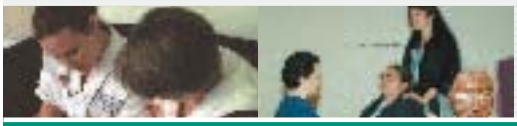
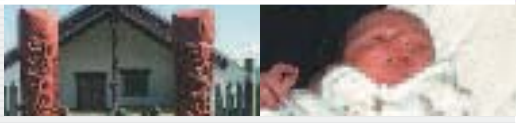


Hutt Valley District Health Board

Report for the year ended 30 June 2002



HUTT VALLEY DHB

Highlights at a glance

- Hutt Valley DHB met or exceeded all significant service performance, planning and funding requirements outlined in the Board's Statement of Intent
- Operating deficit held to $2.103 million, despite not realising expected income from the sale of Pilmuir House; a considerable improvement on the budgeted deficit of $2.479 million
- First 5 Year District Strategic Plan developed following considerable community involvement and public consultation
- Board priorities are Primary Care and Healthy Communities focusing on population health promotion and lifestyle advice
- Organisational focus changed from being solely a provider of health services to being responsible for determining needs, planning and funding health services throughout the Hutt Valley
- Organisation more responsive to community: publicly elected board, surveys, community consultation
- At Hutt Hospital, inpatient and day-case activity exceeded contracted levels, waiting lists continued to drop, and staff turnover was within prescribed limits; better utilisation of capacity to satisfy treatment needs resulting in improved community health
- Relationships with Maori and Pacific Peoples' communities strengthened: three 'by Pacific for Pacific' health services established; first ever Pacific Peoples' Advisor appointed; new Maori Workforce Policy; new consultation processes
- First Primary Health Organisation established, between Hutt Valley DHB and the PHO partners Kokiri Marae, Hutt Union and Community Health Centre, and Whai Oranga O te Iwi.
- New health initiatives including diabetes identification and treatment, skin lesion removal and flu vaccination
- Site optimisation programme and further upgrades completed, on time and within budget; new or refurbished facilities for ENT, burns and plastics, community health, general surgical and gynaecological outpatients and audiology and ophthalmology outpatients
- New website launched: staff intranet providing comprehensive operational data, clinical policies, educational and career information; public Internet site contains comprehensive material about Hutt Valley DHB and the community it serves. www.huttvalleydhb.org.nz

Contents

Head Office
Pilmuir House, Pilmuir Street, Lower Hutt

Bankers
Bank of New Zealand

Postal Address
Private Bag 31-907, Lower Hutt

Solicitors
Impact Legal

Website Address
www.huttvalleydhb.org.nz

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

Hutt Valley DHB People

Board Members

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

Warren Young
Chairman
BComm, FCA, CMA, FCIS, FNZIM, FinstD

Peter Glensor
Deputy Chair
BA

Katy Austin
BA, MBA, NROT

Pat Brosnan

Sharron Cole
MA, DipEd, Dip CBEd

Vera Ellen
RRC, JP, RN, RM, Dip Health Admin

Dr Catherine Love
BA, DipSocSci (Dist), PhD

Hon Peter McCardle
BA

Grant Moffat
MBE, JP, BSc (Otago), Dip Ed

Fuimaono Karl Pulotu-Endemann
MNZM, JP, RPN, RGON, AdvDipNsg

Brenda Tahi
BSocSci, MBA

Committee Members

The membership of the committees is as follows:

Community and Public Health Advisory Committee

Peter Glensor
(Chairperson)

Dr Catherine Love
Katy Austin
Fuimaono Karl Pulotu-Endemann
Vera Ellen
*** Marian Redwood**
*** Neville Baker**
*** Shelley Stansfield**
*** Mike Cooper**
*** Maree Tukukino**
*** Dr Stephen Palmer**

*Co-opted Members

Disability Support Advisory Committee

Katy Austin
(Chairperson)

Dr Catherine Love
***Beryl Harris**
***Geoff Stenton**
***Joan Taylor**

*Co-opted Members

Hospital Advisory Committee

Sharron Cole
(Chairperson)

Brenda Tahi

Peter McCardle

Pat Brosnan

Grant Moffat

Finance, Property and Audit Committee

Warren Young
(Chairman)

Peter Glensor

Peter McCardle

Bruce Gollop

Executive Management Team

Stephen McKernan
Chief Executive (to 31 May 2002)

Bruce Gollop
Acting Chief Executive (1-30 June 2002)

Sam Bartrum
General Manager Public, Primary, Community and Mental Health

Trevor Coad
Chief Financial Officer

Rob Eaddy
General Manager Communications

Warrick Frater
General Manager Hospital and Secondary Services

Suafole Gush
Pacific Peoples' Health Advisor

Martin Hefford
General Manager Planning and Funding

Rhondda Knox
Director of Nursing

Dr Robert Logan
Director of Medicine

Kuini Puketapu
Maori Health Advisor

Justin Te Rangiita
Human Resources Manager

David Williment
Board Secretary

Statement of Purpose

Vision

To be New Zealand's foremost District Health Board in optimising the health and wellbeing of our community.

Mission

To excel in the way we consult, communicate, plan and provide health services to our community.

Values

Working together: with our providers, community groups and other agencies;

Leadership: within our community and through setting a positive example;

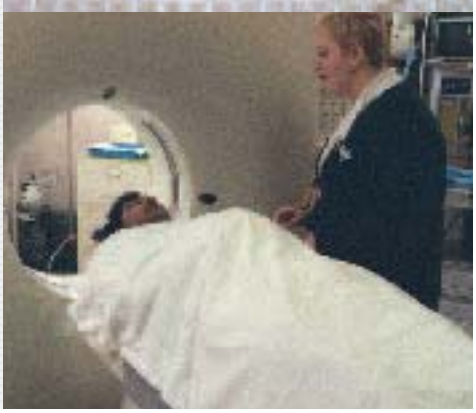
Respect: for each other and the rights of individuals;

Communicating effectively: with our community, with our staff and our clients;

Caring: for our community and for each other; and

Excellence: in all that we do.

Hutt Valley DHB Profile



The Hutt Valley DHB is responsible for planning, prioritising, funding and providing government-funded health care and disability support services for the 135,000 people who live in the Hutt Valley. The Hutt Valley DHB as an organisation employs 1,800 people, most of whom work for Hutt Hospital and our community and regional health services. This is the part of the Hutt Valley DHB that we refer to as the 'provider arm'.

The Board, comprising 11 people of whom seven are elected by the community and four appointed by the Minister of Health, have strategic oversight or governance over the Hutt Valley DHB. The Board has responsibility for delivering on local and national health objectives within a current annual budget of approximately $165 million.

The Hutt Valley DHB has been in existence since 1 January 2001. Over the past year it has provided a wide range of services and implemented a number of initiatives detailed in this report to meet its commitment to:

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

This has involved buying services from a wide range of health and disability service providers, including GPs, Maori and Pacific Island health providers, mental health providers, rest homes, pharmacies, private laboratories and independent hospitals.

Board Members' Report

This is the Hutt Valley DHB's first statutory report, which covers a full 12-month period, namely, from 1 July 2001 to 30 June 2002.

Principal Activities

Hutt Valley DHB is responsible for funding all local personal health, mental health, Maori health and Pacific Peoples' health services. To meet this responsibility, the Board places considerable emphasis on broad-based consultation with the community and key stakeholders.

Hutt Valley DHB's public health services operate from sites in Porirua, Wellington and the Hutt Valley. The community mental health services have sites situated in the Hutt Valley, and certain physiotherapy services that are provided from an Upper Hutt base. In addition, it contracts local providers to deliver a wide range of primary and community health services to the people of the Hutt Valley.

At the secondary level, Hutt Hospital provides the specialities of medicine, surgery, mental health, child health, maternity and public health. Within that general description are specialist services in burns, plastic and maxillo-facial surgery, rheumatology, coronary care, intensive care, radiology and rehabilitation, a hospital dental service and an associated child oral health service.

Committees of the Board

The Board has three statutory committees to provide advice in key areas. They are the Community and Public Health Advisory Committee, the Disability Support Advisory Committee and the Hospital Advisory Committee. The Board has also established a Finance, Property and Audit Committee.

Board Members' Interests

There have been no financial transactions during the period which require Board Members to declare an interest. Hutt Valley DHB has arranged policies for Board Members' liability insurance to ensure that, generally, Board Members will incur no monetary loss as a result of actions they undertake in their capacity as Board Members. Certain actions are specifically excluded, for example, penalties and fines imposed in respect of breaches of law.

Board Members' Remuneration

During the period the following remuneration was paid to the Board Members of Hutt Valley DHB.

	Year to June 2002 Board Fees $000	Year to June 2002 Committee Fees $000	Year to June 2002 Total Fees $000	6 months to June 2002 Total Fees $000
Board Members				
W Young (Chairman)**	36.0	6.3	42.3	19.5
P Glensor (Deputy Chair)*	20.3	5.0	25.3	9.9
K Austin*	9.0	1.9	10.9	
P Brosnan*	9.0	1.5	10.5	
S Cole*	9.0	1.5	10.5	
V Ellen*	9.0	1.5	10.5	
C Love**	7.5	1.3	8.8	
P McCardle*	9.0	2.0	11.0	
G Moffatt*	9.0	1.5	10.5	
Fuimaono K Pulotu-Endemann**	9.0	0.8	9.8	
B Tahi**	18.0	3.0	21.0	9.8
M Shields***	11.3	2.6	13.9	11.8
C Cunningham***	9.0	1.5	10.5	9.8
B Grieve***	9.0	1.8	10.8	10.2
A Moala***	9.0	0.8	9.8	9.8
M Redwood***	9.0	2.1	11.1	9.6
S Stevens***	9.0	1.5	10.5	10.2
V Winitana***	9.0	1.5	10.5	8.5
Total	**210.1**	**38.1**	**248.2**	**109.1**

* Board Member was elected to the Board in October 2001.
** Board Member was appointed to the Board by the Minister of Health
*** Board Member resigned in December 2001, following Board elections

Hutt Valley District Health Board Members. Back row left to right: Katy Austin, Peter McCardle, Brenda Tahi, Fuimaono Karl Pulotu-Endemann, Grant Moffatt, David Williment (Board Secretary), Vera Ellen, Bruce Gollop (Acting Chief Executive).
Front row left to right: Pat Brosnan, Peter Glensor (Deputy Chair), Warren Young (Chairman), Catherine Love, Sharron Cole.

	Year to June 2002 Total Fee $000
Co-opted Commitee Members	
N Baker	0.3
M Cooper	0.3
S Jayathissa	0.5
M MacDonald	1.8
S Merrilees	1.1
S Stansfield	0.3
G Stenton	0.3
S Thompson	0.8
M Tukukino	1.8
Total	**7.2**

Remuneration of Employees

The number of employees (excluding Board Members) whose annual income was within the specified bands is as follows:

$000	June 2002	June 2001
100-109	14	19
110-119	9	9
120-129	9	7
130-139	6	6
140-149	4	3
150-159	4	1
160-169	2	1
170-179	2	2
180-189	2	1
190-199	-	1
200-209	3	1
210-219	-	2
Total	**55**	**53**

The previous Chief Executive's remuneration was in the $260,000-$269,000 bracket. The Acting Chief Executive at 30 June 2002 is a contractor and held this position for one month only during the period under review. He is therefore not included in the above table.

Of the 55 employees shown above, 47 are medical or dental employees (48, June 2001).

If the remuneration of part-time employees were grossed up to an FTE basis, the total number with salaries of $100,000 or more would be 99 (91, June 2001), compared to the actual number of 56.

Termination Payments

This information is presented in accordance with section 42(3)(f) of the New Zealand Public Health and Disability Act 2000. Termination payments include payments that the person is entitled to under contract on termination such as retirement payment, redundancy and gratuities. During the year Hutt Valley DHB made the following payments to former employees in respect of termination of employment with the Board. There were no employees who fell into this category in the six-month period following the formation of Hutt Valley DHB, 1 January to 30 June 2001, hence there are no comparative figures.

Number of employees	Amount $
1	1,923
1	3,500
1	6,151
1	7,000
1	8,117
1	9,000
1	9,129
1	10,385
1	11,406
1	11,875
1	14,350
1	14,567
1	15,000
1	20,000
1	20,683
1	28,592
1	33,407

Auditor

The Auditor-General is appointed auditor under section 43 of the New Zealand Public Health and Disability Act 2000. Audit New Zealand has been contracted to provide these services.

For and on behalf of the Board

Warren C Young

Chairman
1 October 2002

Chairman's Report

It is with pleasure that I report on behalf of my fellow board members on the results of the Hutt Valley DHB for the year ended 30 June 2002. This is the first full year in which the organisation has existed in its present form. It is therefore most gratifying that virtually all of our key operating and financial targets for the year have been met or exceeded. That this is so is testimony to the focus and dedication of the people that constitute the Hutt Valley DHB. It is also noteworthy that in terms of most of the comparative measurements with counterpart district health boards our organisation is one of the top performers in the sector. This is not to suggest that there is room for complacency. It merely evidences the progress being made against the benchmarks reflected in our District Strategic Plan.

The structure of this year's Annual Report has been somewhat modified to enable the chairs of the respective statutory committees to comment on the highlights of their severable activities throughout the year. In our governance we have three statutory sub-committees. They play a critical part in our decision-making processes and, where appropriate, are comprised of not only DHB board members but also community representatives. We have one sub-committee, styled the Hospital Advisory Committee, which carries responsibility for the affairs and performance of the hospital. Another, the Community and Public Health Advisory Committee, guides us in connection with the health needs of our catchment population, and the mix and range of services required to improve the overall health status of our people. And the third, the Disability Support Advisory Committee, deals with the special issues faced by those in our community with disability or physical handicap. Although not required under statute, we also have a Finance, Property and Audit Committee to ensure that adequate controls are applied in meeting our financial and capital budgets. Whilst these sub-committees are advisory in nature, and the responsibility for policy settings resides squarely with the full board, the terms of reference for each are quite prescriptive. They are designed to ensure that the statutory intentions of Government are indeed fulfilled.

In the conduct of the Board's affairs we seek to be transparent in everything we do. We undertook extensive consultation in connection with our 5 Year District Strategic Plan, and the initial draft was modified in a number of respects to acknowledge the concerns raised by the community. Most of our meetings are convened in public, we encourage participation by regularly arranging special interest group discussions, and we provide meaningful papers in support of our Board and committee meetings. This approach gives practical effect to our mission statement that we will 'excel in the way we consult, communicate, plan and provide health services to our community.'

The implementation of the Government's health policies resides with the Board Members of the district health boards. The composition of the Hutt Valley DHB Board was significantly altered at the time of the local body elections last year. We now have eleven Board Members, seven of whom are elected, with the remaining four being appointed by the Minister of Health. This brings to the Board table a wide diversity of background, experience, and cultural understanding. The Hutt Valley DHB is very cohesive in the way it governs, is united in its objectives, and is entirely focused on improving the health and wellbeing of our people. The continuing challenge for the Board is to balance the very understandable needs and aspirations of our community with the ever-present funding limitations. There is simply insufficient money currently available to enable us to implement the range of primary health initiatives we have identified as desirable.

The detailed financial results for the year are set out elsewhere in the report. In summary, we incurred a net loss of $2.10 million, about $380,000 better than the budgeted loss of $2.48 million. However, to the extent that the budgeted gain of $604,000 on the sale of the Pilmuir Accomodation Building did not in fact materialise in the 2002 year, the operating performance of Hutt Valley DHB was nearly one million dollars better than budget. By any yardstick, this is a most commendable effort, and especially so in the public health sector which is characterised by funding shortfalls. The key financial targets contained in the Statement of Intent and Business Plan in respect of the 2002 year were all met. We are forecasting a return to surplus in the current year to 30 June 2003, and this will give us greater capacity to introduce the primary care initiatives outlined in the 5 Year Strategic Plan.

Financial Results

The financial results cover the 12-month period ended 30 June 2002.

	June 2002 Actual $000	June 2002 Budget $000
Operating income	165,294	163,304
Operating expenses	(154,589)	(153,158)
Depreciation	(6,907)	(7,313)
Capital charges	(4,512)	(4,508)
Interest expense	(1,390)	(1,408)
Net operating surplus	**(2,104)**	**(3,083)**
Gain on sale of assets	1	604
Net surplus	**(2,103)**	**(2,479)**

Financial Position

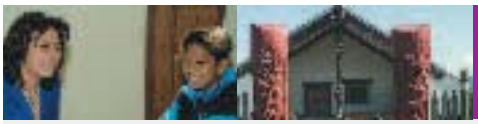
The equity of the Hutt Valley DHB is represented by:

	June 2002 Actual $000	June 2001 Actual $000
Current assets	17,444	13,850
Current liabilities	(25,076)	(18,362)
Net working capital	**(7,632)**	**(4,512)**
Non-current assets	69,106	68,250
Non-current liabilities	(21,852)	(22,013)
Public equity	**39,622**	**41,725**

Financial Ratios

As disclosed in the Statement of Intent the following performance indicators have been achieved.

