: 102 Pacific: 39	Overall hospitalisations are down with a small rise for Pacific and higher for Maori however these changes are not significant

[9] Ministry does not publish newborn enrolment rates with an ethnic split by DHB
[10] Latest information available

DELIVER SHORTER, SAFER AND SMOOTHER CARE

Shorter, safer and smoother care means:

- People and whanau can communicate with a wider range of health providers electronically
- Patients, their whanau 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 whanau
- 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.

Choosing Wisely

We've embraced the Choosing Wisely campaign, which promotes a culture where patients and health professionals have well-informed conversations around their treatment options. This leads to improved health literacy and a better understanding of what really matters to patients, as well as better decisions and improved outcomes (and where low-value and inappropriate clinical interventions are avoided).

Patient: "I had excellent care and support. I was consulted each step of the way. Explanations were given as to the best treatment options."

Red2Green Initiative (improving patient flow)

We've implemented a 'Red2Green Initiative' in the Medical Ward at Hutt Valley Hospital to improve efficiency and avoid wasting the patient's time. Under this initiative, delays in patient care are monitored using a simple measure, where a 'red' bed day is a wasted day for hospital patients and a 'green' bed day is a productive one. Red days are when a patient does not receive all their planned value-adding care. Green days are when everything that had been planned for the patient occurs without delays. Red2Green helps find the reasons why there are delays in care so they can be addressed, through applying quality improvement methods or changing systems. Getting accurate data on the number of red days, and why they occurred, will help clinicians and managers clear the blockages and improve care.

Smooth Sailing

The Smooth Sailing project is focused on improving patient flow from our Emergency Department into the General Medicine service at Hutt Hospital. It also seeks to improve the flow of patients through our Medical Ward and our Medical Assessment and Planning Unit.[11] Under the Smooth Sailing project, clinicians are encouraged to actively 'pull' medical admissions from ED and accept early referrals for patients that clearly need admission into the hospital.

[11] The Medical Assessment and Planning Unit is a 16 bed unit for acute medical patients. The unit accepts patients presenting from the Emergency Department. The unit consists of a multidisciplinary team and provides rapid access to in-patient medical assessment, decision-making and treatment.

Elective surgical services

We've continued to improve access to elective surgery services, with 6,238 elective surgeries performed for Hutt Valley residents in 2018/19. To plan for the forecast demand in surgeries, we have initiated Theatre Optimisation Project to examine how we can further improve theatre efficiency and capacity. The project includes roll-out of an electronic theatre booking system to replace manual processes and the development and assessment of options to improve theatre efficiency and meet the forecast demands on services in the coming years.

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.[12] 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.

Winter Surge Planning

We've developed a winter plan for the DHB to ensure we proactively manage demand over the busy winter flu season. The plan includes a range of actions across the system to address, plan for, and manage the increased demand experienced over the winter period. An operational committee from across primary, community, and hospital care meets to oversee the plan and monitor surges in demand. We've also developed a system-wide surge monitoring framework to closely monitor demand and capacity throughout winter periods.

Health Pathways

We've improved consistency of best practice care, and seamless referral between services, by making it easier for primary care clinicians to access best practice online advice, based on local clinical and service pathways. Health Pathways are localised to each DHB and provide an electronic best practice clinical pathway for primary care. Pathways for more than 440 conditions are now live. Recent pathways have been developed for intimate partner violence, sexual assault, dehydration in adults, hypertension, unintentional weight loss in adults, excess weight in children, measles, and night sweats. Multiple pathways are also under development.

Improved care for frail and elderly patients

Our Emergency Department has introduced an electronic screening tool to identify frail patients early and provide them with appropriate care and support, including activities to reduce deconditioning (loss in muscle strength). We've introduced initiatives such as communal table to help patients socialise, with a focus on getting them up and dressed in their own clothes to help boost their recovery.

Our Older Persons and Rehabilitation Service (OPRS) has also embraced the 'Live Stronger for Longer' campaign, which offers practical advice, information and resources for over 65s, and those who care for

[12] The Safe Staffing and Healthy Workplaces Unit sits within District Health Boards New Zealand and is part of a collaborative agreement between the New Zealand Nurses' Organisation and the DHBs.

them. OPRS also has a 'Close Care' programme for older patients with mental health or neurological conditions, such delirium or dementia, encouraging engagement and activities. OPRS is also piloting animal assisted therapy pilot with a Labrador to support stroke rehabilitation. The pilot scheme is one of the first to have been undertaken in New Zealand and is showing promising results for patients.

A new programme called 'Whānau as Partners' has been developed at Hutt Hospital to encourage family/whanau to help with care for their loved one while they are in hospital. A familiar face can help them feel safe and experience less anxiety. The programme has received positive feedback from whānau, patients and staff.

Early recognition and response to patient deterioration

Hutt Valley DHB has implemented the National Early Warning Score (EWS) in all adult inpatient areas of Hutt Hospital. EWS is part of a Health Quality and Safety Commission initiative and will ultimately be used throughout New Zealand hospitals to standardise how we detect, manage and communicate about patient deterioration.

We also have a 'Patients at Risk' service to support hospital staff in providing the best care to patients and, when necessary, quickly identify and respond to patient deterioration. The service comprises four experienced nurse specialists who walk the wards, check in with the nurses on duty, and offer support, education and coaching for health care professionals who are delivering patient care or planning care needs. The ethos of the service is always to be proactive, and help staff recognise a patient at risk before they deteriorate. The service operates 365 days a year.

Shorter, safer and smoother care for people with mental health or addiction needs

Te Whare Ahuru Reconfiguration

We're continuing to work with our sub-regional DHB partners (Capital & Coast and Wairarapa DHBs) to modernise and reconfigure Te Whare Ahuru, an acute mental health inpatient service located on the Hutt Hospital campus that services the Wellington region and the Wairarapa.[13] Te Whare Ahuru was opened in 1997 and requires reconfiguration and upgrading to ensure we deliver culturally safe and best practice clinical care in the future. As part of the first phase of this project, we undertook a co-design process that included input from mental health clinicians, other health service providers, iwi and Māori health providers, consumers, their families and whānau. We then worked with stakeholders to refine the proposal and the key design features for the refurbished facility. Phase two of the project is well advanced with several user group workshops now completed with architects to inform a preferred building option. This is a significant sub-regional project and we aim to starting the building and refurbishment process in 2020.

3DHB Mental Health Acute Care Continuum Project

Hutt Valley DHB is leading a 3DHB Mental Health Acute Care Continuum project. The project aims to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system. The design of the acute care continuum / service model has now been completed and each DHB has begun implementation planning. This includes work to improve the coordination of existing services and determining the services that need to be introduced over time in each locality, with a focus on responding to Māori mental health needs.

New Youth Respite Service

In September 2018, we opened a new Youth Respite Service in Lower Hutt for the Wellington region. Respite and recovery services offer a welcoming place for young people experiencing mental health difficulties to rest and recover in a home-like environment. Well trained staff are available 24 hours a day. Respite and recovery may be a planned break away from home, a transition from hospital, or a way of preventing further distress and avoiding admission to hospital. The service is the result of work with Capital & Coast DHB and was a co-designed with the provider and in consultation with local Iwi. The service comprises a six-bed

[13] Te Whare Ahuru Acute Inpatient Unit services three DHBs: Capital and Coast, Hutt Valley, and Wairarapa.

facility and staff will work collaboratively alongside Child & Adolescent Mental Health Services to deliver a responsive, youth-friendly, family-whānau supportive, and clinically safe environment where young people are supported towards wellness.

Wrap-around care for pregnant women

We provide a midwifery drop-in service at Tamariki Ora/Waiwhetu Medical Centre, which provides wrap-around care for pregnant women - many of whom have complex social needs - in partnership with other relevant health and social services to help mother and baby get the best outcomes.

Programme Management Office

We've established a Programme Management Office to help implement our strategic objectives and support service improvement projects across the DHB to enable shorter, safer and smoother care. In 2018/19, the Project management office has contributed to a number of service improvement projects focussed on delivering shorter, safer and smoother care. These include work on digital dental, community nursing, community integration, radiology, the Theatre Optimisation Project, and the Medical Service Improvement Plan.

Progress Measure	Baseline	Target 2018/19	Actual 2018/19	Trend – including equity gap
Length of inpatient stay in hospital (average days)	2017/18: Acute: 2.3 Elective: 1.5	Acute: 2.4 Elective: 1.5	Acute: 2.1 Elective: 1.4	Target achieved.
Time patient is in ED (discharged or transferred with 6 hours)	2017/18: 91.9%	95%	89.2%	Target not met. Performance is falling
Waiting time to access mental health / addiction services (Referred to service and seen within 3 weeks and within 8 weeks)	2017/18: 53% < 3 wks 88% < 8 wks	Targets: 80% < 3 wks 95% < 8 wks	71% < 3 wks 89% < 8 wks	Targets were not achieved but waiting times are reducing and have improved significantly.
Readmission to Mental health services within 28 days	2017/18 9.4%	<9%	2017/18 7.9%	Target achieved
Access to electives	2017/18: 105%	100%	101%	We consistently exceed the Government targets set for us to improve access to elective services.
Patient experience in hospital (Average patient score out of 10 across four domains)	2017/18 Communication: 8.8 Coordination: 8.8 Partnership: 8.9 Physical and	Average of 8.8 across the four domains	Communication: 8.7 Coordination: 8.6 Partnership: 8.7 Physical and emotional needs: 8.7	We have not met the target and performance has reduced

Progress Measure	Baseline	Target 2018/19	Actual 2018/19	Trend – including equity gap
	emotional needs: 8.9 Average of 8.8 across the			
Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	94.9%	≥85%	93%	Achieved
Age of entry into Age Residential Care	2017/18 84.54	Increasing trend	2018/19 83.46	The average age of entry was unusually high in 2017/18 but has returned to previous average in 2018/19

ADAPTABLE WORKFORCE

An adaptive workforce means:

- A health system culture that nurtures professional competence and staff wellbeing
- A well-trained workforce able to motivate and support people to stay well
- A flexible and adaptable workforce with greater diversity in skill mix
- A workforce that is technologically capable
- Different workforces take on new roles and responsibilities
- Health professionals, leaders and managers engage and collaborate in training, leadership and quality improvement activities and opportunities.

Nursing Strategy: 'Nursing at its Best'

We've launched Nursing at its Best, Hutt Valley DHB's five-year nursing workforce strategy (2018-2023). The strategy aims to ensure that all people and their families/whanau accessing health care in the Hutt Valley, will receive excellent nursing care from a competent, culturally responsive, evidence-based and person-centred workforce. We are now progressing implementation of the strategy. Key pieces of work include being progressed under the four nursing strategic priorities include:

- Nursing Workforce - implementing the Care Capacity Demand Management project.[14]
- Clinical Leadership - increasing senior nurse participation in the Professional Development and Recognition Programme.[15]

[14] Care Capacity Demand Management is a programme for matching care capacity with care demand, and aims to enable staff to provide high quality and safe care to our patients, improve the work environment and improve organisational efficiency.

[15] The PDRP provides a framework that helps nurses develop their professional practice and assist them on a career pathway.

- Education and Professional Practice - implementing the Nurse Entry to Practice (NETP) Programme.[16]
- Quality, Patient Safety and Innovation - implementing Lippincott's Nursing Procedures and Skills across the sector.[17]

Staff member: "I want to keep upskilling and learning. I feel supported here. It is like a family and I would be happy to have a family member looked after here. I love my job."

Building workforce diversity

We're building a workforce that is responsive and reflects our population. We value cultural intelligence and are working to strengthen and grow the cultural competence of our workforce. In June 2019 all 20 DHB Chief Executives committed to introducing targets for DHBs to increase Māori participation in the workforce. To meet this commitment Hutt Valley DHB will be reviewing our current recruitment policies and procedures to enhance the ability to attract, appoint and retain Māori staff. We are also developing a diversity recruitment policy to help us attract and recruit a diverse mix of staff reflective of our community.[18] This work includes the development of a sustainable Māori workforce plan and further staff development of cultural competencies, in particular Tikanga (Māori customs and traditional values) and Te Ao Māori (the Māori world).

Our Pacific Health Unit delivers cultural support through training for health practitioners within the hospital and in the community. Te Awakairangi Health[19] is also providing specific training and practical skills development relating to equity, institutional racism and cultural safety to the general practice workforce in the Hutt Valley. These activities support our collaboration with primary care partners to improve and achieve health equity and outcomes for Māori and Pacific people.

Mauri Ora - Making Wellbeing Meaningful

We've developed and launched a dedicated staff wellbeing programme, Mauri Ora, to help build a healthy workplace culture that promotes wellbeing and supports the DHB's values. Staff have been involved in the development of a Mauri Ora Action Plan, which includes a range of activities and events for staff that promote mental health and wellbeing, healthy eating, and physical activity.

Allied Health, Scientific & Technical Career Frameworks

We've collaborated with Wairarapa and Capital & Coast DHBs to develop and roll out a new Allied Health Career Framework. The framework supports the growth and development of the Allied Health workforce through developing advanced clinical and/or leadership roles with consistency across DHBs. The framework also supports services to have the optimal allied health skill mix to meet current and future patient and community health needs. Work is progressing on developing career frameworks for further Allied Health,

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[16] The NETP programme provides graduate Registered Nurses support and professional development to facilitate their transition during their first year of practice.

[17] Lippincott's Nursing Procedures and Skills provides real-time access to step-by-step guides for evidence-based procedures and skills in a variety of specialty settings.

[18] 'Diversity' can relate to culture, ethnicity gender, disabilities, and age.

[19] Te Awakairangi Health is the largest Primary Health Organisation (PHO) operating in Hutt Valley DHB. The other PHO is Cosine, which supports one general practice in Hutt Valley DHB.

Scientific & Technical professions with the initial focus on Anaesthetic Technicians, Sterile Technicians and Dental/Oral Health Therapists. This work is being done collaboratively across the Central Region DHBs and more professional groups will be progressively added to framework.

Quality and Safety Walk-Rounds

We've continued with Quality and Safety Walk-Rounds, where members of the Executive Leadership Team visit an area in the DHB to meet with patients and staff. This helps increase staff engagement and demonstrate the DHB's commitment to quality and safety for patients, staff and the public. Through structured and informal discussions, issues can be raised, good practices identified, and actions agreed to improve quality and safety. The walk-rounds have been held on a monthly basis since June 2016.