	June 2002 Actual $000	June 2002 Budget $000
Debt/(Debt + Equity)	33%	50%
Interest cover	4.46	2.50
Revenue to net funds employed	2.80	1.28
Total Liabilities/Total Assets	54%	55%



The Statement of Financial Position at 30 June 2002 reveals that the value of the Crown's investment in the Hutt Valley DHB has fallen from $41.72 million last year to $39.62 million, a drop of $2.10 million. This decline equates to the loss for the year. However, and notwithstanding the current year loss, the organisation continues to generate positive cash flows mainly as a result of high levels of depreciation and a very cautious approach to capital expenditure. The debt ratio, which measures the extent to which the entity is reliant upon borrowed monies, remains one of the lowest in the sector. It is hoped that these features will assist in negotiating favourable rates when the term debt, which presently stands at around $19.0 million, is refinanced on 30 November 2002 with the Crown Financing Agency.

Work continues on campus to upgrade our property assets. Although the formal site optimisation programme begun four years ago and involving some $22.0 million is now complete, we spent about $3.45 million during the year in upgrading our facilities. This related to the ENT and burns and plastics inpatient services, renovating the community health building and office accommodation in the Pilmuir block, and improving the front entrance to the hospital through the Heretaunga block. It is pleasing to note that, consistent with earlier years, these projects were all completed on time and within budget. There was a further $1.6 million incurred on a range of equipment required to maintain and enhance the standard of clinical outcomes for hospital-based patients.

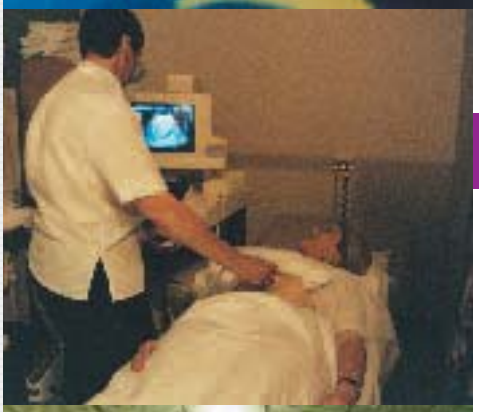
The detailed content of the Annual Report refers to the nomination of the Hutt Valley DHB for this year's prestigious Energy Efficiency and Conservation 'EnergyWise' award. This nomination recognises the strenuous efforts undertaken by our Building Services team to maximise the conservation and efficient use of energy during the past five years. This has produced not only environmental gain. It has also delivered substantial financial benefit to the organisation. The cost of electricity and gas has fallen from $1.2 million in the 1997/8 year to $730,000 in the financial year just concluded, a saving of $470,000.

As far as the clinical activity of the hospital of the Hutt Valley DHB is concerned, inpatient and day-case activity was in excess of contracted levels, resourced bed occupancy and average length of stay were successfully held at anticipated rates, the waiting lists continue to drop, the quality of theatre management remains high, regional public health achieved the key targets, work place injuries were well down, and staff turnover was within prescribed limits. Further work is required in connection with staff and patient satisfaction ratings, timely resolution of customer complaints, and credentialling of clinical services.

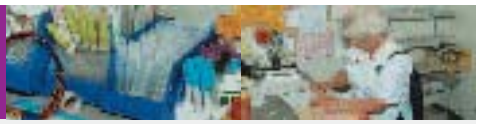
In relation to the funding, planning and contracting output class, the performance baselines are still very much in the course of being developed. A full and comprehensive comparison of actual and budgeted thresholds is therefore not possible in connection with the year just concluded. More exact measurement of performance will become possible after 1 July 2002.

One of the principal tasks of any board is to manage and monitor the risk profile of the organisation. This is equally true of a Crown Owned entity. During the year, and in conjunction with outside advisers, we developed a methodology for identifying, assessing, controlling and reporting the risks to which Hutt Valley DHB might ordinarily be exposed. This is a dynamic process and creates an appreciation by all staff of the potential for risk related events. The objective is to have this broad based understanding of risk factored into our everyday processes.

The Board is committed to delivering worthwhile health gains through the implementation of the Government's Primary Health Care Strategy. There is sufficient statistical evidence to suggest that about 25 percent of all deaths and approximately 30 percent of total hospital admissions throughout New Zealand are potentially avoidable if the population at large receives timely and improved primary care. In the case of the Hutt Valley DHB, we have assessed that there are over 500,000 primary care consultations undertaken each year. This compares with about 26,000 hospital admissions in any twelve-month period. Primary care providers are therefore in a much better position than district health boards to apply population-based solutions to health needs.



Chairman's Report



The successful implementation of the Primary Health Care Strategy is significantly dependent upon the establishment of Primary Health Organisations (PHOs). The Primary Health Care Strategy itself is intended to improve access to care, reduce health inequalities, and more generally enhance the health status of our community. The development of PHOs is crucial to the successful application of the strategy. A PHO has defined characteristics, can comprise one or more organisations, and might typically include medical practitioners, nurses, community workers and other health providers. They are funded in accordance with 'enrolled populations', and are required to consult in relation to the range and priority of services offered. It is noteworthy that the Hutt Valley DHB signed its first PHO agreement on 2 July 2002, and we are currently working on several others.

We continue to modify and upgrade our information systems. However, the Board adopts a commercial and prudent approach to new developments and has preferred incremental rather than wholesale changes. History has proven this approach to be the correct one. Whilst previously these enhancements had a strong financial orientation, we are now focusing on those systems that enable clinicians to better manage their activities, and ultimately improve the outcome for patients. We also seek better technology interface with community based primary care providers. In the past year further progress has been made in the development of clinical information and patient management systems. These include the successful implementation of phase one of the Electronic Medical Record system and the establishment of a comprehensive Intranet and Internet website. As evidence of our commitment to the continuous improvement of information systems generally, our recently updated Information Systems Strategic Plan calls for annual expenditure of several millions of dollars over the next five years.

For some years now we have sought to encourage quality-related initiatives through the Chairman's Spirit of Quality Awards. Those eligible for the award must demonstrate improved patient care as a result of more efficient and effective processes. Since inception, the award has been presented in connection with a very wide range of hospital activities. More recently we have extended this philosophy to third party and community based providers, and have conceived the notion of 'excellence awards' in the provision of primary care. Those deemed eligible are nominated by members of the community, are short-listed by our own staff, and the successful candidates are determined by the Board. The first awards were presented in a ceremony hosted by the Minister of Health at Parliament on 25 September.

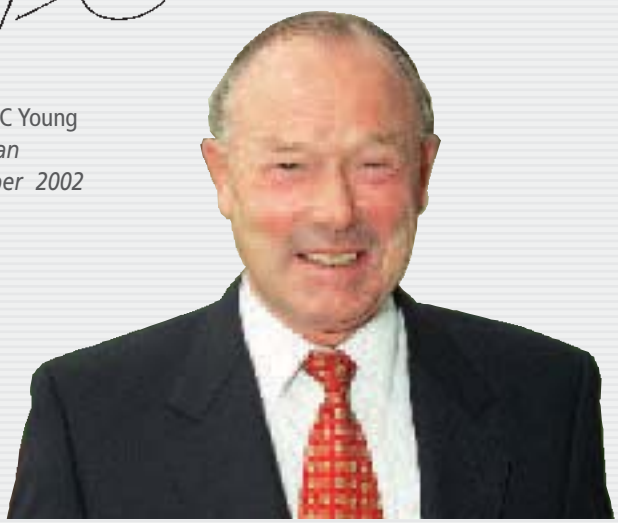
In the Statement of Intent we undertook to have an independent party circulate to key stakeholders a questionnaire designed to establish how best the Hutt Valley DHB can improve its processes and outcomes, and create more effective working relationships. Those invited to participate in the survey included general practitioners, pharmacies, Maori and Pacific personnel and organisations, mental and disability health service providers, central and local authorities, and various non-Government entities. The responses overall were most complimentary, with more than 70% commenting favourably on the performance and effectiveness of the Hutt Valley DHB in developing sound working relationships. Over 50% of respondents were approving of the contracting processes adopted in entering into third party arrangements for the provision of primary care. We will continue to work on improving our understandings with external providers, and intend to repeat the stakeholder survey later this financial year.

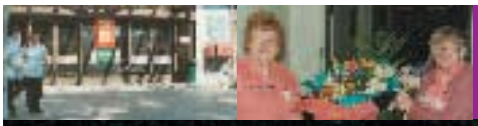
Recipients of the Hutt Valley DHB Inaugural Primary Care Excellence Awards with Minister of Health Hon. Annette King and Board Chair Warren Young.

Our Chief Executive of some three years standing, Stephen McKernan, resigned in May to take up an equivalent position with the Counties-Manukau DHB. I wish to acknowledge and place on record the significant contribution made by Stephen to the successful development of the Hutt Valley DHB. We formally welcomed our new Chief Executive, Chai Chuah, at a Powhiri held on 19 August. Chai has settled in well, and the Board is confident that he has the professional skills and personal qualities required to continue the record of success achieved by the Hutt Valley DHB.

Finally, and on behalf of the Board, I would like to thank all staff for their contribution during the year. The willing and proficient way in which staff bring their skills to bear produces the successes for which the Hutt Valley DHB is widely recognised. It is truly our people who make the difference.

Warren C Young
Chairman
1 October 2002





Committee Chairs' Reports

Central to Hutt Valley DHB's governance and strategic direction has been the work over the past year of the three statutory committees that support the Board. The following comments from the respective chairs touch on the activities and highlights of each committee.

The Hospital Advisory Committee (HAC)

The Hospital Advisory Committee functions are to monitor the operational and financial performance of the Hutt Hospital and to assess strategic issues relating to the provision of hospital services by or through the Hutt Valley DHB.

The committee meets monthly, with a typical agenda comprising a public session in which the General Manager, Hospital and Secondary Services and the General Manager, Public, Primary, Community and Mental Health Services speak to their written reports, as well as any items of general interest. The private session which follows contains issues of a commercially sensitive nature such as the DHB Operating report or personnel matters and industrial relations.

Among the important strategic projects that have been monitored by the committee in the past year, the major capital works projects that have formed part of the Site Optimisation Project stand out. It has been particularly pleasing that, owing to excellent management by all involved in the projects, the works have been completed both on time and within budget. The committee has also monitored the extensive quality assurance and risk management work that has taken place in the hospital provider arm, including the credentialling of surgical teams and the accreditation of various services.

Members of the Executive Management Team are always present to answer questions, clarify points or undertake to obtain further information required by the committee in order for it to discharge its statutory responsibilities.

At each meeting, there has been a presentation by the manager of one of the hospital services. These presentations have given members an overview of each service, including the ambit of the service, any difficulties or challenges and looking forward to the future. Committee members have found these presentations extremely informative, particularly as we seek a better understanding of the integration of secondary and primary healthcare services in the Valley.

Sharron Cole
Chairperson

The Community and Public Health Advisory Committee (CPHAC)

At the heart of the move to set up DHBs is the need for greater engagement with our local community, and for better integration of health services in our area. We are delighted that we have been able to have as full members of the Board a number of people from the wider Hutt Valley community. They are Marian Redwood, Neville Baker, Mike Cooper, Shelley Stansfield , Maree Tukukino and Dr Stephen Palmer. We have sought people with particular expertise, so that the work of the committee can be done in an environment where we have our fingers on the pulse of our local community.

Every two months, our committee meeting is preceded by a one hour 'Community and Provider Forum'. These well-attended meetings give a chance for further dialogue between the DHB and our community. The topics for our forums during the past year were Diabetes, Youth Health, Mental Health, After Hours Services, Integration between Primary and Secondary Care, Child Health, and Disability Issues.

Information about the forums was sent out to hundreds of groups, providing a reminder that the DHB is committed to dialogue with our community. Our committee meetings, like those of the Board itself, are open to the public, and opportunity is given each meeting for people to comment or ask questions.

Our strategic planning process included invitations to health and disability groups throughout the Valley to give feedback to our Draft Strategic Plan. As well, a number of public meetings were held. Feedback from the community resulted in a number of changes to our Strategic Plan.

CPHAC has the responsibility of advising the full DHB on spending priorities for our health dollars. We do this by an ongoing monitoring of the people who live in our district, their health needs, and their responses to us.

Our approach was to set up seven integrated service planning groups – with people from the hospital, primary health groups, community agencies, Maori, Pacific – covering the main health priorities. They were charged with a review of current services and proposals for new work. Over 120 people took part in this process, and even that work has helped build relationships within our local health system.

In reality, there is very little discretion for our spending. The bulk of our funds is already committed to vital services, which we wish to maintain and strengthen. This means that we must set clear priorities for new initiatives. Our Board has taken the step of setting out both a set of criteria for making new spending decisions and a list of new work we want to support.

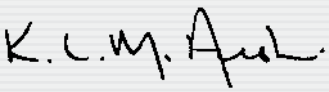
We are confident that this transparent process will mean our community will both understand and support the new initiatives that emerge in the coming months. A high priority is integration – getting better collaboration among various groups in the health system so that the patient can receive the best care possible.

Peter Glensor
Chairperson

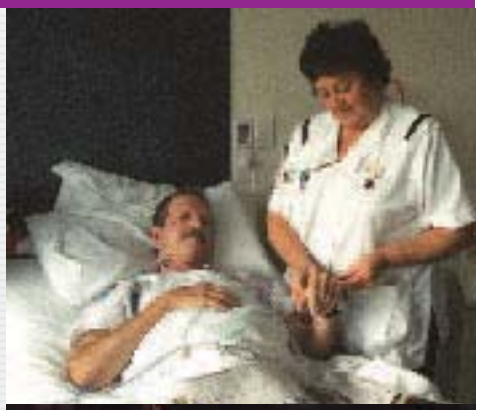
The Disability Services Advisory Committee (DSAC)

The DSAC provides advice to the Board on the disability support needs of the resident population of the Hutt Valley as well as advising the Board on priorities for use of disability support funding. To enable these tasks to be achieved effectively it has been important for the DSAC to have a close relationship with the community. Following the 2001 District Health Board elections, membership of the DSAC Committee changed. New community representatives, including a representative of the Disabled Persons Assembly (DPA) and others involved in the disability sector were appointed to the committee as fully participating members. The co-opted members are Beryl Harris, Geoff Stenton and Joan Taylor. During the 2001-2002 year, the DSAC has met bi-monthly.

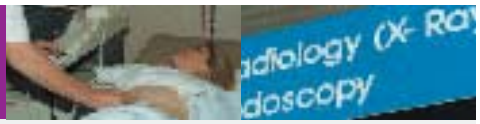
The Hutt Valley DHB has contracts that fall within the disability area and are monitored through the Funding and Planning Unit, which reports on the progress of these contracts at each meeting of the DSAC. With the development of the 5 Year Strategic Plan, the DSAC committee considered the implications of the Plan for people with disabilities. A major part of the Committee's focus during the year and continuing into the coming year, has been to support the Board in preparation for the Ministry of Health's devolution of funding for 'The Health of Older People'. The DSAC is monitoring a project on establishing an integrated continuum of care for older people in the Hutt Valley. A work plan of activities has been established including a series of one-hour public forums on topics around Community Care for the Elderly. The first of these forums, which take place prior to each DSAC meeting, has been held and involved many people who are concerned with supporting the elderly in the community. The forum provided valuable comment to the DHB on issues that must be considered for the future and reinforced the continued commitment the DHB has to listen to the community. The DSAC looks forward to continuing the positive engagement with the local community and to supporting the needs of the resident population.



Katy Austin
Chairperson



Chief Executive's Report



This is the first full year for which the Hutt Valley District Health Board is able to provide a report on its activities and thereby more accurately reflect the impact of operating as a larger, multi-faceted public health organisation. It has been a year of considerable achievement, building on the earlier six-month period of transition, which began in January 2001.

A key aspect of consolidating the transition to the District Health Board model has been communicating to staff and the community that the organisation's focus has shifted from almost exclusively being a provider of health services to an organisation responsible for determining needs, planning, prioritisation, and funding health services in our community. Our role now is to promote and protect the health of the people of the Hutt Valley, facilitating the effective integration of primary and secondary care services as well as providing care and support to those in need of personal health services or disability support.