Calderdale framework for safe skills sharing and delegation

The Calderdale Framework provides a clear and systematic method of reviewing skill mix and roles within a service to ensure quality and safety for patients.[20] The framework identifies tasks that may be skill shared or delegated, and can help develop new roles and new ways of working that are safe, effective, and patient-centred. The international recognised programme has proven to increase job satisfaction and reduce patient incidents. Hutt Valley DHB has two Calderdale facilitators (and another in training). They are raising awareness and helping to deliver the foundation-stage training to DHB staff. The Central Region is committed to supporting the implementation of the Calderdale Framework and will be training two practitioner-level Calderdale experts who will be able to support our facilitators.

Emergency Management

A new Emergency Preparedness Manager has brought a change of focus for the department, building relationships with other DHB's and supporting agencies, (e.g. Wellington Region Emergency Management Office). We are sharing information and working collaboratively to ensure that the DHB is well placed to respond to a major event.

The Emergency Operations Centre (EOC) has been activated in response to the doctor's strike and other significant onsite events, which led to a review of existing response documentation and the introduction of EOC action cards. Action cards support the initial actions and decision making while under pressure.

Coordinated Incident Management Training is continuing for senior staff and a new emergency management training package is being developed for clinical staff, which will be rolled out over the next year, culminating in an Emergo Train Exercise (a simulation system used for education and training in emergency and disaster management).

[20] https://www.calderdaleframework.com/

EFFECTIVE COMMISSIONING

Effective commissioning means:

- Decisions by all those working in the system demonstrate responsible stewardship of resources
- Commissioning for outcomes – measuring against what matters to patients and whanau
- Whānau, communities and health professionals are central to allocation decisions
- Available resources achieve equitable and sustainable outcomes
- Resources are considered across the whole of system, including across the broader social sector
- 'Smart investments' are based on sharing of data and pooling of resources.

Future Pharmacist Services 2018–2023

In 2018/19 we launched a five year pharmacist services strategy for the Hutt Valley. The strategy builds on other strategic work guiding the future direction of pharmacist services, including the national Pharmacy Action Plan[21] and Integrated Pharmacist Services in the Community[22].

The health sector faces several challenges. There are material gaps in how we deliver services to meet the needs of some population groups and communities, and demand for health services continues to increase due to the growing and ageing population and the growing numbers of people experiencing long-term and increasingly complex health conditions. The Future Pharmacist Services Strategy focusses on unlocking the full potential of this highly qualified health workforce so that they can help us address the challenges we face.

We need an adaptable pharmacist workforce, where pharmacists can work in a way that better serves community needs. Changes in technology allow us to realise this vision of freeing pharmacists from the medication supply process allowing them to spend more time providing advice and information to patients. Many pharmacies are small, and appear constrained in their ability to provide higher value services.

We need to better integrate pharmacists into the wider care team including primary care, DHBs, community health, mental health and aged residential care providers. We also need more community pharmacists located where our population need is highest. Effective planning and purchasing will be important in leading pharmacists to provide the services that make the most difference to patient health.

Partnership with Iwi

We've established an Iwi Relationship Board to formalise the relationship between local Iwi and Hutt Valley DHB. Both Iwi and the DHB want to build on existing relationships, share aspirations and strategic directions, and develop a robust engagement partnership so Māori and Iwi have opportunities to engage across the DHB system.

Clinical Services Plan 2018-2028

Our Clinical Services Plan for the Hutt Valley provides a high-level understanding of our clinical needs and demands across the system over time. Analysis of the demands on the heath system in the future shows that Hutt Hospital will run out of inpatient beds if it keeps on doing things the same way. Its bed use rate will exceed beyond capacity and operating costs will become increasingly unaffordable unless changes are made. The Clinical Services Plan provides options on how we can best plan and address the challenges we will face. The plan considers changes to service configurations and models of care, additional investment in strategic

[21] https://www.health.govt.nz/publication/pharmacy-action-plan-2016-2020

[22] https://tas.health.nz/assets/Pharmacy/Evolving-Consumer-Pharmacist-Services.pdf

enablers such as IT and workforce, and moving services into the community and closer to home. The plan provides practical options to increase our focus on prevention and early intervention, and will guide our commissioning of services for the years to come.

We've started implementing the Clinical Services Plan through a number of initiatives aimed at strengthening primary and community services, keeping people well and out of hospital, and constraining the growing demand on hospital services. This has included roll out of the Health Care Home model of care, the provision of timely specialist advice to general practice, and the development of 'Neighbourhood Teams' where DHB services (older persons, community nursing, allied health and assistant workforce) support general practice teams. Hutt Valley DHB has also established a Project Management Office to support the changes needed. It is supporting a number of projects to improve hospital integration with community services, and enhance patient flow and efficiency within hospital.

Planning our future infrastructure needs

Hutt Valley DHB is responsible for the stewardship of the health resources and infrastructure in the district. The service changes signalled in the Clinical Services Plan require us to assess the current state of the hospital campus as well as the changes to our facilities needed in the years to come. We've started this process with a comprehensive condition assessment of our current infrastructure and facilities. We're also working closely with Capital & Coast DHB to better understand the service options across our network of hospitals in Lower Hutt, Kenepuru, and Wellington. We are working in partnership with Capital & Coast DHB to plan how we can best coordinate and configure our services in the future.

Resilient facilities

Ensuring our facilities are safe and resilient is an important part of our stewardship. Hutt Valley DHB has upgraded its facilities for earthquake resilience. While we have no earthquake prone buildings, we have strengthened our resilience through practical upgrades. For example, we are currently replacing all the heavy plaster ceiling tiles with lightweight tiles in our main inpatient block. We are in the process of improving bracing and restraints to ensure 'non-structural' items are all well restrained in the event of an earthquake. We've also installed a generator for Pilmuir House (so our management and administration teams can still operate in a power failure) and upgraded the Control Panel to two of our main generators. We have installed a treatment plant for our existing on-campus water-bore so we can provide water to the hospital, and the wider community, in an emergency. We have also installed bladders across the site to increase our capacity to store wastewater in the event of isolation from the Council connection.

Consumer Involvement

We want the consumer perspective to become part of the way we do things. In 2018/19 we developed and delivered a training programme to staff on 'consumer co-design' methodology for use in service improvement projects, and service development and commissioning. Nursing staff have also been implementing the Patient Care Planning Project, which is focussed on including patient goals in care planning and involving their whānau in the process. Patient goals are documented and monitored and shared with the patient, their whānau, and the team involved in their care.

Staff member: "The overall purpose of the Patient Care Planning Project is to ensure that patients receive the best possible, safe and timely care, and achieve improved health outcomes that are individualized and goal-driven. Letting patients write down their goals involves them in their care, and empowering them in this way promotes positive outcomes."

We also established a Consumer Council with members from diverse backgrounds, experiences and knowledge. The Consumer Council gives our patients, whānau and communities, a strong voice in planning, designing and delivering great services across the Hutt Valley. Hutt Valley DHB also receives consumer feedback through its complaints and compliments processes, patient experience surveys and consumer group forums. This information is analysed and directly informs continuous quality improvements and effective commissioning.

Clinical involvement

Our Clinical Council comprises hospital and primary care clinicians from different disciplines. It facilitates clinical engagement in organisational decisions and informs effective commissioning based on clinical evidence and expertise. The Council's principal focus is on quality and safety, but it also provides advice on key proposed organisational service changes and measures to use organisational resources effectively and equitably.

We've also established clinical networks (or steering groups) to guide planning and provide oversight to our integration work programme. This work is focussed on improving how primary and secondary health services work together so people in the Hutt Valley have well-coordinated and seamless healthcare. We have a Child Health Network, an Acute Demand and Community Care Network, a Long Term Conditions Network, and a recently-established Mental Health Network. The networks meet regularly to drive and oversee relevant areas of work under the integration work programme. The clinical networks report to our Alliance Leadership Team (called Hutt Inc.), which is made up of senior DHB managers, clinical leaders and other experts, including representation from Pacific and Māori Health Services and a mix of both hospital and community practitioners. The clinical networks make recommendations to Hutt Inc. on the best use of resources to achieve the optimal outcomes.

SMART INFRASTRUCTURE

Smart Infrastructure means:

- A digitally-enabled health system that finds technological solutions to improved care and experience for people and whānau; support people and whānau to stay well with more individualised care; allow the patient, and those involved in the care of that patient, to share information/care plans; and improve quality of care through better tracking of care, reduced variation in care, and reduced errors
- Use of data to understand people's needs and drive people focused services
- A hospital facility footprint designed for complex care, and networked with other hospital services.

Professional Development and Recognition Programme - ePortfolio

The Professional Development and Recognition Programme (PDRP) is a competency-based clinical programme that supports the practice development and career progression of enrolled and registered nurses. In April 2019, Hutt Valley DHB launched PDRP ePortfolio, which enables nurses to display digital collections of professional and educational evidence showing their aptitude, skill, competencies and knowledge. The initial response to the ePortfolio has been very encouraging and work will continue to maintain and increase staff engagement.

Staff member: "The ePortfolio process was much easier to follow, it felt easier and took less time. There is much less paperwork and it was clear what was needed".

Capacity Planning

A new capacity planning tool went live in June 2019. The tool provides day-to-day clinical leaders and operations managers with the tools to better predict demand and complements Trendcare, the workforce tool used as part of the Care Capacity Demand Management initiative. Hutt Valley DHB can better predict service demand days or weeks in advance, and staff can better plan resources such as rostering, using fewer casual/agency staff, and scheduling planned care surgery around days where acute demand is predicted to be low.

Patient portal

Patient portals are secure online sites, provided by general practices, where patients can access their health information and interact with their general practice. Patient portals give people convenient and secure electronic access to their health information, increasing their ability to manage their own health care. Hutt Valley DHB is continuing to support roll out of patient portals. Hutt Valley DHB's largest Primary Health Organisation, Te Awakairangi Health Network (TeAHN), has 17 practices using patient portals with over 30,000 people activated in the Hutt Valley.

Electronic referrals and software robots

Some time ago we implemented secure electronic 'eReferrals' between Hutt Hospital and general practice. This speeds up the referral process and also helps ensure that referral criteria are applied consistently. As part of the national screening programme, eReferrals have also been implemented for bowel screening. Software robots are now used to process a majority of the 24,000 e-referrals Hutt Hospital receives every year. This task used to be done by clinical support staff. Enabling software robots to perform this repetitive task has freed up employees to do more complex, value added tasks. This has had the added benefit of improving staff satisfaction as they are now able to focus on more engaging and patient-focused work.

Additionally, the Mental Health Intake assessment form has been automated. This improves the efficiency of the Service intake process and the accuracy of referral and activity data. It will also ease the team's administrative workload, allowing them to focus further on the quality of their service.

Quality & Patient Safety Dashboard

We're continuing to enhance Hutt Valley DHB's Quality and Patient Safety 'dashboard'. This reports on quality and patient safety indicators that are internationally recognised in a range of aspects of quality. The data in the dashboard presents trends over time and helps staff identify and understand why there are variations in the data. For instance, variation may be normal and due to seasonal variability of health service demand, or it could be caused by other circumstances. Understanding the type of variation enables staff to determine the improvement approach required to address it. The data included in the dashboard is drawn from Hutt Valley DHB's Safety, Quality and Reportable Events (SQuARE) database, on the first available working day of the month. Managers are able to see what is happening in their areas of accountability and, if necessary, make changes to improve patient safety and care.

'Ubook' – our online booking system

We're promoting our upgraded Ubook - our online booking system that enables patients to book outpatient hospital services online. Ubook gives patients the flexibility to choose appointments that work for them. It means our patients are more in control of and avoids unnecessary letters and paperwork. Ubook is a good example of 'smart infrastructure' with the inclusion of its multiple booking function. Patients who require multiple tests will have these booked as close together as possible – and will only get one notification. Patients are also be able to update their contact details online so our database will be more up-to-date and our administration staff will be freed up for other work. Putting the control into the hands of patients has also dramatically reduced the number of missed appointments, saving us time and resources.

Progress on other 'smart infrastructure" projects

- *A 3DHB ICT Strategy*: Hutt Valley DHB is working with our sub-regional DHB partners on a new Information Technology and Communications (ICT) strategy for Capital & Coast, Hutt Valley and Wairarapa DHBs. The strategy will guide the development of a digitally enabled health and disability system to support the quality, efficiency and sustainability of our health and disability system.
- *National Maternity System*: Hutt Valley DHB is planning to adopt the National Maternity System, which enables a new way of collecting, sharing and viewing maternity and neonatal data to support women to be involved in their own care and, in time, enable them to have electronic access to their maternity information.
- *eVitals*: Hutt Valley DHB will be piloting eVitals in the coming months. This is a new system for digitally collecting nursing observations and assessments, alerting clinicians to deterioration in a patient's health. The real-time system eliminates the need to search for records to identify patterns, ultimately resulting in more clinical time to focus on the patient.
- *Health services via digital technology*: Hutt Valley DHB is deploying a modern and integrated digital solution that enables regional sharing of information, optimal use of clinical resources, and new models and processes of care. Work is progressing on a common regional Shared Care Record for use by community, primary, and hospital health services across the Central Region. The Shared Care Record allows authorised health practitioners involved in a patient's care to access up-to-date health information from the patient's medical centre. It also enables the patient to view and participate in their care plans with online, self-service options.
- *NZ ePrescription Service:* Our Hutt Valley DHB clinicians now have access to the NZ ePrescription Service (NZePS). This access helps a health practitioner review the medicines the patient is actually taking and check them against what they should be taking (medicines reconciliation).
- *Electronic Whiteboards* – Hutt Valley DHB have been developing a range of electronic whiteboards to help our clinicians keep track of our patients on their journey through our system. Our most recent developments include a Whiteboard for our Community Nursing team, our ACC team, and our Infection Control clinicians.
- *eHandover* – At the end of every shift our Doctors 'handover' their assigned patients to the new doctor coming to work. This handover includes what lab results to chase, what radiology reports to monitor, what medication needs changing, what patients need especially close monitoring etc. We have developed an electronic tool that greatly assists with this handover process – providing a hospital wide view of our patients care needs during their stay.

Our People

Good employer obligations report

The Hutt Valley DHB takes its obligations to be a good employer very seriously and has appropriate plans, policies and processes to meet the seven key elements of 'the Good Employer' as prescribed by the EEO Commissioner. These are:

- Leadership, accountability, and culture
- Recruitment, selection, and induction
- Employee development, promotion, and exit
- Flexibility and work design
- Remuneration, recognition, and conditions
- Harassment and bullying prevention
- Safe and healthy environment

We continue to progress our organisational culture programme and this year the focus has been on embedding our organisational values through a series of interactive workshops with staff to embed the values. We have introduced a series of eLearning modules around providing feedback and are introducing a leader led workshop that our people managers can facilitate with their teams on "bringing the values to live" within their teams and day to day work activities.