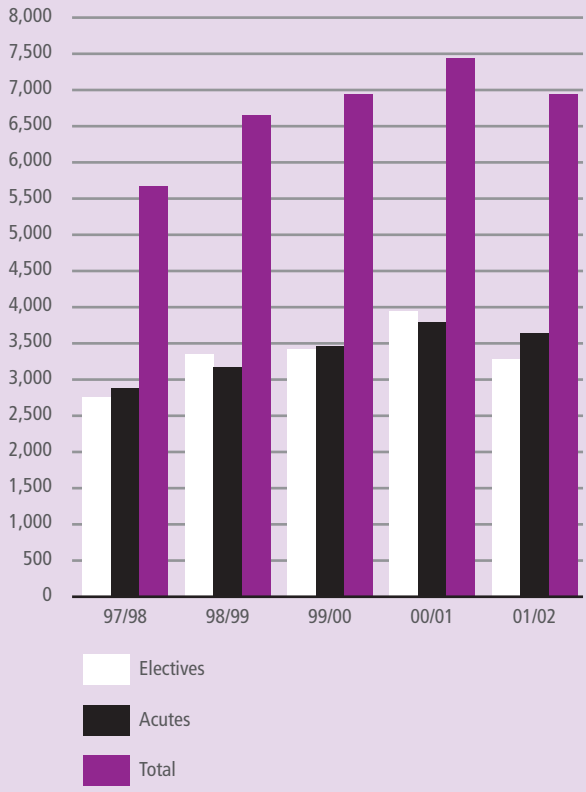
We are also an organisation that is more responsive to community aspirations and direction. In October 2001, elections were held for seven of the 11 Board Member positions at the DHB, signalling the beginning of direct community involvement in the governance of the Hutt Valley DHB. This was followed soon after with the commencement of a major community consultation process on the DHB's 5 Year District Strategic Plan.

Hutt Valley DHB met or exceeded all significant service performance, planning and funding requirements outlined in the Board's Statement of Intent. In addition, the organisation achieved an improved financial position with the forecast deficit of $2.10 million comparing favourably with a budgeted deficit of $2.48 million. Given the pressures on service and consumable costs as well as costs around the new responsibilities for planning and funding health services, this is a very pleasing result. Providing quality healthcare within the financial budget is a tribute to the commitment and sheer hard work of all staff.

The past year has also seen the services provided by the Hutt Valley DHB meeting and, in a number of cases, exceeding the delivery targets set. As in the previous two reporting years, there has been an increase in inpatient medical treatments and discharges over the past year by 5 percent. The year also registered increases in laboratory tests of 7.4 percent and medical outpatient attendances of 13.1 percent. For the first time in three years, attendances at the Hospital's Emergency Department showed a slight decrease of 1 percent over the previous year. This is an encouraging sign that the community is now more aware that minor primary care health problems should more appropriately be cared for by GPs or After Hours Services rather than at the Emergency Department. This change in attitude will be further reinforced by a public awareness programme that has been developed with primary care providers, particularly After Hours Services, to promote primary based care services to the public as well as providing a greater range of care in the community such as minor fracture management.

There have also been encouraging signs in other key service areas where levels of attendance and interventions have been consistent with last year's results or slightly lower. Overall inpatient discharges have fallen by 1.9 percent and day case discharges by 0.7 percent. While the capacity to undertake increased numbers of treatments exists, the need has lessened. This suggests the various health strategies and initiatives being implemented by Hutt Valley DHB are having a positive impact on the overall health of our community. In particular, it would appear that placing greater emphasis on addressing lower level health problems by community based primary care providers has resulted in more appropriate patient management and referral practices.

Operations Acute and Elective



In short, the health services delivered by Hutt Valley DHB over the past year have grown in complexity and diversity while volumes have stabilised and this has had a positive impact on waiting lists which have markedly declined by 8.5 percent while keeping within national guidelines.

In addition to a strong commitment to quality and consumer satisfaction, the highlights of which are reported below, Hutt Valley DHB continues to emphasise excellence in clinical standards, expertise and training. For the second year in a row, all Hutt Valley DHB medical registrars sitting clinical and written Fellowship exams for admission to the Royal Australasian College of Physicians have been successful, the highest pass rate throughout New Zealand.

Hutt Valley DHB has therefore retained a strong hospital sector while putting focus on primary care and the formation of Primary Health Organisations where the accent is on preventative medicine and health promotion. A key element of this approach gives priority to the disadvantaged and those who will be able to have the largest health gain.


In this regard, the last twelve months has seen continued broadening and strengthening of our relationships with the Maori and Pacific Peoples' communities in the Hutt Valley. The DHB's partnerships with Maori health providers have focused on building provider capacity as well as more effectively targeting health services to meet the personal, community and mental health needs of our Maori community. A significant achievement has been the development and signing of an agreement to establish a Primary Health Organisation (PHO) between Hutt Valley DHB and the PHO partners Kokiri Marae, Hutt Union and Community Health Centre, and Whai Oranga O te Iwi. The PHO, called Piki Te Ora Ki Te Awakairangi, will provide and co-ordinate GP, community health, maternity, diabetes, health promotion and disability liaison services to 15,000 people currently enrolled in the new organisation and will be operating fully in October 2002.

The past year has also seen three 'by Pacific for Pacific' health services established in the Hutt Valley. The three Hutt Pacific Health providers, Tanumafili Trust, Pacific Health Service and Naku Enoi Tamariki, have focused on addressing Pacific workforce development issues and identifying projects that are consistent with the key features of The Pacific Health and Disability Action Plan. During the year the DHB appointed a Pacific Peoples' Health Advisor who will be central in helping meet one of the Board's key goals of improving the health of the Pacific people in the region.

The year under report has been particularly busy in the area of employment relations. The most significant development has been the decision by a number of occupational groups within Hutt Valley DHB to negotiate employment terms and conditions under Multi-employer Collective Agreements (MECA). Negotiations for the first MECA with the New Zealand Nurses' Organisation were concluded in June 2002 and, while the negotiation process was protracted and at times difficult, a satisfactory agreement was reached with the NZNO and our nursing staff.

Significant work was also undertaken in the areas of recruitment and retention, career and performance management and developing our new organisational culture. Human Resources have led project teams and focus groups made up of managers, staff and union representatives to address these key areas. To become the 'employer of choice' requires the support of the whole organisation and the efforts of all those contributing to the work of these groups have been essential to their success.

It has therefore been a very busy year, but a year of considerable achievement. This successful result owes an enormous amount to the staff of Hutt Valley DHB who have shown considerable dedication and professionalism in carrying out their responsibilities providing the highest standard of service to the local community. I want to place on record my thanks for their commitment and outstanding efforts over the last 12 months.

Finally, I wish to acknowledge the tremendous support given by the Executive Management Team and to thank the Chairman and Members of the Board who have given strong governance and clear direction throughout the year.

Bruce Gollop
Acting Chief Executive




Healthcare Planning

The advent of the district health board model places greater focus on the requirement for boards to plan, fund and provide comprehensive health services for the communities they serve. Over the past year, Hutt Valley DHB has focused on and put considerable effort into meeting this challenge. In particular, the Board sought every opportunity to engage the local community in the planning process to ensure Hutt Valley DHB's strategic direction better reflected local health needs and service expectations.

Hutt Valley Health Profile

Demographics

- The total population in the Hutt is decreasing slightly.
- The Hutt Valley Maori and Pacific populations are increasing.
- The Maori and Pacific population make up 1/4 of the total population and 1/3 of the 0-14 age group.
- HVDHB is one of only seven DHBs in NZ with a significant Pacific population.
- HVDHB also has a significant Asian and refugee minority population.
- The population is ageing.

Socio-economic Status

- Poverty and deprivation are key determinants of health.
- Maori and Pacific people are much more likely to live in deprived situations.
- People living in the most deprived areas have a lower life expectancy.
- Lower Hutt has more people in the most deprived and least deprived categories than Upper Hutt.
- Lower Hutt has a larger deprived population than Upper Hutt.

Health Status

- About 4,500 hospital admissions every year are potentially preventable through community action and lifestyle changes or better access to primary care.
- About 350 deaths each year are potentially preventable through community action and lifestyle changes or through primary care interventions.
- Maori and Pacific people have a disproportionately high number of preventable deaths and hospitalisations.
- The greatest gains in years of healthy life can be obtained by encouraging people to be more physically active, not to smoke, and to eat less fat and more fruit and vegetables.

Hutt Valley DHB 5 Year Strategic Plan

A key strategic objective for the Board was to develop the first 5 Year Strategic District Plan. Community involvement and public consultation were essential elements of the strategic planning process.

Seven planning groups in the areas of Primary Care, Healthy Communities, Mental Health, Chronic Diseases, Child & Family, Youth, and Disability Support were established during the year with major contributions to each group by public nominees, GPs, Pacific community representatives and Maori representatives. A health needs assessment and demographic analysis were undertaken and a series of fact sheets produced to support the work of these groups. This planning and health assessment process provided information about the Hutt Valley health profile that was essential in determining and responding to local health needs.

Major Cause of Deaths

The leading causes of death in the Hutt Valley are similar to those nationally. Cardiovascular diseases (mainly ischaemic heart disease and stroke) account for around 40 percent of deaths while cancer accounts for around 30 percent. Injuries account for around 6 percent of deaths (mainly road traffic injuries and suicides) but these are concentrated into the 15-24 and 25-44 age groups. Diabetes is a major contributor to cardiovascular and other mortality.

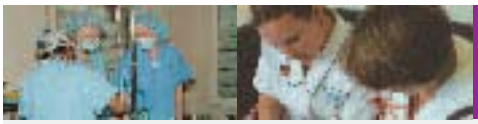
Avoidable Deaths

Almost 70 percent of deaths in those aged under 75 years in the Hutt Valley were assessed as being avoidable. About half, or 180 deaths could be prevented through individual lifestyle changes and population health measures. For this reason the Board's priorities are the Primary Care and Healthy Communities service plans, which focus on population health promotion and lifestyle advice, rather than more hospital services.

Males have a 50 percent higher rate of avoidable mortality than females while Maori and Pacific peoples' rates are 2.5 and two times higher than the rest of the population, respectively. The leading causes of avoidable death in the Hutt Valley are similar to the national causes.

This assessment led to 13 service plans being produced by the planning groups and a prioritisation methodology being developed and used to rank the 40+ proposals for new initiatives that came out of the service plans for use in public consultation. Ten consultation meetings were held during March 2002 with various community groups, health providers and the general public to discuss the draft Plan. In addition, the draft Plan attracted more than 80 written submissions. The Plan has ten key goals:

- **Primary Care:** implementing the New Zealand Primary Care strategy, including developing a robust, accessible primary care sector that focuses on improving the health of the population, and effectively manages people with chronic conditions
- **Healthy Communities:** encouraging people to exercise more, eat more healthily, stop smoking and improve parenting skills through a range of health promotion strategies including inter-sectoral initiatives, community development, healthy public policies and supportive environments
- **Reduce Inequalities:** reducing the inequalities in health status among certain disadvantaged populations, including Maori and Pacific peoples, so that they can enjoy the same length and quality of life as other Hutt Valley residents
- **Disease Management:** improving the treatment of people with chronic diseases, particularly cardiovascular disease, diabetes or respiratory disease to improve their quality and length of life



Hutt Valley Residents' Annual Average Leading Causes of Mortality

Age Group	Death (average number per year)	
	Females	Males
0-14	Sudden Infant Death Syndrome 1 Perinatal Conditions 3 Birth Defects 3 Injuries 2 (Road Traffic) Cancer 0.5 (Leukaemia, Lymphomas)	Sudden Infant Death Syndrome 2 Perinatal Conditions 4 Birth Defects 3 Injuries 3 (Road Traffic) Cancer 0.5 (Leukaemia, Lymphomas)
15-24	Injury 3 (Road Traffic & Suicide)	Injury 14 (Road Traffic & Suicide)
25-44	Cancer 10 (Breast) Injury 4 (Road Traffic & Suicide)	Injury 14 (Road Traffic & Suicide) Circulatory Disease 6 (Heart Attacks/Strokes)
45-64	Cancer 34 (Breast, Colorectal, Lung) Circulatory Disease 17 (Heart Attacks/Strokes)	Circulatory Disease 45 Cancer 35 (Lung, Colorectal)
65-85	Circulatory Disease 17 Cancer 120 (Lung, Colorectal) Respiratory Disease 31 (Pneumonia/Influenza)	Circulatory Disease 126 Cancer 81 (Lung, Colorectal, Prostate) Respiratory Disease 37 (Pneumonia/Influenza)
85+	Circulatory Disease 72 Respiratory Disease 25 Cancer 15	Circulatory Disease 25 Respiratory Disease 16 Cancer 11

- **Elective Services:** ensuring people have access to elective medical and surgical services before they reach an unreasonable state of ill health
- **Child Health:** giving children the opportunity to grow up in a healthy supportive environment by implementing the new 'Well Child' framework and providing co-ordinated maternity services
- **Youth Health:** developing youth friendly services that reduce teenage road traffic accidents, pregnancies, drug and alcohol misuse and suicides
- **Maori Health Development:** working to achieve equity of outcome for Maori, including through the development of services provided by Maori, for Maori.
- **Mental Health:** improving service quality, and developing primary mental health services to complement the specialist secondary services
- **Integration:** providing seamless care across health providers and across different services, so that people receive the right service from the right person at the right time.

Primary Care Service Plan

Over and above maintaining access to core services, the Board considers that the single highest priority for the next five years is implementing the primary care strategy. The reasons are:

1. Development of excellent primary care services will make the single largest difference to people's health in the short to medium term;
2. The primary care strategy is pivotal to achieving most of the other goals.

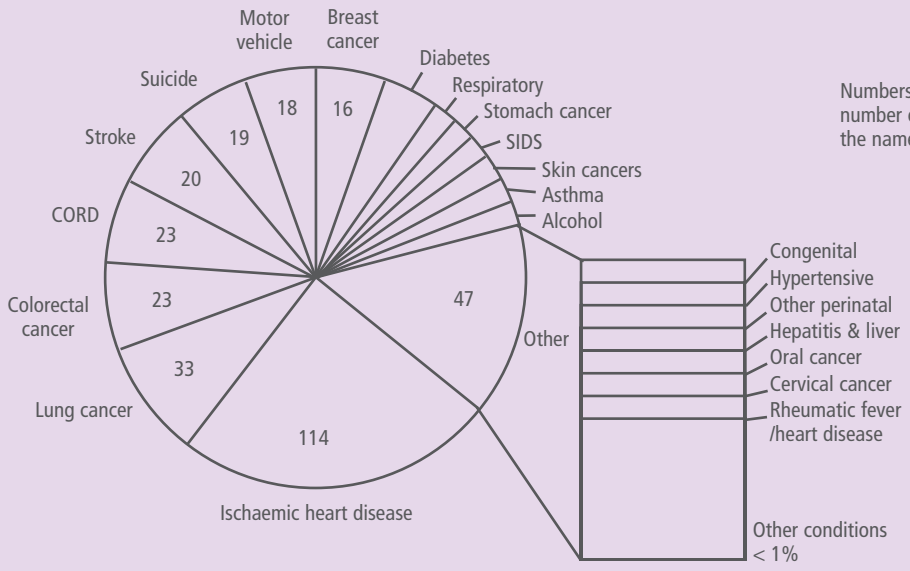
During the year under review, Hutt Valley DHB prepared a comprehensive service review and five year plan for primary care services, designed to implement the Government's Primary Care Strategy locally. This includes a proposal to facilitate an expanded role for practice nursing and a workforce development plan that includes training opportunities, a locum bureau and a post-entry intern training programme for aspiring primary care nurses.

Disability Support Services

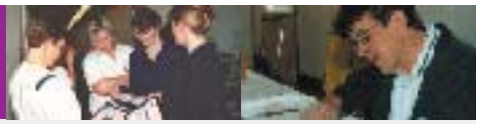
The strategic plan includes a particular focus on disability issues. A working group including nominees from the disability community prepared the disability section of the plan. The plan is now being put into place beginning with age care services. We have also appointed a Disabled Persons Assembly representative on the DSAC.

Hutt Valley Residents' Avoidable Mortality for Age <75 Years, 1988 - 1998

(out of 353 avoidable deaths in those aged < 75 years)



Healthcare Funding



A major new role for district health boards is managing the DHB Fund. This involves deciding each year what mix of services should be funded (within the overall parameters set by the Government), including how much to spend on hospital and community health services provided by the DHB and how much to spend on services provided by independent service providers. The strategic goal is to select that mix of services that will maximise health outcomes within the available resources.

Most of the funding provided by the Government each year is required to ensure continued access to essential services such as emergency services, surgical services, pharmaceuticals and GP visits. The Board has approved a prioritisation methodology to assist in determining the highest priorities for the small amount of discretionary funding available each year. The decision-making principles behind this methodology are effectiveness, equity, value for money and Maori development in health. Against this background, the Board agreed to several service development initiatives to be funded by the DHB, which were successfully put in place during the year. These included:

Primary Care Service Development Fund

A fund of $60,000 over three years has been established to support primary care service development and to help GPs move into larger primary care teams if they wish. Kowhai Health is administering the programme.