As a good employer, the DHB values professionalism through leadership. Unacceptable employee behaviour is not tolerated and we have been developing a DHB specific approach to providing staff with a safe pathway for staff to raise concerns about unacceptable behaviour. We continue to monitor the incidence of bullying and harassment within our organisation. This year we are reviewing our current HR policies and guidelines to ensure that our management practices related to bullying and harassment prevention remain current.

Training and development opportunities are considered for all staff and development plans are included as part of the annual performance review process. We continue to review and improve the eLearning and face to face learning experiences for staff. This year we have been part of a central regional DHB pilot to talent map our executive and senior leadership positions. This will enable us to better understand the leadership aspirations and capability of our senior leaders and identify targeted professional development activities to grow our leadership strength.

We are currently developing an "Emerging Leaders" programme for our emergent and first time leaders. This will bring together the core principles of leadership and provide new leaders with the foundation skills for leading effectively. We also share access to a DHB formatted Front Line Leadership training course and hold training sessions throughout the year for all managers aimed at developing core managerial skills.

During 2018 we upgraded our recruitment management software and introduced online workflow to enable smoother process as well as improved information collection and reporting of our key EEO metrics. We continue to apply a values based recruitment approach to our Recruitment and Selection processes. This year we have committed to reviewing our recruitment policies and processes to support our goal of achieving a more ethnically diverse workforce, reflective of our population and communities.

The DHB has provided training for all health and safety representatives on the health and safety legislation. Similar training is provided to managers, with a particular focus on their role in creating a safe workplace and

managing health and risk. Our worker engagement, participation and representation framework has been revised to enable greater involvement from workers, managers and health and safety representatives. This is being implemented alongside changes to our health and safety committee structure. We are continuing with our ACC Accredited Employer Partnership Programme. Employees also have 'no questions asked' access to a confidential employee assistance programme.

The DHB remains focussed on building a positive and inclusive workplace. A key element of our employee well-being plan is to build an inclusive and safe workplace, and to harness the strengths of our diverse workplace enabling all employees to bring their whole self to work. This year we are developing a Diversity and Inclusion policy and actively promoting diversity, inclusion and equity into our workplace. A recent appointment of a Disability Coordinator within the clinical training team provides an opportunity for us to extend disability awareness training across the DHB.

Approximately 90% of our employees are covered by Collective Agreements (CA). All the CAs have remuneration, recognition and conditions clauses. The DHB is also actively engaged in supporting the national programme in response to a number of pay equity claims. We also take a similar approach for those employees on an individual employment agreement to ensure fairness and equity in remuneration, recognition and conditions across the organisation.

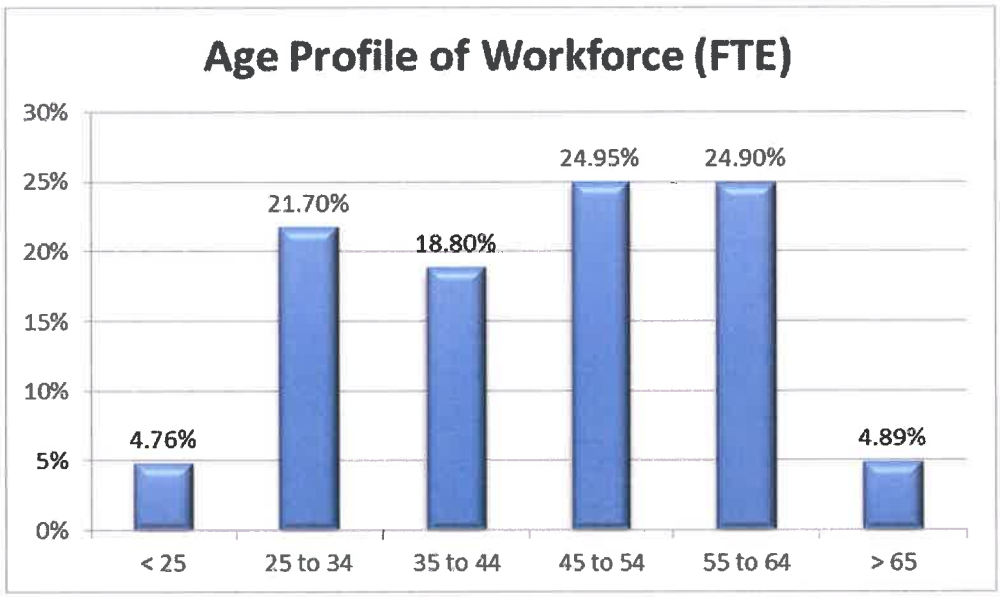
Where an individual may feel personally disadvantaged, there are established grievance procedures available - including external mediation or the mechanisms covered by the Employment Relations Act 2000.

Workforce Profile

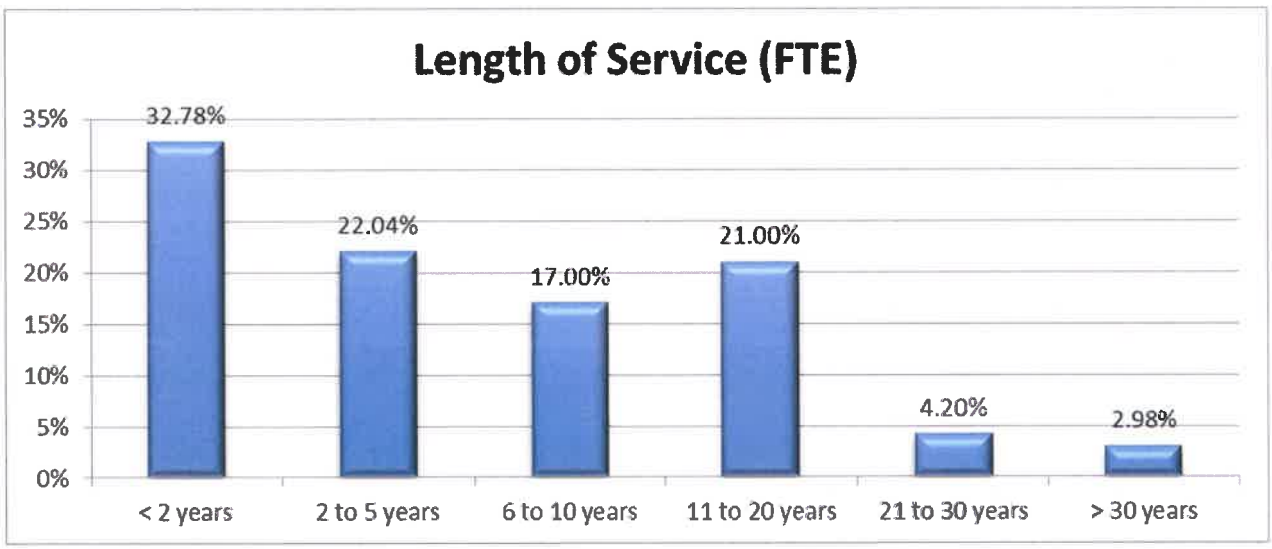
Full Time Equivalent Staff Numbers

	2019	2018	2017	2016	2015	2014	2013	2012
Medical	253	268	244	236	246	232	232	238
Nursing	707	709	696	696	755	717	708	712
Allied Health	409	410	395	401	440	428	435	422
Other	457	450	427	410	442	434	467	480
Total	1,826	1,837	1,762	1,743	1,883	1,811	1,841	1,851

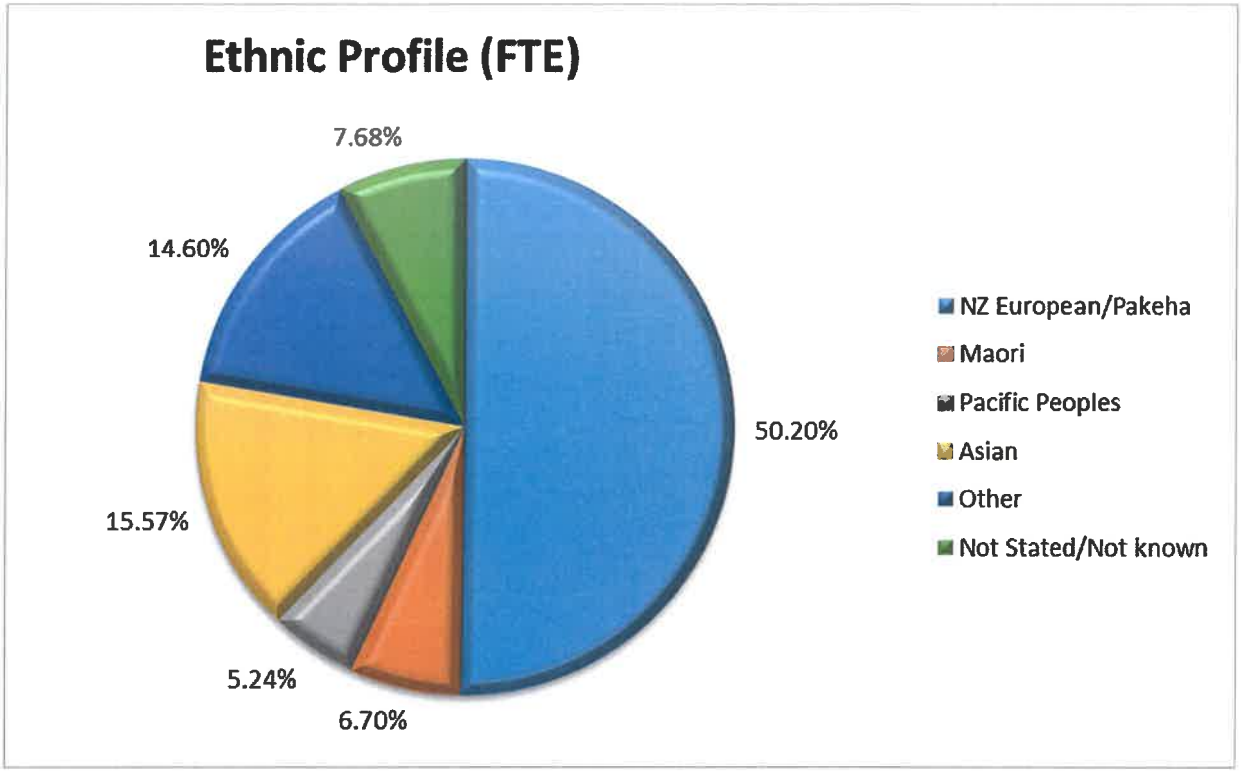
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2019	2018	2017	2016	2015	2014	2013	2012
Female	81.31%	82.51%	80.56%	81.05%	81.65%	81.89%	82.41%	81.95%
Male	18.69%	18.48%	19.44%	18.95%	18.35%	18.11%	17.59%	18.05%

Termination payments

During the year ended 30 June 2019, 8 (2018: 10) employees received compensation and other benefits in relation to cessation totalling $128,849 (2018: $512,993). The payments were in the nature of redundancy or retirement gratuities.

Remuneration of employees

Annual remuneration	2019	2018	2017	2016
100,000-109,999	77	48	40	40
110,000-119,999	37	29	26	29
120,000-129,999	25	19	17	19
130,000-139,999	13	13	15	14
140,000-149,999	10	10	10	15
150,000-159,999	12	12	16	11
160,000-169,999	7	13	11	2
170,000-179,999	15	13	12	8
180,000-189,999	9	8	7	9
190,000-199,999	10	11	6	7
200,000-209,999	9	6	6	5
210,000-219,999	4	10	4	6
220,000-229,999	8	6	9	7
230,000-239,999	13	6	6	3
240,000-249,999	10	8	9	13
250,000-259,999	4	7	4	5
260,000-269,999	9	4	8	7
270,000-279,999	4	7	6	3
280,000-289,999	4	4	4	6
290,000-299,999	6	2	3	1
300,000-309,999	5	3		2
310,000-319,999	3			3
320,000-329,999		1		1
330,000-339,999	1	2	3	
340,000-349,999	2	3	2	2
350,000-359,999	1		1	
360,000-369,999	2			
370,000-379,999				
380,000-389,999		1	1	1
390,000-399,999	1			
400,000-409,999	1	2		
420,000-429,999			1	
430,000-439,999			1	
440,000-449,999				1
450,000-459,999		1		
460,000-469,999		1		
470,000-479,999		1		
520,000-529,999	1			
560,000-569,999				1
Grand Total	**303**	**251**	**228**	**221**

Health Targets

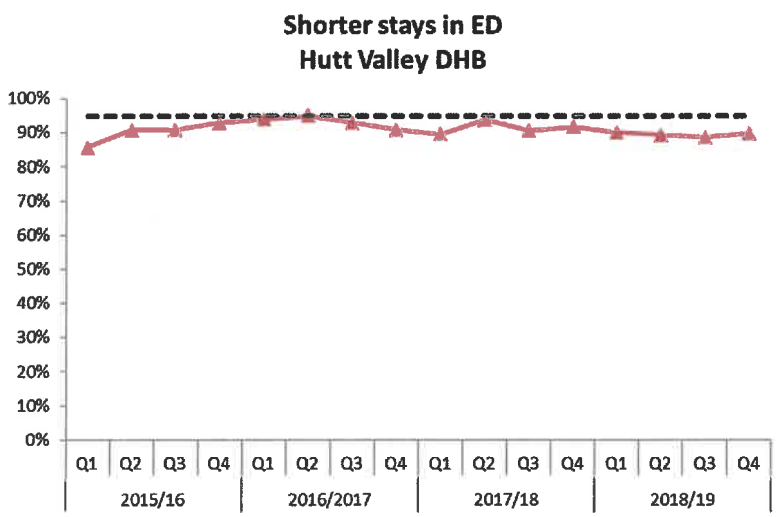
Health targets are a set of national performance measures specifically designed to focus work on improving the performance of health services in areas that reflect significant public and government priorities.[23]

Shorter stays in Emergency Departments

95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Target: 95%

2018/19 Performance: 89%

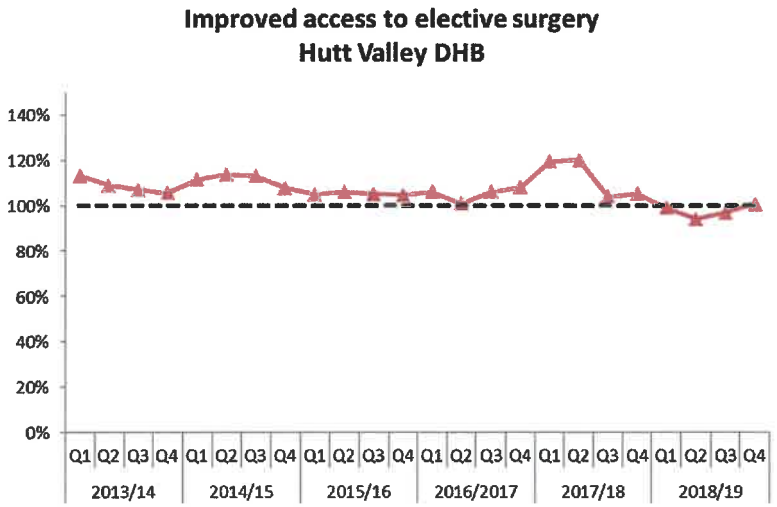


Improved access to elective surgery

More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.

Target: 100%

2018/19 Performance: 6,238 (100.7%)



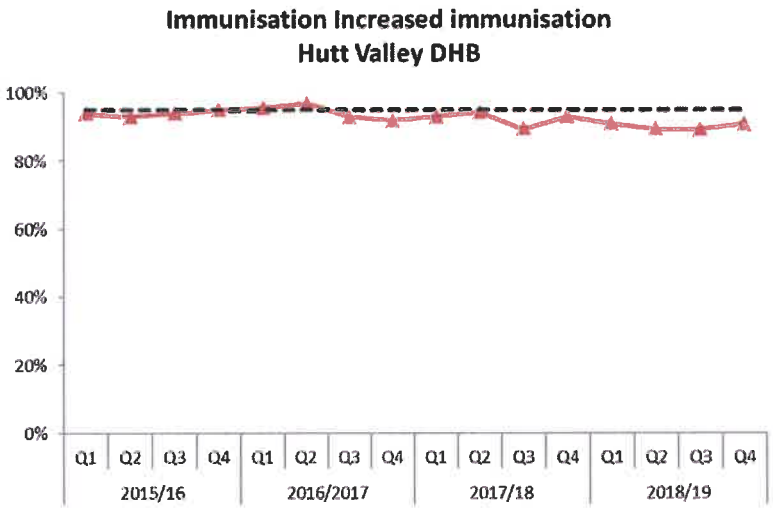
[23] Note the changing vertical (y) axis between graphs and that the 2018/19 performance is the performance for the final quarter.

Increased immunisation

95 percent of eight month olds will have their primary course of immunisation on time.[24] (Primary course immunisation events occur at six weeks, three months and five months.)

Target: 95%

2018/19 Performance: 90%

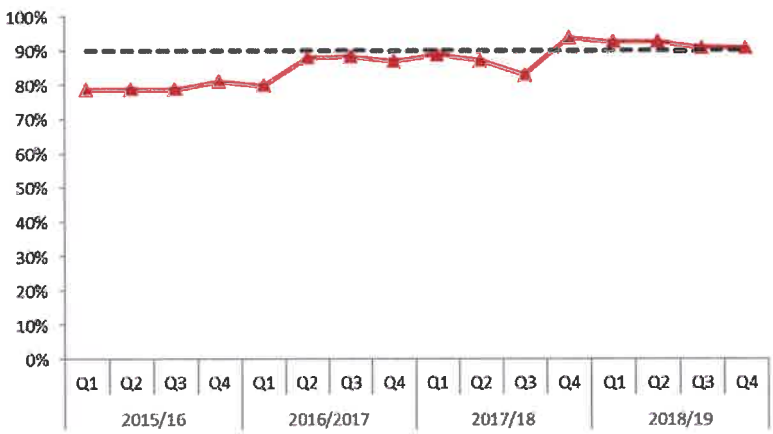


Better help for smokers to quit – Primary care

90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.[25]

Target: 90%

2018/19 Performance: 91%



[24] Target for on-time immunisation set at 95% from December 2014.

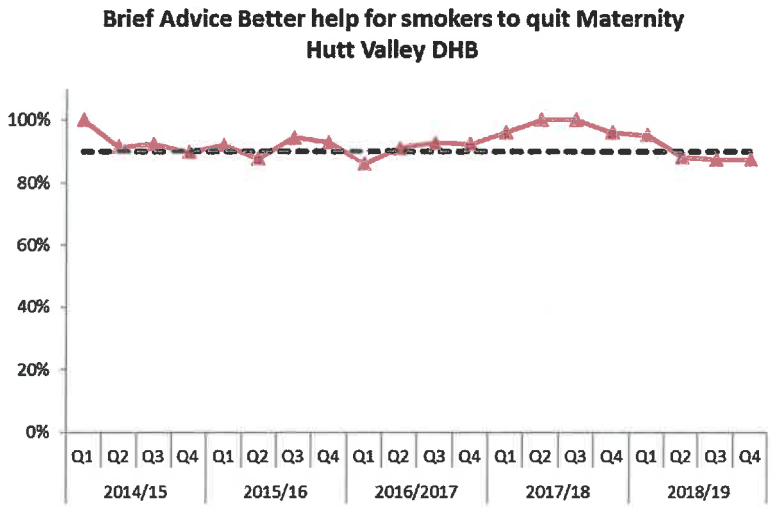
[25] From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking.

Better help for smokers to quit – Maternity

90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.

Target: 90%

2018/19 Performance: 88%

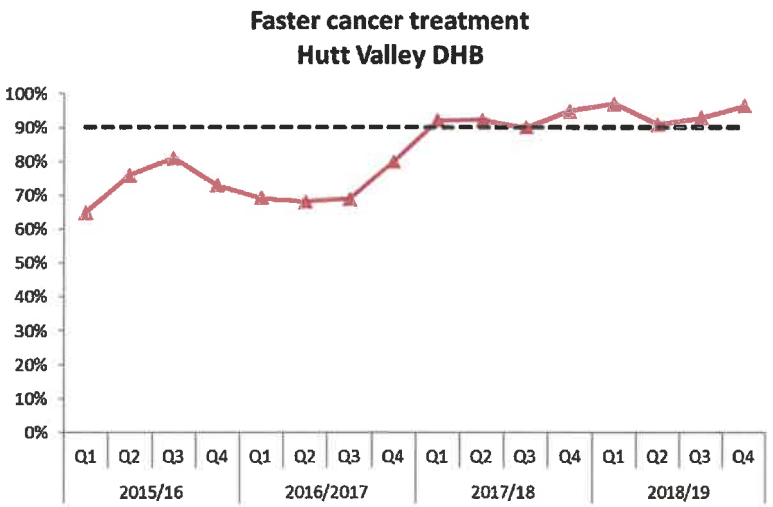


Faster cancer treatment

90 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks[26].

Target: 90%

2018/19 Performance: 96%

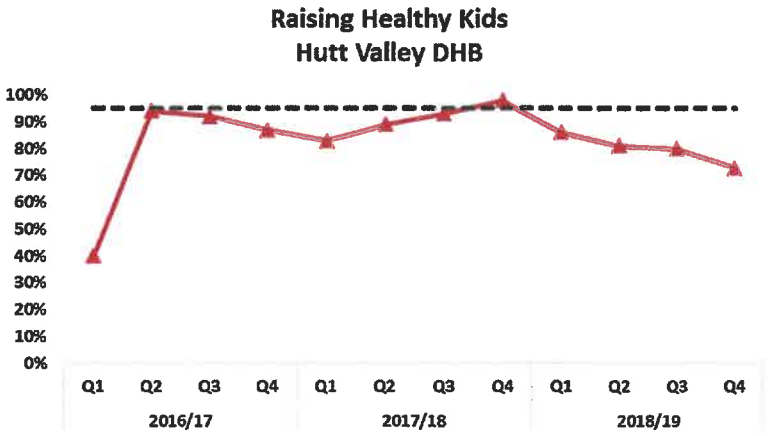


Raising Healthy Kids

95 per cent of obese children (BMI>98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Target: 95%

2018/19 Performance: 73%



This Health Target was introduced in 2016/17; there is no data for prior years.

[26] Target increased from 85% in July 2016 to 90% June 2017.

Comments on Performance

Shorter stays in Emergency Departments

Despite a lot of work and focus in this area, we have not achieved the Shorter stays in Emergency Departments target. The volume of patients increased significantly over the last year, and meeting the 6-hour target is complex and challenging, requiring a system-wide approach. The time it takes to admit a patient to a hospital ward often creates the biggest barrier, and late discharges have a significant impact on the ability to move patients to the wards.

Individual meetings with the clinical heads of department, the chief operating officer and the business development manager have been held to identify key issues, improve access and patient flows, enable timely discharges, and help us achieve the 6 hour target. A plan of key actions is being developed to improve our performance in this area.

Immunisation services

Immunisation saves lives and is one of most successful and cost-effective health interventions.[27] Our immunisation services continue to focus on lifting our immunisation rates, especially for people on low incomes and Māori and Pacific populations. Our primary goal is to make getting vaccinated easier, especially for busy low-income parents. This includes following up with families that are behind on their immunisation, offering advice and education to parents with questions or concerns, extending our opportunistic vaccination sites and pop-up clinics in the community, and providing opportunities for vaccinating after-hours, on weekends, and during school holiday periods.

TeAHN has worked alongside the Kōkiri Marae Immunisation Outreach Service and Whai Oranga Medical Centre to provide two education sessions for the Tākiri Mai te Ata whānau ora collective kaimahi and whānau ora navigators who work alongside many of our targeted whānau. The education sessions have focused on an overview of the immunisation schedule, immunisation safety and providing positive information to whānau to support them to get into practices to have their immunisations on time and with full informed consent.

Raising Healthy Kids

Performance has dropped against the Raising Healthy Kids measure over the last year because new staff had not been trained to identify and action referrals of children who met the criteria. Also, sometimes parents decline the referral. To lift our performance in this areas, our B4 School Check service is providing dedicated training to staff that will include:

- Use of the weight and Height application to identify child(ren)
- Use of referral pathway for child(ren) that meet criteria
- 'How to have' conversations with whānau and child(ren) who meet criteria e.g. motivational interviewing.

We are also working collaborately with other DHBs, and exchanging information and sharing strategies to mitigate challenges and improve performance.

[27] https://www.who.int/en/news-room/fact-sheets/detail/immunization-coverage

Statement of Performance

Output Classes contributing to desired outcomes

In this section 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 Hutt Valley health system and help us to monitor that we are on track to achieve positive long term outcomes. Some of the measures that we have chosen to reflect outputs of services we fund or deliver are also Performance Measures used by the Ministry to monitor DHB performance through the quarterly reporting system.

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

	2017/18 Actual $000	2018/19 Budget $000	2018/19 Actual $000
Appropriation revenue	383,574	397,128	396,618

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 Classes: Financial Performance ($000s)

Revenue	2017/18 Actual	2018/19 Budget	2018/19 Actual
Prevention	20,337	20,442	20,508
Early Detection and Management	252,308	282,138	284,125
Intensive Assessment and Treatment	205,331	210,957	215,091
Rehabilitation and Support	72,469	53,938	55,162
Total	**550,445**	**567,475**	**574,886**

Expenditure	2017/18 Actual	2018/19 Budget	2018/19 Actual
Prevention	21,492	20,961	20,378
Early Detection and Management	251,407	283,324	279,964
Intensive Assessment and Treatment	213,646	218,042	239,256
Rehabilitation and Support	70,791	53,198	55,164
Total	**557,336**	**575,525**	**594,762**

Output Class 1: Prevention Services

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

Description

'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.

Context

New Zealand is experiencing a growing prevalence of long-term conditions. These conditions have a significant impact on peoples' lives, and include diabetes, cancers, cardiovascular diseases, respiratory diseases, mental illness (including depression and anxiety), chronic pain, chronic kidney disease, and musculoskeletal conditions. Māori, Pacific, and people with disabilities are disproportionately affected by many long-term conditions. These conditions are major cause of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services.[28] With an ageing population, the burden of long-term conditions will increase. Multiple long-term conditions are more common in older people.

Research suggests that over one-third (38%) of all health lost by the New Zealand population as a whole is caused by known modifiable risk factors (ie, is potentially preventable through reducing exposure to these hazards).[29] Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors.

[28] Ministry of Health. 2016. Health Loss in New Zealand 1990–2013: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study. Wellington: Ministry of Health.

[29] Ministry of Health. 2016. Health Loss in New Zealand 1990–2013: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study. Wellington: Ministry of Health.

Prevention services also support people to address any risk factors that contribute to both acute events (e.g., alcohol-related injury) and the development of long-term conditions (e.g. obesity or diabetes). Our main focus is on high health need and at-risk population groups (low socio-economic, Māori and Pacific) who are more likely to be exposed to environments less conducive to making healthier choices. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Health promotion and public health services: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices. Health promotion and public health services enable people to increase control over their health and its determinants, and thereby improve their health. The range of strategies used, includes those described by the Ottawa Charter: public policy, reorienting the health system, developing supportive environments, community action, and supporting individual personal skills. While health has a significant role here, some outcomes such as obesity require a joined-up approach to address the wider determinants of health, such as income, housing, food security, employment, and quality working conditions; our DHB and Regional Public Health work with other sectors (e.g. housing, justice, education) to enable this.

Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations by ensuring high rates of immunisation in our populations. The work spans primary and community care, allied health and public health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

Smoking cessation services: are provided to smokers to help smokers quit. Clinicians follow the ABC process:[30] Ask all patients whether they smoke and document their response; if the patient smokes, provide brief advice to quit smoking; and if patient agrees, provide Cessation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

Screening services: encourage uptake of services predominately funded and provided through the National Screening Unit that help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

[30] ABC for Smoking Cessation Quick Reference Card, PHARMAC

How we measure the performance of our Prevention Services

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Health protection and statutory regulation						
The number of disease notifications investigated.	V	HVPI	HVDHB 543 Maori 76 Pacific 52	Total: 425 Maori: 49 Pacific: 25	Total: 513 Māori: 75 Pacific: 32	Demand driven. Higher than estimated
The number of environmental health investigations.	V	HVPI	214	316	199	Demand driven.
The number of premises visited for alcohol controlled purchase operations.	V	HVPI	26	3	15	Demand driven. Higher than estimated
The number of tobacco retailers visited during controlled purchase operations	V	HVPI	0 volunteers withdrew	40	34	Demand driven.
Health promotion and education						
Number of adult referrals to the Green Prescription program.	V	HVPI	1,203	2,777	2,060	Less than estimated
Number of new referrals to Public Health nurses in primary/intermediate schools.	V	HVPI	HVDHB 818 Māori 380 Pacific 172	HVDHB: 898 Maori: 408 Pacific: 180	HVDHB: 834 Māori: 369 Pacific: 179	Demand driven.