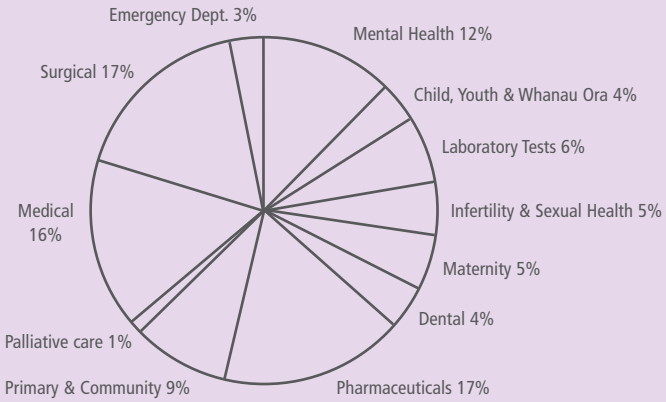
Skin Lesion Removal Funding

Hutt Valley DHB is funding a skin lesion removal service to help reduce waiting times for minor surgery. This service involves GP training and credentialling, spot check clinics and skin lesion removal funding through GPs for people with community service cards.

After Hours Services

To address problems that arose regarding after hours medical services, Hutt Valley DHB developed and consulted on draft guidelines clarifying responsibilities for the provision of after hours services.

Hutt Valley DHB Funded Health Services 2001-02
(Total Spend $135 Million)



Flu Vaccine

Hutt Valley DHB Planning and Funding staff worked with Regional Public Health, primary care providers and the hospital staff on a project to increase uptake of the influenza vaccine. As a result, vaccination rates have increased by 9 percent over last year, with 18 of 27 practices having achieved 60+ percent vaccination rates of the over-65 group.

Diabetes

During the year additional community podiatry and community dietetics services targeting people with diabetes were put in place. A publicity campaign was undertaken to promote uptake of the free diabetes annual check. A check is vital in helping treatment of diabetes and ensures that the diabetes register is comprehensive. The register helps us to plan the delivery of services, and also to link people to important ancillary services such as retinal screening. The number of annual checks went up from 723 to 1760 for the 2001/2002 year, bringing the Hutt Valley DHB detection rate to around 60 percent (up from 23 percent at the beginning of the year).

Retinal Screening Programme Introduced

An important component of care for people with diabetes is access to retinal screening to help prevent blindness. Hutt Valley DHB worked with Wairarapa and Capital & Coast DHBs to develop a regional retinal screening programme for people with diabetes. Since the service commenced in May this year, volume targets are shown to be on track. The service has been very well accepted by providers and consumers with 328 people having been screened in the first six months compared to a target of 340.

Rape Crisis

For the first time the DHB provided funding to support the provision of medical services by Rape Crisis to victims of sexual assault.

Integrated Care

Significant progress has been made in integrating the Primary and Secondary sectors during the 2001/2002 year, with a number of projects under way. A Primary Secondary Steering Group representing Kowhai Health, Planning and Funding Division, the Hutt Valley DHB, Ropata Medical Centre, Upper Hutt Health Centre, Hutt Union Health Services, Te Runanganui O Taranaki Whanui ki te Upoko O Te Ika a Maui Inc, and Pacific Health Hutt Valley has overseen completed initiatives to date as follows:

Information Flow

- Electronic transfer of radiology and breast screening reports from the hospital to GPs
- Patient status report containing information on patient flows, ED presentations, admissions, discharges, deaths, referrals received, triaged and patients booked sent to GPs every 24 hours
- The setting up of an Information Flow Group (GPs) meets regularly with different hospital departments to address waiting times issues.

Discharge and transfer processes

- A new discharge summary form, improving the quality of information sent to GPs on patients' discharge from hospital is being piloted

- Improved timeliness of discharge summaries
- Improved discharge process for patients new to a residential facility
- Improved transfer of information between residential facilities and Hutt Hospital.

Emergency Department

- Identification that a significant number of ED users expect to require an X-ray and fracture services and others who do not understand what services GPs can provide
- External fracture services being established at after hours GP centres
- A Primary Care promotion campaign has been developed to encourage people to see their GP for urgent medical advice and treatment.

Pacific Peoples' Health

Over the last 12 months three 'by Pacific for Pacific' health services were established in the Hutt Valley. These are managed respectively by Tanumafili Trust Incorporated, Pacific Health Services and Naku Enai Tamariki and provide primary health care, mental health support and Pacific services for young mothers and families. This is consistent with the Primary Healthcare Strategy and the Pacific Health & Disability Action Plan in terms of providing greater access to services and focusing on population needs.

The three Hutt Pacific health providers were successful in their submission to the Ministry of Health for Pacific provider development funding. The DHB was also awarded Pacific provider development funding and is working with Capital & Coast DHB on these initiatives. Priorities on projects such as workforce development are closely aligned to the key features of the Pacific Health & Disability Action Plan.

During the year the hospital's first Pacific Peoples' Advisor was appointed, with the establishment of this position helping to meet the key goals for HVDHB to improve the health of the Pacific people in the region. Our aim is to encourage participation by the various groups in our Hutt Valley Pacific population in identifying and providing health programmes and services that best meet their needs.

Secondary Care Initiatives

A range of secondary care initiatives were also funded during the past year. These include:

- Specialist nurse-led clinics designed to improve efficiency of specialist clinics and with full assessment work-ups, in respiratory and rheumatology services
- Specialist nurse-led respiratory clinics, diagnostic clinics and pathways assisting 96 percent of people attending first specialist assessments being seen within six months of referral
- Telephone follow-up service for patients with cardiac diagnosis discharged from medical wards and Coronary care Unit.

Palliative Care

Te Omanga Hospice has been funded to develop a new education and liaison programme aimed at improving the understanding and application of palliative care principles by health professionals.

A Palliative Care Educator will also develop guidelines to assist health professionals with symptom management, and to determine the stage in a person's illness or condition when palliative care services are needed.

Mental Health

A key priority for the Board over the past year has been to fund a range of initiatives to improve support for people with mental health issues in the Hutt Valley and this has resulted in some notable achievements including:

- The establishment of a Mental Health Community Support Service by the Tanumafili Trust. This service, which has the support of several other mental health providers in the Hutt Valley, is aimed at supporting the needs of Pacific people with mental health disorders living in the community
- The establishment of an Alcohol and Drug Day Programme involving the activities of a number of A&D providers in the Hutt Valley. The programme provides greater access to consumers and a range of programmes more appropriate for their needs
- Local Maori and Iwi participating in a process to design and establish Kaupapa Maori Mental Health Community Support Services for the Hutt Valley. Funding of $600,000 has been reserved for this initiative
- The contracting for new youth services, which include an education/vocation brokerage service and an activity, based rehabilitation programme
- The establishment of a Mental Health Local Advisory Group to advise on the planning and funding of services used by Hutt Valley residents
- Contracting for additional Mental Health community support workers in the Hutt Valley
- Providing support for a hui on community housing for mental health consumers.

Maori Health

The Maori Policy Development Taskforce completed the development of the Recruitment, Retention and Development of a Maori Workforce Policy during the year. The taskforce has representatives of both the Maori community and organisations working with DHB staff in the development of key policies that affect both Hutt Valley DHB and the wider Maori communities. Training is being developed to assist staff involved in recruitment to use the policy effectively and appropriately.

In May 2002, a careers initiative to promote Hutt Valley DHB as a good place of employment, as well as to target potential Maori and Pacific people interested in working for the organisation, and in the health sector in general, was launched. Although the project is in its early stages, it has generated considerable interest amongst schools, tertiary institutes, government and non-government organisations and the local Maori community. Another positive initiative is the DHB Maori staff forum. The purpose of the forum is to profile all existing Maori staff to identify, among other things, their preferred career pathways and the opportunities within the organisation or wider community to support staff development.

A Maori Customer and their Whanau Satisfaction Survey was piloted towards the end of 2001. The purpose of the survey was

to obtain feedback from Maori patients and their whanau on their satisfaction with the quality of services received during their time as an inpatient or consumer of Hutt Valley DHB services. The evaluations and comments received have been analysed and developed into a formal report to enable the organisation to seek quality improvement initiatives where issues have been identified. Particularly pleasing was an overall high level of satisfaction from Maori customers and their whanau in terms of the services provided by Hutt Valley DHB.

While the Maori Provider Development funding and responsibility is maintained by the Ministry of Health, there are a number of practical activities at a local level in which the DHB's Maori Health Development Unit is involved. In addition to helping build local provider capacity, the Unit assisted Maori health providers with advice and facilitation toward achieving accreditation with Quality Health New Zealand. One provider signed a contract with QHNZ during the year and is in the process of identifying appropriate staff to be trained in the quality assessment process.

Maori Care Co-ordination has developed considerably since it was trialled two years ago. The role, which is reliant on the particular individual having a wide community network and knowledge base, has proved invaluable to the organisation. Staff involved have greater understanding of other roles within the sector, such as social workers and therapists, and have developed excellent working relationships with all clinical staff. They have the ability to deal personally with clients and, where necessary, refer them to the appropriate agency for support. Support is being provided to the Funding & Planning Portfolio Manager to develop an appropriate model and collective working opportunities to deliver a non-clinical Kaupapa Maori mental health service.


Over the past year, Hutt Valley DHB has again provided a broad range of community and hospital based primary and secondary health services to the people of the Hutt Valley and, for the wider Wellington area, Regional Public Health services. The following service reports detail the highlights in each area over the period 1 July 2001 to 30 June 2002.

Surgical

An important goal for the Board over the last 12 months was to retain and improve on secondary services provided to the local community. Once again, Hutt Valley DHB surgical service has met contract volumes, waiting list requirements and quality enhancement.

Highlights for the surgical service include:

- The completion of the site optimisation project for the general surgical, and gynaecological outpatients department as well as the completion of the ENT, audiology and ophthalmology outpatients department
- Credentialling of General and Orthopaedic surgical teams
- Achievement of contract volumes, which increased over previous years.

The average length of stay (ALOS) for surgical patients for the year has been further reduced as a result of clinical improvements and treatment pathways. In addition, more outpatients were seen and more caseweights generated than the previous year while still meeting budget requirements. Throughout the year, the service continued to receive positive patient feedback reports and staff turnover recorded a small but important reduction.

To enable surgical services to meet core contract targets and booking system requirements, caseweights in gynaecology were contracted out to Boulcott Clinic. The ongoing relationship and development of new initiatives and responsibilities have provided opportunities and challenges to both organisations. The ACC contract is now a joint venture between Boulcott Clinic and Hutt Valley DHB. Following clinical assessment patients are admitted to the most appropriate hospital for surgery.

Medical

The service continues to manage increasing acute demand in volume and patient acuity. This year the service discharges were 5 percent more than 2000-2001. To manage this demand and meet recruitment and retention needs for nurses, the service has focused on quality improvement opportunities to provide improved care to patients and career and training opportunities for nurses.

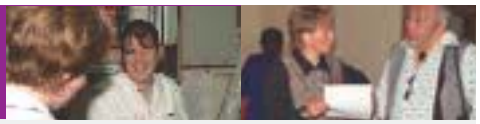
The general medical floor has introduced a discharge lounge with a discharge lounge co-ordinator role. This initiative has significantly improved discharge planning across the service, including initiating discharge activities on admission, referring patients to other internal and external health providers, targeting patients with complex health needs, teaching nurses and doctors systems and processes to enhance discharge, and establishing a lounge area for patients to wait prior to leaving the service. After six months of operation, this approach has reduced length of stay and readmission rates for targeted complex patients.

The service has a high new graduate ratio (30 percent) and service-specific clinical competencies have been developed by the service educator to ensure new staff at all levels are given a clinical framework to guide and support them in their roles. These clinical competencies link directly into the organisational clinical career pathway. For the second year in a row the medical registrars sitting Royal Australasian College of Physicians Fellowship exams have been 100% successful. This year the Wellington region had the highest pass rate in the country – HVDHB at the top.

The medical staff workload was reviewed in January. The aim was to improve the balance of workloads for junior and senior staff, decrease frequency of call for cardiologists, ensure greater cardiology input for all cardiology patients, clearly define cardiac patient responsibilities, and improve teaching opportunities for junior medical staff. A four-month







trial has demonstrated that these points have been successful and well received by staff. The length of stay has reduced by 0.75 of a day across general medicine and cardiology as well.

The waiting list for gastroenterology patients awaiting first specialist appointments has been reduced to less than six months for the first time in over two years. This is due to the appointment of an additional gastroenterologist in January 2002 and a review of those patients on the waiting list.

Emergency Department

Presentations to the Department met budget for the year and were 1 percent less than in 2000-2001. The continued increase in admissions to the hospital's Medical Service indicates more appropriate presentations to the Emergency Department.

A survey to identify why people chose to attend the Emergency Department for minor 'primary care' health problems was undertaken in January 2002. The survey identified that people liked the 'one-stop shop' concept of the Department, saw it as authoritative and 'knowing what to do', as well as liking the fact that the care is provided free. As a result the Department is working closely with the primary care providers, particularly After Hours Services, to promote the primary-based care services to the public and to up-skill those services to provide a greater range of care in the community, for example, in fracture management.

The Department appointed a new clinical nurse manager early in 2001 who has developed and strengthened the nursing team. To enhance the skills of new nurses to the Department and increase retention, a new nurse educator position also commenced in March 2002. Both these appointments have brought an increased focus and training level to 24-hour nurse co-ordination of the Department and triage activities.

Recruitment of a specialist emergency physician continues. There is an international shortage of emergency specialists. Once a specialist is in place the Department plans to achieve Australasian College of Emergency Medicine accreditation as a training department, which will enable the service to attract junior medical staff on the emergency medicine training programme. This will improve recruitment and retention opportunities for junior medical staff in the Department.

Specialist Rehabilitation Services

The service reviewed the outpatient and community-based services, realigned the staff resources to activities and clearly related those activities to contracts. From this the service has identified opportunities for patients with strokes and patients convalescing, and is working with primary providers (e.g. GPs and rest home services) and the acute medical service on these two areas.

Nurse recruitment and retention continues to challenge the service. Opportunities developed over the last 12 months include shared positions with general medicine, new graduate rotations, career opportunities in co-ordination and specialist roles and a newly developed educator and liaison role.

Nursing

The Nursing Development Unit continues to provide advice and support across the organisation at all levels and it has been an exciting and challenging year for nursing overall.

Highlights for nursing in this past year include:

- Development of integrated projects across primary and secondary services, clinical pathways, palliative care education, triage education, acute care options, co-morbidity case management and intravenous fluid management in residential facilities
- The graduate nursing programme, which provided professional development to 23 beginning practitioners. The programme is being extended to include primary health placements and this will be linked to a Primary Health Entry to Specialty Practice Programme
- The credentialling framework for nursing, the 'Clinical Career Pathway' which has been reviewed and forwarded to the Nursing Council for accreditation
- Supporting individual nurses towards advanced scopes of practice, both at Masters level and in preparing portfolios for Nurse Practitioner status.

Mental Health

A wide range of initiatives were carried out by the Mental Health Service over the year to further improve support for the mental health consumers in the Hutt Valley. A major achievement has been the establishment of a Mental Health Community Support Service by the Tanumafili Trust. This service, which has the support of several other mental health providers in the Hutt Valley, is aimed at supporting the needs of Pacific people with mental health disorders living in the community. The Service also established an Alcohol and Drug Day Programme involving the activities of a number of A&D providers in the Hutt Valley. The programme provides greater access to consumers and a range of programmes more appropriate for their needs. Contracts were also let for new Youth Services, which include an education /vocation brokerage service and an activity-based rehabilitation programme. During the year a Mental Health Local Advisory Group was established to advise on the planning and funding of services used by Hutt Valley residents.

Maternity and Children's Health

Over the past year, significant progress has been made in realising the objectives of the Maternal and Children's Health Service plans. The continued focus on quality improvement, with each service establishing key quality projects and initiatives, has resulted in:

- Collaboration with key community providers to extend the comprehensive breast-feeding policy, training and field assessor programme beyond the confines of the hospital setting. This will go some way to ensuring women get the support they require in the critical postnatal period
- The number of children admitted to the Child Assessment Unit exceeds contracted volumes. This model of care is very positive for children, families and their GPs. 80 percent of children seen and assessed have avoided an inpatient admission and were subsequently cared for in their own homes by our skilled team of paediatric nurses with direct contact back to the consultant paediatrician, or referral back to their primary health care provider. This initiative has also allowed a 25 percent increase in paediatric surgical admissions.

Towards the end of 2001 it appeared that for a number of reasons some Lead Maternity Caregiver practitioners were withdrawing from maternity care or reducing their case loads. This led to an increase in the number of women seeking care through the Secondary Care Clinic. An alternative model was introduced to ensure that women receive a high standard of care from a midwifery service.

Regional Public Health

Regional Public Health's service delivery area encompasses the geographical boundaries of three District Health Boards – Hutt Valley, Capital & Coast and Wairarapa. Ensuring the most effective spread of resources across the region, and providing services that meet DHB priorities, have been major focuses for Regional Public Health staff in the past year.

Health Promotion

Over the past year the Health Promotion Programme has included the Nutrition and Physical Activity team's involvement with the annual 10-week Hikoi programme which encourages participants to walk as part of a team with supervision, motivation and support by RPH staff. The success of Hikoi, which has grown from 208 participants in 1999 to 750 this year, can be attributed to health promotion strategies put in place by Hutt Valley DHB.