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Smoking cessation						
Percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in last 15 months.	Q	HT5	94%	≥90%	91%	Achieved
Percentage of hospitalized smokers receiving advice and help to quit.	Q	PP31	83.4%	≥95%	95%	Achieved
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC being offered brief advice and support to quit smoking.	Q	HT5	96%	≥90%	88%	Not achieved

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Immunisation						
Percentage of 2-year olds fully immunised.	C	PP21	HVHDB 91.2% Maori 90.4% Pacific 93.8%	≥95%	HVHDB 92% Maori 88% Pacific 91%	Not achieved
Percentage of 8-month olds fully vaccinated	C	HT4	HVDHB 93.1% Maori 86.9% Pacific 92.3%	≥95%	HVHDB 90% Maori 83% Pacific 90%	Not achieved
Percentage of year 7 children provided Boostrix vaccination in Hutt Valley district.	C	HVPI	HVHDB 78% Maori 85% Pacific 87%	≥70%	Total: 76% Māori: 78% Pacific: 87%	Higher than estimated

Percentage of year 8 girls vaccinated against HPV (final dose).	C	PP21	HVDHB 66% Maori 57% Pacific 57%	≥75%	Total: 62% Māori: 65% Pacific: 66%	Not achieved Demand driven.

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Breastfeeding						
Percentage of infants fully or exclusively breastfed at 3-months.	Q	PP37	HVDHB 55% Maori 46% Pacific 49%	≥60%	HVDHB 54% Maori 46% Pacific 43%	Not achieved
Population based screening services						
Percentage of eligible children receiving a B4 School Check.	C	HVPI	HVDHB 101.5% High Dep 100%	≥90%	HVDHB 98% High Dep 99%	Achieved
Percentage of eligible women (25-69 years) having cervical screening in last 3 years.	C	SI10	HVDHB 67% Maori 70% Pacific 75%	>80%	HVDHB 75.5% Maori 68.4% Pacific 68.9%	Not achieved
Percentage of eligible women (45-69 years) having breast screening in the last 2 years.	C	SI11	HVDHB 68.9% Maori 68.3% Pacific 71.8%	>70%	HVDHB : 74.5% Maori 69.2% Pacific 69.0%	Achieved

Comments on Performance

Health promotion and public health services

The number of disease notifications and environmental health issues investigated is demand driven and the expected volume is an estimate based on the total for the previous year. Notifiable common gastric related illness dominates the notification volumes (e.g. campylobacter). In addition, pertussis has remained high across the 3DHB sub-region. Whilst there has been a decrease in the total number of environmental investigations recorded, this does not represent the significant activity from Regional Public Health in responding to environmental health issues.

The expected volumes of controlled purchase operations (CPOs) are an estimate based on the previous year. The increase in premises visited for alcohol CPOs represents one CPO that resulted in two sales to a minor. All alcohol CPOs are carried out under the authority of the Police, as per the Sale and Supply of Alcohol Act 2012. Although the total number of premises visited for the three tobacco CPOs was slightly lower, there were no sales to minors (under 18 year olds).

The most frequently identified conditions for primary and intermediate aged children referred to the RPH Public Health Nurses were behavioural, developmental, social, hearing and vision concerns. One child may be referred with several conditions. PHNs respond with assessments, home visits, phone calls, as well as referrals and follow up with other services.

Smoking cessation services

Smoking is a major risk factor for many cancers and for respiratory and cardiovascular disease. It is one of the leading modifiable risks to health accounting for about 9 percent of all illness, disability and premature mortality.[31] While overall rates of smoking have decreased within Hutt Valley, our rates of smoking amongst Māori, in particular, are high. It is estimated that 32 percent of Māori smoke in the Hutt Valley, compared to 17 percent across the total Hutt Valley population. Nationally, it is estimated that 37 percent of Māori smoke and 16 percent of the total New Zealand population smoke.[32]

We are working to decrease smoking rates in the Hutt Valley through youth appropriate communication strategies and health promoting activities, smoking cessation training to midwives and pharmacists, continuing the brief advice and cessation support by general practices, and implementing the Hapu Mama programme at Kokiri Marae. The Hapu Mama programme is a new incentivised programme that encourages pregnant women and their partners to give up smoking.

Regional Public Health designed an incentivised quit programme focused on participants quitting to benefit whanau of Te Kōhanga Reo (TKR) whānau - Te Kōhanga Reo Tupeka Kore (Quit smoking incentive programme). Regional Public Health partnered with stop smoking provider, Tākiri Mai Te Ata, to enrol participants, with incentives offered (vouchers) at a quit milestone. Resources were supplied to TKR to raise awareness of the effects of smoking on mokopuna and whānau.

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[31] Institute for Health Metrics and Evaluation (IHME). 2016. *GBD Compare.* Seattle, WA: IHME, University of Washington.

[32] New Zealand Health Survey: https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update/_w_b4015220/_w_befe7127/#!/home

We have developed a Hutt Valley Tobacco Control Action Plan with key stakeholders (including RPH, Healthy Families Lower Hutt, Hutt City and Upper Hutt Councils, Takiri Mai te Ata, Cancer Society, Vibe and Quitline). This plan includes initiatives where we can work collectively to make most difference for our priority populations (Māori, Pacific peoples, rangatahi and mental health consumers). This work includes work to decrease smoking rates in the Hutt Valley through:

- Youth appropriate social media and other comms messaging
- Closer working relationships with, support of and links to our local stop smoking provider (including two of their employees working onsite at the hospital, prioritising Māori and Pacific patients)
- A DHB Smokefree coordinator to train hospital staff in the provision of ABC advice, accurate coding and improved referrals
- Support of a new role at Upper Hutt Council to develop a Smokefree Outdoor Public Places Policy
- Development of a Hutt Valley wide Vaping Position Statement
- Support of the Hapu Mama smoking cessation programme at Kokiri Marae to incentivise pregnant women and their partners to give up smoking
- Identifying ways to improve smoking advice and cessation rates in pregnant women.

Breastfeeding Support

We are working hard to improve our breastfeeding rates in the Hutt Valley. Breastfeeding is important for the physical health and wellbeing of mothers and babies. Hutt Valley DHB's hospital Lactation Service offers breastfeeding support to mothers and babies in the hospital and runs outpatient appointments. On discharge from the antenatal ward, over 95 percent of mums have established breastfeeding. However, our breastfeeding rates drop at around six weeks postnatal, due in part to other broader wellbeing issues. Our breastfeeding rates are particularly low for Māori and Pacific and we are focused on addressing this.

A Māori health provider, Te Rūnanganui, has been contracted to provide community breastfeeding support targeted to Māori women. This service is provided by an experienced lactation consultant, supported by Tamariki Ora staff and the Iwi Health Coordinator. Hutt Valley DHB also has a Breastfeeding Support Service that provides free drop-in clinics in the community as well as home visits. We also fund community antenatal classes with two hours of breastfeeding education. This includes specific antenatal classes for women under 24 and their support persons, and Kaupapa Māori Antenatal and Kaiāwhina Education classes held on Te Kakano o Te Aroha Marae.

Screening services

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 continuing to focus the programme on improving participation for priority populations.

We are continuing to focus on improving our breast and cervical screening rates for Māori and Pacific women to reduce inequities. 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.

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 are 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 after-hours smear clinics 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.

Output Class 2: Early Detection and Management

Description

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.

Context

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, with some population groups suffering from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For our DHB, diabetes, COPD, asthma, and chronic respiratory conditions are significant long-term conditions that are prevalent in our population. Early detection and management services based in the community ensure earlier identification of risk, provide opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.

Oral health services: are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.

How we measure the performance of our Early Detection & Management Services

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Primary Care services / Long term conditions management						
Percentage of DHB-domiciled population enrolled in a PHO.	C	PP33	T : 90% M: 86% P: 87%	≥98%	T : 98% M: 91% P: 98%	Achieved
Percentage of practices with a current Diabetes Practice Population plan (or LTC plan that includes diabetes).	C	HVPI	100%	≥90%	100%	Achieved
Percentage of eligible population assessed for CVD risk in last 5 years.	C	PP20	87.1%	≥90%	82.3%	Not achieved
The number of new and localised HealthPathways in the sub-region.	V	3DHB	390	Est. 472	454	Partially Achieved
The average number of users accessing the HealthPathways website in the last month of the financial year.	V	3DHB	2,103	≥2,317	3,398	Achieved
Oral health						
Percentage of children under 5 years enrolled in DHB-funded dental services.	C	PP13	T : 93.7% M: 77.7% P: 80.5%	≥95%	Total: 93.2% Maori: 81.6% Pacific: 84.1%	Achieved
Percentage of adolescents accessing DHB-funded dental services.	C	PP12	69%	80%	67%	Not achieved

Pharmacy services						
Number of initial prescription items dispensed.	V	HVPI	1,507,080	1,620,221	1,526,670	Not achieved
Percentage of DHB domiciled populations dispensed at least one prescription item.	C	HVPI	81%	≥80%	81%	Achieved
Number of people participating in a Community Pharmacy anticoagulant management service in a pharmacy.	C	HVPI	206	220	191	Not achieved

Comments on Performance

Primary care services

The DHB has maintained the high percentage of DHB domiciled population that is enrolled in practices within the Hutt Valley DHB area. The DHB continually monitors the health care provided to the populations that are known to have poorer outcomes, in particular Māori, Pacific and lower socio-economic groups.

All Hutt Valley primary care practices have Long Term Condition Plans. Practices achieved slightly under the target for assessment of Cardiovascular Disease risk in their eligible population. The PHOs have continued to support general practices to achieve the target by providing feedback on performance and IT support to ensure that all eligible individuals are encouraged to get a check when due.

Significant work has focused on future sustainability of primary care through roll out of the Health Care Home development programme. This work will strengthen the delivery and future sustainability of primary care services in the Hutt Valley.

Work has continued on localising and launching more Health Pathways resulting in the target being well exceeded. The number of users to the website has grown substantially, indicating the value of the site to primary care practitioners.

Oral health services

The oral health target for percentage of children under five years are enrolled in DHB-funded dental services was achieved. Achieving the target is the outcome of working in collaboration with PHOs to identify children not enrolled in the dental services and automatically enrolling preschool children in this service. However, families are given the option to 'opt out' of enrolment in the service.

Pharmacy services

The total number of initial prescriptions and percentage of DHB domiciled population who were dispensed at least one prescription item are descriptive measures of volumes only and indicate the significant number of interactions between people/whānau and community pharmacists and potential for enhanced pharmacist input to the health system.

Output Class 3: Intensive Assessment and Treatment

Description

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.

Context

Equitable and timely access to intensive assessment and treatment can significantly improve a person's quality of life, either through early intervention (i.e. removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided.

Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

Medical and surgical services: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need for care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service; addressing increasing needs and matching commitments to capacity.

Cancer services: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

Mental health and addictions services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates are monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we measure the performance of our Intensive Assessment & Treatment Services

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Mental Health and Addiction services						
Number of people accessing secondary Mental Health Services.	V	PP6	Total: 6583 Maori: 1784 Pacific: 376	Total:6,509 Maori: 1,808 Pacific: 417	Total:6,588 Maori: 1,871 Pacific: 415	Achieved
Percentage of patients 0-19 yrs referred to non-urgent child & adolescent mental health services & seen within 8 weeks.	T	PP8	88%	95%	89%	Not achieved
Percentage of patients 0-19 years referred to non-urgent child & adolescent Addiction services & seen within 8 weeks.	T	PP8	97.1%	95%	93.1%	Not achieved
Percentage of people admitted to an acute mental health inpatient service that were seen by the mental health community team in the 7 days prior to admission.	Q	HVPI	38.6%	75%	73%	Not achieved
Percentage of people discharged from an acute mental health inpatient service that were seen by the mental health community team in the 7 days following discharge.	Q	HVPI	65%	90%	71%	Not achieved

Elective and Acute (Emergency Dept.) inpatient/outpatient						
Number of surgical elective discharges.	V	PP45	105.2%	6192	6,238 100.7%	Achieved
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	T	HT1	91.9%	95%	89%	Not achieved
Standardised inpatient average length of stay ALOS (Acute).	T	OS3	2.31	2.4	2.10	Achieved
Standardised inpatient average length of stay ALOS (Elective).	T	OS3	1.47	1.45	1.43	Achieved
Rate of inpatient falls causing harm per 1,000 bed days.	Q	HVPI	1.42	≤2.0%	2.19	Not Achieved
Rate of hospital acquired pressure injuries per 1,000 bed days.	Q	HVPI	0.89	≤0.5%	0.49	Achieved
Rate of identified medication errors causing harm per 1,000 bed days.	Q	HVPI	4.6	<3.1	2.31	Achieved
Weighted average score in Patient Experience Survey	Q	SI8	Communication: 8.8 Coordination: 8.8 Partnership: 8.9 Physical and emotional needs: 8.9	8.8	Communication: 8.7 Coordination: 8.6 Partnership: 8.7 Physical and emotional needs: 8.7	Not Achieved
Percentage Did Not Attend (DNA) appointments for First Specialist assessments.	Q	HVPI	7%	≤7%	7%	Achieved
Percentage DNA appointment for follow-up Specialist appointments.	Q	HVPI	8%	≤8%	7%	Achieved

Cancer services						
Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	T	PP30	94.9%	≥85%	93%	Achieved
Percentage of patients with a high suspicion of cancer and a need to be seen within 2 weeks that received their first cancer treatment (or other management) within 62 days of being referred.	T	HT3	87.1%	≥90%	96%	Achieved

Comments on Performance

Medical and surgical services

We have continued to improve access to elective surgery services with 6,238 surgical elective discharges in 2018/19. Our standardised inpatient average length of stay in the hospital, for both acute and elective/planned care, has reduced and we have met our targets in these areas. However, we have struggled to reduce the time our patients spend in the Emergency Department before being discharged to specialist wards or sent home. This is an area that we are continually aiming to improve. Collaborative work is underway to improve access and flows across the service, including planning actions in key specialty areas to support more timely assessment, review and treatment of patients within the Emergency Department, to support quality and safe patient care. The Smooth Sailing project is also focused on improving patient flow from our Emergency Department into the General Medicine service at Hutt Hospital.

Our inpatient experience survey results have dropped slightly across all four areas. This is concerning and we are looking to see what has caused this and how we can improve.

Our rate of inpatient falls causing harm per 1,000 bed days has increased. We have several initiatives in place, overseen by our Falls Committee, to improve the proportion of patients who receive a risk assessment, including putting the assessments on Trendcare. We are closely monitoring monthly data and holding discussions with staff at ward level to reduce our rate of inpatient falls. Our Falls Committee is also reporting on our progress to the Quality and Patient Safety Committee.

Our rates of hospital acquired pressure injuries and identified medication errors have improved since 2017/18 and we have achieved our targets. Our Medicines Committee is continuing to monitor identified medication errors, including data analysis by ward medication group. We also have a Pressure Injury Steering Group overseeing a plan to reduce the incidence of hospital acquired pressure injury and improve the management of those that do occur. This is supported by a Pressure Injury prevention coordinator role (funded by ACC).

Cancer services

We have achieved our targets for cancer services by providing timely access to first cancer treatments. Ensuring that cancer patients receive prompt high quality care is a high priority for our DHB. There has been a significant effort made to improve the care for cancer patients and to sustain the improvements made.

Mental health and addictions services

The demand for mental health services in our district is growing in line with expectations. Work is continuing on reducing wait times. The 3DHB Mental Health, Addictions and Intellectual Disability Service (MHAIDS) has commenced a project to implement automatic entry of Te Haika (contact centre) referrals using robot technology. All Te Haika referrals will automatically be entered into WebPas within three minutes of a clinician saving/completing an intake document. This will improve the accuracy of referral and activity data, and reduce wait times for initial entry into the service.

A number of other initiatives are underway to reduce wait times for service users, including processes to reduce 'Did Not Attend' rates for initial assessments, work to improve processes between providers, and regular individual and team caseload reviews.

Output Class 4: Rehabilitation and Support

Description

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.

Context

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions. As a result, effective support services will help to reduce demand for acute services and improve access to other services and interventions. Support services will have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. It will also free up resources for investment into early intervention, health promotion, and prevention services that will help people stay healthier for longer. Our DHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as

eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that our DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Outputs

Health of older people services: These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, working with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports.

How we measure the performance of our Rehabilitation & Support Services

Outputs measured by	Note		2017/18 Performance	2018/19 Target	2018/19 Performance	2018/19 Achievement
Disability care services						
Number of sub-regional and Disability forums.	V	HVPI	0 (A forum is planned for 2018/19)	≥1	2	Achieved
Number of sub-regional Disability newsletters published.	V	HVPI	2	≥3	0	Not Achieved
Total number of hospital staff that have completed the Disability Responsiveness eLearning module.	Q	HVPI	734	≥840	389	Not Achieved
Total number of Disability alert registrations	Q	HVPI	4,817	≥4,000	3 DHB 5,550 HVDHB 910	Achieved

Health of Older People (HOP) services						
Percentage of people 65+ years who have received long term home support services in the last 3 months who have had comprehensive clinical [InterRAI] assessment and a completed care plan.	C	PP23	99.7%	100%	99.2%	Not Achieved
Percentage of people 65+years receiving DHB funded HOP support that are being supported to live at home.	C	PP23	66%	≥65%	64%	Not Achieved
Percentage of the population aged 75+ years that are in Aged Residential Care (including private payers).	C	HVPI	12%	11%	12%	Not Achieved
Percentage of residential care providers being awarded 3-year (or more) certification in the planned year.	Q	HVPI	100%	100%	100%	Achieved

Comments on Performance

Disability services

Our focus on increasing the uptake of Disability Alerts is paying off and we achieved our target. Disability Alerts contain specific information provided by the patient on how best to meet their support needs. The Disability Alerts make is much easier for disabled people to communicate their needs to health practitioners.

Health of Older People Services

The percentage of people aged 65 years and over who have received long term home support services in the last three months and who have had an InterRAI assessment has been sustained. This means that people have been assessed using a comprehensive clinical tool (the InterRAI) and the information used to complete a care plan. The number of people continuing to live at home with support is in line with expectations for our district. Our aim is to enable people to remain living well in their own home with DHB investment in appropriate support services. We are again pleased to report that 100% of the aged residential care facilities in our district meet the three-yearly certification standard requirements.

Financial Statements

Contents

Statement of comprehensive revenue and expense

For the year ended 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Revenue				
Operating Revenue	2	574,391	566,925	549,848
Interest		454	550	597
Dividends		41	-	-
Total revenue		**574,886**	**567,475**	**550,445**
Expenditure				
Personnel Costs	3	190,558	185,086	175,326
Depreciation and Amortisation	10-11	14,118	14,136	13,673
Outsourced Services		16,478	11,556	17,002
Clinical Supplies		23,475	25,736	26,153
Infrastructure and Non-Clinical expenses		16,427	12,922	15,532
Other District Health Boards		95,136	97,633	93,040
Non-Health Board Providers		211,615	210,802	202,382
Capital Charge	4	12,022	12,070	10,092
Finance costs	5	23	71	51
Other expenses	6	3,373	5,512	4,085
Total expenditure excluding Holidays Act and NOS*		**583,225**	**575,524**	**557,336**
Surplus/(deficit) excluding Holidays Act and NOS*		**(8,339)**	**(8,049)**	**(6,891)**
Holidays Act Provision	29	9,321	-	-
National Oracle System (NOS) impairment		2,216	-	-
Surplus/(deficit) for the year		**(19,876)**	**(8,049)**	**(6,891)**
Other comprehensive revenue and expense				
Gain/(loss) on property revaluations		(7,175)	-	38,246
Total comprehensive revenue and expense		**(27,051)**	**(8,049)**	**31,355**

*NOS = National Oracle System

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 27.

Statement of changes in equity

For the year ended 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Equity as at 1 July		201,606	201,605	170,458
Capital Contributions from the Crown		-	-	-
Repayment of equity to the Crown		(207)	(207)	(207)
Revaluation reserves		(7,175)	-	38,246
Net surplus/(deficit)		(19,876)	(8,049)	(6,891)
Equity as at 30 June	17	**174,347**	**193,349**	**201,606**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 27.

Statement of financial position

As at 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	3,783	8,648	15,443
Debtors and other receivables	8	27,822	18,332	18,093
Inventories	9	1,434	1,415	1,387
Total Current Assets		**33,039**	**28,396**	**34,923**
Non-Current Assets				
Property, Plant and Equipment	10	210,947	232,806	223,284
Intangible Assets	11	19,246	10,111	20,470
Investments in Joint Ventures	12	1,150	1,150	850
Trust and bequest funds	13	1,409	1,389	1,389
Total Non-Current Assets		**232,752**	**245,456**	**245,993**
Total Assets		**265,791**	**273,852**	**280,916**
Liabilities				
Current Liabilities				
Creditors and other payables	14	39,230	28,688	37,802
Employee entitlements and provisions	15	42,340	32,363	31,766
Borrowings	16	221	509	509
Total Current Liabilities		**81,791**	**61,560**	**70,077**
Non-Current Liabilities				
Employee entitlements and provisions	15	8,245	7,769	7,623
Borrowings	16	-	221	221
Trust and bequest funds	13	1,409	10,952	1,389
Total Non-Current Liabilities		**9,654**	**18,942**	**9,233**
Total Liabilities		**91,445**	**80,503**	**79,310**
Net Assets		**174,347**	**193,349**	**201,606**
Equity				
Crown equity	17	124,123	124,123	124,330
Revaluation reserves	17	126,422	133,597	133,597
Accumulated deficit	17	(76,199)	(64,372)	(56,321)
Total Equity	17	**174,347**	**193,349**	**201,606**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 27.

Statement of cash flows

For the year ended 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Cashflows from Operating Activities				
Cash receipts		564,711	566,686	548,294
Payments to providers		(304,063)	(308,434)	(294,279)
Payments to suppliers & employees		(249,482)	(239,648)	(233,277)
Goods and Services Tax (net)		(308)	-	(128)
Capital charge paid		(12,022)	(12,070)	(10,092)
Net cash flows from Operating Activities	18	**(1,165)**	**6,534**	**10,518**
Cashflows from Investing Activities				
Interest received		454	550	597
Dividends received		41		
Proceeds from sale of property, plant and equipment		-	-	-
Purchase of property, plant and equipment and Intangible assets		(9,950)	(13,300)	(7,947)
Investments		(300)	(300)	(300)
Net cash flows from Investing Activities		**(9,755)**	**(13,050)**	**(7,650)**
Cashflows from Financing Activities				
Equity Contribution		-	-	-
Loans and finance lease raised/(paid)		-	-	-
Interest paid		(23)	(71)	(51)
Payment of Finance Leases		(510)	-	(404)
Repayment of Equity		(207)	(207)	(207)
Net cash flows from Financing Activities		**(740)**	**(278)**	**(662)**
Net (Decrease) / Increase in Cash and Cash Equivalents		**(11,660)**	**(6,794)**	**2,206**
Cash and cash equivalents at beginning of year	7	15,443	15,443	13,237
Cash and Cash Equivalents at end of year		**3,783**	**8,649**	**15,443**

The accompanying notes form part of these financial statements. Explanations of major variances from last year are provided in note 27.

Notes to the financial statements

For the year ended 30 June 2019

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 2019, and were approved by the Board on 31 October 2019.

Basis of Preparation

Going Concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that Hutt Valley DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect Hutt Valley DHB during the period of one year from the date of signing the 2018/19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort, dated 21 October 2019 from the Ministers of Health and Finance which states that the Crown acknowledges that equity support may be required and that the Crown will provide such support where necessary to maintain viability.

Operating and cash flow forecasts

Taking the Letter of Comfort into consideration, the Board has considered forecast information relating to operational viability and is satisfied that there will be sufficient cash flows from income and overdraft facilities available to meet the operating and financing cash flow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements

The forecasts for the next three years prepared by Hutt Valley DHB show that the peak borrowing requirement, excluding any Holiday Act remediation, will not exceed the available borrowing facilities, based on the assumption that the DHBs approved facility will be available taking into account the needs of the rest of the health sector. Furthermore, the forecast borrowing requirements can be met without breaching covenants of other borrowing restrictions.

While the Board is confident in the ability of Hutt Valley DHB to continue as a going concern, if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether Hutt Valley DHB would be able to continue as a going concern based on current trading terms and legislative requirements.

If Hutt Valley DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Statement of Compliance

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

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

These financial statements comply with 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 Policies

In line with the Financial Statements of the Government, Hutt Valley DHB has elected to early adopt PBE IFRS 9 Financial Instruments.

PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 30.

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 annual periods

beginning on or after 1 January 2021, with early application permitted. Hutt Valley DHB does not intend to early adopt the amendment.

PBE IPSAS 34 Separate Financial Statements, PBE IPSAS 35 Consolidated Financial Statements, PBE IPSAS 36 Investments in Associates and Joint Ventures, PBE IPSAS 37 Joint Arrangements, PBE IPSAS 38 Disclosure of Interests in Other Entities

PBE IPSAS 34-38 replace the existing standards for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019. Hutt Valley DHB will apply these new standards in preparing the 30 June 2020 financial statements. No effect is expected as a result of this change.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Hutt Valley DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Hutt Valley DHB has not yet determined how application of PBE FRS 48 will affect its Statement of Performance.

Significant Accounting Policies

Revenue

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. The MoH credits Hutt Valley DHB with a monthly amount based on estimated patient treatment for non-Hutt Valley residents within Hutt Valley. An annual wash up occurs at year end to reflect the actual non-Hutt Valley patients treated at Hutt Valley DHB.

Interest income

Interest income is recognised using the effective interest method.

Rental income

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

Provision of services

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

Donations and bequests

Donations and bequests which have restrictive conditions are recognised as liabilities of the DHB. They are recognised as revenue in the statement of comprehensive income when spent in accordance with the conditions.

Expenses

Capital Charge

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

Borrowing costs

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

Leases

Finance Leases

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

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

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

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

Operating Leases

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

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

Foreign currency transactions

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

Cash and Cash equivalents

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

Debtors and other receivables

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.

In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was objective evidence that the amount due would not be fully collected.

Investments

Bank deposits

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

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

Inventories

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

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

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

Property, plant and equipment

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

- land;
- site improvements;
- building services fit out;
- 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. 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.% to 10.0%
Building Structure, Services and Fit out	6 to 53 years	1.9% to 18.0%
Plant and equipment	2.5 to 29 years	3.5% to 40.0%
Computer equipment	3 to 22 years	4.5% to 33.3%
Leased assets	3 to 15 years	6.5% to 33.3%
Motor vehicles	6 to 10 years	10.0% to 18.0%

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.

Intangible assets

Software acquisition and development

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

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

Costs associated with maintaining computer software 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 21 years	4.8% to 20.0%

Impairment of property, plant, and equipment and intangible assets

Property, plant, and equipment and intangible assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds

its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

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

Creditors and other payables

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

Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Hutt Valley DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where Hutt Valley DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if Hutt Valley DHB expects to settle the liability within 12 months of the balance date.

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 entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, long service leave, retirement gratuities, continuing medical education and expenses, and other entitlements such as sabbatical leave, have been calculated on an actuarial basis. The calculations are based on 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 classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

Hutt Valley DHB is a participating employer in the National Provident Fund (NPF) Superannuation Scheme ("the Scheme") which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the employer could be responsible for an increased share of the surplus or deficit of the Scheme.

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

Provisions

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

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.

Equity

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

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

Revaluation reserves

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

The budget figures are derived from the statement of 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.

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.

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

Critical accounting estimates and assumptions

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

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

Estimating the fair value of land and buildings

See note 10 for the estimates and assumptions applied in the measurement of revalued land and buildings

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

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

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

Critical judgements in applying accounting policies

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

Classification of Leases

Determining whether a lease agreement is 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 two lease arrangements are finance leases.

2 Operating income

	2019 Actual $000	2018 Actual $000
Ministry of Health contract funding	453,977	429,555
ACC Contract revenue	7,539	6,221
Other Government	2,165	1,483
Revenue from other District Health Boards	106,382	105,904
Other patient care related revenue	3,705	6,026
Other Income:		
Donations and bequests received	286	280
Gain on sale of fixed assets	-	-
Rental income and services	337	379
Total Operating Income	**574,391**	**549,848**

3 Personnel costs

	2019 Actual $000	2018 Actual $000
Salaries and wages	184,284	169,411
Defined contribution plan employer contributions	4,394	3,991
Increase/(decrease) in liability for employee entitlements	1,881	1,924
Total Personnel Costs	**190,558**	**175,326**

Employer contributions to defined contribution schemes include contributions to KiwiSaver, the Government Superannuation Fund and the National Provident Fund Superannuation Scheme.