Regional Public Health, Crown Public Health and the Heart Foundation began piloting a School Food Registration Programme in the Wellington region, which involves the development of a register of healthy food products suitable for sale in schools. The aim of this is to make it easier for canteen/lunch order operators within the region's 200 schools to select healthier food options, and bring to their attention food products that meet specific nutrient criteria consistent with recommendations for children's health.

Throughout the year the Injury Prevention Team has been successful at strengthening Kidsafe Coalitions throughout the region and encouraging the involvement of various organisations in the Kidsafe Week activities planned for October 2002. The various coalitions – Wellington, Hutt, Porirua and Kapiti – have developed strategies to raise community awareness of drownings and pedestrian injuries.

An extremely successful Pacific Health Day involving Regional Public Health's Pacific Programme team and many other organisations was held in April at Lower Hutt to promote the health and wellbeing of Pacific people. A further achievement of the Pacific team this year was an excellent presentation on Pacific Island sexual and reproductive health to the National Youth Development Conference held recently at Victoria University.

The Alcohol, Tobacco and Other Drugs team has also had a busy year. For the last six months the team has been working on the 'After Ball' project concerning youth alcohol use. Nine out of 18 schools are using the new Alcohol Liquor Advisory Committee 'Planning Parties Guide' and working through this with the students and parents to ensure that after ball events are as safe as they can make them.

World Smokefree Day was again a major event in the health promotion calendar for the Alcohol Tobacco and Other Drugs team. A range of community activities was supported including a Top Town event organised by the Timberlea Residents' Association. The focus of the event was promoting 'Smokefree' and sponsorship from Te Kiwai (Health Sponsorship Council) provided each child with a prize and local schools also receiving new resources such as sports gear.

Health Protection

One of the major challenges in the past year for the Health Protection team has been recognition of the risks around threats of terrorism. Following the events in New York on 11 September 2001 there were worldwide threats about the release of biological agents such as anthrax. In the Wellington region, the New Zealand Golf Open in Kapiti was the focus of a cyanide threat. The threat involved a quantity of high-grade cyanide and was taken very seriously by police, public health and other services. RPH assessed food and water security at the tournament and associated events and had a team on standby at the course throughout the event. Fortunately it was a false alarm, but the operation provided a very good opportunity to test the ability of emergency services to work together.

Food-borne illness rates are high in New Zealand. During the past year, two national outbreaks of food-borne illness have been investigated. In 2001 there was an increase in cases of salmonella across the country due to a specific serotype. Public Health staff worked with the Institute of Environmental and Scientific Research in a multi-centre case control study, which found an association between the illness and contact with wild birds. In March 2002 an increase in the number of cases of Hepatitis A was investigated also using a case control study. This investigation found the source to be a blueberry farm in the Waikato.

Regional Public Health staff have investigated and responded to 23 outbreaks of enteric illness in the greater Wellington Region including two large outbreaks of gastroenteritis caused by Norwalk-like viruses occurring in school camps. RPH has worked with national camp operators to provide them with skills to reduce the risk of outbreaks in camps.

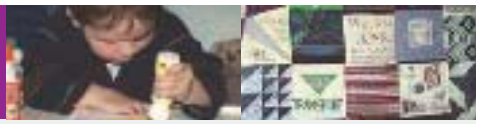
School Health

Last year, the School Health team successfully ran and completed the MMR 2001 School Immunisation Programme for Regional Public Health in the greater Wellington region. This programme included immunisation of 5-10 year olds in all primary schools. The Year 7 Immunisation Programme was successfully completed over the same period. 13,094 students were vaccinated against MMR. This represents 54 percent of all eligible students. The combined coverage achieved by RPH and GPs will be 70 percent, providing all intending students present for their MMR vaccination at their GPs.

During 2001, the School Health team was also involved with the development of the new information system based on the electronic transfer of information between schools, GPs and RPH about all children to be vaccinated. Although there were some initial problems, this system has proved to provide the most accurate data for the School Immunisation Programme.

Regional Screening Services

Breast and cervical screening services were combined under one umbrella this year and became the Regional Screening Services, servicing the greater Wellington area. BreastScreen Central provided screening services at Wakefield and Hutt hospitals while the Services' mobile unit visited the Kapiti Coast, Wellington City and



the Wairarapa. The response from women to the free breast screening service was excellent this year with BreastScreen Central achieving a 33.3 percent coverage (target 35 percent) rate in only its third year of screening.

The cervical screening register saw many changes this year, owing to the implementation of the new quality and policy standards. The register continues to provide information and other services to smeartakers (GPs, practice nurses and midwives) and registered women. It strives to have an accurate and up-to-date national database that allows us to track women, who choose to be part of the register, through the screening pathway.

Community Dental

The Community Dental Service (School Dental Service and Hospital Dental Department) underwent a significant service review in mid 2001 which has resulted in a service that fosters professional development, quality improvement and the provision of responsive, high quality dental care to people in the Hutt Valley. The Department along with the Regional Plastics Surgical Service continues to develop the regional multi-disciplinary clinic for children and adults with cleft lip and palate, and it co-sponsored a successful Cleft Lip and Palate seminar, contributing to the best practice of care and treatment of these patients.

The School Dental Service provides a regional service improving the oral health of children in the Hutt Valley, Wellington, Porirua and Kapiti regions. Longstanding national workforce shortages, particularly of Dental Therapists, continues to challenge the ability of the Service to deliver care in a timely fashion. Despite these shortages, oral health statistics for children in the region remain one of the best in the country. This is in part a result of the service concentrating on developing community links and improving relationships with schools in order to increase the enrolment of pre-school and school-aged children into the service. In addition, the service has secured a new contract with the Ministry of Health to provide a regional co-ordination service which aims to increase the uptake of adolescents into the free dental care schemes provided by private dentists.

Clinical Support

The year has seen major changes for the outpatient services with two new clinic areas created. The site optimisation plan has seen the completion of a new surgical and gynaecological suite. This has enabled the clinics to be held in a single area. The ENT, eye and audiology clinics were relocated to their new refurbished facility in June of this year. This area includes two state-of-the-art soundproof rooms designed specifically for audiology testing. With increasing uptake in the breastscreening programme, diagnostic radiology has commissioned a new mammography suite offering a comprehensive diagnostic mammography service to women with clinical problems or with a family history of breast cancer.

The year has seen continued focus on quality improvement. Both radiology and laboratory services retained their International Accreditation New Zealand (IANZ) accreditation after successful audits. Biomedical safety testing has moved from 82 percent to 92 percent compliance. Dietetic services have implemented a project to better support community-referred weight management clients through the use of 'Starter Packs' that encourage healthy lifestyles.

Community Health Service

Over the past year, the Community Health Services have placed greater emphasis on closer partnership with primary services with a number of new initiatives being developed including:

- The provision of an acute nursing service to primary services. The district nursing team is now involved as a primary option service for GPs to use when nursing interventions can assist in preventing hospital admissions
- The introduction of combined district nurse and practice nurse meetings to gain better understanding and appreciation of each role, and the services available, as well as developing networks
- The establishment of a Wound Care Nurse Specialist position, which provides expertise for both primary and secondary services. Wound care pathways are being developed to improve management of patients with chronic wounds in both primary and secondary settings.

The community specialist nurse team expanded to include the oncology nurse specialists when administration of chemotherapy at Hutt Hospital was discontinued during the year. The main emphasis of the role is now supporting people in the community who have a cancer diagnosis and who are undergoing treatment. ACC contracts remain an important source of revenue. During the year Community Health Service obtained a further ACC contract to provide long term nursing assessment.

Summary of Healthcare Provision Over Five Years

Hutt Valley District Health Board	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002	2001/02 2000/01 Var %	2001/02 1997/98 Var %
Inpatient discharges	16,013	16,145	16,968	17,040	16,724	-1.9	4.4
Daycase discharges	4,578	5,331	6,948	7,823	7,771	-0.7	69.7
Total discharges (incl newborns)	20,591	21,476	23,916	24,863	24,495	-1.5	19.0
Discharges per day	56.4	58.8	65.3	67.9	67.1	-1.2	19.0
Available bed days (incl cots)	104,399	91,052	85,805	89,71	91,250	1.7	-12.6
Occupied bed days	86,473	75,597	75,614	78,864	77,745	-1.4	-10.1
Average occupancy	82.8%	83.0%	88.1%	87.9%	85.2%	-3.1	2.9
Inpatient operations	3,865	4,408	4,848	5,015	4,825	-3.8	24.8
Daypatient operations	1,754	2,298	2,214	2,444	2,130	-12.8	21.4
Total operations (theatre cases)	5,619	6,706	7,062	7,459	6,955	-6.8	23.8
Elective operations	2,705	3,391	3,504	3,822	3,332	-12.8	23.2
Acute operations	2,914	3,315	3,558	3,637	3,623	-0.4	24.3
Total operations	5,619	6,706	7,062	7,459	6,955	-6.8	23.8
Waiting list total at 30 June	1,979	1,146	873	868	821	-5.4	-58.5
Outpatient Attendances							
– Surgical	30,268	29,363	31,163	31,644	31,262	-1.2	3.3
– Medical	13,212	15,045	14,901	15,411	16,130	4.7	22.1
– Paediatric	4,045	3,978	4,365	4,207	4,366	3.8	7.9
Emergency Department							
– First attendances	28,154	27,308	28,888	30,259	29,439	-2.7	4.6
– Total attendances	29,678	28,735	30,558	31,986	30,851	-3.5	4.0
Community Contacts							
Community contacts – district nursing	41,356	30,691	34,772	41,063	36,652	-10.7	-11.4
Births – Hutt Hospital	1,987	1,928	2,112	2,117	2,061	-2.6	3.7
Radiology examinations	44,531	45,638	47,839	48,202	46,853	-2.8	5.2
Laboratory tests performed	741,647	518,503	563,600	596,983	643,678	7.8	-13.2

Organisational Activities

Hutt Valley DHB engages in a range of activities that are applied across the organisation relating to staffing, campus services, information services, and quality and risk monitoring. The Board set a number of key performance measures in the areas detailed below to be met during the period under review.

Human Resources

During the last 12 months, significant work has either commenced or been completed in the areas of recruitment and retention, career and performance management. Vocational project teams were established and lead by Human Resources to implement a number of career development initiatives for Hutt Valley DHB employees including:

- Clinical Career Pathways (CCP) for Allied Health Staff. The CCP framework for allied health staff was completed during the year. The therapies staff will be the first professional groups to participate on the CCP. Other groups have agreed to develop descriptions of the competencies for their occupational groups over the next 12 months. The benefit to the individual and the organisation is significant and it will ensure that individual career development and organisational performance are addressed together.
- Coaching Programme. This programme is focused on developing coaches internally who are able to provide support to staff to assist them in the achievement of their goals and career objectives
- 'The Pulse' – Staff Survey. During May, staff at Hutt Valley DHB were invited to participate in the DHB's staff survey, called 'The Pulse'. The survey was undertaken to obtain information and feedback about Hutt Valley DHB as an environment people want to work in, as 'an employer of choice'. This is the first time that a survey of this nature has been carried out at the Hutt campus and will serve as a benchmark for further surveys, which will be undertaken annually. The survey report identified a number of issues needing to be addressed. Over the next 12 months we will identify and address with our staff the most important areas of concern.

Mainstream Supported Employment Programme

The mainstream employment programme is managed by the State Services Commission to maximise employment opportunities for people with disabilities. Hutt Valley DHB has been actively supportive of the mainstream programme since mid-2000. Currently we have five employees participating in the programme and a further three participants have come off the programme recently, having been appointed to permanent positions within various departments of the DHB.

Last year Hutt Valley DHB was nominated by one of the participants for the Mainstream Employer of the Year award and we subsequently received a merit award for our contribution to and support of the programme.

Employment Relations

This year has been a particularly busy year in the employment relations area. The most significant development has been the desire of unions, supported by the Employment Relations Act, to pursue Multi-employer Collective Agreements (MECAs).

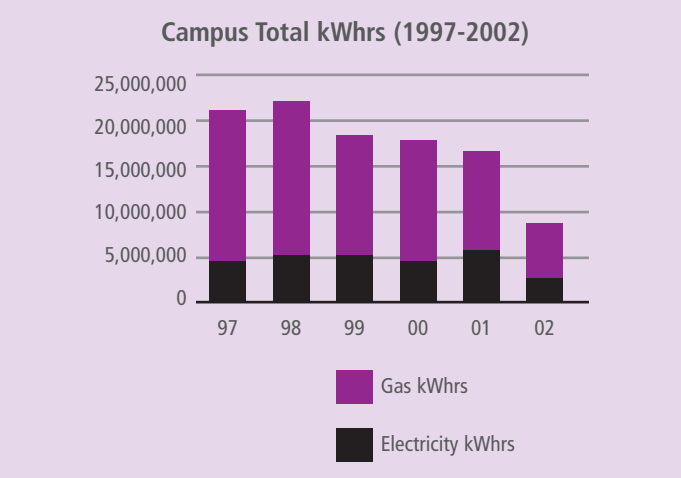
The first MECA to be concluded was with the NZ Nurses' Organisation. The NZNO initiated bargaining last year for a Multi-Employer Collective agreement for the seven lower North Island DHBs. The negotiation process was protracted and at times difficult, but an agreement was reached with the NZNO and our nursing staff.

Campus Environmental Management

Since 1998 Hutt Valley DHB has been active in the area of energy management. The process has included collecting information on energy use, identification of areas for potential savings, education of maintenance staff, implementing energy savings projects, negotiating energy supply contracts, appointing an energy manager and signing of an energy efficiency agreement with the Energy Efficiency and Conservation Authority (EECA).

Altogether there have been over 20 individual projects for the purpose of improving our overall energy efficiency performance and this has led to significant reductions in energy use throughout the campus, the most significant savings being made during the last year. This result has significant financial benefits to the DHB and reflects the Board's commitment to environmental sustainability. This achievement has also resulted in Hutt Valley DHB being nominated as a finalist in this year's prestigious EECA EnergyWise conservation awards.

The following graph shows the results of these projects over the last six years.



Quality and Risk

This year the organisation has continued to focus on quality improvement initiatives. Progress has been made in completing 59 percent of the recommendations from the accreditation survey in March 2001. Mental Health Services in particular has achieved a high level of compliance with the national mental health standards through regular review and implementation of quality improvement projects throughout the year.

Staff and our ethnic communities have benefited from improvements to interpreting resources within the hospital and education for staff regarding the rationale for the use of trained interpreters.

The integration of Maori health objectives within the quality framework has resulted in a pilot survey focusing on Maori patients and their Whanau. The results of this pilot were very positive and the survey will be repeated on an annual basis.

It is important to note that safety must be considered at both a system and an individual level. Hutt Valley DHB therefore views the quality and risk framework as an integral part of the systems necessary to support individual clinical practice.

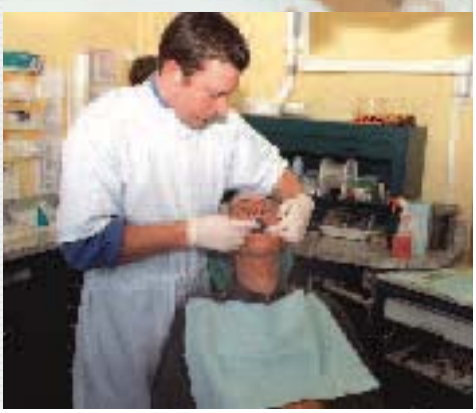
Information Services

This year many clinical users have been exposed to the use of information systems for the first time. This is the beginning of a quiet revolution in the way patient information will be handled at Hutt Valley DHB. Clinical users will come more and more to rely on the clinical information system as their first source of patient information rather than the patient notes. These initiatives have arisen out of the SMILE project (System for More Information Less Effort) and have really been driven by the clinical staff themselves through the Clinical User Group who not only selected the systems, but who also work closely with Information Services to guide the implementation effort.

A new web browser-based patient information system, the Ward Information Centre, was introduced into wards. This system provides much better access to patient information on the ward and has replaced a number of previously manual processes.