4 Capital charge

Hutt Valley DHB pays a capital charge to the Crown every six months. The charge is now based on the actual closing equity balance excluding the value of donated assets. The capital charge rate was 6% for the year ending 30 June 2019 (2018: 6%).

5 Finance costs

	2019 Actual $000	2018 Actual $000
Interest on Crown Loans	-	-
Interest on finance leases	23	51
Total Finance Costs	**23**	**51**

6 Other expenses

	2019 Actual $000	2018 Actual $000
Audit Fees for financial statement audit	158	162
Audit-related fees for internal audit services	85	96
Operating lease expense	2,777	3,443
Allowance for credit losses on receivables	46	93
Board member and other fees	307	290
Loss on disposal of property, plant and equipment	-	1
Total Other expenses	**3,373**	**4,085**

7 Cash and cash equivalents

	2019 Actual $000	2018 Actual $000
Call Deposits with NZ Health Partnerships Ltd	(1,451)	5,874
Cash at bank and on hand	5,234	9,569
Total Cash and cash equivalents	**3,783**	**15,443**

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value.

The 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 debit balance 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 $20.1m (2018: 20.1m).

8 Debtors and other receivables

	2019 Actual $000	2018 Actual $000
Ministry of Health	9,198	8,300
Other DHBs	5,044	1,154
PHARMAC	8,478	6,171
Trade debtors - other	4,678	2,023
Other Departments	56	140
	27,454	**17,788**
Less: Allowance for credit losses	(359)	(366)
	27,095	**17,422**
Prepayments	727	671
Total Debtors and other receivables	**27,822**	**18,093**
Total Debtors and other receivables comprises:		
Revenue from the sale of goods and services (exchange transactions)	8,910	9,489
Revenue from grants (non-exchange transactions)	18,912	8,604
Total Debtors and other receivables	**27,822**	**18,093**

The expected credit loss rates for receivables at 30 June 2019 and 1 July 2018 are based on the payment profile of revenue on credit over the prior two years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

The changes resulting from PBE IRFRS 9 are provided in note 30.

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

	2019 Actual $000	2018 Actual $000
Allowance for credit losses as at 1 July calculated under PBE IPSAS 29	(366)	(311)
PBE IFRS 9 expected credit loss adjustment – through opening accumulated surplus/deficit	-	N/A
Opening allowance for credit losses as at 1 July	(366)	(311)
Increase in loss allowance made during the year	(46)	(94)
Receivables written off during the year	53	39
Closing Balance	**(359)**	**(366)**

9 Inventories

	2019 Actual $000	2018 Actual $000
Pharmaceuticals	190	137
Surgical and medical supplies	1,254	1,260
	1,444	**1,397**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,434**	**1,387**

All inventories are distributed to operating areas in the normal course of business and recognised as an expense at the time of distribution. The write-down of inventories held for distribution amounted to $nil (2018: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2018: nil) however some inventories are subject to retention of title clauses.

10 Property, plant and equipment

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

	Land	Site Improve-ments	Building Services Fit out	Plant & Equipment	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance 1 July 2017	20,040	2,634	171,343	42,746	2,062	2,291	241,116
Additions	-	9	3,889	1,929	809	-	6,636
Disposals			-	(51)	-	-	(51)
Adjustments	-	-	(4,595)	(3,169)	-	-	(7,764)
Revaluation increase/(decrease)	8,010	52	6,638	(1,123)	(587)	-	12,990
Work In progress	-	-	2,279	3, 682	-	-	5,961
Balance at 30 June 2018	28,050	2,695	179,554	44,014	2,284	2,291	258,888
Balance 1 July 2018	28,050	2,695	179,554	44,014	2,284	2,291	258,888
Additions	-	3	1,578	2,958	-	-	4,539
Disposals			-	(99)	-	-	(99)
Adjustments	-	-	(2,279)	(3,682)	-	-	(5,961)
Revaluation increase/(decrease)	-	-	(7,175)	-	-	-	(7,175)
Work In progress	-	-	3,284	4,135	-	195	7,614
Balance at 30 June 2019	28,050	2,698	174,962	47,326	2,284	2,486	257,806

Accumulated depreciation and impairment losses							
Balance at 1 July 2017	-	268	16,486	29,900	1,104	1,599	49,357
Depreciation expense	-	146	8,315	2,605	213	275	11,554
Depreciation on disposals	-	-	-	(51)	-	-	(51)
Elimination on revaluation	-	(401)	(23,807)	(625)	(423)	-	(25,256)
Balance 30 June 2018	-	13	994	31,829	894	1,874	35,604
Balance 1 July 2018	-	13	994	31,829	894	1,874	35,604
Depreciation expense	-	146	8,303	2,261	372	271	11,353
Depreciation on disposals	-	-	-	(98)	-	-	(98)
Elimination on revaluation	-	-	-	-	-	-	-
Balance 30 June 2019	-	159	9297	33,992	1,266	2,145	46,859
Carrying Amounts							
At 30 June 2017 and 1 July 2017	20,040	2,366	154,857	12,846	958	692	191,759
At 30 June 2018	28,050	2,682	178,560	12,185	1,390	417	223,284
At 30 June 2019	28,050	2,539	165,665	13,334	1,018	341	210,947

The net carrying amount of assets held under finance leases is $0.5m (2018: $0.7m) for plant and equipment.

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.

Capitalised interest of $7.175m was included in the 2018 land and building revaluation and reversed in the 2019 Financial Accounts.

Valuation

Land and building valuations are done on a five year cycle. Desktop valuation updates are done in the interim years between full valuations. A desktop valuation was done in 2019, by an independently contracted registered valuer, Peter Schellekens, ANZIV, SPINZ of CBRE Limited. Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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.
- For Hutt Valley DHBs earthquake prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement costs in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Seismic Status of Building

Hutt Valley DHB's buildings have been assessed against the earthquake standards. All the assessed buildings met the current minimum standards of the Building Code for existing buildings.

11 Intangible assets

	Acquired Software	NOS Shared Services Rights	Investment In RHIP	Total
	$000	$000	$000	$000
Cost or valuation				
Balance 1 July 2017	21,744	1,910	6,551	30,205
Additions	784	-	-	784
Adjustments	(1,986)	-	(964)	(2,950)
Work In progress	3,592	-	1,688	5,280
Balance 30 June 2018	24,134	1,910	7,275	33,319
Balance 1 July 2018	24,134	1,910	7,275	33,319
Additions	2,221	-	-	2,221
Adjustments	(3,592)	-	(7,275)	(10,867)
Impairment	-	(1,910)	-	(1,910)
Work In progress	3,760	-	8,337	12,097
Balance 30 June 2019	26,523	-	8,337	34,860
Accumulated amortisation and impairment losses				
Balance at 1 July 2017	10,730	-	-	10,730
Amortisation expense	2,119	-	-	2,119
Balance 30 June 2018	12,849	-	-	12,849
Balance at 1 July 2018	12,849	-	-	12,849
Amortisation expense	2,765	-	-	2,765
Balance 30 June 2019	15,614	-	-	15,614
Carrying Amounts				
At 30 June 2017 and 1 July 2017	11,014	1,910	6,551	19,475
At 30 June 2018	11,285	1,910	7,275	20,470
At 30 June 2019	10,909	-	8,337	19,246

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

During 2015 Hutt Valley DHB and the other DHBs involved in the RHIP project (formally CRISP project) signed a variation to the original agreement regarding investment in RHIP. It was agreed that investments in CRTAS would no longer be for the acquisition of Class B redeemable Preference Shares. The capital payments to CRTAS for the RHIP project have been reclassified as Work in Progress as at 30 June 2016 as all partners in the RHIP project are to share ownership of the intangible assets resulting from RHIP. Hutt Valley DHB had treated the initial contributions as Investment in Associates in the financial statements to 30 June 2014. These have now been reclassified as Work in Progress.

12 Investments in companies and joint ventures

	2019 Actual $000	2018 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares – Allied Laundry Limited	1,150	850
Closing Balance	**1,150**	**850**

13 Trust and bequest funds

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

	2019 Actual $000	2018 Actual $000
Opening balance	1,389	1,369
Funds received	241	321
Interest received	21	22
Funds disbursed	(242)	(323)
Closing Balance	**1,409**	**1,389**

14 Creditors and other payables

	2019 Actual $000	2018 Actual $000
Payables under exchange transactions		
Creditors	5,539	3,046
Accrued expenses	26,028	23,386
Inter-district flows	(159)	(2,227)
Interest	-	-
Income in advance	272	2,015
Total payables under exchange transactions	31,680	26,220
Payables under non-exchange transactions		
Taxes	2,334	2,025
Trusts	5,216	9,557
Total payables under non-exchange transactions	7,550	11,582
Total Creditors and other payables	**39,230**	**37,802**

See note 25 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

	2019 Actual $000	2018 Actual $000
Current provision		
Salary and Wages Accrued	6,449	6,558
Annual leave	19,256	17,989
Long Service Leave	2,252	2,402
Retirement Gratuities	373	332
Continuing Medical Education Leave and Expenses	1,049	995
Other Entitlements	12,961	3,490
Total Current provision	**42,340**	**31,766**
Non-current provision		
Long Service leave	2,125	1,908
Retirement Gratuities	755	648
Continuing Medical Education Leave and Expenses	3,052	2,969
Other Entitlements	2,313	2,098
Total Non-current provision	**8,245**	**7,623**
Total Employee Entitlements and Provisions	**50,585**	**39,389**

The present value of long service leave, retirement gratuities, sabbatical 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 4.30% (2018: 4.75%) and an inflation factor of 2.5% (2018: 2.0%) has been used.

16 Borrowings

	2019 Actual $000	2018 Actual $000
Current portion		
Finance Leases	221	509
	221	**509**
Non-current portion		
Finance Leases	-	221
	-	**221**
Total borrowings	**221**	**730**

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

The fair value of finance leases is $.221m (2018: 0.730m). Fair value is estimated at the present value of future cash flows.

Analysis of Finance Lease

	2019 Actual $000	2018 Actual $000
Minimum lease payments payable:		
Not later than one year	223	532
Later than one year and not later than five years	-	223
Later than five years	-	-
Total minimum lease payments	223	755
Future finance charges	(2)	(25)
Present value of minimum lease payments	221	730
Present value of minimum lease payable:		
Not later than one year	221	509
Later than one year and not later than five years	-	221
Later than five years	-	-
Total present value of minimum lease payments	221	730

Description of finance leasing arrangements

Hutt Valley DHB did not enter into any new finance leases during 2019 (2018: Nil). In total Hutt Valley DHB holds 2 (2018: 3) finance leases. The finance leases are for medical equipment. There are no restrictions placed on Hutt Valley DHB by any of the finance leasing arrangements.

17 Equity

	$000	Land Revaluation Reserve $000	Buildings Revaluation Reserve $000	Equipment Revaluation Reserve $000	Retained Earnings/ (Deficit) $000	$000
Balance at 1 July 2017	**124,539**	**15,679**	**79,672**	**-**	**(49,432)**	**170,458**
Crown Loan converted into Equity	-	-	-	-	-	-
Repayment of Equity	(207)	-	-	-	-	(207)
Revaluation surplus	-	8,010	30,898	(662)	-	38,246
Surplus/(deficit) for the year	-	-	-	-	(6,891)	(6,891)
Balance at 30 June 2018	**124,332**	**23,689**	**110,570**	**(662)**	**(56,323)**	**201,606**
Balance at 1 July 2018	**124,332**	**23,689**	**110,570**	**(662)**	**(56,323)**	**201,606**
Crown Loan converted into Equity	-	-	-	-	-	-
Repayment of Equity	(207)	-	-	-	-	(207)
Revaluation Reserve	-	-	(7,175)	-	-	(7,175)
Surplus/(deficit) for the year	-	-	-	-	(19,876)	(19,876)
Balance at 30 June 2019	**124,125**	**23,689**	**103,395**	**(662)**	**(76,200)**	**174,347**

18 Reconciliation of net surplus/deficit to net cash flow from operating activities

	2019 Actual $000	2018 Actual $000
Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities		
Net surplus/(deficit)	(19,874)	(6,891)
Add/(less) non-cash items:		
Depreciation and amortisation expense	14,118	13,673
Impairment expense	2,216	-
Increase/(decrease) in Provisions	11,189	1,978
Total non-cash items	**27,523**	**15,651**
Add/(less) items classified as investing or financing activity:		
(Gains)/losses on sale of property, plant and equipment	-	1
Dividends received	(41)	-
Net interest received	(431)	(546)
Total items classified as investing or financing activity	**(472)**	**(545)**
Add/(less) movements in statement of financial position items:		
(Increase)/decrease in debtors and other receivables	(9,722)	1,352
(Increase)/decrease in inventories	(47)	56
Trust Movement	(4,341)	3,435
Increase/(decrease) in creditors and other payables	5,769	(2,540)
Net movements in Working Capital items	**(8,342)**	**2,303**
Net cash flow from Operating Activities	**(1,165)**	**10,518**

19 Capital commitments and operating leases

	2019 Actual $000	2018 Actual $000
Capital commitments	6,053	5,097
Operating Leases as lessee		
Not later than one year	1,626	1,599
Later than one year and not later than five years	2,971	3,235
Later than five years	-	68
Total Non-cancellable Commitments	**10,650**	9,999

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

The DHB leases premises, vehicles, EFTPOS machines and medical equipment under operating leases. The major leases are outlined below:

- The Regional Public Health premises in Porirua are leased for six years with one right of renewal in March 2021 and a final expiry date of March 2025.
- The 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.
- The Community Mental Health premises in Upper Hutt are leased for six years with two rights of renewal in June 2021 and June 2027 and a final expiry date of August 2029.
- The CT scanner and four ultrasound machines are leased for five years with an expiry date of August 2022.
- The Magnetic Resonance Imaging (MRI) machine is leased for three years with an expiry date of September 2019.

20 Contingencies

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2019 (2018: Nil).

21 Related party transactions

Hutt Valley DHB is a wholly owned entity of the Crown. All related party transactions have been entered into on an arm's length basis.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect Hutt Valley DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other Government agencies 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.

	2019 Actual $000	2018 Actual $000
Leadership Team		
Salaries and other short-term employee benefits	$2,097	$2,377
Full-time equivalent members	*11.08*	*11.33*
Board Members		
Remuneration	$255	$260
Full-time equivalent members	*1.29*	*1.29*

An analysis of Board member remuneration is provided in Note 22.