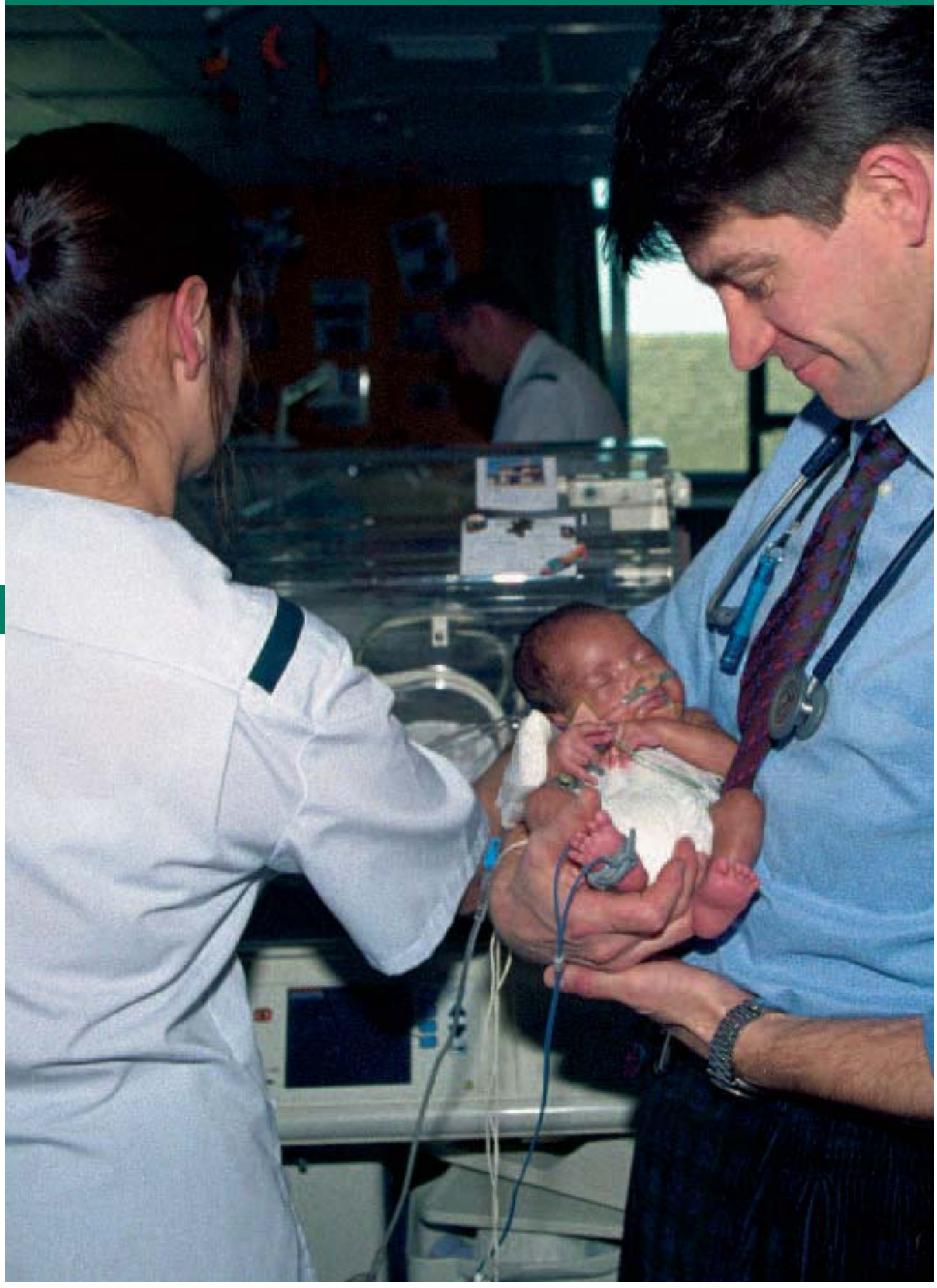
Hutt Valley DHB Website

In March 2002, the DHB launched its new website. The Intranet service, available to all staff of the DHB, provides a comprehensive electronic information system containing key operational data, clinical policies, educational and career information. The DHB Internet site, which is available to the public, also contains comprehensive material about Hutt Valley DHB and the community it serves. This is proving extremely successful and an important organisation recruitment mechanism.



Financial Report

For the year ended 30 June 2002



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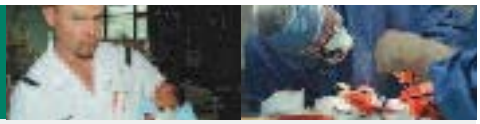
For the year ended 30 June 2002



Reporting Entity

Hutt Valley District Health Board was established on 1 January 2001 following the enactment of the New Zealand Public Health and Disability Act 2000. Under the New Zealand Public Health and Disability Act 2000 the assets and liabilities of Hutt Valley Health Corporation Limited were vested in Hutt Valley District Health Board. The Board's operations combine the functions of the predecessor and some of the functions previously performed by the Health Funding Authority.

General Accounting Policies

Hutt Valley District Health Board is a crown entity in terms of the Public Finance Act 1989 and the New Zealand Public Health and Disability Act 2000. These financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Particular Accounting Policies

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

Budgets

The budget figures are those presented in the Statement of Intent that was approved by the Minister of Health. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by Hutt Valley District Health Board in the preparation of the financial statements.

Leases

Finance leases

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset are transferred to Hutt Valley District Health Board, are classified as finance leases. Where assets are acquired by finance leases, the lower of the present value of the minimum lease payments and fair value is recognised as an asset at the beginning of the lease term and depreciated on the same basis as equivalent fixed assets. A corresponding liability is also established and each lease payment is allocated between the liability and interest expense.

Operating leases

Operating lease payments, where lessors effectively retain substantially all the risks and benefits of ownership of the leased items are charged as expenses in the periods in which they are incurred.

Investments

Investments are stated at the lower of cost and net realisable value. Dividend income is recognised in the Statement of Financial Performance when received.

Goods and Services Tax

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

Employee Entitlements

Provision is made for annual leave, long service leave, retirement gratuities, parental leave and senior medical officers' allowances for conference leave and reimbursement of expenses.

Annual leave and parental leave are calculated on an actual entitlement basis at current rates of pay. Conference leave and expenses reimbursement allowances are calculated on an actual entitlement basis per the senior medical officers' employment contract. Other provisions are calculated on an actuarial basis utilising current rates of pay.

Accounts Receivable

Accounts receivable are stated at expected realisable value after providing for doubtful and uncollectable debts.

Inventories

Inventories are stated at the lower of cost, determined on a weighted average basis, and net realisable value. This valuation includes allowances for slow moving and obsolete inventories.

Obsolete inventories are written off.

Fixed Assets

Fixed assets were vested in Hutt Valley District Health Board from Hutt Valley Health Corporation Limited on 1 January 2001. These assets are recorded at the initial cost incurred by Hutt Valley Health Corporation Limited.

Assets acquired by the Board subsequent to its establishment are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation including materials, labour, direct overheads and transport costs.

Depreciation of Fixed Assets

Depreciation is provided on a straight-line basis on all tangible fixed assets other than freehold land, at rates, which will write off the cost of the assets, less their estimated residual value, over their useful lives.

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

Buildings	33.3 years
Building fitout	4-18 years
Plant and equipment	1-15 years
Motor vehicles	5.6 years
Computer equipment	1-5 years
Leased assets	6.5-8 years

Gains and losses on disposal of fixed assets are taken into account in determining the net operating surplus/(deficit) for the period.

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.

Taxation

Hutt Valley DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Trust and Bequest Funds

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

Cost of Services Statements

The Cost of Services Statements report the net cost of services provided by each significant activity. The net cost is the significant activity's cost of providing the service, less revenue collected by the activity.

Statement of Accounting Policies

For the year ended 30 June 2002

Cost Allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

Cost drivers for allocation of indirect costs

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

Statement of Cash Flows

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

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

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

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

Financial Instruments

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

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

Changes in Accounting Policies

Investments

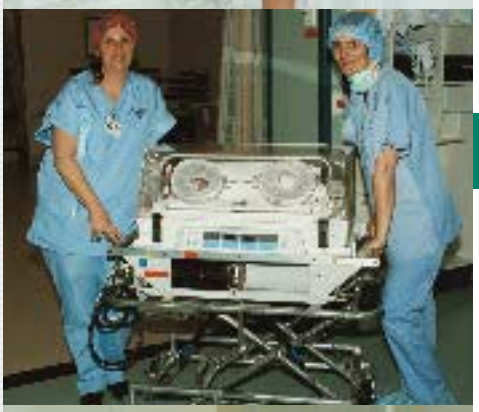
The Board has changed its accounting policy for the shareholding in Central Region's Technical Advisory Services Limited (CRTAS). The shareholding in CRTAS is treated as an investment, whereas it was considered an associate company in the previous year. This change has been determined appropriate because the Board does not consider it has significant influence over the operating and financial policies of CRTAS. This change in accounting policy does not have a material effect on these financial statements.

Other

There have been no other changes in accounting policies adopted and all policies, other than that noted above, have been applied on a basis consistent with the previous period.

Comparatives

The comparatives are for the six-month period from 1 January 2001 to 30 June 2001. This period represented the first financial period for Hutt Valley District Health Board.



Statement of Financial Performance

For the year ended 30 June 2002

	Notes	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Operating income		165,294	163,304	54,053
Total expenses		(154,589)	(153,158)	(47,209)
Operating surplus before depreciation, capital charge and interest	**1**	**10,705**	**10,146**	**6,844**
Gain on sale of assets		1	604	1
Depreciation	1	(6,907)	(7,313)	(3,235)
Capital charge		(4,512)	(4,508)	(2,294)
Interest expense	1	(1,390)	(1,408)	(718)
Net operating (deficit)/surplus		**(2,103)**	**(2,479)**	**598**

Supplementary Information

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

	June 2002 Provider $000	June 2002 Governance $000	June 2002 Fund $000	June 2002 Elimination $000	June 2002 Consolidated $000
Operating income	107,248	1,588	138,849	(82,391)	165,294
Operating expenses	(96,689)	(1,742)	(138,549)	82,391	(154,589)
Operating surplus before depreciation, capital charge and interest	**10,559**	**(154)**	**300**	**0**	**10,705**
Gain on sale of assets	1	0	0	0	1
Depreciation	(6,906)	(1)	0	0	(6,907)
Capital charge	(4,512)	0	0	0	(4,512)
Interest expense	(1,390)	0	0	0	(1,390)
Net operating (deficit)/surplus	**(2,248)**	**(155)**	**300**	**0**	**(2,103)**

The accompanying notes and accounting policies on pages 30 to 31 and 37 to 43 form an integral part of these financial statements.

Statement of Movements in Equity

For the year ended 30 June 2002

	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Total equity at beginning of period	**41,725**	**41,725**	**41,127**
Net operating (deficit)/surplus	(2,103)	(2,479)	598
Total recognised revenues and expenses for the period	***(2,103)***	***(2,479)***	***598***
Total equity at the end of period	**39,622**	**39,246**	**41,725**

The accompanying notes and accounting policies on pages 30 to 31 and 37 to 43 form an integral part of these financial statements.

Statement of Financial Position

For the year ended 30 June 2002

	Notes	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Equity				
Crown equity	2	41,127	41,725	41,127
Retained earnings	2	(1,505)	(2,479)	598
Total equity		**39,622**	**39,246**	**41,725**
Represented by:				
Current Assets				
Bank in funds		1,926	0	0
Receivable and prepayments	3	13,181	13,996	11,895
Inventories	4	704	695	695
Properties intended for sale	8	1,633	0	1,260
Total current assets		**17,444**	**14,691**	**13,850**
Current Liabilities				
Payables and accruals	5	17,922	17,323	11,397
Employee entitlements and provisions	6	6,892	5,975	6,475
Bank overdraft		0	1,870	182
Borrowings	7	262	0	308
Total current liabilities		**25,076**	**25,168**	**18,362**
Net working capital deficit		**(7,632)**	**(10,477)**	**(4,512)**
Non-Current Assets				
Fixed assets	8	68,514	71,566	67,645
Trust and bequest funds	10	592	605	605
Total non-current assets		**69,106**	**72,171**	**68,250**
Non-current Liabilities				
Employee entitlements and provisions	6	2,161	2,025	2,046
Borrowings	7	19,099	19,818	19,362
Trust and bequest funds	10	592	605	605
Total non-current liabilities		**21,852**	**22,448**	**22,013**
Net assets		**39,622**	**39,246**	**41,725**

For, and on behalf of, the Board

Board Member

Board Member

1 October 2002

The accompanying notes and accounting policies on pages 30 to 31 and 37 to 43 form an integral part of these financial statements.

Statement of Cash Flows

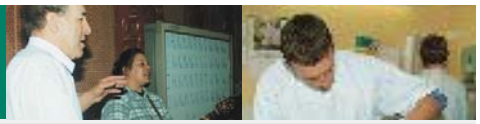
For the year ended 30 June 2002

	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Cashflows from Operating Activities			
Cash was provided from:			
Health-related services	156,272	151,492	46,129
Non health-related services	8,096	7,484	6,697
Interest received	242	200	142
	164,610	**159,176**	**52,968**
Cash was disbursed to:			
Payments to providers	49,916	51,444	0
Payments to suppliers	30,560	27,617	13,399
Payments to employees	67,718	66,143	31,744
Net goods and services tax paid	(112)	250	936
Net other tax paid	(4)	0	0
Interest paid	1,364	1,449	704
Capital charge paid	4,541	4,550	2,271
	153,983	**151,453**	**49,054**
Net cash inflow from operating activities	**10,627**	**7,723**	**3,914**
Cashflows from investing activities			
Cash was provided from:			
Proceeds from sale of assets	0	2,053	2
Realisation of trust funds	14	0	0
	14	**2,053**	**2**
Cash was applied to:			
Purchase of fixed assets	8,224	11,655	5,868
Additional trust funds	0	0	51
	8,224	**11,655**	**5,919**
Net cash outflow from investing activities	**(8,210)**	**(9,602)**	**(5,917)**
Cashflows from financing activities			
Cash was provided from:			
Loans raised	0	500	0
	0	**500**	**0**
Cash was applied to:			
Repayment of loans	309	309	139
	309	**309**	**139**
Net cash outflow from financing activities	**(309)**	**191**	**(139)**
Net increase/(decrease) in cash held	**2,108**	**(1,688)**	**(2,142)**
Add opening cash	(182)	(182)	1,960
Ending cash carried forward	**1,926**	**(1,870)**	**(182)**
Cash balances in the Statement of Financial Position:			
Bank in funds	1,926	0	0
Bank overdraft	0	(1,870)	(182)
Ending cash carried forward	**1,926**	**(1,870)**	**(182)**

The accompanying notes and accounting policies on pages 30 to 31 and 37 to 43 form an integral part of these financial statements.

Statement of Cash Flows

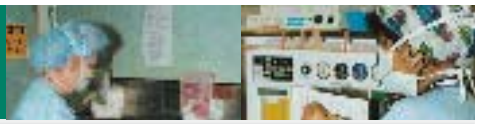
For the year ended 30 June 2002



	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Reconciliation of net operating surplus with net cash flow from operating activities			
Net operating (deficit)/surplus	(2,103)	(2,479)	598
Add back non-cash items:			
Depreciation	6,907	7,313	3,235
Increase/(decrease) in employee entitlements	532	(521)	567
Total non-cash items	**7,439**	**6,792**	**3,802**
Add/(substract) items classified as investment activity:			
Net gain/(loss) on sale of assets	(1)	(604)	1
Total investing activity	**(1)**	**(604)**	**1**
Movements in working capital:			
(Increase)/decrease in receivables and prepayments	(1,255)	(2,101)	(854)
(Increase)/decrease in inventories	(9)	0	7
Increase in tax payable	0	0	152
(Decrease)/increase in capital charge payable	(30)	(42)	24
Increase in payables and accruals	6,586	6,157	184
Total net working capital movements	**5,292**	**4,014**	**(487)**
Net cash inflow from operating activities	**10,627**	**7,723**	**3,914**

The accompanying notes and accounting policies on pages 30 to 31 and 37 to 43 form an integral part of these financial statements.