During the year Hutt Valley DHB transacted with Capital & Coast DHB on normal inter-DHB terms. In addition the DHBs share some board members and also hold combined Community Public Health Advisory Committee meetings.

During the year Hutt Valley DHB transacted with Wairarapa DHB on normal inter-DHB terms. In addition the DHBs share an executive management team and also hold combined Community Public Health Advisory Committee meetings.

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 (2018: nil).

22 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**	**2018/19 actual ($000)**	**2017/18 actual ($000)**
Andrew Blair	Chair	44	45
Wayne Guppy	Deputy Chair	29	28
David Ogden	Current Member	23	23
John Terris	Current Member	21	22
Ken Laban	Current Member	23	23
Peter Douglas	Current Member (until 31 August 2017)	-	6
Yvette Grace	Current Member	22	22
Tim Ngan-Kee	Current Member	24	23
Kim von Lanthen	Current Member	23	23
Prue Lamason	Current Member	24	23
Lisa Bridson	Current Member	22	22
Total Board member remuneration		255	260

Board and committee meeting attendances in the year to 30 June 2019:

Board Member	Position	Meetings Attended				Meetings held			
		Board	FRAC	HAC	CPHAC-DSAC	Board	FRAC	HAC	CPHAC-DSAC
Andrew Blair	Board Chair	11	11	0	0	11	11	0	7
Wayne Guppy	Deputy Board Chair	10	10	0	0	11	11	0	7
David Ogden	Current Member	10	10	0	0	11	11	0	7
John Terris	Current Member	10	0	0	5	11	11	0	7
Ken Laban	Current Member	10	8	0	3	11	11	0	7
Yvette Grace	Current Member	7	0	0	5	11	11	0	7
Tim Ngan Kee	Current Member	11	11	0	4	11	11	0	7
Kim von Lanthen	Current Member	10	10	0	0	11	11	0	7
Prue Lamason	Current Member	11	9	0	6	11	11	0	7
Lisa Bridson	Current Member	10	0	0	6	11	11	0	7

Ken Laban – only appointed to CPHAC from August 2018.

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.

23 Employee remuneration

Details of employee remuneration can be found in the 'Our People' section – please refer to page 37 of this report.

24 Events after the balance date

There are no significant events subsequent to balance date.

25 Financial instruments

Fair Values

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

	2019		2018	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	$000	$000	$000	$000
Cash and cash equivalents	3,783	3,783	15,443	15,443
Debtors and other receivables	27,822	27,822	18,093	18,093
Creditors and other payables	39,230	39,230	37,802	37,802
Borrowing	221	221	730	730
	71,056	**71,056**	**72,068**	**72,068**

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 Hutt Valley 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 2019, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2018/19, 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 obligations 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. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks, 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 amount of credit exposure to any one financial institution for term deposits is limited to no more than 25% of total investments held. Investments are entered into only with registered banks that have a Standard and Poor's credit rating of at least A2 for short term and A- for long-term investments. 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 credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates:

	2019 Actual $000	2018 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
AA+	6,643	10,958
AA-		-
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	(1,451)	5,874
Total	**5,192**	**16,832**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	3,783	15,443
Trust and bequest funds	1,409	1,389
Debtors and other receivables	27,822	18,093

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

Management of 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 as described in Note 7.

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2018					
Creditors and other payables	33,762	33,762	33,762	-	-
Finance leases	730	755	277	254	224
Total	**34,492**	**34,517**	**34,039**	**254**	**224**

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2019					
Creditors and other payables	45,945	45,945	45,945	-	-
Finance leases	221	223	532	223	-
Total	**46,166**	**46,168**	**46,477**	**223**	-

26 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.

27 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 2019 are provided below.

Statement of Comprehensive revenue and expense

The Hutt Valley DHB recorded a deficit of $8.339m (excluding one off exceptional items) compared with a budget deficit of $8.049m. The major variances were:

- Revenue for the DHB was $7.4m (1.3%) over budget due to fluctuations in the operational funding received during the year
- Expenditure for the DHB was $7.7m (1.3%) over budget due to additional costs in the Personnel area relating to the cost of covering the industrial action and nursing costs relating to one on one care. These were offset by savings in other areas to bring the total expenses close to budget.

Two exceptional items included a provision of $9.321m for the Holidays Act remediation and a $2.216m write off relating to NOS. Including these items the total deficit was $19.876m

Statement of Financial Position

- Current Assets were $4.6m (16.4%) higher than budget due to an increase in Accounts Receivable which was a timing issue between Pharmac ($2.3m) and other DHB ($3.9m) payments.
- Non-Current Assets were $12.7m (5.2%) lower than budget due to a revaluation of Land and Buildings adjustment ($7.175m), Asset Impairment ($2.2m) and less than budgeted Capex spend.
- Current Liabilities were $20.2m (32.8%) due to an increase in Accrued Expenses around the Holiday Act Provision ($9.3m) and accrued Trust payments ($5.2m).
- Non-Current Liabilities were $9.3m (49.0%) lower than budget due to Trust payments being accrued and higher than budget.

Statement of Cash Flows

Payments to suppliers and staff have been higher than budget as per above hence the decrease in the cash position.

28 Cost of service statements for output classes

For the year ended 30 June 2019

$000s	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
	2018\19 Actual	2018\19 Budget	2017\18 Audited	2018\19 Actual	2018\19 Budget	2017\18 Audited	2018\19 Actual	2018\19 Budget	2017\18 Audited	2018\19 Actual	2018\19 Budget	2017\18 Audited	2018\19 Actual	2018\19 Budget	2017\18 Audited
Income															
Operating Income	20,485	20,414	20,307	284,110	282,120	252,288	214,676	210,454	204,785	55,161	53,937	72,468	574,432	566,925	549,848
Interest Income	23	28	30	15	18	20	415	503	546	1	1	1	454	550	597
Total Income	20,508	20,442	20,337	284,125	282,138	252,308	215,091	210,957	205,331	55,162	53,938	72,469	574,886	567,475	550,445
Expenditure															
Personnel Costs	12,680	12,634	12,797	11,638	12,139	10,369	161,708	156,010	147,843	4,532	4,303	4,317	190,558	185,086	175,326
Depreciation	255	339	463	804	824	930	13,039	12,957	12,262	20	16	18	14,118	14,136	13,673
Outsourced Services	1,520	1,371	1,346	1,358	1,078	1,272	13,387	8,922	14,220	213	185	164	16,478	11,556	17,002
Clinical Supplies	503	478	504	537	817	446	20,884	23,268	23,764	1,551	1,173	1,439	23,475	25,736	26,153
Infrastructure and Non Clinical Expenses	549	515	530	818	992	1,091	24,279	11,327	13,741	102	88	170	25,748	12,922	15,532
Other District Health Boards	0	0	0	91,434	93,844	88,441	0	0	0	3,702	3,789	4,599	95,136	97,633	93,040
Non Health Board Providers	0	0	0	167,471	168,042	143,338	0	0	0	44,144	42,760	59,044	211,615	210,802	202,382
Capital Charge	568	570	470	1,083	1,096	1,031	10,351	10,384	8,575	20	20	16	12,022	12,070	10,092
Interest Expense	0	0	0	0	0	0	23	71	51	0	0	0	23	71	51
Other	289	1,037	881	560	229	516	4,682	4,192	2,610	58	54	78	5,589	5,512	4,085
Internal Allocations	4,014	4,017	4,501	4,261	4,263	3,973	(9,097)	(9,089)	(9,420)	822	810	946	0	0	0
Total Expenditure	20,378	20,961	21,492	279,964	283,324	251,407	239,256	218,042	213,646	55,164	53,198	70,791	594,762	575,524	557,336
Net Surplus / (Deficit)	130	(519)	(1,155)	4,161	(1,186)	901	(24,165)	(7,085)	(8,315)	(2)	740	1,678	(19,876)	(8,049)	(6,891)

29 Holidays Act 2003

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 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 work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, the Hutt Valley DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

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 and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

30 Adoption of PBE IFRS 9 financial instruments

In accordance with the transitional provisions of PBE IFRS 9, Hutt Valley DHB has elected not to restate the information for previous years to comply with PBE IFRS 9. There were no adjustments arising from the adoption of PBE IFRS 9 to be recognised in opening equity at 1 July 2018.

Accounting policies have been updated to comply with PBE IRS 9. The main updates are:

- Note 7 Cash and Cash Equivalents: This policy has been updated to explain that a loss allowance for expected credit losses is recognised only if the estimated credit loss allowance is not trivial.
- Note 8 Debtors and Other Receivables: This policy has been updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.

On the date of initial application of PBE IFRS 9, being 1 July 2018, the classification of financial instruments under PBE IPSAS 29 and PBE IFRS 9 is as follows:

	Measurement Category		Carrying Amount		
	Original PBE IPSAS 29 category	New PBE IFRS 9 category	Closing balance 30 June 2018 (PBE IPSAS 29) $000	Adoption of PBE IFRS 9 adjustment $000	Opening balance 1 June 2018 (PBE IFRS 9) $000
Call deposits, Cash at bank and on hand	Loans and receivables	Amortised Cost	15,443	0	15,443
Debtors and other receivables	Loans and receivables	Amortised Cost	18,093	0	18,093
			33,536	**0**	**33,536**

Statement of Responsibility

We are responsible for the preparation of Hutt Valley DHBs 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 2019.

Signed on behalf of the Board:

Andrew Blair
Board Chair
31 October 2019

Wayne Guppy
Deputy Board Chair
31 October 2019

Independent Auditor's Report

To the readers of Hutt Valley District Health Board's financial statements and performance information for the year ended 30 June 2019

The Auditor-General is the auditor of 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 appropriations, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 62 to 100, that comprise the statement of financial position as at 30 June 2019, 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 38 to 60.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the basis for our qualified opinion section of our report:

- The financial statements of the Health Board on pages 62 to 100:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; 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.

- The performance information of the Health Board on pages 38 to 60:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, 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 appropriations; 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 of the financial statements and the performance information was completed on 31 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we draw 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.

Basis for our qualified opinion

As outlined in note 29 on page 99, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $9.3 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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 qualified opinion.

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in the statement of accounting policies on pages 66 and 67 that outline the financial difficulties being experienced by the Health Board and the expected reliance on borrowing facilities. The Health Board has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown acknowledges that equity support may be required and that the Crown will provide such support, where necessary to maintain viability. We consider these disclosures to be adequate.

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. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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 going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- 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 108, 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(Revised): 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 DHB 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:	Head Office Physical Address:
Hutt Valley District Health Board	Executive Reception
Private Bag 31-907	Pilmuir House, Pilmuir Street
Lower Hutt 5040	Hutt Hospital Campus
Website: www.huttvalleydhb.org.nz	Lower Hutt 5010
Facebook: www.facebook.com/HuttValleyDHB	
Phone: (04) 566 6999	

Bankers	Auditor
Westpac New Zealand Limited (to 25 June 2018) Bank of New Zealand (from 26 June 2018)	Audit New Zealand Wellington, on behalf of the Controller and Auditor-General

Board Members

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 August 2017.

Andrew Blair, Chair	**Lisa Bridson**
Wayne Guppy, Deputy Chair	**David Ogden**
Tim Ngan Kee	**John Terris**
Kim von Lanthen	**Ken Laban**
Yvette Grace	**Prue Lamason**

Executive Leadership Team for Hutt Valley DHB *as at 30 June 2019*

Dale Oliff	Acting Chief Executive Officer	**Judith Parkinson**	General Manager – Finance and Corporate Services
Melissa Brown	Interim Chief Operating Officer	**Debbie Gell**	General Manager – Quality, Service Improvement and Innovation
Chris Kerr	Director of Nursing	**Kerry Dougall**	Director of Māori Health
Sisira Jayathissa	Chief Medical Officer	**Tofa Suafole Gush**	Director of Pacific Peoples Health
Christine King	Director of Allied Health, Scientific & Technical	**Helene Carbonatto**	General Manager – Strategy, Planning and Outcomes
Fiona Allen	General Manager – Human Resources and Organisational Development	**Kristine McGregor**	Executive Officer
Nigel Fairley	General Manager, MHAIDs	**Rommel Anthony**	Acting Chief Information Officer, 3DHB IT Services

3DHB Disability Support Advisory Committee			
The Disability Support Advisory Committee advises the Boards on the disability support needs of the resident populations of the DHBs and the priorities for the use of the disability support funding provided. This is a joint committee with Wairarapa, Hutt Valley, and Capital & Coast District Health Boards.			
Dame Fran Wilde (Chair)	Capital & Coast	**Yvette Grace (Deputy)**	Hutt Valley
Sue Kedgley	Capital & Coast	**Andrew Blair**	Capital & Coast / Hutt Valley
Sue Driver	Capital & Coast	**Eileen Brown**	Capital & Coast
'Ana Coffey	Capital & Coast	**Dr Tristram Ingham**	Capital & Coast
Lisa Bridson	Hutt Valley	**Prue Lamason**	Hutt Valley
John Terris	Hutt Valley	**Derek Milne**	Wairarapa
Alan Shirley	Wairarapa	**Jane Hopkirk**	Wairarapa
Kim Smith	Iwi Kainga Chairperson, Wairarapa	**Fa'amatuainu Tino Pererira**	Chair, Sub-regional Pacific Strategic Health Group
Bob Francis	Chair, Sub-regional Disability Advisory Group		

Community & Public Health Advisory Committee	
The Community & Public Health Advisory Committee advises the Board on the health needs and status of our population.	
Yvette Grace (Chair)	**Andrew Blair**
Lisa Bridson	**Prue Lamason**
John Terris	**Tim Ngan Kee**
Ken Laban	**Teresea Olsen (co-opted)**
Taefa Heker Robertson (co-opted)	

Finance Risk and Audit Committee	
Wayne Guppy (Chair)	**David Ogden**
Andrew Blair	**Prue Lamason**
Ken Laban	**Kim von Lanthen**
Tim Ngan Kee	

Hospital Advisory Committee	
The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Hutt Hospital and its services. From 5 December 2016, HAC business has been carried out at board meetings by the full Board, rather than through separate HAC meetings. Separate HAC meetings will be held if needed.	
Andrew Blair, Chair	**Lisa Bridson**
Wayne Guppy, Deputy Chair	**David Ogden**
Tim Ngan Kee	**John Terris**
Kim von Lanthen	**Ken Laban**
Yvette Grace	**Prue Lamason**