	Year to June 2002 $000	6 months to June 2001 $000
1. Net Operating Surplus		
After crediting revenue:		
Interest income	242	142
Net gain on sale of fixed assets	1	1
After charging expenses:		
Fees paid to external auditors		
Audit fees	63	63
Other services	2	0
Board and Committee Member fees	255	109
Rental and operating lease costs	1,391	635
Bad debts – movements in provision	103	5
Bad debts written off	32	21
Depreciation		
Buildings	1,077	530
Building Fitout	2,425	1,162
Plant & Equipment	2,114	993
Motor Vehicles	34	17
Computer Equipment	930	381
Leased Plant & Equipment	327	152
Total depreciation	**6,907**	**3,235**
Interest expense		
BNZ	1,312	681
Finance leases	52	35
Other	26	2
Total interest expense	**1,390**	**718**
2. Equity		
Crown Equity		
Opening balance	41,127	41,127
Closing balance	**41,127**	**41,127**
Retained earnings		
Opening balance	598	0
Net operating (deficit)/surplus	(2,103)	598
Closing balance	**(1,505)**	**598**
Total Equity	**39,622**	**41,725**
3. Receivables and Prepayments		
Trade debtors	13,080	11,811
Provision for doubtful debts	(292)	(218)
	12,788	**11,593**
Prepayments	393	302
	13,181	**11,895**



	Year to June 2002 $000	6 months to June 2001 $000
4. Inventories		
Pharmaceuticals	130	154
Surgical and medical supplies	594	561
	724	**715**
Provision for obsolescence	(20)	(20)
	704	**695**
Certain inventories are subject to restriction of title (Romalpa clauses).		
5. Payables and Accruals		
Trade creditors	10,110	4,594
Accrued expenses	5,707	4,753
GST and other taxes payable	890	774
	16,707	**10,121**
Capital charge payable to shareholders	1,139	1,169
Fixed assets payable	76	107
	17,922	**11,397**
6. Employee Entitlements and Provisions		
Annual leave	5,200	4,907
Long service leave	364	361
Retirement gratuities	1,395	1,398
Other employee provisions	2,094	1,855
	9,053	**8,521**
Made up of:		
Current	6,892	6,475
Non-current	2,161	2,046
	9,053	**8,521**

	Year to June 2002 $000	6 months to June 2001 $000
7. Borrowings		
Loans are repayable as follows:		
Current (payable to 30 June 2003)	19,000	0
One to two years (payable to 30 June 2004)	0	19,000
Two to five years (payable subsequent to 30 June 2004)	0	0
	19,000	**19,000**
Finance leases are repayable as follows:		
Current (payable to 30 June 2003)	262	308
One to two years (payable to 30 June 2004)	99	262
Two to five years (payable subsequent to 30 June 2004)	0	100
	361	**670**
Total current portion of loans	262	308
Total non-current portion of loans	19,099	19,362
Total loans	**19,361**	**19,670**
Interest rates per annum:	%	%
BNZ loan	6.16 to 7.72	6.16 to 7.72
Finance leases	8.50 to 11.0	8.50 to 11.0
Borrowings are net of finance charges.		
Line of credit restricted access		
Bank loan facilities	4,000	4,000
Used at balance date:	0	200
Unused at balance date	**4,000**	**3,800**

A facility with the BNZ of $28 million was available at 30 June 2002. Of this $4 million is for working capital requirements of which no draw down has been made. The balance of $24 million is for term borrowings of which $19 million has been drawn at balance date.

Subject to the continuance of satisfactory credit ratings the bank loan facility may be drawn at any time. Bank facilities are unsecured. Interest rates on all facilities are fixed.

The $19 million on loan from the BNZ is repayable on 30 November 2002. It is the Board's intention that this amount be refinanced. In compliance with the New Zealand Public Health and Disability Act 2000 this amount will be refinanced with the Crown Financing Agency on 30 November 2002. Accordingly the amount has been treated as a non-current liability.

8. Fixed Assets

	Year to June 2002 $000	6 months to June 2001 $000
Freehold land		
At cost	1,582	1,848
Total freehold land	**1,582**	**1,848**
Freehold buildings		
At cost	34,824	34,953
Accumulated depreciation	(7,635)	(6,598)
Total freehold buildings	**27,189**	**28,355**
Buildings fitout		
At cost	41,097	36,990
Accumulated depreciation	(15,808)	(13,382)
Total buildings fitout	**25,289**	**23,608**
Plant & equipment		
At cost	23,960	22,130
Accumulated depreciation	(14,822)	(12,839)
Total plant & equipment	**9,138**	**9,291**
Motor vehicles		
At cost	184	184
Accumulated depreciation	(98)	(64)
Total motor vehicles	**86**	**120**
Computer equipment		
At cost	6,871	5,291
Accumulated depreciation	(4,392)	(3,591)
Total computer equipment	**2,479**	**1,700**
Leased assets		
Plant & equipment	2,046	2,046
Accumulated depreciation	(1,341)	(1,005)
Total leased plant & equipment	**705**	**1,041**
Work in progress	**2,046**	**1,682**
Total fixed assets, leased assets and work in progress	**68,514**	**67,645**

The Board Members note that the latest Government valuations as at 1 September 1998, shown below for land and buildings, are likely to be an indication of fair value.

Government valuation as at 1 September 1998	
Land	4,900
Buildings	59,000
Total land and buildings	**63,900**

Land is not subject to any restrictions or claims under the Treaty of Waitangi Act 1975.
Work in progress is substantially attributable to the site optimisation programme and the electronic medical records project.

Properties Intended for Sale
Properties with a net book value (valued at cost less accumulated depreciation) of $1,633,000 have been reclassified as a current asset at 30 June 2002 and do not form part of the total for fixed assets. An agreement for sale and purchase has been signed and it is intended that the properties will be realised within the next 12 months.

On 3 July 2002 an Order in Council was signed authorising the transfer of $450,000 from the total of $1,633,000. The funds for this transfer, totalling $840,000, were received on 31 July 2002.

9. Other Investments

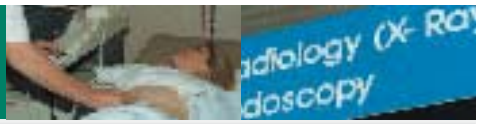
Other investments comprise the 16.7% shareholding in Central Region's Technical Advisory Services Limited (CRTAS). CRTAS was incorporated on 6 June 2001. CRTAS has a total share capital of $600 of which Hutt Valley DHB's share is $100. At balance date all share capital remains uncalled.

10. 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.

Restricted assets are included in the Statement of Financial Position and are administered on behalf of patients, the Hutt Valley DHB Chapel and the Thomas & George McCarthy Trust, totalling $156,835. Hutt Valley DHB does not have, nor will it have, ownership of these funds.

	Year to June 2002 $000	6 months to June 2001 $000
Opening balance	605	554
Funds received	88	71
Interest received	24	32
Funds disbursed	(125)	(52)
Closing balance	**592**	**605**



	Year to June 2002 $000	6 months to June 2001 $000

11. Statement of Commitments

The following amounts have been committed to by Hutt Valley DHB but are not recognised in the financial statements.

Capital commitments approved and contracted	2,826	5,149
Operating lease commitments	3,576	2,615
Total commitments	**6,402**	**7,764**
Term classification of commitments		
Less than one year	4,049	5,970
One to two years	864	757
Two to five years	1,431	984
Over five years	58	53
	6,402	**7,764**

12. Statement of Contingencies

There are no contingent liabilities as at 30 June 2002 (Nil, 30 June 2001).

13. Segmental Reporting

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

Segmental reporting is not applicable.

14. Financial Instruments

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

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

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

Hutt Valley DHB has fixed rate borrowings from the BNZ and other sources which are used to fund ongoing activities. Hutt Valley DHB policy is to monitor the interest rate exposure with a view to refinancing if appropriate. The interest rates on borrowings as at 30 June 2002 are disclosed in note 7.

There are no interest rate options or swap agreements in place as at 30 June 2002.


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

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

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

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

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

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

Trade debtors, trade creditors, cash, bank overdraft and bank loan facility – the carrying amount of these items is equivalent to their fair value.

Term loans and current portion of term loans – the fair value of term loans is based on current market interest rates available to Hutt Valley DHB for debt of similar maturities. The interest rates on the term loans range from 6.16% to 11.00%. These rates are fixed and accordingly the fair value will be the same as the carrying value.

15. Transactions with Related Parties

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

During the period Hutt Valley DHB received 92.8 percent of its revenue from the Government, through the Ministry of Health, to fund and provide health services. The amount outstanding at 30 June 2002 was $12.1 million.

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

16. Capital Charge

All DHBs are required to pay a capital charge to the Crown based on total equity. The charge was set at 11 percent for the financial period.

For the financial period, DHBs have been separately funded for most of the capital charge and that funding is included in the revenue figure in the Statement of Financial Performance.

17. Post Balance Date Events

A property included in the properties intended for sale in the Statement of Financial Position has been sold subsequent to balance date. Details are included in note 8.

Other than noted above there are no significant events subsequent to balance date.

Statement of Objectives and Service Performance

For the year ended 30 June 2002

Introduction

As a crown entity, Hutt Valley District Health Board is required by the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 to report on its service performance. The level of performance to be achieved for the year to 30 June 2002 was detailed in the Board's Statement of Intent.

In this section the actual performance of Hutt Valley District Health Board for the year ended 30 June 2002 is measured against the undertakings made in the Statement of Intent. The Audit Office has audited this performance report for accuracy and reasonableness.

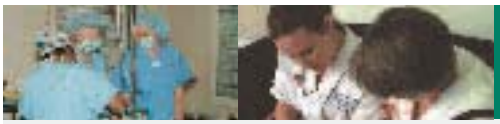
DHB Fund Output Class

This dimension of the Hutt Valley DHB refers to the receipt of funds from the Crown and the allocation of funds to providers, including its own hospital. It excludes governance, management and administration activities relating to the allocation of funds.

Service Performance

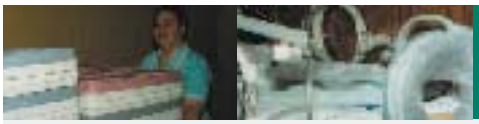
Measure	Definition	Target	Achievement
Percentage of providers paid on signed active contracts	This measure identifies those providers with contracts that have expired or are negotiating variations to their contract and will continue to be paid. This indicator is designed to measure funder timeliness and success in renegotiating contracts before they expire. A baseline will be set to determine an appropriate measure for future years.	Set baseline	82 percent (or 63 out of 77) of providers are being paid on signed contracts. The remaining 14 have draft contracts. Six months ago percentage active was 88 percent. A target of 90 percent has been set for 2002/03. This measure has been fully achieved.
Ratio of expenditure on services provided by Maori providers to total expenditure versus last year	To ensure that the level of Maori providers contracted to deliver services is no less than the previous year. A baseline will be set to determine an appropriate measure for future years.	Set baseline	Maori Health expenditure is 0.8 percent of total spend. New contracts with Maori providers, however, are often funded from the Personal Health or Mental Health budgets, where it is not easy to identify Maori-specific expenditure. In the future it is likely that the current Maori Health budget will only increase with inflation or through specific tagged funding from the Ministry of Health. A percentage of no less than the percentage achieved in the previous year has been set as the baseline target. This measure has been fully achieved.
Percentage of payments made on services where compliance with the contract has been actively audited and confirmed	This measure ensures that there are no significant issues arising from the regular monitoring of provider contracts and that a regular audit programme is in place. A baseline will be set to determine an appropriate measure for future years.	Set baseline	2001/02 payments actively audited and confirmed are confined to Health Payments Agreements and Claims Processing (Health PAC previously Health Benefits and Share Services Support Group) expenditure through their Audit and Compliance Programme. Through their 2001/02 audit programme recovery of over $1 million is sought from Hutt Valley providers. Central Region's TAS has been establishing an audit programme on behalf of HVDHB for our other contracted providers. The aim is to have a routine audit programme that will cover other contracted providers at least once every three years (the first audit is scheduled for July 2002). Scoping for the audit for DHB provider arms has not yet been completed, although current quality and accreditation programmes are in place. A baseline of 40 percent has been determined, being the percentage of current expenditure on demand driven aspects of primary health care services and one third of other contracted provider expenditure. This measure has been fully achieved.

Measure	Definition	Target	Achievement
Percentage of patients who receive first specialist assessment (FSA) within six months	This measure ensures that the health services are delivered in accordance with the Government's service priority area for reducing waiting times for public hospital elective services. This indicator is designed to measure the number of people who wait less than six months for their first specialist assessment as a percentage of all those who are offered a first specialist assessment.	Qtr 1 80% Qtr 2 85% Qtr 3 90% Qtr 4 95%	The performance achieved is as follows: Quarter 1 79% Quarter 2 73% Quarter 3 78% Quarter 4 88% Comments on percentage FSA seen in six months: **General Surgery:** An additional general surgical clinic was put in place to clear the backlog and under performance of FSA's in general surgery. The number waiting longer than six months for their FSA reduced from 57 to 25 in the past 12 months. **Orthopaedics:** The number waiting for first specialist assessment for more than six months has decreased from 154 at 30 June 2001 to 49 at 30 June 2002. An additional 80 FSAs were purchased to meet demand for increased booking list, as the service was performing above contract. The surgeons are keen to work with primary care regarding new referral guidelines and education on these. **Gynaecology:** An additional 80 FSAs were purchased to meet booking list demands, as the service was performing to the contracted level and the waiting list was growing. **ENT:** The total number of people waiting for FSAs has increased from 410 to 533 with the number of people waiting longer than six months for their FSA increasing from 73 to 108. An additional clinic was implemented in the fourth quarter to assist with clearing this booking list and to meet the contracted level. A specialist ear nurse clinic is currently being developed in ENT outpatients to assist with clearing the backlog of children waiting for ENT assessment. **Gastroenterology:** Active review of this booking list has been undertaken. The number waiting longer than six months has decreased from 79 to 16 in the past 12 months. **Dermatology:** The number of people waiting longer than six months for their FSA has reduced from 56 to 41 over the past 12 months.



Measure	Definition	Target	Achievement
			Active review of this booking list has been undertaken and an additional outpatient clinic was put in place in the fourth quarter to address the number of people on the waiting list. **Respiratory:** 96 percent of people attending FSAs are seen within six months of referral. Specialist nurse led respiratory clinics, diagnostic clinics and a COPD nurse and pathways have assisted in achieving this result. A primary secondary respiratory management service specification has been submitted to the national team for these services. This measure was not achieved.
Percentage of patients offered publicly funded procedures receive treatment/investigation within six months	This measure ensures that those patients who have received a first specialist assessment will receive treatment no later than six months. This measure is designed to reduce waiting times for public hospital elective services.	Qtr 1 85% Qtr 2 85% Qtr 3 90% Qtr 4 95%	The performance achieved is as follows: Quarter 1 90% Quarter 2 90% Quarter 3 91% Quarter 4 88% Comments on percentages treated within six months: **Orthopaedics:** The number of people waiting more than six months for treatment is currently 80. This service has a growing waiting list and an additional 20 CWDs have been purchased in the 2002/03 year to address this. **Plastic Surgery:** The number of people waiting for treatment remains relatively stable but the number waiting more than six months has increased to 182. Tighter application of the lower threshold and scoring system would assist in addressing this. A skin lesion removal service is being implemented in primary care to help address this booking list issue. This service involves GP training and credentialling, spot check clinics, and skin lesion removal funding for people with community service cards. This measure was partially achieved.

Measure	Definition	Target	Achievement
Set baselines to improve priority health outcomes by developing and implementing initiatives, subject to funding, and measuring priority health outcomes (and changes in priority outcomes)	This indicator is used to measure actual results of the MOH key accountability measures for the 13 priority health objectives/outcomes. Of the 13 priority objectives the DHB will focus on those measures that are applicable to the Hutt Valley DHB and relevant baselines will be determined for the following: **Child health** Children fully vaccinated by their second birthday. Repeat admissions for asthma in children under 5 and 5-14. Percentage of babies born in public hospital with low birth weight. Full breastfeeding rate at six weeks and three months. **Oral health** Mean MF (missing-filled) score at form 2 (year 8). Caries free at age 5. **Diabetes** Diabetes case detection rate. Diabetes case management. Retinal screening of people with diabetes in the last two years. **Primary care** A report is provided to the MOH outlining progress towards implementing the Primary Health Care Strategy.	Set baseline	**Child health:** Children fully vaccinated by their second birthday. The baseline for this measure is 80 percent based on immunisation co-ordinator data. Repeat admissions for asthma in children under 5 and in children 5-14. The number of children in these categories is too low for this to be a useful measure. Total re-admissions of children for asthma is less than 20 per year. Percentage of babies born in public hospital with low birth weight. The numbers of low birth weight babies is subject to seemingly random variation, and is not amenable to DHB influence in the short term. Full breastfeeding rate at six weeks and three months. The data source for this indicator is Plunket reporting. However Plunket do not have 100 percent coverage, making this measure problematic. According to Plunket figures HVDHB has significantly lower than average breastfeeding rates at six weeks (59% vs 65% nationally) and three months (43% vs 50% nationally). Measures have been put in place to bring up the breast feeding rates, including lactation training and a baby friendly hospital initiative. **Oral health:** The following baselines have been set: Mean MF (missing-filled) score at form 2 (year 8): Total = 1.1 Maori = 1.2 Pacific Peoples = 1.5 Other = 1.0 Caries free at age 5 Total = 65% Maori = 50% Pacific Peoples = 45% Other = 70% **Diabetes:** The following baselines have been set: Diabetes case detection rate = 60% Diabetes case management = 30% Retinal screening of people with diabetes in the last two years = 58% **Primary care** A report is provided to the MOH outlining progress towards implementing the Primary Health Care Strategy – see above. *This measure was fully achieved.*

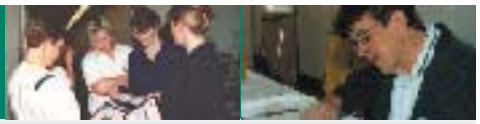


Cost of Services

For the year ended 30 June 2002

	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Operating income	138,849	138,603	0
Operating expenses	(138,549)	(138,603)	0
Net operating surplus	**300**	**0**	**0**

Provider Services



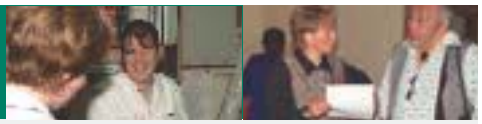
DHB Governance & Administration Output Class

This dimension of Hutt Valley DHB refers to the governance, management and administration activities relating to the allocation of funds. This captures and reports on the cost of resources engaged in undertaking funding activities, such as needs assessment, contracting with providers and monitoring the providers.

Service Performance

Measure	Definition	Target	Achievement
Engagement and participation of the Maori community	The objective of this measure is to ensure that processes for participation, engagement and input by communities are in place in respect to Health Needs Assessment, Prioritisation, Planning, Service Delivery, Monitoring, Evaluation of Services. The Strategic Plan demonstrates that engagement has occurred and that input has been gained from the Maori community. The Maori community will be represented in the service planning groups for input into the Strategic Plan.	31 March 2002	Seven service planning groups were established to assist in the development of strategic service plans. Membership of each group included public nominees, GPs, Pacific community representatives, and Maori representatives. In general two Maori representatives were included – one nominated by the Runanganui Taranaki Whanui ki te Upoko O Te Ika, the other by another Maori group. Maori health issues were a major focus of each group's deliberations. This measure was fully achieved.
Engagement and participation of the Pacific people's community	The objective of this measure is to ensure that processes for participation, engagement and input by communities are in place in respect to Health Needs Assessment, Prioritisation, Planning, Service Delivery, Monitoring, Evaluation of Services. The Strategic Plan demonstrates that engagement has occurred and that input has been gained from the Pacific people's community. The Pacific people's community will be represented in the service planning groups for input into the Strategic Plan. A Pacific Health Advisor will be appointed to the management team to provide advice to the Chief Executive.	31 March 2002	Seven service planning groups were established to assist in the development of strategic service plans. Membership of each group included public nominees, GPs, Pacific community representatives, and Maori representatives. Pacific health issues were a major focus of each group's deliberations. An appointment has been made for the Pacific People's Advisor to provide advice to the Chief Executive and the Board. This measure was fully achieved.
Engagement and participation with people who have disabilities	The objective of this measure is to ensure that processes for participation, engagement and input by communities are in place in respect to Health Needs Assessment, Prioritisation, Planning, Service Delivery, Monitoring, Evaluation of Services. The Strategic Plan	31 March 2002	The strategic plan includes a particular focus on disability issues. The disability section of the plan was prepared by a working group including nominees from the disability community. The plan is now being put into place beginning with age care services. We also have a DPA representative on the Disability Support Advisory Committee.

Measure	Definition	Target	Achievement
	demonstrates that engagement has occurred and that input has been gained from the disabled community. People with disabilities will be represented in the service planning groups for input into the Strategic Plan.		This measure was fully achieved.
DHB completes 'Effective Health Needs Assessment'	A strategic plan including a Health Needs Assessment report (which covers the first two sections of the document *Health Needs Assessment for New Zealand: An Overview and Guide*, December 2000) will be submitted to the Minister by 31 May 2002 which: 1. Is consistent with the approach in *Health Needs Assessment for New Zealand: An Overview and Guide*, December 2000 2. Gives particular attention to the NZ Health Strategy Population Health Priorities 3. Analyses the distribution of diseases, environmental factors and their determinants across the population to identify those groups experiencing poor health outcomes 4. Lists the providers, services and numbers of patients receiving services from those providers giving particular attention to the New Zealand Health Strategy priorities 5. Considers a range of evidence-informed interventions including public health measures, actions on wider health determinants and health care services 6. Involves participation and appropriate targeted consultation with groups within the populations for which they are responsible, including local Iwi/Maori and, where appropriate, Pacific communities	31 May 2002	DHB completes 'Effective Health Needs Assessment' Health Needs Assessment was undertaken as part of the work to develop a Strategic Plan and incorporated within the Service Planning Group processes. The results are summarised in the 13 Service Plans on the website. A series of factsheets are also available on the HVDHB website. This information has been provided to the Ministry of Health. This measure was fully achieved.



Measure	Definition	Target	Achievement
	7. Involves mainstream services provided to Maori and Pacific communities and services, provided by Maori and Pacific health providers are captured in the Health Needs Assessment.		
Annual Plan and Statement of Intent completed/approved within timeframes	Annual Plan and Statement of Intent completed and approved by the Board and presented to the Minister. The annual plan is consistent with the Government's policy directions as set out in the New Zealand Health and Disability Strategies.	30 June 2002	The business planning process commenced late January and the first draft of the District Annual Plan (DAP) was tabled at the 21 March Finance, Property and Audit Committee meeting and the 2 April Board meeting. The final Annual Plan and Statement of Intent was approved at the June Board meeting and has been sent to the MOH for signing. This measure was partially achieved.
Strategic Plan completed/approved within timeframe	Strategic Plan is completed and approved by the Board and presented to the Minister. Both parties must be satisfied that the Strategic Plan is consistent with the Government's policy directions as set out in the New Zealand Health and Disability Strategies.	31 May 2002	Revisions to the Strategic Plan were approved by the Board in May and the plan sent to the MOH before 31 May. Feedback from the MOH was not received until 5 July 2002. This measure was partially achieved.
Percentage of complaints resolved	A complaint is considered to be closed when the investigation has been completed and the complainant has been informed in writing of actions that will be taken to address the issue within a 30-day period.	95%	A total of 100 percent of complaints have been resolved within the required timeframe. This measure was fully achieved.
Ensure risk management framework and reporting to the Board is in place	This indicator is designed to ensure that initiatives to manage and reduce risks are implemented on time, within budget and to the specified quality. This would include evaluating risks in regard to the DHB objectives, establishing risk management policies and continually evaluating the risk exposure of the organisation.	Ongoing	A risk management framework is in place and monthly risk reports are included in the Board papers. The Risk and Performance Reporting (RAPR) system has been developed and has been implemented throughout the organisation. This measure was fully achieved.
Undertake DHB stakeholder survey	A survey will be undertaken of our key stakeholders to determine the perception of the organisation, to identify the level of satisfaction in how we conduct ourselves and the competence of the staff within the organisation.	30 June 2002	The questionnaire was finalised and issued to stakeholders in June 2002. The survey was conducted by an independent research and surveying organisation to ensure anonymity for the respondees. Results were received in late August 2002. This measure was partially achieved.
Complete orientation of Board Members within three months of appointment	To ensure Board Members are oriented so that they understand their responsibilities and receive an appreciation of the current health environment.	10 March 2002	Orientation for Board Members has been completed within the timeframe. This measure was fully achieved.

Cost of Services

For the year ended 30 June 2002

	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Operating income	1,588	1,412	440
Operating expenses	(1,742)	(1,797)	(602)
Operating deficit before depreciation, capital charge and interest	**(154)**	**(385)**	**(162)**
Depreciation	(1)	(2)	0
Net operating deficit	**(155)**	**(387)**	**(162)**

Provider Services

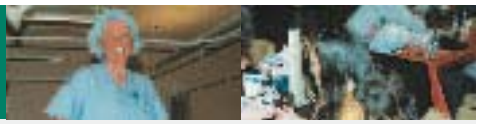
Hutt Valley DHB Provider Output Class

This dimension of Hutt Valley DHB refers to the provision of health and disability services incorporating the hospital and public and community health services.

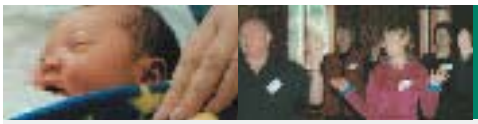
Service Performance

Measure	Definition	Target	Achievement
	Operational Performance		
Maintain DHB accreditation and action percentage of recommendations	The accreditation process is an important step in achieving recognition that certain standards have been achieved by an external and independent party. To maintain our accreditation status we must ensure that all recommendations have been implemented to the satisfaction of the surveyors. The DHB will implement the recommendations over the next two years to allow itself sufficient time to prepare for the next accreditation process in three years.	50 percent of total recommend-ations	59 percent of recommendations were completed by year end with projects underway accounting for an additional 27 percent. This measure was fully achieved.
Resource utilisation ratio	Total dollar value of actual outputs, for core contracts including ACC to total dollar value of actual net operating costs during the period being reported.	>0.90	The result for the year to date shows the organisation is achieving a strong result of 0.95. This measure was fully achieved.
Performance to contract	Value of actual production compared to the value of contracted outputs during the period being reported. This measure is intended to show the variance between actual production levels and those production levels required by contract.	100% +/- 2%	Performance was at 100.4 percent for the year. This measure was fully achieved.
Percentage of resourced bed occupancy	Resourced bed occupancy is a measure of utilisation of resource capacity. It is expected that this will range between 80-90 percent, which allows for unexpected bursts of acute activity.	80-90%	A result of 84.3 percent was achieved across the year. This measure was fully achieved.
Casemix weighted average length of stay (excluding well newborns)	This indicator measures how long the patient stays in hospital. The less time spent as an inpatient reduces the cost of a stay in the hospital although this needs to be balanced with the clinical care provided for the patient.	Top Quartile of Sector	A result of 2.50 was achieved for the year. However this measure is not reported by a number of DHBs and therefore we are not able to compare the result achieved with the remainder of the sector. This measure was not achieved.

Measure	Definition	Target	Achievement
Ensure medical records are coded on a timely basis (calculated on a 12-month rolling average)	This measure assists the provider in determining how well they are performing against contract in relation to the volumes they are contracted to achieve. The indicator measures how many medical notes one month post discharge have been coded and correspondingly those that remain uncoded.	98%	Current performance is 98 percent for the year. This measure was fully achieved.
Ensure the Regional Public Health Service achieves the agreed targets outlined in its District Plan	This measure will assist the DHB in meeting the health outcome objectives. It is also designed to ensure we meet our contractual commitments to our neighbouring DHB's (Wairarapa/Capital & Coast).	95%	The Public Health service has achieved 93% of the District Plan. This has been impacted by considerable additional work on emergent issues including the anthrax issue, the cyanide threat to the New Zealand Golf Open, the influenza pandemic simulation and extra work required to successfully deliver the immunisation catch up project. This measure was not achieved.
	Organisational Health and Learning		
Undertake an annual staff survey	This measure addresses whether staff agree that they understand their job requirements, have the capabilities to do the job, are supported within the team and are in a learning environment.	>50% satisfaction rate	A satisfaction result of 34 percent has been achieved. This compares to a benchmark of 41 percent across other NZ entities surveyed by the independent firm employed to conduct the survey. It is also noted that 47 percent (or 660 people) completed the survey. This measure was not achieved.
Sick leave days per FTE	Sick leave can be attributable to many factors, but in particular it can give an indication of the culture of an organisation as well as the health status of its employees. A low rate of sick leave is desirable or at the very least a declining trend should be apparent.	<9 days	Sick leave days per FTE for the financial year ended 30 June 2002 is 8.6. This measure was fully achieved.
Staff turnover percentage	The staff turnover indicator as defined by the Ministry of Health, is designed to capture how successful we have been in retaining staff. Hence the need to have robust and well defined retention and recruitment strategies. These numbers exclude junior doctors, casual and contract staff and non-voluntary resignations.	<20%	The performance for the year to date is 19.2 percent. There were 254 total staff resignations during the financial year. This measure was fully achieved.



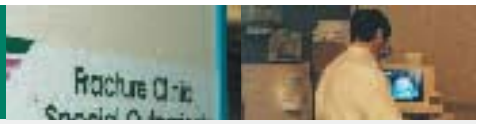
Measure	Definition	Target	Achievement
Organisational health and learning initiatives implemented on time, within budget and to the specified quality	This indicator will focus on the key Human Resources projects and will ensure the projects are delivered on time, to budget and to the specified quality. In particular this relates to recruitment/retention.	Set baseline	Project teams have been set up by the Human Resources Department. These teams have been established to implement health and learning initiatives covering staff retention, staff turnover and recruitment. The projects include: **Recruitment and retention** A number of items have been completed following this project. These include employment of a DHB-wide recruitment resource, introduction of a new advertising style, commencement of an EEO focus group and approval of a recruitment policy by the Executive team. **Orientation and induction** Key projects include nursing and junior medical staff orientation and induction review being completed and introduced, departmental and organisational orientations having being reviewed and a new programme about to be introduced. A review of management and Senior Medical Officer orientations has just commenced. **Performance management** A review of the performance management system has been completed with a new format for performance appraisals developed. This measure was partially achieved.
Workplace injuries per million hours worked (annualised)	This indicator is a measure of the number of workplace injuries that occur during working hours and provides an indication of the organisation's efforts to minimise the occurrence of workplace injuries through managing occupational hazards and risks to the health and safety of employees.	<60	A pleasing result for the year to date of 14.8 has been achieved. This reflects the efforts of the OSH team in reducing the number of workplace injuries. This measure was fully achieved.
	Customer/Patient		
Customer/Patient satisfaction (Inpatients & Outpatients)	The customer satisfaction survey provides feedback on various activities the patient has encountered during their hospital stay and how they rate each of the services provided. The percentage obtained from the survey is in response to how the patients rate their stay overall by answering a single question. The responses can range from poor to very good and are weighted to give an overall satisfaction rate.	89%	The performance for the year is 90 percent. This measure was fully achieved.



Measure	Definition	Target	Achievement
Percentage of complaints resolved	Percentage of complaints resolved provides information on the ability to address patient and family concerns regarding treatment. A complaint is considered to be closed when the investigation has been completed and the complainant has been informed in writing of actions that will be taken to address the issue within a 30-day period.	95%	The performance for the period is 93.2 percent with 219 complaints resolved from a total of 235 complaints. This measure was not achieved.
Senior Medical Officers who have been credentialled	Credentialling of Senior Medical Officers is a process used to assign specific clinical responsibilities to medical practitioners on the basis of their training, qualifications, experience and current practice within an organisational context. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.	4 services	The Orthopaedic, Rheumatology and General Surgical services have been credentialled. This measure was partially achieved.
Achievement of IV certification for registered nurses in an acute care setting who have been employed for more than six months	IV certification for our registered nurses is a measure of efficiency, quality and patient safety. It is imperative the organisation has trained staff that can complete this task with a high level of competency	95%	The overall level of IV certification is 96.8 percent with nine services (from 16 total services) achieving 100 percent of nurses IV certified. This measure was fully achieved.

Cost of Services

For the year ended 30 June 2002



	Year to June 2002 Actual $000	Year to June 2002 Budget $000	6 months to June 2001 Actual $000
Operating income	107,248	105,671	53,613
Operating expenses	(96,689)	(95,140)	(46,607)
Operating surplus before depreciation, capital charge and interest	**10,559**	**10,531**	**7,006**
Gain on sale of assets	1	604	1
Depreciation	(6,906)	(7,311)	(3,235)
Capital charge	(4,512)	(4,508)	(2,294)
Interest expense	(1,390)	(1,408)	(718)
Net operating (deficit)/surplus	**(2,248)**	**(2,092)**	**760**

Statement of Responsibility

1. The Board and management of Hutt Valley District Health Board accept responsibility for the preparation of the financial statements and the judgements used in them;
2. The Board and management of Hutt Valley District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting; and
3. In the opinion of the Board and management of Hutt Valley District Health Board, the financial statements for the period ending 30 June 2002 fairly reflect the financial position and operations of Hutt Valley District Health Board.

Warren C Young	Chai Chuah	Trevor Coad
Chairman	Chief Executive	Chief Financial Officer
1 October 2002	1 October 2002	1 October 2002

Report of the Audit Office

Audit New Zealand

To the readers of the Financial Statements of Hutt Valley District Health Board
for the year ended 30 June 2002.

We have audited the financial statements on pages 30 to 58. The financial statements provide information about the past financial and service performance of Hutt Valley District Health Board and its financial position as at 30 June 2002. This information is stated in accordance with the accounting policies set out on pages 30 to 31.

Responsibilities of the District Health Board
The New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 require the District Health Board to prepare financial statements in accordance with generally accepted accounting practice in New Zealand that fairly reflect the financial position of Hutt Valley District Health Board as at 30 June 2002, the results of its operations and cash flows and the service performance achievements for the year ended on that date.

Auditor's responsibilities
Section 15 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000 require the Auditor-General to audit the financial statements presented by the District Health Board. It is the responsibility of the Auditor-General to express an independent opinion on the financial statements and report that opinion to you. The Auditor-General has appointed Stephen Lucy, of Audit New Zealand, to undertake the audit.

Bases of opinion
An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:
- the significant estimates and judgements made by the District Health Board in the preparation of the financial statements; and
- whether the accounting policies are appropriate to Hutt Valley District Health Board's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with the Auditing Standards published by the Auditor-General, which incorporate the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

During the year, we performed an assurance assignment in respect of ACC levies. Other than this assignment and in our capacity as auditor acting on behalf of the Auditor-General, we have no relationship with or interests in Hutt Valley District Health Board.

Unqualified opinion
We have obtained all the information and explanations we have required.
In our opinion the financial statements of Hutt Valley District Health Board on pages 30 to 58:
- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - Hutt Valley District Health Board's financial position as at 30 June 2002;
  - the results of its operations and cash flows for the year ended on that date; and
  - the service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 1 October 2002 and our unqualified opinion is expressed as at that date.

S B Lucy
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand.