HUTT VALLEY DHB

Annual Report 2011

HUTT VALLEY DISTRICT HEALTH BOARD

Healthy People | Healthy Families | Healthy Communities

Welcome Mihi

Tihei Mauriora

He honore he kororia ki te Atua

He maungarongo ki te whenua

He whakaaro pai ki ngä tängata katoa

E mihi ana tënei ki a Te Atiawa ötira ki ngä iwi o te motu e noho mai nei i roto i te rohe o Awakairangi arä Te Upoko o te Ika.

Tënei te karanga, te wero, te whakapä atu ki a tätou katoa kia hörapa, kia whakakötahi o tätou nei kaha ki te whakatikatika o tätou mäuiui. Hei aha Hei oranga mö te tangata

Welcome

All honour and glory to our maker

Let there be peace and tranquillity on Earth

Goodwill to Mankind

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

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

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Chair's Foreword

I have real pleasure in presenting Hutt Valley DHB's Annual Report for 2010/2011.

Our vision of 'healthy people, healthy families, healthy communities' has stood the test of time, as has our mission to 'work together for health and wellbeing.'

We finish the 2010/11 year on a high note, nearing the completion of our new operating theatre suite and emergency department, on time and on budget. The building project will continue into next year to decommission the clip-on theatres and complete refurbishment of the vacated areas.

It is a testament to staff of all disciplines that we have achieved so well against the national health targets this year.

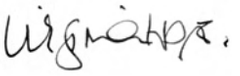
Meeting the Emergency Department wait times has not been physically possible in the 'old' department, which was built to accommodate around 15,000 presentations a year while we routinely see more than 40,000. Never the less, we have taken a hospital-wide approach to identify and address factors which were contributing to long waiting times. These improvements have meant that we have got as close as possible to achieving the waiting times target.

Since the Board elections last year, we have some shared members between Hutt Valley DHB and Capital and Coast DHB, and I chair both Boards. We have combined the Community and Public Health Advisory Committees and the Disability Support Advisory Committees, which has enabled a more sub-regional focus to our deliberations.

A particular strength of Hutt Valley DHB springs from the way in which staff live the values of the organisation. Our values include leading, innovating, and acting courageously; working together with passion, energy and commitment; and engendering trust through openness, honesty, respect and integrity. These qualities have been evident not just as they work for the Hutt Valley population, but also in the way they have worked with our neighbours in sub-regional and regional initiatives to develop services that better meet the needs of our wider population.

An excellent example of this is the development of 'e-tree' – a clinician inspired breakthrough developed by Hutt Valley IT staff, that enables clinicians to view patient's electronic clinical notes in their DHB of origin, no matter if the clinician is working in Hutt, Wellington or Wairarapa DHBs. This development foreshadows the benefits of the Central Region Information Systems Plan, which is being developed by the six lower North Island DHBs.

Finally, it is pleasing to note that the DHB met its 2010/11 budget to deliver a deficit of $2.9M. Many staff worked on a variety of 'lean thinking' and other efficiency projects to make this possible, while still delivering quality services to improve and protect the health of our population.



Virginia Hope
Board Chair
Hutt Valley District Health Board

Health Highlights

It gives me great pleasure to report on the progress made by Hutt Valley DHB over the 2010/11 year.

Our DHB's key priorities were reaffirmed at the beginning of the year and the summary of highlights in this Annual Report is structured around these priorities.

Collective leadership

Collective leadership is a key enabler to developing and implementing changes that improve patient care.

Over the 2010/11 year, a new way of managing our services was researched to provide better integration between hospital services and primary care, tertiary care, and planning and funding activity. This plan was nearing consultation stage by the end of June 2011, for implementation in the 2011/12 year.

This realignment builds on the concept of collective leadership that has been established in previous years, where clinicians and managers have worked with notable cooperation. This was evidenced as the organisation found ways to minimise the impact on patients of the prolonged industrial action by APEX union members in the early part of the year.

Credentialing

Hutt Valley DHB piloted the credentialing of a nursing Expanded Practice role within the Cardiology service and the Senior Medical Officer credentialing process.

Jennie Dean, Clinical Nurse Manager, Cardiology was credentialed in her role of managing the atrial fibrillation (AF) clinic and electro-cardioversion. Jennie is believed to be the only nurse in New Zealand offering this service.

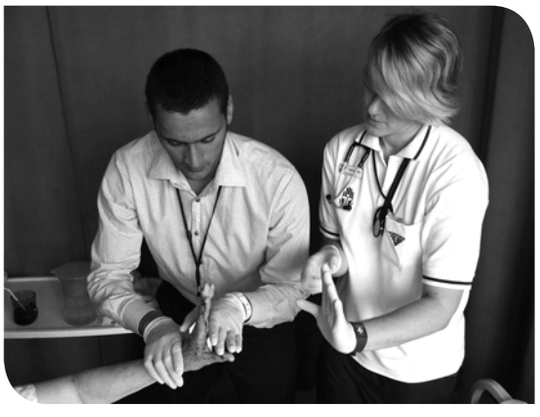
Research Publication

For the third consecutive year, Hutt Valley DHB has published a detailed account of the more than 130 research papers published and conference extracts delivered by our staff, often in collaboration with clinicians both nationally and internationally.

Summer Studentships

Collective leadership has also been demonstrated in the highly acclaimed Summer Studentship programme, where 3rd year medical students vie to experience 'real life' 2 month internships in Hutt Valley DHB – this year the experience included Wairarapa DHB settings as well.

The feedback from the students and their mentors is stunning, and many students are now choosing to return for their more advanced years of training at Hutt Hospital.



Live it UP!

Collective leadership improves both patient and staff experiences. This year saw the launch of the 'Live it UP!' campaign aimed at staff wellbeing, encouraging staff to model the healthy lifestyle they advocate to patients.

More than 130 staff ran or walked the 'Round the Bays' challenge, and multidisciplinary teams contested a 'cook-off' in the 'Ready, Steady, Kai' competition so fiercely that it's been repeated and many of the recipes are now served in the hospital cafeteria. The 'Step Up' challenge almost made our lifts redundant and the in-house weightwatchers programme has a steady enrolment.

This kind of activity does not become widespread without active encouragement by many staff, and is a good barometer of the 'wellness' of our organisation.

Better, sooner, more convenient primary health care

New PHO

Throughout the 2010/11 year, our community was consulted on a proposal to bring together the five existing PHOs in the Valley. Te Awakairangi Health PHO was created in February, and takes up the reins of delivering more consistent, integrated primary health services from 1 July 2011.

The PHO is in the process of carrying out service reviews to integrate the best of the services provided by the previous PHOs.

Primary Secondary Strategy Group

We have done significant work to strengthen relationships between the DHB and primary health care. The benefits of a more integrated approach are seen in having the Chief Executive of Te Awakairangi Health PHO on the executive team of the DHB, and in the establishment of a Primary Secondary Strategy Group (PSSG).

This group comprises clinicians from primary and hospital care, and is becoming a significant vehicle for effecting positive change. For example, when presented with the issue of orthopaedic services wanting to tighten access criteria to manage spiralling numbers of primary care referrals, PSSG analysed the referral patterns, identified a group of patients which could and should be treated in primary care and arranged training for GPs in steroid joint injections, thus reducing referral rates and enabling patients to be treated closer to home.

Work is also underway with our PHO to expand the roles and opportunities for primary care nursing, including training in diabetes and respiratory care. We also have a strong working relationship with Ropata Medical centre, which is part of the cross-boundary Cosine PHO. Ropata also provides representation on PSSG.

Ambulatory Sensitive Hospitalisations

What happens in our communities has a huge bearing on what happens in our hospital. This year, our Ambulatory Sensitive Hospitalisation (ASH – some times called 'avoidable admission') rates have continued to increase, which is a significant concern to the DHB. The result is that around 20 people a day are hospitalised, when this outcome could have been prevented by earlier or different treatment. This has a cost impact, a patient experience impact, and also suggests a population wide approach needs to be taken.

The DHB has recently developed a clearer focus on reducing these hospital stays by preventing ASH hospitalisations and reducing hospital stays arising from errors and inefficiencies. A draft plan to address this has been favourably received by the Ministry. PSSG is also engaging with this issue, specifically at this stage on skin conditions.

We are working hard to avoid unnecessary hospital admissions. There are several streams of work underway, with the four top condition groups for children age 0-4 years identified as Respiratory, Dental, Gastroenteritis and Dehydration, and Skin conditions.

Several new models of care in relation to long-term conditions and avoidable hospitalisations have been implemented.

- A Congestive Heart Failure (CHF) clinic is now held in Primary care. The Specialist CHF nurse and Cardiologist run a clinic alongside their primary care colleagues to provide support and education for primary care clinicians in the management of patients with CHF. There are two trial clinics.
- A Dietician has started clinics at Pomare. This will allow patients to access nutrition education and support within their own community. A similar service is being developed in Wainuiomata. The service focuses on high needs groups, particularly Maori and Pacific peoples, and works with other services already operating in the area to access those who are not engaging with services provided out of the hospital's outpatient department.
- Our Endoscopy team are currently delivering "Managing Hepatitis C Clinics" in Rimutaka Prison. This is a nurse lead clinic that offers screening, education monitoring and support to prisoners in a prison based clinic where in the past the prisoner would have been seen in the outpatients hospital clinic. This has meant that a greater number of prisoners are seen and there is a more consistent management of the prisoners' health while receiving treatment.
- We have shifted a community physiotherapist service into the health centre in Pomare, one of our highest need suburbs, and are seeing improved uptake by Maori and Pacific patients. The initiative was piloted for a year (November 2009 – November 2010) and has successfully improved access, supported effective Multi-Disciplinary Team working, and resulted in fewer referrals to orthopaedics. The DHB now provides 20 hours per week of musculoskeletal physiotherapy at Pomare Health centre to the enrolled population of approximately 6,500 people.
- Community Mental Health and Addictions services have expanded their community based working approach. In addition to the Alcohol and Other Drug (AOD) and medical clinic in Wainuiomata they established a medical only clinic at the Waiwhetu medical centre. They have also started a community focused psychology service based at a local NGO office. The new partnerships that are evolving between the Community Mental Health team and other providers ensure people are able to access services in a timely manner in the community.
- A Nursing Innovation Respiratory Project has been established in Upper Hutt Health Centre. This nurse led clinic focuses on Asthma and COPD Education. The service targets patients seen in Upper Hutt Health Centre acute clinic, Hutt Valley DHB Emergency Department and patients with multiple visits for respiratory illness.

Skin infections are an important area of work for the DHB moving into 2011/12. In 2010/11 Regional Public Health ran a preventative programme (largely in schools and preschools) and a specific project in Piki te Ora PHO. Primary Care Nurses have received Nursing Innovation funding for 2011 to develop clinical guidelines and standards for the treatment of skin conditions, and also education packages suitable for the Hutt Valley.

The latest CarePlus data shows that 2985 Hutt Valley residents were enrolled in CarePlus as at April 2011. At the same time in 2010 there were 2569 Hutt Valley residents enrolled in CarePlus. This is a real increase, adjusted to take account of Ropata PHO's shift to Capital and Coast DHB Cosine PHO.

Access and after hours care

Since 2009 we have funded a Telephone Nurse Triage Service, which provides 24/7 phone triage for people who telephone their GP for advice. It is well used, with nearly 31,000 calls in the last year. 17% of the calls are received between 11pm and 8am. Less than 1% of callers were referred to the Emergency Department, and over 80% of callers needing care were able to wait to see a doctor in the morning after appropriate advice had been given.

In 2010/11 we agreed with primary care to transfer responsibility for after hours care from 11pm to 7am, from the Lower Hutt After Hours Service to the Hutt Hospital ED. Primary care is paying for this service. Moves to encourage patients to use their GP practice in the first instance are underway.

Cost of after hours services has been identified as a barrier to people accessing services after hours especially for children under six years of age. In April 2011 we agreed with the two After Hours providers in the Valley and with Ropata Medical Centre (which has extended hours), to subsidise the after hours fees charged for children under six years of age. The subsidy is $6.00 and flows directly to the patient. This is a 15 month pilot and will run until 30 June 2012.

Supporting quality in primary care

Hutt Valley DHB staff support the GP Aged Care Peer Group that formed in 2010/11 and meets regularly to provide ongoing continuing medical education (CME).

The Group is open to all GPs. Its focus is improved care for older people with a particular emphasis on palliative care. It is hosted by Te Omanga Hospice so has excellent access to specialist palliative care advice.

There is continued specialist palliative care advice to GPs through the Partnership Programme which supports GPs to provide palliative care to their patients. With improved engagement of GPs, the number of patients on the partnership programme has increased from 40 in 2007 to 90 in 2011.

NASC assessments

The process for Needs Assessments has been improved this year; with a result that 3,576 clients had their assessments accurately completed on time, against a target of 2,586. The average waiting time from receipt of referral to assessment dropped from 7 to 4 days, and two complaints were received in the year, down from a projected 20.

GP training programme

Bringing new primary practitioners to the Hutt Valley is key to providing a good foundation for better, sooner, more convenient healthcare in the future.

This year 15 registrars joined the third annual intake into the successful GP training pilot, which has been highly commended by participants and local GPs alike. The Registrars work within Capital and Coast, Hutt Valley and Wairarapa DHBs.

Six first year Registrars are employed by Hutt Valley DHB and the other 9 are employed within practices,

but with funded clinics and expenses and monitoring. Negotiations continue with Health Workforce New Zealand to gain national recognition of the unique benefits of this innovative pilot.

Primary Care Midwife at the Kokiri Centre

The Maternity Service has extended their primary midwifery care this year after analysing the domicile data of women who were unable to access a Lead Maternity Carer.

A midwife-led clinic is now running weekly at the Kokiri Pukeatua Marae in Wainuiomata, in close conjunction with the community based midwives. This follows on from the successful clinic that has been running in Taita for the last 5 years.

Improving our hospital & health services

Emergency Department

Theatre/Emergency Department building project is nearing completion – on time and on budget.

Emergency Department staff are anticipating the move to facilities that are built to cater for the volume of patients they see. The existing building was built to cater for 15,000 presentations a year, and current trends are for around 40,000. Consequently, we were unable to meet the National Health Target waiting times this year. We reached an average of 86.5% in 2010/11, with a high point of 88% in Quarter 2. Lack of space in the current ED is a significant constraint in achieving this target.

The redeveloped Emergency Department will be a key factor in reaching the 95% target for ED waiting times being less than 6 hours. However, it is not the sole factor and process improvement projects are in place to identify and implement changes.

The 'Shorter Stays by Better Ways' is a hospital-wide initiative, recognising that long waits in ED can be caused by 'log-jams' in other areas of the hospital. 'Shorter Stays' projects include reviewing the pilot Medical Assessment and Planning Unit (MAPU) and incorporating lessons learned into a final extended MAPU; improved flow between ED and wards and rehab services; streamed flows in ED; Patient focussed Outpatients Booking Service; Day of Surgery admissions process improvements; and centralised nurse pre-assessment clinic.

The new ED facility and the hospital-wide approach will position the DHB well for achievement of the ED waiting time target in 2011/12. We will continue to work with Primary Care clinicians and the public to enable access to 'the right care, in the right place, at the right time'.

The Productive Theatre

Introduced early in the 2010/11 year , The Productive Theatre (T-POT) is an international programme to improve quality, safety and processes in operating theatres. Based on a combination of lean thinking methodology and risk management principles the focus is on getting all disciplines working together in the best interests of the patient.

This has seen the adoption of many new measures, including of the World Health Organisation surgical checklist (adapted for local use) and the routine use of the pre-operative team briefing – a verbal check to ensure all critical resources are in place and the whole team is clear about upcoming processes and challenges.

Improving mental health services

The target is a total of 95% of mental health service users having crisis prevention plans. The DHB has moved from a 2009/10 result of 65% to a 2010/11 result of 92%. Even more significant is the improvement for Maori and Pacific clients, moving from 26% to 90%, and 38% to 99%, respectively.

In the community setting, there has been good progress with:

- establishment of the consumer Kaitiaki Group,
- refreshing Hutt Valley Local Leadership Advisory Group (LLAG) membership to include Kaitiaki representation,
- LLAG and Kaitiaki Group providing valuable input into the Mental Health Commission's report on Recovery Indicators.

Healthy homes

We met our target of completing 100 Healthy Housing Programme's Health and Social Assessments for homes for the year.

Financial sustainability

Financial result

The DHB was slightly ahead of its 2010/11 budget by delivering a deficit of $2.9M. This is the result of many projects and initiatives to manage and control costs, while still improving the patient journey, and population health.

A small example is the project in uniform procurement – by joining with the other DHBs in our region, we have entered a joint contract for the provision of uniforms. At the same time, we are working to reduce the cost and standardise our uniforms, so that uniforms could ultimately transfer with staff moving between DHBs.

The culmination of these initiatives has seen the DHB moved to 'standard monitoring' from 'performance watch'. This is recognition of the DHB's good performance against both financial and non-financial measures, and staff and Board alike are congratulated on this.

Delayed breast reconstruction

By year-end 108 referrals for delayed breast reconstruction had been accepted. Of this total, 14 have declined surgery, 13 have been unfit for surgery and 9 are undecided about whether they want surgery at all and are reconsidering.

To date 41 women have had the initial operation for delayed breast reconstruction, 10 of these women have also had the next stage of their surgery and we expect that secondary and tertiary operations will increase in 2011/12.

The DHB is taking all reasonable steps to ensure access to this surgery is taken up, and it appears likely that although the level of demand for referral is in line with expectations, the number of patients who have chosen not to go ahead for surgery or are unfit for surgery has been higher than anticipated (25%). A communication plan is being implemented to raise awareness of renewed access to this service.

Working with our neighbours

'Business as usual' is moving to a more collaborative setting, particularly at a sub-regional level, both between DHBs and between clinicians and managers. The 'sub-region' consists of Capital and Coast, Hutt Valley and Wairarapa DHBs.

Sub-Regional Clinical Leadership Group

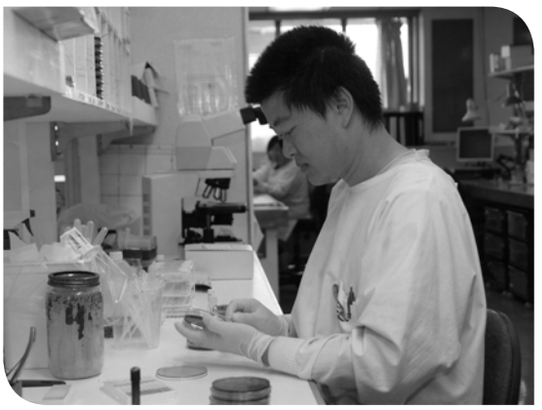
This group, established in early 2010, has proved a valuable forum for collaboration across the DHBs. The group has commissioned a series of service reviews, focussing first on those services which are vulnerable, or would most benefit from a sub-regional approach. The regular meeting between senior clinicians and managers from the 3 DHBs is helping cement new relationships and new ways of thinking.

The sub-regional workstreams led by the SRCLG are developing into concrete programmes, under the banner of the '3D' initiative (3 DHB Health Service Development). Care is being taken to align work with regional initiatives, particularly those contained in the Regional Services Plan.

Other collaborative initiatives

Good examples of the increased focus on a sub-regional approach are seen in shared Planning and Funding projects, the joint proposal for delivery of bariatric surgery for our shared populations; the opening of a new breast screening facility at Kenepuru Hospital as part of the regional screening service; the proposal to explore with Capital and Coast DHB (CCDHB) a joint approach to laboratory services and the coordinated rollout of the Health Passport pilot. Capital and Coast DHB also does excellent work on our behalf to meet the cancer waiting times health target.

On our other geographical boundary, Hutt Valley DHB now supplies payroll services to Wairarapa DHB following a seamless transition, and there is a memorandum of understanding enabling a Wairarapa surgeon to operate on his more complex Wairarapa patients at Hutt Hospital where there is full ICU back-up. In return, some Hutt Valley patients are offered their lower acuity surgery sooner at Wairarapa Hospital.



Similar collaboration has occurred to enable a sub-regional approach to cover for speech language therapists' leave, as this is a very small regional workforce.

The central region is the first in the country to develop a collective clinical information systems plan (CRISP) and at year end had prepared a business case that establishes, on a regional basis, the implementation of a full electronic clinical record, able to be shared across the 6 DHBs. The planned rollout will take place over 4 years.

Foreshadowing the benefits of this, Hutt Valley IT staff developed 'e-tree', which enables clinicians to access the Concerto-based electronic medical notes of a patient in their DHB of origin. For example, when Wairarapa Hospital clinicians performed some waiting list procedures on Hutt Valley patients, they were able to access diagnostic results, clinic letters, discharge summaries, eReferrals etc. held on the Hutt Valley patient management system.

National health targets

Performance is strong, with four and arguably five targets being met. Only one target has not been achieved or substantively achieved, Shorter Stays in ED.

Elective discharges

The DHB has achieved (and slightly exceeded) its 2010/11 Electives Discharge Target.

Advice to help smokers quit

The DHB has moved from strength to strength, with the 90% secondary target being achieved in Quarters 3 and 4.

Primary

Our 2010/11 successes include:

- Training - Six primary care training sessions have been held in collaboration with Kowhai Health Trust, and three combined ABC training sessions for primary care professionals from Capital and Coast DHB & Hutt Valley DHB. We provided 1300 HelpCards to PHOs, practices, and Kowhai Health.
- Awareness - Discussion of the target was included in primary care training and in collaborative work with Kowhai Health Trust
- Support - We have 48 primary care health professionals registered as Quit Card Providers including Rimutaka Prison staff and Whitireia student Nurses.

Diabetes

The DHB has, through its primary care partners, achieved well in 2010/11. It has exceeded its Diabetes Review Target by 11%, its CVD Target by 0.9%, and is only 0.9% below target for Diabetes Management. As this is a composite target, it can fairly be considered that this target has been achieved

Hutt Valley DHB was selected from eight competing DHBs to be one of the four demonstration sites for the Diabetes Nurse Prescribing Pilot, run by Health Workforce New Zealand.

This workforce innovation enabled two of our diabetes nurses to prescribe identified medications under the supervision of a physician. To date the pilot has been highly successful, with the nurses able to deliver a more streamlined service. They have been well supported by hospital and general practice staff. Most importantly, patients are full of praise for the new service.

Hutt Valley DHB is proud to have been part of this innovation, extending the scope of practice for suitably qualified nurses and will be contributing to the evaluation of the pilot through to November this year, in anticipation of a national roll-out.

Immunisation

The DHB, in conjunction with its primary care partners, received an “Outstanding” rating from the Ministry of Health (MoH), achieving 91% against a 90% Target in Quarter 4, with a high point of 95% in Quarter 3.

Cancer waiting times

The DHB has, mainly through excellent service provided by Capital & Coast DHB, achieved the 100% target for shorter waits for cancer and radiotherapy treatment.

The half-year performance for ‘Before school checks’ was well behind target. A recovery plan was successfully implemented, with 1703 checks achieved against a target of 1685. MoH notes that the “DHB is congratulated on meeting target, and the MoH acknowledges the hard work done to meet this.”

Graham Dyer
Chief Executive
Hutt Valley District Health Board

Our Key Priorities for 2010/11

Our 2006/2011 District Strategic Plan described the following goals, which informed the priorities we set for the 10/11 year:

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

Our District Annual Plan described the following priorities for the 2010/11 year:

1. Collective Leadership – Ensuring clinical leaders and managers are working together to ensure we provide high quality yet cost effective services for our consumers and our population.
2. Financial Sustainability – Improving the delivery of services while coping with ongoing fiscal restraint requires improved financial performance
3. Collaboration with other DHBs – Engaging in meaningful collaboration with Capital and Coast and Wairarapa DHBs to improve services to our respective populations and reduce costs.
4. National Health Targets - Ensuring we focus on reaching the National Health Targets, in line with Government and community expectations
5. Emergency Department / Operating Theatre redevelopment – Ensuring the Emergency Department / Operating Theatre project progresses on time and on budget and that the changes in practice and staffing necessary to allow it to function effectively when it opens (eg: increase in day surgery) are advanced.
6. Primary Care – Redirecting existing resources to projects agreed with primary care as being of the most value, particularly those addressing long term conditions, and high needs populations.

Our District Annual Plan also described the influence of collaboration with our neighbours:

Three major initiatives have shaped our collaborative activity in the 2010 / 11 year.

1. The Regional Clinical Services Plan (RCSP) laid the foundation for collaborative service planning between the 6 lower North Island DHBs.
2. The Regional Services Plan (RSP) initiated a process to replace our respective District Strategic Plans with a document that looks regionally at the planning issues we collectively face.
3. The Sub Regional Clinical Leadership Group (SRCLG) was established in early 2010 by the Chairs, Chief Executives and clinical leaders of Hutt Valley, Wairarapa and Capital and Coast DHBs with the aim of working more closely together to provide better and more sustainable services for our combined population. SRCLG is made up of the Chief Medical Officers, Directors of Nursing, Directors of Allied Health, Primary Care Liaisons, other clinical leaders as required, Chief Executives, Chairs, General Managers of Planning and Funding and Chief Operating Officers, and supported by the Communications Managers.

Statement of Purpose

Vision Mission and Values

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

Vision

Whanau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities.

Mission

Working together for health and wellbeing

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

Values

'Can do' – leading, innovating and acting courageously

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

Working together with passion, energy and commitment

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

Trust through openness, honesty, respect and integrity

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

Striving for excellence

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

Hutt Valley DHB Profile

The Hutt Valley District Health Board (DHB) is responsible for planning, funding and providing government-funded health care and disability support services for the 145,000 people who live in the Hutt Valley. Of these 104,000 people live in Hutt City and 41,000 live in Upper Hutt City.

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

The Hutt Valley DHB employs over 2,200 people, most of whom work at Hutt Hospital and for our community and regional health services. This part of the DHB is often referred to as our 'provider' arm.

The Board has governance and strategic oversight of the Hutt Valley DHB. Since the Board elections we have a shared Chair with Capital and Coast DHB, seven community elected members, and four members appointed by the Minister of Health, including the Chair. We also have a Crown Monitor. Our Community and Public Health Advisory Committee, and Disability Services Advisory Committee have the same members as their Capital and Coast equivalents and operate jointly.

The Board has responsibility for delivering objectives in local and national health within a current annual budget of approximately $421 million.

The Hutt Valley DHB was established on 1 January 2001. Over the 2010/2011 year the DHB has provided a wide range of services and implemented a number of initiatives in order to meet its commitment to:

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

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

- Primary healthcare providers, including general practices and youth health services.
- Maori and Pacific health providers.
- Mental health providers.
- Health of older people providers, including aged residential care and home support services
- Pharmacies.
- Laboratory and radiology providers.
- Hospitals, including local, regional and national.

Hospital Service Indicators

	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011
Inpatient Discharges	17,272	17,835	17,687	17,678	17,546
Daycase Discharges	9,079	9,365	10,114	10,960	10,783
Total Discharges (Inc Newborns)	26,351	27,200	27,801	28,638	28,329
Discharges per day	72.2	74.3	76.0	78.2	77.6
Available Bed Days	93,075	95,526	102,565	102,565	102,565
Occupied Bed Days	80,076	85,183	81,961	82,115	82,008
Average Occupancy	86.0%	89.2%	80.0%	80.0%	80.0%
Inpatient Operations	5,369	5,535	5,637	5,936	5,925
Daypatient Operations	2,274	2,549	2,642	3,509	3,279
Total operations (theatre cases)	7,643	8,084	8,279	9,445	9,204
Elective Operations	3,615	4,136	4,337	4,793	4,658
Acute Operations	4,028	3,948	3,942	4,652	4,546
Total operations (theatre cases)	7,643	8,084	8,279	9,445	9,204
Inpatient Waiting List total 30 June	1,279	1,312	1,585	1,834	1,783
Outpatient Attendances					
- Surgical	43,245	43,687	47,461	44,895	46,231
- Medical	22,123	22,455	30,779	32,663	34,743
- Paediatric	5,706	5,918	9,226	10,763	11,389
Emergency Attendances	37,440	39,360	40,356	40,331	42,453
Births - Hospital	2,035	2,182	2,208	2,248	2,038
Radiology examinations	47,375	52,833	61,156	61,229	57,265
Laboratory tests performed	864,759	901,154	934,346	967,112	994,722

Statement of Objectives & Service Performance

For the year ended 30th June 2011

Statement of Objectives & Service Performance

For the year ended 30 June 2011

Introduction

As a crown entity, Hutt Valley DHB is required by the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 to report on its service performance. In this section the actual performance of Hutt Valley DHB for the year ended 30 June 2011 is measured against the undertakings made in its Statement of Intent 2010/11-2012/13. The Auditor-General has audited this performance report for accuracy and reasonableness.

Key measures

The DHB's 2010-13 Statement of Intent includes a group of key performance measures intended to provide an overview of the services delivered by the DHB. These measures, and performance against them, are set out in the table below.

Impacts	Measure	Target	Baseline	2010/11 Actual	Impact result
Health protection is enhanced; public trust, confidence, and security.	Disease outbreaks are controlled.	100%	100%	100% There have been no uncontrolled outbreaks and all notifications have been investigated.	Health protection has been enhanced through the investigation and control of infectious diseases.
Health risk is reduced. People in the Hutt Valley are healthy and able to self manage and live longer.	Reduced number of smokers in the population.	<18%	22.6%	No report available as no census was undertaken in 2011.	N/A due to no information being available.
	Percentage of 2 year old children fully vaccinated.	90%	87%	91%	Achieved – high percentage of population immunised, reducing risk of disease.
	Percentage of infants solely and exclusively breastfed at 6 weeks.	74%	62%[1]	59%	Breastfeeding assists healthy growth of infants. Although the target has not been achieved, the % of infants breastfed has increased, for example from 56% in 2009 to 59% in 2010 (6 weeks, all ethnicities). The target was agreed at an aspirational level to reinforce the importance of this service.
	Proportion of people in the population who are obese.	<25%	27.8%	No report available as no census was undertaken in 2011.	N/A due to no information being available

1 The baseline figure of 62% in the 2010-13 SOI was an error. The correct baseline was 52%.

<table>
<tr><th>Impacts</th><th>Measure</th><th>Target</th><th>Baseline</th><th>2010/11 Actual</th><th>Impact result</th></tr>
<tr><td rowspan="4">Intervention is early; people who are at risk of illness are diagnosed and managed earlier.</td><td>Breast Cancer Screening - % of eligible population screened every two years.</td><td>70%</td><td>69.5%</td><td>75%
This is an excellent result, with the DHB achieving above the national target.</td><td>High rates of screening allow for early diagnosis and treatment.</td></tr>
<tr><td>Improved oral health in children – reduced decayed, missing, filled, teeth at Year 8 (DMFT)[2.]</td><td>0.9</td><td>1.09</td><td>1.08</td><td>Improved DMFT rates demonstrate an improvement in oral health, and indicate that oral health treatment is effective.</td></tr>
<tr><td>Reduced number of people experiencing a mental health crisis - % of people with crisis prevention plans.</td><td>90%</td><td>59%</td><td>92%</td><td>Increased levels of crisis planning means people who are at risk of illness or injury are managed earlier.</td></tr>
<tr><td>Reduced avoidable hospitalisations (Ambulatory Sensitive Hospitalisation Rates).</td><td colspan="3"><table>
<tr><th></th><th>Baseline</th><th>Target</th><th>Actual</th></tr>
<tr><td>0-74 Maori</td><td>112</td><td>113.5</td><td>134.14</td></tr>
<tr><td>0-74 Pacific</td><td>109</td><td>108</td><td>117.80</td></tr>
<tr><td>0-74 Other</td><td>109</td><td>113.5</td><td>116.79</td></tr>
<tr><td>Children 0-4 Maori</td><td>121</td><td>123.8</td><td>160.32</td></tr>
<tr><td>0-4 Pacific</td><td>128</td><td>123.2</td><td>136.99</td></tr>
<tr><td>0-4 Other</td><td>131</td><td>143.7</td><td>169.34</td></tr>
<tr><td>Adults 45-64 Maori</td><td>90</td><td>102</td><td>111.70</td></tr>
<tr><td>45-64 Pacific</td><td>88</td><td>89.6</td><td>103.15</td></tr>
<tr><td>45-64 Other</td><td>106</td><td>110.5</td><td>105.02</td></tr>
</table></td><td>Earlier intervention has not always occurred. Further work is underway to address this issue, with a specific plan being implemented from 2011/12.</td></tr>
</table>

2 DMFT rates provide the mean number of decayed, missing, or filled teeth among children domiciled in the Hutt Valley examined by Hutt valley DHB funded providers

Impacts	Measure	Target	Baseline	2010/11 Actual	Impact result
Access to services is improved, people with early conditions are treated and managed earlier and illness progression is reduced.	Improved access to mental health services.	3%	0.95% (0-19), 1.98% (20-64), 0.58% (65+)	4%	Improved access to mental health services, leading to earlier treatment.
	Reduced avoidable hospitalisations.	See above	See above	See above	See above
	Elective services standardised intervention rate.	280 per 10,000 population	293 per 10,000 population	342 per 10,000 population[3].	Improved access to elective services, leading to earlier treatment.
Services are better integrated; people with long term conditions have their care co-ordinated across a range of service providers leading to reduced premature disability and death.	Diabetes management – The number of people with Type 1 or Type II diabetes on the diabetes register that had a Hb1Ac < = 8 at their free annual check as a percentage of the number of people with Type 1 or Type II diabetes on the diabetes register.	76%	73%	74.11% A key factor in the target not being achieved was a Ministry of Health change to calculating diabetes prevalence part way through 2010/11. However, the actual number of people having annual reviews has increased.	Improving diabetes management reduces premature death.

3 This result is at 31 December 2010. The full 2010/11 financial year figures were not available in time for inclusion in this report.

Public Health Services Output Class - Keeping Our People Well

Keeping our people well is a priority for Hutt Valley DHB. This focus contributes to enhanced health protection, reduced health risk, earlier intervention, improved infrastructure and regional collaboration and positive partnerships.

Hutt Valley DHB has had two notable successes in 2010/11. These are the achievement of the Better Help for Smokers to Quit and Increased Immunisation Health Targets. These two targets are important population health areas. Childhood disease and conditions associated with smoking are both significant health issues for individuals and their families, but they also impose significant avoidable costs on our health system.

Another excellent result has been the DHB's achievement of its B4 School Check target. This is another important way in which the health system can contribute to early identification and treatment of conditions which could otherwise have a major impact on a child's life.

In other aspects of population health service the DHB has continued to provide effective services.

Health Promotion and Education Services

Better help for smokers to quit

Government Health Target.

Smoking is a major contributor to poor health outcomes and health inequalities. Smoking kills an estimated 5000 New Zealanders a year and smoking related diseases are a significant cost to the health sector. There is evidence that brief advice from health professionals is effective at prompting people to quit.[4] The Government has set a health target that 90% of hospitalised smokers are provided with advice and help to quit.

<table>
<tr><th>Target</th><th>2010/11</th><th>Intended impact and impact results</th></tr>
<tr><td>420</td><td>3504
Achieved</td><td rowspan="2">Intended impact: Health risk is reduced; Reduced number of smokers in the population.
Impact Result: The Ministry of Health advises that there is evidence that brief advice from health professionals is effective at prompting people to quit[4], which in turn reduces health risk. As no census was conducted in early 2011, no census data is available on smoking prevalence in the population.</td></tr>
<tr><td colspan="2">Comment: This is an excellent achievement by our team, with the significant performance improvement in part due to increased efforts, and also to improved data collection. The baseline was set soon after the Health Target was introduced.</td></tr>
</table>

4 Ministry of Health DHB Performance Monitoring Framework 2010/11

Number of education and training sessions provided (Hutt Valley, Capital & Coast, and Wairarapa DHB populations)

Public health leadership input into working groups including (but not limited to) the following topics: preventing skin infections, sexual health, access to income, alcohol, mental health promotion, housing and homelessness, nutrition, physical activity, tobacco, poverty reduction, prisoner re-integration, family violence, built environment, and illicit drugs.

Target	2010/11	Intended impact and impact results
Number of education sessions: 906	922 Achieved	Intended Impact: Health risk is reduced; Reduced number of smokers in the population; Reduced proportion of people who are obese[5], Percentage of infants breastfed increases[6]. Education is assumed to contribute to increased awareness, and awareness is assumed to contribute to increasing the likelihood of healthy lifestyle choices. Impact Result: See above regarding smoking rates. With regard to obesity, as no census was conducted in early 2011, no data is available. The % of infants breastfed has increased, for example from 56% in 2009 to 59% in 2010 (6 weeks, all ethnicities).
Number of working groups: 64	56 Not achieved	
Comment: This target was an estimate as this was the first time we have measured this activity. The measure is demand driven and will vary based on the level of stakeholder and network forums occurring in any given year.		

Number of schools and early childhood services receiving health promotion visits (Hutt Valley and Capital & Coast DHB populations)

Target	2010/11	Intended impact and impact results
138	111 Not achieved	Intended Impact: Health risk is reduced by increased education. Education is assumed to contribute to increased awareness, and awareness is assumed to contribute to increasing the likelihood of healthy lifestyle choices. Impact Result: No measure yet developed. It is assumed that health promotion impacts awareness and decision making around health issues.
Comment: The DHB experienced capacity issues in 2010/11 with a key staff member on parental leave.		

5 As measured by the NZ Health Survey
6 As measured by Plunket – data provided by Ministry of Health

Number of opportunities taken to provide strategic public health input and expert advice to inform policy and public health programming (Hutt Valley, Capital & Coast, and Wairarapa DHB populations)

Including (but not limited to): Housing; Tobacco; Urban environment; Alcohol; Transport; Physical Activity; Nutrition; and Mental Health.

Target	2010/11	Intended impact and impact results
73	45 Not achieved	Intended Impact: Health protection is enhanced, Health risk is reduced through policy and decision making processes being informed about health perspectives, reducing risk that negative health impacts will flow from decisions and policies. Impact Result: No measure yet developed. However, the DHB has received positive feedback from key stakeholders about the quality and comprehensiveness of their submissions, and there are examples of impacts on decisions e.g. liquor license not given to a specific outlet.
Comment: This includes preparing submissions, which is demand driven based on local government consultation requirements, as well as engagement with policymakers in other agencies.		

Statutory and Regulatory Services

Including services provided by Regional Public Health based at Hutt Valley DHB to Capital & Coast DHB and Wairarapa DHB.

Number of communicable disease notifications investigated
(Hutt Valley, Capital & Coast, and Wairarapa DHB populations)

Including but not limited to tuberculosis, meningococcal disease, vaccine-preventable and enteric illness.

Target	2010/11	Intended impact and impact results
2733	2031	Intended Impact: Health protection is enhanced; Disease outbreaks are controlled through investigations, which provides opportunity to control outbreaks. Impact Result: Health protection has been enhanced through the investigation and control of infectious diseases.
Comment: The level of work is demand driven. There have been no uncontrolled outbreaks, and all notifications were investigated.		

Number of environmental health investigations (Hutt Valley, Capital & Coast, and Wairarapa DHB populations)

Audits, or incidents within (but not limited to) the following Service areas: Food Safety; Drinking Water; Hazardous Substances; Border Health & Emergency Management, Burial and Cremation.

Target	2010/11	Intended impact and impact results
1281	1074	Intended Impact: Health protection is enhanced; Disease outbreaks are controlled. Impact Result: Health protection has been enhanced through the investigation and control of infectious diseases.
Comment: The level of work is demand driven, and all notifications were investigated.		

Number of controlled purchase operations carried out on tobacco and alcohol retailers

(Hutt Valley, Capital & Coast, and Wairarapa DHB populations)

<table>
<tr><th>Target</th><th>2010/11</th><th>Intended impact and impact results</th></tr>
<tr><td>29 (controlled purchase operations)</td><td>344 (premises visited achieved)</td><td rowspan="2">Intended Impact: Health risk is reduced; Reduced illegal supply of tobacco, and alcohol health protection is enhanced.
Impact Result: No measure yet developed. It is assumed that regulation and investigation and enforcement create a disincentive to violating Smoke Free and Alcohol retailing legislation. In turn, this is expected to reduce the uptake of tobacco and misuse of alcohol by young people.</td></tr>
<tr><td colspan="2">Comment: This measure has been updated to reflect the way we capture data on Controlled Purchase Operations [CPOs]. We report the number of premises visited as part of a CPO. Each “operation” could include several premises. This gives a more accurate reflection of the level of work and regulation being undertaken.</td></tr>
</table>

Population based screening programmes

Provided by Regional Screening Services based at Hutt Valley DHB to Capital & Coast DHB and Wairarapa DHB. Includes breast cancer screening services direct to the public and national cervical screening programme regional coordination services, provided under contract to the Ministry of Health.[7]

Number of women screened for breast cancer (Hutt Valley, Capital & Coast, and Wairarapa DHB populations)

Breast cancer is an important health concern in New Zealand. International evidence has shown that breast screening delivered through a properly organised programme is efficacious in reducing mortality from breast cancer for women aged 50-69 by 30 percent. It has been estimated that an organised breast screening programme in New Zealand could save approximately 100 lives per year in the first five years, and up to 175 lives per year after twenty years of screening.[8]

<table>
<tr><th>Target*</th><th>2010/11</th><th>Intended impact and impact results</th></tr>
<tr><td>All: 10,066
Maori: 896
Pacific 539
Target: 70%</td><td>11,349
1,019
557
75% Achieved</td><td rowspan="2">Intended Impact: Intervention is early; 70% of the eligible population screened for breast cancer every 2 years.
Impact Result: Achieved.</td></tr>
<tr><td colspan="2">Comment: The DHB has also delivered services for Capital & Coast DHB and Wairarapa DHBs as below:

Capital & Coast DHB
Target: 70%
Not Achieved: 67.03%
<table>
<tr><th>Ethnicity</th><th>Age</th><th>Target</th><th>Actual</th></tr>
<tr><td>All</td><td>50-69</td><td>20,920</td><td>20,033</td></tr>
<tr><td>Maori</td><td>50-69</td><td>1519</td><td>1264</td></tr>
<tr><td>Pacific</td><td>50-69</td><td>1364</td><td>967</td></tr>
</table>
Wairarapa DHB
Target: 70%
Achieved: 75.2%
<table>
<tr><th>Ethnicity</th><th>Age</th><th>Target</th><th>Actual</th></tr>
<tr><td>All</td><td>50-69</td><td>3,738</td><td>4,017</td></tr>
<tr><td>Maori</td><td>50-69</td><td>301</td><td>333</td></tr>
<tr><td>Pacific</td><td>50-69</td><td>28</td><td>34</td></tr>
</table></td></tr>
</table>

* For 24 months from 01/07/09 to 30/06/11

7 Regional National Cervical Screening Services do not fit the definition of an output, good or service provided for a third party – these services are enablers or internal capability.

8 BreastScreen Aotearoa National Policy and Quality Standards, National Screening Unit, Ministry of Health, July 2008. Figures for lives saved are not available at a DHB level.

Immunisation Services

Provided by Primary Care, Well Child Providers, and Regional Public Health. Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people.[9]

Number of 2 year old children fully vaccinated (Hutt Valley DHB population)

Government Health Target

Target	2010/11	Intended impact and impact results
1949 (90%)	2,080 (91%) Achieved	Intended Impact: Health risk is reduced; Percentage of target population immunised. Impact Result: Achieved – percentage of population immunised, reducing the risk of disease.
Comment: This is an excellent result, with the DHB exceeding the national target.		

Number of Year 7 children (cohort) vaccinated in Schools (Hutt Valley and Capital & Coast DHB populations)[10]

Target	2010/11	Intended impact and impact results
CCDHB - 3000 HVDHB - 2000 Total - 5000	CCDHB - 3450 HVDHB - 1985 Total 5435 Achieved	Intended Impact: Health risk is reduced; Percentage of target population immunised. Impact Result: Achieved – percentage of population immunised, reducing risk of disease.

Number of over 65 years flu vaccinated (Hutt Valley DHB population)[10]

Target	2010/11	Intended impact and impact results
14,889	11,273 Not achieved	Intended Impact: Health risk is reduced; Percentage of target population immunised. Impact Result: Achieved – a significant proportion of the population has been vaccinated, thereby reducing risk of disease.
Comment: The target was not achieved due to forecasts including an allowance for a high demand based on previous year's H1N1 concerns. This did not eventuate as expected.		

9 Ministry of Health DHB Performance Monitoring Framework 2010/11
10 Measured on a calendar year basis

Number of HPV vaccinated 12 year old girls (Hutt Valley and Capital & Coast School Health Service)[11]

The HPV (human papilloma virus) programme aims to reduce cervical cancer in New Zealand by protecting girls against HPV infection. Currently, each year around 160 New Zealand women are diagnosed with cervical cancer and 60 women die from cervical cancer. Girls and young women born from 1 January 1990 are eligible to participate in New Zealand's HPV Immunisation Programme.

<table>
<tr><th>Target</th><th>2010/11</th><th>Intended impact and impact results</th></tr>
<tr><td>632</td><td>568
Not achieved</td><td rowspan="2">Intended Impact: Health risk is reduced; Reduced cervical abnormalities
Impact Result: Achieved – 64% of the eligible cohort of the population have been vaccinated, reducing risk of disease. The rate of cervical abnormalities will only become clear over time, and at a national level.</td></tr>
<tr><td colspan="2">Comment: The actual result achieved was below our initial target. This was expected as the Ministry of Health asked DHBs to provide more "catch up" vaccinations than was originally planned and funded. The impact was that resources were reoriented to deliver the "catch ups" with the coverage in the target cohort somewhat lower than planned. No additional funding was provided so resources were divided between these objectives.</td></tr>
</table>

11 Measured on a calendar year basis

Well Child, School Health Services

Provided by Primary Care, Well Child Providers, and Regional Public Health.

School and Preschool Health Services are those services and programmes that are delivered in schools and early childhood centres. The focus of the service is on the identified needs of children and young people (hearing & vision screening, assessment and referral services, case management services, involvement in strengthening families, adolescent clinics and self referral clinics, opportunistic immunisation, communicable disease prevention). The evidence suggests that school-based and youth-specific health services are effective in connecting young people into health care; particularly young people from high need populations. The primary objective for providers of School and Preschool Services is to support and assist children and young people to maximise their physical, mental and emotional health potential, thereby establishing a strong foundation for ongoing healthy development.[12]

The Before School Check is a nationwide programme offering a free health and development check for four year olds. The B4 School Check aims to identify and address any health, behavioural, social, or developmental concerns which could affect a child's ability to get the most benefit from school, such as a hearing problem or communication difficulty. It is the eighth core contact of the Well Child Tamariki Ora Schedule of services.[13]

Number of School Health visits by school health nurses

Target	2010/11	Intended impact and impact results
CCDHB - 3363 HVDHB - 1632	CCDHB - 2327 HVDHB - 1132 Not achieved	Intended Impact: Intervention is early; Improved developmental, social and educational outcomes; Reduced avoidable hospitalisations. Impact Result: It is assumed that greater contact with health professionals at school will allow issues to be identified and treated earlier. Avoidable hospitalisations have not decreased, but this is only one of many services which contribute to reducing avoidable hospitalisation rates. It is assumed that improved health status will contribute to improved developmental, social, and educational outcomes.
Comment: This variance was a result of several factors. These include staff redeployment to support the response to the H1N1 influenza pandemic, and prioritising resource to higher needs Hutt Valley primary schools in response to the low number of students self-referring in higher decile CCDHB colleges (8-10).		

Number of Before School Checks (Hutt Valley DHB population)

Target	2010/11	Intended impact and impact results
1180	1703 Achieved	Intended Impact: Intervention is early; Improved developmental, social and educational outcomes; Reduced avoidable hospitalisations. Impact Result: Greater contact with health professionals at an early age allows issues to be identified and treated earlier.
Comment: We agreed a higher target of 1685 after the Statement of Intent was finalised.		

12 Nationwide Service Framework; Service Specifications; Tier 2 Preschool and School Health, Ministry of Health 2010/11
13 Ministry of Health website http://www.moh.govt.nz/b4schoolcheck

Primary and Community Services Output Class

Primary Health Care is a key priority area for Hutt Valley DHB, and an ongoing strategic focus as we work to deliver and develop better, sooner, more convenient health services. A focus on primary health care as a priority contributes to achievement of the key outcomes of reduced health risk, improved access to services, earlier intervention, better service integration, more efficient and effective services, higher quality and safe services, improved infrastructure and regional collaboration and positive partnerships.

The DHB has again achieved well in this area, with particular successes in its work with its primary care partners to address diabetes, and our efforts in improving access to our community mental health services. A cornerstone for the future of successful primary/secondary relationships is to grow our partnership relationship with primary care so that increasingly, appropriate services are located in communities, and the movement of people between primary and secondary care is smoother and more patient focused.

The main area where our performance has been below our expectations is in avoidable hospitalisations, with the deterioration in Ambulatory Sensitive Hospitalisation (ASH) rates being of concern. This will be an area of particular focus in 2011/12 and outyears.

Primary Health Care Services

Primary health care relates to the professional health care received in the community, usually from a GP or practice nurse. Primary health care covers a broad range of health and preventative services, including health education, counseling, disease prevention and screening. A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups. The launch of the Primary Health Care Strategy in 2001, followed by the establishment of Primary Health Organisations (PHOs), set a new direction and vision for primary health care services in New Zealand.

Number of Hutt Valley people enrolled in a Primary Healthcare Organisation

Primary Health Care Services are subsidised via a national contract between DHBs and Primary Healthcare Organisations (PHOs) based on the number of people enrolled.[15]

Target	2010/11	Intended impact and impact results
140,581	139,699[15]	Intended Impact: Health risk is reduced, Intervention is early, Access to services is improved, Services are better integrated; Reduced avoidable hospitalisations. Impact Result: It is assumed that high numbers of enrolment will mean that people have better access to services, and will be treated earlier. Avoidable hospitalisations have not decreased, but this is only one of many services which influence avoidable hospitalisation rates.
Comment: There is a relatively small variance between forecast, and the actual result. The main factor is that Ropata Medical Centre has joined a PHO based in the Capital & Coast District, which means that around 600 people who otherwise would have been included within the Hutt Valley catchment are not now included in our result.		

14 Ministry of Health http://www.moh.govt.nz/primaryhealthcare
15 As at July 2011 (for the July - September period)

Oral Health Services

Include services provided by Hutt Hospital based at Hutt Valley DHB to Capital & Coast DHB. Child Oral Health Service is the provision of a range of dental care to assist the maintenance of a functional natural dentition and to bring about an improvement in oral health status of the population. It includes preventive care.

Number of enrolled pre-school and school children (Hutt Valley and Capital & Coast DHB populations)[16]

Target	2010/11	Intended impact and impact results
57,959	54,044 Not achieved	Intended Impact: Intervention is early; Improved oral health; DMFT at Year 8[17] Impact Result: DMFT at Year 8 has deteriorated from 0.9 in 2008 to approximately 1.1 in 2010. However, this is not consistent across ethnicity, noting improvements in Maori rates from 1.4 to 1.2 over the last two years. High rates amongst Pacific people remain concerning.
Comment: The dental service considers that the target was not calculated correctly for 2010 (as it related to pre-school children), and has discussed its concerns with the Ministry of Health. These concerns have not been fully resolved. The service is confident of improved performance against target in 2011/12.		

Total number of school dental service examinations (Hutt Valley and Capital & Coast DHB populations)

Target	2010/11	Intended impact and impact results
53,395	42,834 Not achieved	Intended Impact: Intervention is early; Improved oral health; DMFT at Year 8[17] Impact Result: DMFT at Year 8 has deteriorated from 0.9 in 2008 to approximately 1.1 in 2010. High rates amongst Pacific people remain concerning.
Comment: See above regarding enrolments.		

16 Measured on a calendar year basis

17 Average number of decayed/missing/filled teeth (DMFT) at year 8 for different ethnic groups provides information that allows DHBs to evaluate how health promotion programmes, and services such as the DHB Community Oral Health Service (COHS) and other child oral health providers, are influencing the oral health status of children. The data enables DHBs to identify and target the pockets of deprivation in their district where children's oral health status is poorest.

Number of adolescents examined (Hutt Valley DHB population)[18]

Target	2010/11	Intended impact and impact results
6,796 (70.5% of 9,640 cohort)	5,666 (58.8% of 9,640 cohort) Not achieved	Intended Impact: Intervention is early; reduced avoidable hospitalisations. Impact Result: It is assumed that high numbers of examinations mean that people have better access to services, and are being treated earlier, resulting in better oral health.
Comment: The variance is a result of lower than expected availability of private providers. During 2010 a full stocktake of adolescent utilisation was completed. The three areas of concern were Wainuiomata, Naenae and Taita. A private provider has initiated a mobile service in Wainuiomata with a view to a similar service for Taita. To improve the Naenae situation the hospital dental department is trialing an initiative where they provide services from the new Naenae hub.		

18 The total number of completions and non-completions under the Combined Dental Agreement for adolescent patients plus additional adolescent examinations with other DHB funded dental services (Adolescents are defined as people from Year 9 up to and including age 17 years)/ Eligible population (Ministry denominator)

Primary and Community Care programmes

Provided by Hutt Hospital, Primary Care, and NGOs. Includes CarePlus, Health Promotion, Services to Improve Access, Diabetes Annual Review, CVD Risk Assessment, Cellulitis, Skin Lesions, Sexual Health, Whanau Ora, Primary Mental Health, Podiatry, Dietary, Retinal Screening, Asthma/COPD, care coordination, integrated services, other long term condition programmes. A key priority for implementation of the Primary Health Care Strategy is to reduce barriers for the groups with the greatest need through additional services to improve health and improve access to existing first-contact services.

Services to Improve Access (SIA) funding are available for all PHOs for new services or improved access and is additional to the main PHO funding for general practice-type care. PHOs are funded to develop health promotion programmes for their enrolled populations. Care Plus is a primary health care initiative targeting people with high health need due to chronic conditions, acute medical or mental health needs, or terminal illness. Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.

The Diabetes Annual Review is funded by the DHB and ensures that Hutt people with diabetes can have a free annual check up with their GP or GP practice nurse. The objectives of the programme are to: screen for the risk factors and complications of diabetes, promote early detection and intervention, agree on an updated treatment plan for each person with diabetes, update the information in the diabetes register used as a basis for clinical audit and planning improvements to diabetes services in the area, and prescribe treatment and refer for specialist or other care if appropriate.

Number of people accessing primary and community programmes (described above)

Target	2010/11	Intended impact and impact results
20,628	23,820	Intended Impact: Intervention is early, Access to services is improved; Improved Cardiovascular risk assessment, Reduced avoidable hospitalisations. Impact Result: Cardiovascular Disease assessments have increased (from 76% of the eligible population in 2008/09 to 76.9% in 2010/11. However avoidable hospitalisations have not decreased (further detail above).
Comment: The main contributor to this result is higher than expected numbers of people accessing diabetes annual reviews. This is likely to be driven by increased emphasis on diabetes and obesity in primary care.		

Number of diabetes annual reviews

A diabetes annual review or “free annual check” is a group of tests and checks including cholesterol, blood pressure, height and weight for a person with Type I or II diabetes on a diabetes register.

Target	2010/11	Intended impact and impact results
4351	4461 Achieved	Intended Impact: Intervention is early, Access to services is improved, Services are better integrated; Diabetes management of HBA1C < 8. Impact Result: People with well managed diabetes, that is, the percentage of diabetics with HBA1C < 8 has improved from 73% to 74% since 2009/10.

Number of people enrolled in CarePlus

Care Plus is a primary health care initiative targeting people with high health need due to chronic conditions, acute medical or mental health needs, or terminal illness. Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.

Target	2010/11	Intended impact and impact results
3,117	2,975 Not achieved	Intended Impact: Intervention is early, Access to services is improved; Improved Cardiovascular risk assessment and diabetes management, Reduced avoidable hospitalisations. Impact Result: CVD risk assessment has improved slightly from 2008/09 (76% to 76.9% - with a high point of 77% in 2009/10). People with well managed diabetes (the percentage of diabetics with HBA1C < 8) has improved from 71% to 74% since 2008/09. However, avoidable hospitalisation rates have not in the main improved on previous years.
Comment: The latest CarePlus data shows that 2975 Hutt Valley residents were enrolled in CarePlus as at April 2011. At the same time in 2010 there were 2569 Hutt Valley residents enrolled in CarePlus. This is a real increase, adjusted to take account of Ropata shift to CCDHB Cosine PHO. This shift has meant that people previously included in the Hutt Valley calculation are now included within Capital & Coast DHB.		

Pharmacist Services

The Hutt Valley DHB funds Community Pharmaceutical Services for community prescribing by GPs and hospital specialists. Pharmacy Services are funded to enable people to have access to Pharmaceuticals and advice services that are responsive to their health needs and priorities. Pharmacy Services are funded as part of an integrated community based health service. The service provides people with the best quality and most cost-effective services, within the available funding, based on established professional and quality management standards and codes of practice; provides specialist advice as required to ensure optimal service user management; and ensures people's safety.[19]

Number of dispensed items

Target	2010/11	Intended impact and impact results
2,276,000	2,159,227	Intended Impact: Intervention is early, Access to services is improved, Services are better integrated; Prescribing is in accordance with best practice Impact Result: No available measure. An Optimising Pharmaceuticals programme is working with specific groups of clinicians to assist them in prescribing in accordance with best practice.
Comment: The volume of dispensed items is demand driven, based on prescribing of health professionals.		

19 Nationwide Service Framework; Service Specifications; Community Pharmacy Services, Ministry of Health 2010/11

Community Referred Test/Diagnostic Services

The Hutt Valley DHB funds Community Referred Laboratory and Radiology Services requested by GPs and hospital specialists.

Laboratory services are funded for Hutt Valley and Capital & Coast DHB populations. Laboratory services provide diagnostic laboratory testing for patients referred by general practitioners, private medical specialists, oral and maxillofacial surgeons, oral surgeons, midwives and certified cervical smear takers. Community laboratory services are funded as part of an integrated community based health service that: Provide patients with the best quality and most cost-effective services based on established professional and quality management standards and codes of practice, provides timely reporting of results to referrers, provides specialist advice as required to ensure optimal patient management, ensures patient and staff safety at all times.[20]

Diagnostic imaging services provide images of bodily structure and function to aid diagnosis and treatment. Community diagnostic imaging services are funded as part of an integrated community based health service that: Provides patients with quality and cost-effective services based on established professional and quality management standards and codes of practice, encourages best use of resources in the aid of diagnosis in accordance with best clinical practice and the Radiology National Referral Guidelines, provides timely reporting of results to referrers, provides specialist advice as required to ensure optimal patient management, ensures patient and staff safety at all times.[21]

Number of laboratory tests

Target	2010/11	Intended impact and impact results
2,081,000	2,114,711	Intended Impact: Intervention is early, Access to services is improved, Services are better integrated; Referrals are in accordance with clinical guidelines Impact Result: Access to services has increased based on an increase in test numbers from 2,081,000 to 2,114,711 over the last year.

Number of radiological examinations

Target	2010/11	Intended impact and impact results
10,660	10,500	Intended Impact: Intervention is early, Access to services is improved, Services are better integrated; Referrals are in accordance with clinical guidelines Impact Result: Continued access to radiological services allows for early intervention, diagnosis and treatment.

20 Nationwide Service Framework; Service Specifications; Community Laboratory Services, Ministry of Health 2010/11
21 Nationwide Service Framework; Service Specifications; Community Radiology Services, Ministry of Health 2010/11

Community Mental Health Services

The Hutt Valley funds community mental health services provided by Hutt Hospital and NGOs, for the Hutt Valley DHB population, and for other central region DHB populations for specific services and contracts.

Specialist mental health and addiction services are delivered to those people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population.

A focus on early intervention strategies means that services are delivered to people who are at greater risk of developing more severe mental illness or addiction. The aim is for people to have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. Specialist mental health and addiction services are publicly funded for those who are most severely affected by mental illness or addiction.[22]

Total number of community mental health clients seen[23]

Target	2010/11	Intended impact and impact results
3,558	3,900 Achieved	Intended Impact: Intervention is early, Access improved, Services are better integrated; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: Acute mental health inpatient admissions have reduced from 543 in 2009/10 to 474 in 2010/11.
Comment: This result reflects better data reporting and increased performance leading to an increased number of clients being seen.		

Total number of occupied beddays

Target	2010/11	Intended impact and impact results
12,867	15,005 Achieved	Intended Impact: Intervention is early, Access improved, Services are better integrated; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: Acute mental health inpatient admissions have reduced from 543 in 2009/10 to 474 in 2010/11.
Comment: This variance to forecast is predominantly a result of better data reporting, and also increased performance leading to an increased number of clients being seen.		

22 Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification Ministry of Health 2010/11

23 Clients seen is the total of unique clients seen by each service. A client who uses more than one service will be counted more than once. Output data includes data for clients from other DHBs who used regional services that Hutt Valley DHB is lead DHB for (DHB of service) e.g. AOD residential services etc

Hospital Services Output Class

Acute Services

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

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

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

Elective Services

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

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

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

Our hospital has performed well in 2010/11, with our delivery against the Better Access to Elective Surgery Health Target being a particular highlight. The measures which help us to understand our efficiency and the way Hutt Valley people access our services tell us that we are doing a good job, but that there is room for improvement in how we manage our work, for example, in making sure that we plan our surgery in a way which means people spend less time in hospital.

Our most significant performance concern in our hospital this last year has been our performance against the Shorter Stays in Emergency Department Health Target. Although we have seen improvements, we did not meet our target. We expect that our recently completed new Emergency Department will be a major contributor to us meeting the 95% target in 2011/12, but we know this will also require changes in process, which we are committed to making.

Mental Health Services

Include services provided at Hutt Hospital and in the community, including by contracted providers. These also include services provided regionally, including to other DHB populations. Specialist mental health and addiction services are delivered to those people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. The aim is for people to have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. Specialist mental health and addiction services are publicly funded for those who are most severely affected by mental illness or addiction.[24] Service users need easy and well-recognised access to services that are: focused on wellness and recovery, high quality, built on an evidence base of what works best, and provided in the least restrictive environment.[25]

Total number of clients seen[26]

Target	2010/11	Intended impact and impact results
1,524	6,931 Achieved	Intended Impact: Access to services is improved, Intervention is early; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: Acute mental health inpatient admissions have reduced from 543 in 2009/10 to 474 in 2010/11.
Comment: This significant variance to forecast is driven by improved data collection (in both the hospital and by external providers), which has been an area for improvement. This more accurate collection and reporting will allow more accurate forecasting.		

No more than 30 days waiting time for Alcohol and Drug Services

Target	2010/11	Intended impact and impact results
< 30 days	N/A	Intended Impact: Access to services is improved, Intervention is early; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: N/A
Comment: At present the service is unable to fully draw the required information to report accurately on waiting times for AoD services. We are currently working on our data collection system in order to improve and expand on the breakdown of data collected. We anticipate being able to report on this measure during 2011/12.		

24 Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification Ministry of Health 2010/11
25 Ministry of Health Performance Monitoring Framework, 2010/11
26 Clients seen is the total of unique clients seen by each service. A client who uses more than one service will be counted more than once. Output data includes data for clients from other DHBs who used regional services that Hutt Valley DHB is lead DHB for (DHB of service) e.g. AOD residential services etc

Total number of occupied beddays

Target	2010/11	Intended impact and impact results
6,649	8,072	Intended Impact: Access to services is improved, Intervention is early; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: Acute mental health inpatient admissions have reduced from 543 in 2009/10 to 474 in 2010/11.
Comment: There is no main identified driver of the high occupancy rates in 2010/11. The 2011/12 year will show more clearly whether there has been a shift in demand or if the 10/11 year was an outlier. We have full staffing in our inpatient area and are making contingency plans when the ward is full to manage additional admissions by boarding with other services when appropriate. We do not believe safety and quality have been impacted by the increase in occupancy, and a key marker for this - complaints – has decreased in 2010/11.		

90 % of people have up to date crisis prevention plans

Crisis prevention/resiliency planning has been shown to be a key component of service delivery that allows the medium to longer impacts of a serious mental illness to be minimised. Effective prevention planning can be expected to contribute materially to improved outcomes for services. Accordingly, all clients with enduring serious mental illness are expected to have an up-to-date crisis prevention plan. A crisis prevention plan identifies the needs and early warning signs for the services user and their families. The plan identifies what the service users can do for themselves and what the service will do to support the service users.[27]

Target	2010/11	Intended impact and impact results
90%	92% Achieved	Intended Impact: Access to services is improved, Intervention is early; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: Acute mental health inpatient admissions have reduced from 543 in 2009/10 to 474 in 2010/11.
The increased performance in this area has resulted from specific service focus on crisis prevention planning.		

27 Ministry of Health Performance Monitoring Framework, 2010/11

Elective Services

Includes:

- Services provided by Hutt Hospital for the Hutt Valley population (provider and population view as measured by Health Targets)
- Services provided by other DHBs for the Hutt Valley population (population view as measured by Health Targets)
- Services provided by Hutt Hospital for other DHB populations (provider and other DHB population view as measured by their Health Targets)

The Minister has set an expectation that the national annual increase in elective surgical discharges will improve. The growth in elective surgical discharges will increase access and should achieve genuine reductions in waiting times for patients. Eight Elective Services Performance Indicators have been specified as measures of performance for elective services – measuring quality, timeliness and effectiveness

Elective services provided by Hutt Hospital and by other DHBs for the Hutt Valley population

Government Health Target.

Target	2010/11	Intended impact and impact results
Elective services provided by Hutt Hospital and by other DHBs for the Hutt Valley population: 4896	5,042 Achieved	Intended Impact: Access to services is improved; More people receive more surgical procedures with better outcomes (reduced infection, reduced readmission, reduced acute inpatient admissions). Impact Result: More surgery has been delivered (4841 in 2009/10 increased to 4896 for the Hutt Valley population in 2010/11). Acute readmission rates have decreased, from 10.15 in 2009/10 to 9.19 in 2010/11.
Elective services Provided by Hutt Hospital for the Hutt Valley and other DHB Populations: 6,458	6,627 Achieved	
First Specialist Assessments (FSA) Provided by Hutt Hospital for the Hutt Valley and other DHB Populations: 18,354	19,436 Achieved	
First Specialist Assessments (FSA) Provided by Hutt Hospital and by other DHBs for the Hutt Valley population: 14,999	15,907 Achieved	

Less than 2% of patients will wait longer than six months for their first specialist assessment (FSA)

Target	2010/11	Intended impact and impact results
<2%	0.6% Achieved	Intended Impact: See above. Reduced "long waits" means overall faster access to services, and reduces the risk of wait times contributing to acute admissions. Impact Result: See above.

Patients given a commitment to treatment but not treated within six months

Target	2010/11	Intended impact and impact results
<5%	2% Achieved	Intended Impact: See above. Impact Result: See above Reduced "long waits" means overall faster access to services, and reduces the risk of wait times contributing to acute admissions.

Percentage of day case discharges

One important way in which DHBs can increase hospital throughput is through increasing the proportion of surgery carried out on a day surgery basis. For planned admissions (arranged and elective) it should be possible to improve the management of surgery in order to improve day surgery rates. In addition to the efficiency gains available through day surgery, experience from the United Kingdom has established that patient feedback around day surgery is positive, and day surgery therefore represents a quality experience from the patient perspective.[28]

Target	2010/11	Intended impact and impact results
60%	58.1% Not achieved	Intended Impact: Access to services is improved; increased theatre utilisation; increased number of procedures and reduced beddays. Impact Result: The number of procedures has increased from 6,458 in 2009/10 to 6,627 in 2010/11. Elective length of stay has reduced from an average of 3.91 days to 3.6 days (Q4).
Comment: The DHB will be developing a process for our new 23 hour day surgery unit. This will create a group of staff and dedicated area with a specific focus on day surgery, starting in January 2012.		

28 Ministry of Health Performance Monitoring Framework, 2010/11

Day of surgery admission rate

One important way in which DHBs can improve attainable bed days and increase hospital throughput is through increasing the proportion of surgery carried out on the same day the patient is admitted. The usual term for surgery received on the same day as patient admission is 'day of surgery admission' (DOSA). For planned admissions (arranged and elective) it should be possible to improve the management of surgery in order to improve DOSA rates. The number of patients for which a pre-operative in-hospital overnight stay is clinically required is relatively small.[29]

Target	2010/11	Intended impact and impact results
70%	88.4% Achieved	Intended Impact: See above. Impact Result: Improved day of surgery admission rate assists access to elective surgery by freeing up bed capacity.
Comment: A significant contributing factor to the DHB's improved performance is that we are better managing Plastics patients from out of the Hutt Valley. Many of these patients were admitted the night before their surgery, and are now admitted on the day of their surgery.		

30 Day mortality

Mortality rates are a well-established measure of clinical outcomes for hospital patients, due to the fact that mortality is an explicit and readily available measure related to the safety and efficacy of treatment. Overseas experience shows that systemic changes to the way care is offered to patients can lead to measurable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia, and hospital-acquired infections in patients.[29]

Target	2010/11	Intended impact and impact results
1.58%	1.43% Achieved	Intended Impact: Reduced mortality. Impact Result: Mortality rates have reduced from 1.58 in June 2009 to 1.43 in March 2011. The lowest result in that period has been 1.36.

29 Ministry of Health Performance Monitoring Framework, 2010/11

Acute Services

Include services provided by Hutt Hospital for the Hutt Valley population and also for people from other DHB areas

Number of Emergency Department (ED) attendances

This service is a 24-hour, clinically integrated service that is part of a secure pathway from pre-hospital to definitive care. A hospital Emergency Department treats patients with injury, illness, or obstetric complications. Access to this service must be universal irrespective of an individual's ability to pay. Key roles for the Emergency Department will include: assessment and initial management for medical, surgical and psychiatric emergencies, assessment and initial management for serious injury, assessment and initial management for obstetric emergencies, access to the service may be initiated by an emergency ambulance callout, a primary care provider, a mental health crisis team, or an individual presenting at an emergency department. The service must contribute to the regional system for emergency care and operate in synergy with pre-hospital care, ambulance services, and specialised referral hospitals or services.[30]

Target	2010/11	Intended impact and impact results
42,601	42,453	Intended Impact: Services are better integrated; The number of ED attendances reflects true need for emergency services and not poor access to primary and community care. Impact Result: No measure available.
Comment: This figure is largely demand driven though it is generally intended that ED attendances reduce through our work with primary care.		

Number of inpatients

Specialist medical and surgical inpatient services provide services to people whose condition is of such severity or complexity that it is beyond the capacity and technical support of the referring service.[31]

Target	2010/11	Intended impact and impact results
13,697	13,370	Intended Impact: Access to services is improved; The number of inpatients reflects true need for acute services and not poor access to primary and community care resulting in avoidable hospitalisations or poor access to elective services. Impact Result: No measure.

Number of beddays[30]

Target	2010/11	Intended impact and impact results
71,572	72,233	Intended Impact: The number of beddays reflects best practice and appropriate occupancy. Reduced avoidable hospitalisations. Impact Result: The lower number of beddays has improved the average length of stay (see below). Avoidable hospitalisation rates have deteriorated, as discussed above.

30 Ministry of Health Performance Monitoring Framework, 2010/11
31 Nationwide Service Framework; Service Specifications; Medical and Surgical Specialist Services Tier One Service Specification, Ministry of Health 2010/11

Number of ED attendances with an ED length of stay less than 6 hours

Government Health Target.

Emergency Department (ED) length of stay is an important measure of service quality in DHBs, because: EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery (and any time spent waiting) is by definition important for patients, long stays in emergency departments are linked to overcrowding of the ED, the medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay, overcrowding can also lead to compromised standards of privacy and dignity for patients, for instance, through the use of corridor trolleys to house patients.[35]

Target	2010/11	Intended impact and impact results
40,471 (95%)	36,934 (86%) Not achieved	Intended Impact: See above. Impact Result: See above.
Comment: Our performance against this target was lower than planned. There are many factors which influence this result, with an important factor being the limited space in the current ED. This is being addressed with the building of a new ED facility. This facility has just been completed and we expect that this new facility, as well as changes to how we do things, will mean a clear improvement in our performance to meet this important health target.		

Acute Readmission rate

Hospital unplanned acute readmission rates are a well-established measure of quality of care, efficiency, and appropriateness of discharge for hospital patients, particularly as a counter-measure to average length of stay. International experience is that shorter lengths of stay can contribute to higher rates of acute readmissions.

Unplanned acute readmissions may imply a possible failure in patient management such as discharge too early, or inadequate support at home.[32]

Target	2010/11	Intended impact and impact results
10.15%	9.19% Achieved	Intended Impact: Reduced readmission rate; The average length of stay reflects best practice. Reduced cost. Impact Result: Readmission rates have reduced, indicating improved quality of service resulting in fewer patients having to be readmitted.

32 Ministry of Health Performance Monitoring Framework, 2010/11

Average length of stay (ALOS)

Reductions in the length of stay for inpatients (where clinically appropriate) allow more patients to be treated in hospitals without additional capital investment in hospital beds. This capacity to treat more patients contributes to goals such as decongestion of emergency departments, or increases in elective surgery. As well as the improvement in throughput, shortened hospital length of stay for patients reduces risks of nosocomial infections and allows patients to return home. In some cases it may also reflect lowered rates of patient complications, or improvements in the time clinical staff are able to give to direct patient treatment. Treating increasing numbers of patients as day cases or outpatients, or moving less complex services into primary care setting, could increase inpatient length of stay. For this reason, it is important to consider ALOS in conjunction with other measures of hospital (and system) performance, such as day surgery rates and ambulatory sensitive hospitalisations.[33]

Target	2010/11	Intended impact and impact results
4.02	4.03	Intended Impact: Access to services is improved; The average length of stay reflects best practice. Reduced beddays. Reduced nosocomial infection rate. Reduced cost. Impact Result: Beddays have decreased from 72,572 in 2009/10 to 72,233 in 2010/11.
Comment: Given the very small variance between target and result, the Ministry of Health considers this measure to be achieved.		

Assessment, Treatment and Rehabilitation Services

Includes services provided at Hutt Hospital and in the community. Assessment, Treatment and Rehabilitation (ATR) Services provide a coordinated multidisciplinary response to meet the complex needs of people with disability and/or aged related disorders in order to restore their functional ability and enable them to live as independently as possible. The AT&R service includes specialist inpatient units, services to people in their usual living or working environments, outpatient clinics and day hospital. The aims of an AT&R service are; provide specialised and clinical assessment of a person's needs, apply appropriate clinical treatment/s, restore/optimise a persons functioning, facilitate the person in reaching their full potential and maximising their ability to participate in their community of choice.[34]

Total number of patients seen

Target	2010/11	Intended impact and impact results
2,114	1,948	Intended Impact: Access to services is improved; The number of patients seen reflects appropriate use of services. Reduced acute inpatient admissions. Impact Result: As intended, there has been a slight reduction in acute inpatient admissions over the last year, down from 13,697 to 13,502.

33 Ministry of Health Performance Monitoring Framework, 2010/11
34 Nationwide Service Framework; Service Specifications; Assessment, Treatment, Rehabilitation Services Tier One Service Specification, Ministry of Health 2010/11

Maternity Services

Includes services provided at Hutt Hospital and in the community. The Maternity Service provides care, from twenty weeks gestation to six weeks following a delivery. The vision is that each woman, and her whanau and family, will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice. Pregnancy and childbirth are a normal life-stage for most women. Additional care will be available to those women who require it.[35]

Number of deliveries

Target	2010/11	Intended impact and impact results
2200	2017	Intended Impact: Access to services is improved; Length of stay reflects best practice, Women are confident to return home with their baby. Impact Result: Continued access to maternity services is an important aspect of hospital services.
Comment: This result is demand driven.		

Post natal length of stay

Extending postnatal stays for women who choose to stay in a birthing facility longer allows women to establish breastfeeding and gain the confidence to return home.[36]

Target	2010/11	Intended impact and impact results
2.34 days	1.9 days Not achieved	Intended Impact: Access to services is improved; Length of stay reflects best practice, Women are confident to return home with their baby, Reduced readmissions for neonates. Impact Result: Reduced readmissions for neonates - in 2009-10 2.36%, and in 2010-11 1.59%.
Comment: Although the average has not met target, the DHB has worked to ensure that women who could benefit from longer stays are specifically made aware of the ability to remain at the hospital for a longer period if they wish to do so. There have been no recorded complaints about length of stays.		

Neo-natal length of stay

This refers to specialist services provided for newborn babies with significant health issues (low weight, requiring surgery, short or long term ventilation, parenteral nutrition, specialist medical care, and failure to thrive).[37]

Target	2010/11	Intended impact and impact results
12 days	9.4 days	Intended Impact: See above. Impact Result: See above.
Comment: The reduced length of stay is a good result, reflecting the quality of antenatal care, treatment in hospital, and after care support. There is no single identified factor leading to this improvement.		

35 Nationwide Service Framework; Service Specifications; Maternity Services Tier One Service Specification, Ministry of Health 2010/11
36 Government priorities, District Annual Plan 2009/10
37 Nationwide Service Framework; Service Specifications; Specialist Neonates Services Tier One Service Specification, Ministry of Health 2010/11

Fertility Treatment

Includes services provided under contract by Fertility Associates for the populations of the Hutt Valley DHB, Capital & Coast DHB, Hawke's Bay DHB, MidCentral DHB, Tairawhiti DHB, Wairarapa DHB, Whanganui DHB. The Assisted Reproductive Technology Service (Fertility Treatment) provides a range of specialist treatment services for people experiencing infertility and people with familial genetic disorders.[38]

Number of fertility cycles

Target	2010/11	Intended impact and impact results
280	307	Intended Impact: Access to services is improved. Impact Result: Increased access to fertility services.

Support Services Output Class

Older Peoples Health Services

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

Needs Assessment Services Coordination (NASC)

A needs assessment is a process of determining the current abilities; resources, goals and needs of a client and identifying which of those needs are the most important to maximise independence and participation in society. Service co-ordination is the process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the client. Service co-ordination will also determine which of those needs can be met by government funding and other services, and will explore all options and linkages for addressing prioritised needs and goals.

Number of assessments completed on time and accurate

Target	2010/11	Intended impact and impact results
2,568	3576 Achieved	Intended Impact: Access to services is improved; More services provided for more people for the same resource. Impact Result: Access to services is improved through reduced waiting times from referral to Assessment.
Comment: This variance predominantly represents an increase in assessments, arising from improvements in NASC processes.		

38 Nationwide Service Framework; Service Specifications; Assisted Reproductive Technology Services Tier Two Service Specification, Ministry of Health 2010/11

Average waiting time from receipt of referral to assessment[39]

Target	2010/11	Intended impact and impact results
7 Days	4 Days Achieved	Intended Impact: Access to services is improved; More services provided for more people for the same resource. Impact Result: Access to services is improved through reduced waiting times from referral to Assessment.

Number of client complaints to DHB

Target	2010/11	Intended impact and impact results
<20	0 Achieved	Intended Impact: Access to services is improved; More services provided for more people for the same resource. Impact Result: Access to services is improved through services being more satisfactory to clients.

Home Based Support Services

Includes contracted services provided for the Hutt Valley population. The purpose of the Home Support Service is to promote and maintain independence of people who are experiencing difficulty caring for themselves because of an illness or chronic medical condition, or as a result of hospitalisation. This service enables clients to remain in their own home or other private accommodation in the community or return to their home as soon as practical, by providing services that support and sustain activities necessary for daily living in a way which promotes the client's independence and quality of life. By providing assistance with essential activities of daily living, Home Support Services enable people requiring assistance with activities of daily living to remain safely in their own home for as long as possible.

Number of home based support clients

Target	2010/11	Intended impact and impact results
1,820	1,870 Achieved	Intended Impact: Access to services is improved; More people are able to stay in their home to receive care (ageing in place). Impact Result: More people are able to stay in their home to receive care.

Number of home based support hours

Target	2010/11	Intended impact and impact results
241,500	220,276 Achieved	Intended Impact: See above. Impact Result: Access to services is improved as services are better aligned to need. (Review of services conducted in 2009/10 to identity better alignment, which in turn reduced waste).
Comment: This result reflects the success of our work to better align services with clinical need. We are providing service to more clients without a reduction in quality of service.		

39 Government priorities, District Annual Plan 2009/10

Aged Residential Care Bed Services

Includes contracted services provided for the Hutt Valley population and also for people from other DHB areas. Aged Residential Services will be relevant to the health, support and care needs of each subsidised resident, recognising their cultural and/or spiritual values, individual preferences and chosen lifestyles; Provide a homelike and safe environment for each subsidised resident; Facilitate and assist the subsidised resident's social, spiritual, cultural and recreational needs; Provide the opportunity for each subsidised resident wherever possible, or the their representative, to be involved in decisions affecting the resident's life; and acknowledge the significance of their family/whanau and chosen support networks.[40]

Number of subsidised beddays

Target	2010/11	Intended impact and impact results
299,645	305,201 Achieved	Intended Impact: Access to services is improved; The number of beds reflect the true population need and represents good value for money. Impact Result: Increased access to services through increased beddays.

Number of providers audited

Actual number depends on Ministry of Health certification timetable and length of certification of providers.

Target	2010/11	Intended impact and impact results
4	8 (6 Surveillance audits, 2 Certification audits.)	Intended Impact: Providers are certified by the Ministry of Health certification system. Impact Result: Providers are certified.
Comment: This increase against forecast reflects the change in Ministry of Health policy to increase "surveillance" audits.		

40 National Contract for Aged Residential Care Services, Nationwide Service Framework, Ministry of Health, 2010/11

Respite and Day Care Services

Day Care services are community-based services which assist people with age-related support needs to remain in their own home, and provide support for their carers. The service provides activities, assistance, support and social interaction. It is expected that Day Care services will be part of a comprehensive package of care for people who have been needs assessed and whose support needs are able to be met in the community. Close links will be maintained between Day Care Services, service co-ordinators and Assessment, Treatment and Rehabilitation Units. Residential respite care services are designed to provide a short break for the informal carers of older people, by providing temporary support for the older people in a residential setting. These services can enable older people to stay at home for longer and can improve the health and well-being of their carers.[41]

Number of respite days

Target	2010/11	Intended impact and impact results
32334	1558 Not achieved	Intended Impact: Access to services is improved; Number of respite days provided reflects need for respite services. Impact Result: More people are able to stay in their home to receive care.
Comment: The forecast for 2010/11 was incorrectly stated at 32334, with the correct forecast being 3233. Our actual result remains lower than the corrected forecast. This appears to be a combination of awareness of the service, and lower than anticipated demand. We are assessing our service to understand how we can better communicate its availability, and to determine if it meets people's needs.		

Number of day service clients

Target	2010/11	Intended impact and impact results
182	188 Achieved	Intended Impact: Access to services is improved; Number of respite days provided reflects need for respite services. Impact Result: Increased access to service has resulted.

41 Nationwide Service Framework; Service Specifications; Day Care Services and Respite Care Services Tier Two Service Specifications, Ministry of Health 2010/11

Community Nursing Services

Includes services provided in the community by Hutt Hospital. This service supports clients remaining in their own community by providing nursing services in the client's own home, or on an ambulatory basis. The service provides care for those clients whose level of need is such that they require professional nursing services delivered by nurses or under the immediate direction of nurses. Services include generalist nursing and specialist nursing including complex wound care, IV therapy and enteral therapy, continence, stomal, palliative and home oxygen. The purpose of the service is to prevent avoidable admission to, or enable early discharge from, hospital, minimise the impact of a personal health problem, provide support to people with long term or chronic personal health problems or conditions, promote self care and independence, provide terminal/palliative care in the community where such services are not covered by other service specifications funded by the Ministry of Health.[42]

Total number of contacts (face to face meeting with patient)

Target	2010/11	Intended impact and impact results
32,000	34,759 Achieved	Intended Impact: Access to services is improved; The care provided reflects the need for services in accordance with best practice. Impact Result: Access to services is improved through increased delivery.

Social Work Services

Includes services provided in the community by Hutt Hospital. This service supports clients remaining in their own community by providing non medical, professional health care services in the client's own home, or in residential care, or on an ambulatory basis in (non-medical) outpatient or community-based clinics. The service is aimed at those clients whose level of need is such that they require health and disability services delivered by social workers. A person may be referred, by a medical practitioner, Needs Assessment and Service Co-ordination (NASC) service or other health professional appropriate to the need of the client.[43]

Total number of clients seen

Target	2010/11	Intended impact and impact results
2,042	1,547	Intended Impact: Access to services is improved; The care provided, through face to face meetings with clients or their families, reflects the need for services in accordance with best practice. Impact Result: No measure.
Comment: This variance reflects how much the service was used. There is no waiting list for these services.		

42 Nationwide Service Framework; Service Specifications; Specialist Community Nursing Services Tier Two Service Specifications, Ministry of Health 2010/11
43 Nationwide Service Framework; Service Specifications; Specialist Allied Health Services Tier Two Service Specifications, Ministry of Health 2010/11

Palliative Care

Includes contracted services provided in the community. Palliative care is the active care of people with advanced, progressive disease which is no longer responsive to curative treatment, and whose death is likely within 12 months. It is a holistic programme of care, provided by a multi-disciplinary team, and is aimed at improving the quality of life for people who are dying and their families/whanau.[44]

Number of patients receiving specialist palliative care

Target	2010/11	Intended impact and impact results
384	388 Achieved	Intended Impact: The care provided reflects the need for services in accordance with best practice. Impact Result: No measure.

Community Mental Health Support Services

Includes contracted services provided in the community. Specialist mental health and addiction services are delivered to those people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. A focus on early intervention strategies means that services are delivered to people who are at greater risk of developing more severe mental illness or addiction. The aim is for people to have timely access to high-quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. Specialist mental health and addiction services are publicly funded for those who are most severely affected by mental illness or addiction.[45]

Total number of clients seen

Target	2010/11	Intended impact and impact results
374	392 Achieved	Intended Impact: Access to services is improved; Intervention is early; Improved access to mental health services, Reduced number of people experiencing a mental health crisis, Reduced acute inpatient admissions. Impact Result: Access to services is improved through increased delivery. Acute mental health inpatient admissions have reduced from 543 in 2009/10 to 474 in 2010/11.

Total number of occupied beddays

Target	2010/11	Intended impact and impact results
11,520	12,894 Achieved	Intended Impact: See above. Impact Result: See above.
Comment: this increase is mainly due to better use/reporting of community provider respite services for people with mental illness, and an AOD residential service.		

44 Nationwide Service Framework; Service Specifications; Palliative Care Services Tier Two Service Specifications, Ministry of Health 2010/11
45 Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification, Ministry of Health 2010/11

Hospital Services

Statement of Financial Performance For the year ended 30 June 2011

	2011 Actual $000s	2011 Budget $000s	2011 Variance $000s	2010 Actual $000s
Revenue				
Revenue	230,759	233,676	(2,917)	217,228
Interest Revenue	459	576	(118)	345
Total Revenue	**231,218**	**234,253**	**(3,035)**	**217,573**
Operating Expenditure	(227,794)	(228,968)	1,174	(219,561)
Depreciation	(9,552)	(8,771)	(781)	(8,044)
Interest Expense	(1,243)	(1,506)	263	(1,259)
Capital Charge	(4,774)	(4,677)	(97)	(4,532)
Internal Allocations	6,649	6,594	55	7,316
Total Expenditure	**(236,715)**	**(237,328)**	**613**	**(226,079)**
Net Surplus / (Deficit)	**(5,497)**	**(3,076)**	**(2,421)**	**(8,506)**
Gain / (Loss) on Sale of Assets	(8)	-	(8)	(370)
Net Surplus / (Deficit)	**(5,505)**	**(3,076)**	**(2,429)**	**(8,876)**
Expenditure Breakdown:				
Personnel Costs	(121,119)	(120,146)	(973)	(115,395)
Outsourced Services	(5,052)	(4,093)	(959)	(5,357)
Clinical Supplies	(22,935)	(22,928)	(7)	(22,246)
Infrastructure and Non-Clinical Supplies	(29,749)	(30,926)	1,177	(29,017)
IDF Outflows	(60,031)	(61,367)	1,336	(57,054)
External Contract Payments	(4,478)	(4,462)	(16)	(4,326)
Internal Allocations	6,649	6,594	55	7,316
Total Expenditure	**(236,715)**	**(237,328)**	**613**	**(226,079)**

Public Health Services

Statement of Financial Performance For the year ended 30 June 2011

	2011 Actual $000s	2011 Budget $000s	2011 Variance $000s	2010 Actual $000s
Revenue				
Revenue	23,051	22,385	666	24,655
Interest Revenue	-	-	-	-
Total Revenue	**23,051**	**22,385**	**666**	**24,655**
Operating Expenditure	(19,457)	(18,769)	(688)	(19,981)
Depreciation	(359)	(414)	55	(390)
Interest Expense	-	-	-	-
Capital Charge	-	-	-	-
Internal Allocations	(2,911)	(3,093)	182	(3,572)
Total Expenditure	**(22,727)**	**(22,275)**	**(453)**	**(23,943)**
Net Surplus / (Deficit)	**323**	**110**	**213**	**712**
Gain / (Loss) on Sale of Assets	-	-	-	(2)
Net Surplus / (Deficit)	**323**	**110**	**213**	**710**
Expenditure Breakdown:				
Personnel Costs	(13,078)	(12,857)	(222)	(13,817)
Outsourced Services	(1,091)	(861)	(230)	(1,017)
Clinical Supplies	(2,005)	(1,648)	(357)	(2,239)
Infrastructure and Non-Clinical Supplies	(1,404)	(1,562)	158	(1,597)
IDF Outflows	(74)	(74)	-	-
External Contract Payments	(2,163)	(2,180)	17	(1,701)
Internal Allocations	(2,911)	(3,093)	182	(3,572)
Total Expenditure	**(22,727)**	**(22,275)**	**(453)**	**(23,943)**

Primary & Community Services

Statement of Financial Performance For the year ended 30 June 2011

	2011 Actual $000s	2011 Budget $000s	2011 Variance $000s	2010 Actual $000s
Revenue				
Revenue	109,590	108,158	1,431	109,830
Interest Revenue	-	-	-	-
Total Revenue	**109,590**	**108,158**	**1,431**	**109,830**
Operating Expenditure	(104,482)	(104,495)	13	(105,061)
Depreciation	(162)	(696)	534	(157)
Interest Expense	-	-	-	-
Capital Charge	(213)	(423)	209	-
Internal Allocations	(2,992)	(2,824)	(169)	(3,134)
Total Expenditure	**(107,849)**	**(108,437)**	**587**	**(108,352)**
Net Surplus / (Deficit)	**1,740**	**(278)**	**2,019**	**1,478**
Gain / (Loss) on Sale of Assets	(1)	-	(1)	(4)
Net Surplus / (Deficit)	**1,740**	**(278)**	**2,018**	**1,474**
Expenditure Breakdown:				
Personnel Costs	(11,956)	(12,787)	831	(13,070)
Outsourced Services	(433)	(320)	(113)	(456)
Clinical Supplies	(814)	(1,031)	218	(639)
Infrastructure and Non-Clinical Supplies	(2,305)	(2,323)	18	(1,154)
IDF Outflows	(7,250)	(6,645)	(605)	(6,552)
External Contract Payments	(82,099)	(82,507)	408	(83,348)
Internal Allocations	(2,992)	(2,824)	(169)	(3,134)
Total Expenditure	**(107,849)**	**(108,437)**	**587**	**(108,352)**

Support Services

Statement of Financial Performance For the year ended 30 June 2011

	2011 Actual $000s	2011 Budget $000s	2011 Variance $000s	2010 Actual $000s
Revenue				
Revenue	56,486	56,832	(346)	57,343
Interest Revenue	-	-	-	-
Total Revenue	**56,486**	**56,832**	**(346)**	**57,343**
Operating Expenditure	(55,167)	(55,886)	719	(54,573)
Depreciation	(6)	(6)	1	(5)
Interest Expense	-	-	-	-
Capital Charge	-	-	-	-
Internal Allocations	(745)	(677)	(69)	(609)
Total Expenditure	**(55,918)**	**(56,569)**	**651**	**(55,187)**
Net Surplus / (Deficit)	**568**	**262**	**306**	**2,156**
Gain / (Loss) on Sale of Assets	-	-	-	-
Net Surplus / (Deficit)	**568**	**262**	**306**	**2,156**
Expenditure Breakdown:				
Personnel Costs	(3,334)	(3,266)	(68)	(3,458)
Outsourced Services	(93)	(87)	(6)	(82)
Clinical Supplies	(1,236)	(1,369)	133	(1,266)
Infrastructure and Non-Clinical Supplies	(197)	(168)	(29)	(130)
IDF Outflows	(5,886)	(5,653)	(232)	(5,335)
External Contract Payments	(44,427)	(45,349)	922	(44,307)
Internal Allocations	(745)	(677)	(69)	(609)
Total Expenditure	**(55,918)**	**(56,569)**	**651**	**(55,187)**

Financial Report

For the year ended 30th June 2011

Statement of Accounting Policies

For the year ended 30th June 2011

Reporting Entity

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

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

The financial statements of Hutt Valley DHB are for the year ended 30 June 2011.

The financial statements were authorised for issue by the Board of Hutt Valley DHB on 28 October 2011.

Basis of Preparation

Statement of Compliance

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

Functional and Presentation Currency

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

Measurement Base

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

Change in Accounting Treatment

Hutt Valley DHB has an agency agreement with Capital and Coast DHB around paying for a joint venture contract. In 2009-10, this was shown as Revenue with costs shown as expenses. A subsequent opinion from Audit NZ, on treatment of this transaction, has caused a change in accounting treatment for 2010-11. This change has meant we need to restate the 2009-10 year for comparative purposes.

The effect of this change is shown below:

Item	2010-11 ($000s)	2009-10 ($000s)
Reduction in Government and Crown Agency Revenue	$14,463	$13,962
Reduction in Provider Payments	$14,463	$13,962

The provider funding commitments have also been restated as a result of the above treatment and the effect of the change is as shown below:

A reduction in commitments in

	2010-11 ($000s)	2009-10 ($000s)
Less than one year	$13,159	$14,183
One to two years	$15,774	$7,717
Two to five years	$24,188	$728
Over five years	-	-
Total	$53,121	$22,628

Changes in Accounting Policies

There have been no changes in accounting policy during the year.

Early adoption of the revised NZ IAS 24 (Related Party Disclosures)

The DHB has early adopted NZ IAS 24 Related Party Disclosures (Revised 2009). The effect of early adopting the revised NZ IAS 24 is:

- More information is required to be disclosed about transactions between the DHB and entities controlled, jointly controlled or significantly influenced by the Crown;
- Commitments with related parties require disclosure; and
- Information is required to be disclosed about any related party transactions with Ministers of the Crown with portfolio responsibility with the Ministry. An exemption is provided from reporting transactions with other Ministers of the Crown.

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

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following three main phases: Phase 1 Clarification and Measurement, Phase 2 Impairment Methodology and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new Standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. The DHB has not yet assessed the effect of the new standard and expects it will not be an early adopter.

FRS 44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. The DHB has not yet assessed the effects of FRS 44 and the Harmonisation Amendments.

As the External Reporting Board is to decide on a new accounting standards framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefit entities. This means that the financial reporting requirements for public benefit entities are expected to be effectively frozen in the short term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Significant Accounting Policies

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

Budgets

The budget figures are those approved by Hutt Valley DHB's Board in its District Annual Plan and included in the Statement of Intent. The figures in the statement of comprehensive income relating to Government and Crown Agency Sourced revenue and operating expenses differ from those included in the Statement of Intent due to the change in accounting treatment required by our auditors of a joint contract between ourselves and Capital & Coast DHB. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZ IFRS and other applicable Financial Reporting

Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Hutt Valley District Health Board for the preparation of these financial statements.

Equity

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

- General funds;
- Property revaluation reserves; and

Property Revaluation Reserve

This reserve relates to the revaluation of property, plant and equipment to fair value

Revenue

Crown Funding

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

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Hutt Valley DHB region is domiciled outside of the Hutt Valley. The Ministry of Health credits Hutt Valley DHB with a monthly amount based on estimated patient treatment for non-Hutt Valley residents within Hutt Valley. An annual wash-up occurs at year-end to reflect the actual non-Hutt Valley DHB patients treated at Hutt Valley DHB.

Goods Sold and Services Rendered

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

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

Borrowing Costs

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

Interest paid on borrowings from Crown Health Financing Agency directly attributable to the Theatre and Emergency Department building project has been capitalised to the project in accordance with IAS 23. This policy will apply until such time as the developments are ready for use. This capitalisation policy has been approved by Hutt Valley DHB's Board. The amount capitalised during the period is $1,039,219 (2010: $428,239).

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 DHB, are classified as finance leases. The assets acquired by way of finance leases are stated at an amount equal to the lower of the present value of the minimum lease payments (at the inception of the lease), less accumulated depreciation and impairment losses;

and their fair value. The leased item is recognised as an asset at the beginning of the lease term and depreciated on the same basis as equivalent fixed assets. A corresponding liability is also established and each minimum lease payment is apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Operating Leases

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

Cash and Cash Equivalents

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

Goods and Services Tax

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

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

Employee Entitlements

Short-term entitlements:

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

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

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

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

Long-term employee entitlements:

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

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

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

Defined Contribution Schemes

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

The amount of the expense recognised for defined contribution plans is $17,440

Defined Benefit Contribution Scheme

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

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

Debtors and Other Receivables

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

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

Inventories

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

Obsolete inventories are written off.

Property, Plant and Equipment

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

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

Revaluations

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

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

Accounting for revaluations

Hutt Valley DHB accounts for revaluations of land and buildings on a class of asset basis.

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

surplus or deficit up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

Additions

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

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

Disposal of Property, Plant and Equipment

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

Subsequent Costs

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

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

Depreciation of Property, Plant and Equipment

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

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

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

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

Intangible Assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

Amortisation

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

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

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

Taxation

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 2004.

Creditors and other Payables

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

Trust and Bequest Funds

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

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

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

Cost Allocations

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

Cost drivers for allocation of indirect costs

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

Statement of Cash Flows

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

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

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

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

Impairment of Property, Plant, Equipment and Intangible Assets

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

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

Value in use is depreciated replacement cost for an

asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

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

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

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

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

Financial Instruments

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

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

Provisions

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

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

ACC Partnership Programme

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

Critical Accounting Estimates and Judgements

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based

on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Land and building revaluations

Note 8 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

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

The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires Hutt Valley DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Hutt Valley DHB, and expected disposal proceeds (if any) from the future sale of the asset. An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount.

Hutt Valley DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Critical Judgements in Applying Accounting Policies

Management has exercised the following critical judgement in applying accounting policies.

Lease Classification

Determining whether a lease arrangement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Hutt Valley DHB. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised. Hutt Valley DHB has exercised its judgement on the appropriate classification of lease, and has determined a number of lease arrangements are operating leases.

Statement of Comprehensive Income

For the year ended 30 June 2011

	Note	2011 Actual $'000	2011 Budget $'000	2010 Actual $'000
Government & Crown Agency sourced		414,677	415,970	405,091
Patient & Consumer sourced		950	966	1,009
Other		4,257	4,115	2,950
Operating Income	**1**	**419,884**	**421,051**	**409,050**
Operating Expenses	1	(406,899)	(408,116)	(399,173)
Depreciation, Amortisation & Impairment expense	1	(10,079)	(9,887)	(8,593)
Operating Expenditure		**(416,978)**	**(418,003)**	**(407,766)**
Results from Operating Activities		**2,906**	**3,048**	**1,284**
Interest		459	576	345
Financing Costs	1	(1,243)	(1,506)	(1,259)
Capital Charge		(4,987)	(5,100)	(4,532)
Net finance expenses		**(5,771)**	**(6,030)**	**(5,446)**
Gain/(Loss) on Sale of Assets		(9)	0	(376)
Surplus/(Deficit) for the Year		**(2,874)**	**(2,982)**	**(4,538)**
Total Comprehensive Income for the Year		**(2,874)**	**(2,982)**	**(4,538)**

Statement of Changes in Equity

For the year ended 30 June 2011

	2011 Actual $'000	2011 Budget $'000	2010 Actual $'000
Equity as at 1 July	65,317	64,702	59,110
Total Comprehensive Income for the Year:			
Operating Result	(2,874)	(2,982)	(4,538)
Contributions from the Crown	1,852	7,619	10,952
Repayments to the Crown	(207)	(207)	(207)
Equity as at 30 June	64,088	69,132	65,317

Supplementary Information

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

	2011 Provider $000	**2011 Governance $000**	**2011 Funder $000**	**2011 Elimination $000**	**2011 Consolidated $000**
Operating income	210,586	3,171	381,626	(175,040)	420,343
Operating expenses	(197,322)	(3,168)	(381,449)	175,040	(406,899)
Operating Surplus before Depreciation, Capital Charge and Interest	**13,264**	**3**	**177**	**0**	**13,444**
Gain / (loss) on sale of assets	(9)	0	0	0	(9)
Depreciation	(10,079)	0	0	0	(10,079)
Capital charge	(4,987)	0	0	0	(4,987)
Interest expense	(1,243)	0	0	0	(1,243)
Net Operating (Deficit) / Surplus	**(3,054)**	**3**	**177**	**0**	**(2,874)**
Reconciliation to Retained Earnings					
Opening Balance	(32,578)	970	7,999	0	(23,609)
Net operating (deficit) / surplus for the year	(3,054)	3	177	0	(2,874)
Closing Balance	**(35,632)**	**973**	**8,176**	**0**	**(26,483)**

Mental Health Ring Fence for the year ended 30 June 2011

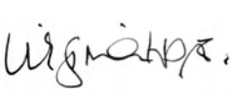
Hutt Valley District Health Board is required by its Crown Funding Agreement to ensure Mental Health funding is used to provide Mental Health Services. Included in the Funder accumulated funds of $2.673 million that is required to be used for future mental health service provision (2010: $928,000).

Statement of Financial Position

As at 30 June 2011

	Note	2011 Actual $'000	2011 Budget $'000	2010 Actual $'000
Equity				
Crown equity		40,203	38,397	38,558
Revaluation reserves		50,368	57,368	50,368
Retained earnings		(26,483)	(26,633)	(23,609)
Total Equity		**64,088**	**69,132**	**65,317**
Represented by:				
Current Assets				
Cash and cash equivalents		4,122	6	8,493
Receivables and prepayments	2	16,111	11,849	12,828
Inventories	3	1,264	1,240	1,355
Total Current Assets		**21,497**	**13,095**	**22,676**
Current Liabilities				
Payables and accruals	4	(40,743)	(40,322)	(35,222)
Employee entitlements and provisions	5	(24,491)	(22,015)	(21,807)
Borrowings	6	0	(3,311)	0
Total Current Liabilities		**(65,234)**	**(65,648)**	**(57,029)**
Net Working Capital Deficit		**(43,737)**	**(52,553)**	**(34,353)**
Non Current Assets				
Property, Plant and Equipment	8	166,583	192,184	133,020
Intangible Assets	9	2,296	0	2,362
Trust and bequest funds	11	902	798	778
Total Non Current Assets		**169,781**	**192,982**	**136,160**
Non Current Liabilities				
Employee entitlements and provisions	5	(4,154)	(1,899)	(3,712)
Borrowings	6	(56,900)	(68,600)	(32,000)
Trust and bequest funds	11	(902)	(798)	(778)
Total Non Current Liabilties		**(61,956)**	**(71,297)**	**(36,490)**
Net Assets		**64,088**	**69,132**	**65,317**

For, and on behalf of, the Board



Board Member

Board Member

28 October 2011

Statement of Cash Flows

For the year ended 30 June 2011

	Note	2011 Actual $'000	2011 Budget $'000	2010 Actual $'000
Cashflows from Operating Activities				
Cash was provided from:				
Cash receipts		430,807	372,854	422,185
		430,807	**372,854**	**422,185**
Cash was disbursed to:				
Payments to providers		(217,712)	(159,348)	(221,322)
Payments to suppliers & employees		(196,835)	(195,642)	(194,456)
Net goods and services tax paid		(711)	0	285
Capital charge paid		(4,927)	(5,100)	(5,510)
		(420,185)	**(360,090)**	**(421,003)**
Net Cash Inflow from Operating Activities	**7**	**10,622**	**12,764**	**1,182**
Cashflows from Investing Activities				
Cash was provided from:				
Interest received		459	576	345
Proceeds from sale of property, plant and equipment		16	0	1,338
		475	**576**	**1,683**
Cash was applied to:				
Interest paid		(2,090)	(1,506)	(1,581)
Purchase of property,plant and equipment		(39,924)	(44,528)	(22,762)
		(42,014)	**(46,034)**	**(24,343)**
Net Cash Outflow from Investing Activities		**(41,539)**	**(45,458)**	**(22,660)**

continued over...

Statement of Cash Flows continued

For the year ended 30 June 2011

	Note	2011 Actual $'000	2011 Budget $'000	2010 Actual $'000
Cashflows from Financing Activities				
Cash was provided from:				
Equity Contribution		1,853	7,412	10,952
Loans raised		24,900	24,900	13,000
		26,753	**32,312**	**23,952**
Cash was applied to:				
Repayment of Equity		(207)	0	(207)
		(207)	**0**	**(207)**
Net Cash Inflow / (Outflow) from Financing Activities		**26,546**	**32,312**	**23,745**
Net Increase / (Decrease) in Cash Held		**(4,371)**	**(382)**	**2,267**
Add opening cash and cash equivalents		8,493	(2,923)	6,226
Ending Cash and Cash Equivalents Carried Forward		**4,122**	**(3,305)**	**8,493**
Cash and Cash equivalent balances in the Statement of Financial Position:				
Cash and Cash Equivalents		4,122	(3,305)	8,493
Ending Cash and Cash Equivalents carried Forward		**4,122**	**(3,305)**	**8,493**

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

Notes to the Financial Statements

For the year ended 30 June 2011

		June 2011 $'000	June 2010 $'000
1	**Operating surplus**		
	After crediting revenue:		
	Interest income	459	345
	Other income	5,207	3,959
	Government & Crown Agency sourced revenue	414,677	405,091
	After charging expenses:		
	Fees paid to external auditors:		
	Audit fees - year end financial statements	109	104
	Fees paid to AuditNZ for other assurance services	0	9
	Board and Committee member fees:		
	Board Member fees	267	237
	Committee Member fees	158	113
	Rental and operating lease costs	2,817	2,396
	Bad debts - movement in provision	(113)	103
	Bad debts written off	96	55
	Net loss on sale of assets	0	376
	Personnel costs	149,487	145,739
	Depreciation:		
	Building Structure	2,448	1,992
	Building Services & Fitout	2,584	2,533
	Site Improvements	70	68
	Plant & Equipment	2,255	2,127
	Motor Vehicles	24	17
	Computer Equipment	886	859
	Computer Software	811	994
	Leased Plant & Equipment	1	3
	Impairment	1,000	0
	Total depreciation	**10,079**	**8,593**
	Interest expense:		
	Crown Health Financing Agency	1,241	1,242
	BNZ	2	17
	Total interest expense	**1,243**	**1,259**

Notes to the Financial Statements

For the year ended 30 June 2011

	June 2011 $'000	June 2010 $'000
2 Receivables and Prepayments		
Trade debtors - Ministry of Health	4,332	3,156
Trade debtors - other	11,692	9,768
Provision for doubtful debts	(371)	(484)
	15,653	**12,440**
Prepayments	458	388
Total Receivables and Prepayments	**16,111**	**12,828**
Reconciliation of movement in Provision for doubtful debts		
Balance as at July 2010	(484)	
Additional Provisions made	17	
Receivables Written off	96	
Balance 30 June 2011	(371)	
3 Inventories		
Pharmaceuticals	125	156
Surgical and medical supplies	1,149	1,209
	1,274	**1,365**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,264**	**1,355**

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

4 Payables and Accruals		
Trade creditors	5,524	1,439
Accrued expenses	25,583	24,625
Income in advance	342	264
Other payables	5,777	6,524
GST and other taxes payable	823	1,535
	38,049	**34,387**
Capital charge payable to shareholders	459	399
Fixed assets payable	2,235	436
Total Payables and Accruals	**40,743**	**35,222**

Notes to the Financial Statements

For the year ended 30 June 2011

		June 2011 $'000	June 2010 $'000
5	**Personnel Costs**		
	Increase/(decrease) in employee entitlements (see below)	3,136	1,905
		3,136	**1,905**
	Employee Entitlements & Provisions		
	Annual Leave	13,880	12,833
	Long Service Leave	3,489	3,362
	Retirement Gratuities	1,571	1,247
	Other Employee Provisions	9,715	8,077
		28,655	**25,519**
	Made up of:		
	Current		
	Annual Leave	13,880	12,833
	Long Service Leave	1,039	1,080
	Retirement Gratuities	251	171
	Other Entitlements	9,321	7,723
		24,491	**21,807**
	Non-current		
	Long Service Leave	2,450	2,282
	Retirement gratuities	1,320	1,076
	Other entitlements and provisions	384	354
		4,154	**3,712**

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

In determining the appropriate discount rate HVDHB considered the risk free rates as calculated from the yields on NZ Government bonds that have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 2.84% (2010: 3.44%) and an inflation factor of 2.75% were used.

If the discount rate were to differ by 1% from HVDHB's estimates, with all other factors constant, the carrying amount of the liability would be an estimated $201,000/$183,000 higher/lower. If the inflation factor were to differ by 1% from HVDHB's estimates, with all other factors constant, the carrying amount of the liability would be an estimated $201,000/$183,000 higher/lower.

Notes to the Financial Statements

For the year ended 30 June 2011

	June 2011 $'000	June 2010 $'000
6 Borrowings		
Crown Health Financing Agency	56,900	32,000
	56,900	**32,000**
Crown Health Funding Agency Loans are repayable as follows:		
Current (payable to 30 June 2012)	0	0
One to two years (payable to 30 June 2013)	2,000	0
Two to five years (payable subsequent to 30 June 2013)	54,900	32,000
	56,900	**32,000**
Total current portion of loans	0	0
Total non-current portion of loans	56,900	32,000
Total Loans	**56,900**	**32,000**
Interest rates per annum:	%	%
Crown Health Financing Agency Loan	4.24 - 6.535	4.88 - 6.535
Line of credit restricted access		
Bank loan facilities	6,000	6,000
Used at balance date:	0	0
Unused at Balance Date	**6,000**	**6,000**

Notes to the Financial Statements

For the year ended 30 June 2011

		2011 Actual $'000	2010 Actual $'000
7	**Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities**		
	Net operating surplus	(2,874)	(4,538)
	Add back non-cash items:		
	Depreciation	10,079	8,593
	Increase/(decrease) in employee entitlements	3,136	1,905
	Total Non-cash Items	**13,215**	**10,498**
	Add/(subtract) items classified as investment activity:		
	Net gain/(loss) on sale of property, plant and equipment	9	(376)
	Total Investing Activity	**9**	**(376)**
	Add/(subtract) items classified as financing activity:	784	(914)
		784	**(914)**
	Movements in working capital:		
	Decrease/(increase) in receivables and prepayments	(3,283)	(208)
	(Increase)/decrease in inventories	91	(153)
	(Decrease)/increase in capital charge payable	60	(978)
	Increase/(decrease) in payables and accruals	2,620	(2,149)
	Total Net Working Capital Movement	**(512)**	**(3,488)**
	Net Cash Inflow from Operating Activities	**10,622**	**1,182**

Notes to the Financial Statements

For the year ended 30 June 2011

8 Property, Plant and Equipment

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

	Land	Site Improve-ments	Buildings Services Fitout	Plant & Equip.	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance at 1 July 2009	10,570	1,119	104,639	40,213	98	552	157,191
Additions	2,450	76	6,062	4,185	0	22	12,795
Work in Progress	0	0	10,198	1,451	0	59	11,708
Revaluations	0	0	0	0	0	0	0
Disposals	0	0	(141)	(3,097)	0	(24)	(3,262)
Balance 30 June 2010	**13,020**	**1,195**	**120,758**	**42,752**	**98**	**609**	**178,432**
Balance 1 July 2010	13,020	1,195	120,758	42,752	98	609	178,432
Additions	0	56	9,390	4,163	4	220	13,833
Work in Progress	0	0	30,169	(150)	0	(59)	29,960
Revaluations	0	0	0	0	0	0	0
Disposals	0	(6)	(1,053)	(554)	0	(18)	(1,631)
Impairment provision	0	0	0	(563)	0	0	(563)
Balance 30 June 2011	**13,020**	**1,245**	**159,264**	**45,648**	**102**	**752**	**220,031**
Accumulated depreciation							
Balance at 1 July 2009	0	183	11,616	26,962	98	493	39,352
Depreciation expense	0	68	4,530	2,987	0	17	7,602
Depreciation on disposals	0	0	(39)	(1,479)	0	(24)	(1,542)
Balance 30 June 2010	**0**	**251**	**16,107**	**28,470**	**98**	**486**	**45,412**
Balance at 1 July 2010	0	251	16,107	28,470	98	486	45,412
Depreciation expense	0	70	5,032	3,141	1	24	8,268
Depreciation on disposals	0	0	0	(214)	0	(18)	(232)
Balance 30 June 2011	**0**	**321**	**21,139**	**31,397**	**99**	**492**	**53,448**
Carrying Amounts							
At 30 June 2010	13,020	944	104,651	14,282	0	123	133,020
At 30 June 2011	13,020	924	138,125	14,251	3	260	166,583

Restrictions

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

Valuation

The most recent valuation of land and buildings was performed by independently contracted registered valuer, Matt Snelgrove, BBS, SPINZ, ANZIV of CB Richard Ellis. The valuation is effective as at 30 June 2011.

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

Notes to the Financial Statements

For the year ended 30 June 2011

9 Intangible Assets

Movements for each class of intangible asset are as follows:

	Computer Software $'000
Cost	
Balance 1 July 2009	8,122
Additions	1,529
Work in progress	0
Disposals	(27)
Balance 30 June 2010	**9,624**
Balance 1 July 2010	9,624
Additions	212
Work in Progress	594
Disposals	(172)
Balance 30 June 2011	**10,258**
Accumulated Amortisation	
Balance 1 July 2009	6,268
Amortisation expense	994
Disposals	0
Balance 30 June 2010	**7,262**
Balance 1 July 2010	7,262
Amortisation expense	811
Disposals	(111)
Balance 30 June 2011	**7,962**
Carrying amounts	
At 30 June 2010	2,362
At 30 June 2011	2,296

10 Other Investments

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

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

Notes to the Financial Statements

For the year ended 30 June 2011

11 Trust and Bequest Funds

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

	June 2011 $'000	June 2010 $'000
Opening balance	778	665
Funds received	331	285
Interest received	37	26
Funds disbursed	(244)	(198)
Closing Balance	**902**	**778**

Notes to the Financial Statements

For the year ended 30 June 2011

	June 2011 $'000	June 2010 $'000
12 Statement of Commitments		
Operating lease commitments		
Less than one year	1,578	1,486
One to two years	1,208	961
Two to five years	871	1,285
Over five years	0	0
	3,657	**3,732**
Provider funding commitments		
Less than one year	13,998	22,931
One to two years	9,818	5,668
Two to five years	12,486	0
Over five years	0	0
	36,302	**28,599**
Capital commitments		
Less than one year	18,952	36,598
One to two years	0	17,024
	18,952	**53,622**
Total Commitments	**58,911**	**85,953**

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

Actual costs are as follows:

Health of Older Persons	35,388	35,148
Primary Care	62,323	60,917
	97,711	**96,065**

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

Notes to the Financial Statements

For the year ended 30 June 2011

13 Statement of Contingencies

There are no contingent liabilities as at 30 June 2011 (Nil: 30 June 2010)

There are no contingent assets as at 30 June 2011 (Nil: 30 June 2010).

14 Segmental Reporting

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

Segmental reporting is not applicable.

15. Financial Instruments

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

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

Credit Quality of Financial Assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

Counterparties with credit ratings

	2011 $000	2010 $000
Cash at bank and Term Deposits		
AA	4,122	8,493

Interest Rate Risk

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

Hutt Valley DHB has fixed rate borrowings from the Crown Health Funding Agency and other sources that are used to fund ongoing activities. Hutt Valley DHB policy is to monitor the interest rate exposure with a view to refinancing if appropriate. The interest rates on borrowings as at 30 June 2011 are disclosed in Note 6.

There are no interest rate options or swap agreements in place as at 30 June 2011.

Currency Risk

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

Concentration of Credit Risk

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

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

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

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

Liquidity Risk

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

Notes to the Financial Statements

For the year ended 30 June 2011

market positions. Hutt Valley DHB aims to maintain flexibility in funding by keeping committed credit lines available.

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

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

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

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

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

	Less than 6 months $'000	6 months to 1 year $'000	Greater than 1 year $'000
Financial liabilities measured at amortised cost			
2010			
Creditors & other payables (Note 4)	35,222	0	0
Borrowings (Note 6)	0	0	32,000
2011			
Creditors & other payables (Note 4)	40,743	0	0
Borrowings (Note 6)	0	0	56,900
Loans and Receivables			
2010			
Cash & cash equivalents	8,493	0	0
Debtors & other receivables	12,828	0	0
2011			
Cash & cash equivalents	4,122	0	0
Debtors & other receivables	16,111	0	0

Notes to the Financial Statements

For the year ended 30 June 2011

16 Transactions with Related Parties

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

During the period Hutt Valley DHB received 84.34% (2010: 84.09%) of its revenue from the Government, through the Ministry of Health, to fund and provide health services. The amount outstanding at 30 June 2011 was $4.3 million (2010: $3.2 million).

In conducting its activities, HVDHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. HVDHB is exempt from paying income tax.

HVDHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2011 totalled $1.659 million (2010: $1.522 million). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post.

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

Notes to the Financial Statements

For the year ended 30 June 2011

		June 2011 $'000	June 2010 $'000
Central Region Technical Advisory Services (Note 11)	Purchased	525	399
Provision of services	Received	1	24
	Outstanding at year-end		
	Payable	0	0
	Receivable	0	0
Capital & Coast District Health Board	Purchased	50,322	46,097
Provision of services	Received	28,970	28,365
	Outstanding at year-end		
	Payable	280	45
	Receivable	383	464
District Health Boards New Zealand	Purchased	228	388
Provision of advisory services	Received	0	3
	Outstanding at year-end		
	Payable	0	0
	Receivable	0	0
Provision of goods and services:			
Wellington Regional Council	Purchased	1	2
	Outstanding at year end	0	0
Upper Hutt City Council	Purchased	48	66
	Outstanding at year end	0	0
Standards New Zealand	Purchased	0	17
	Outstanding at year end	0	0
Hutt City Council	Purchased	315	320
	Outstanding at year end	0	0

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

Transactions with other DHBs are conducted at arms-length and on a normal commercial basis.

17 Capital Charge

All DHBs are required to pay a capital charge monthly to the Crown based on the greater of their actual or budgeted closing equity balance for the month. The charge was set at 8% for the financial period (2010: 8%).

18 Post Balance Date Events

There are no significant events subsequent to balance date (2010: Nil)

Notes to the Financial Statements

For the year ended 30 June 2011

19 Major Variations from the Statement of Intent

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

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

Category	Explanation
Cash and cash equivalents/ Receivables and Prepayments	Cash and cash equivalents have decreased during the year as has inventory although accounts receivable and prepayments have risen.
Payables and Accruals	Payables and accruals have increased mainly due to the increase in accrued expenses caused by additional volumes.
Employee entitlements and Provisions	The increase in employee entitlements is due to increased actuarial valuations and also increased year-end annual accruals for annual leave liabilities.

20 Board Members Remuneration 2011

Board Members	Year to 30-Jun-11 Board Fees	Year to 30-Jun-11 Com. Fees	Year to 30-Jun-11 Total fees	Year to 30-Jun-10 Total fees
P Glensor	28,333	5,750	34,083	48,250
S Cole	10,417	3,062	13,479	30,625
K Austin	20,000	5,813	25,813	25,063
P Brosnan	8,333	1,250	9,583	22,250
S Greig	8,333	2,000	10,333	23,000
W.Guppy	22,917	4,000	26,917	24,813
K Hindle	20,000	4,812	24,812	25,063
K Laban	20,000	3,875	23,875	24,500
C Love	10,000	1,950	11,950	20,750
D Ogden	20,000	4,000	24,000	24,250
D Chin	28,750	1,500	30,250	13,167
V Hope	23,333	3,000	26,333	0
D Bassett	11,667	1,250	12,917	0
I Pahau	11,667	750	12,417	0
J Terris	11,667	1,000	12,667	0
P Douglas	11,667	1,750	13,417	0
Total	267,084	45,762	312,846	281,731

Notes to the Financial Statements

For the year ended 30 June 2011

20 Board Members Remuneration 2011 continued...

Co-opted Committee Members	Year to 30-Jun-11 Total fees	Year to 30-Jun-10 Total fees
G Alcorn	1,000	1,750
J Awatere	250	0
M Aukuso	1,000	0
A Bain	100	0
D Craig	100	0
V Dloak	200	0
K Dougall	300	0
N Dunleavy	200	0
W Dunn	500	1,000
L Hawkins	100	0
D Judd	100	0
L Kepa-Henry	3,250	0
K McKenzie	200	0

Co-opted Committee Members	Year to 30-Jun-11 Total fees	Year to 30-Jun-10 Total fees
P McNeil	100	0
S Mohy	500	0
N Nikalls	100	0
J Paton	300	0
P Puketapu	200	0
S Reid	750	1,000
S Shariff	1,500	0
K Stuart	1,750	3,350
M Tunoho	500	1,750
B Turamai	200	0
P Umanga	350	0
I Vaofusi	1,500	2,000
Total	**15,050**	**10,850**

21 Employees Remuneration 2011

Range	Year to 30 June 2011	Year to 30 June 2010	Med/Dent. Year to 30 June 2011
100,000 - 109,999	33	33	9
110,000 - 119,999	16	16	4
120,000 - 129,999	16	11	14
130,000 - 139,999	7	9	6
140,000 - 149,999	10	11	7
150,000 - 159,999	10	16	9
160,000 - 169,999	4	8	4
170,000 - 179,999	10	4	7
180,000 - 189,999	4	6	4
190,000 - 199,999	8	5	8
200,000 - 209,999	8	8	7
210,000 - 219,999	9	8	9
220,000 - 229,999	6	7	6
230,000 - 239,999	3	4	3
240,000 - 249,999	7	5	7
250,000 - 259,999	3	2	3
260,000 - 269,999	3	4	3

Range	Year to 30 June 2011	Year to 30 June 2010	Med/Dent. Year to 30 June 2011
270,000 - 279,999	4	3	4
280,000 - 289,999	2	1	2
290,000 - 299,999	1	4	0
300,000 - 309,999	1	1	1
310,000 - 319,999	0	1	0
320,000 - 329,999	1	1	1
330,000 - 339,999	1	0	1
340,000 - 349,999	0	0	0
350,000 - 359,999	0	1	0
360,000 - 369,999	1	0	1
370,000 - 379,999	1	1	1
430,000 - 439,999	0	1	0
490,000 - 499,999	1	0	1
590,000 - 590,999	0	1	0
610,000 - 619,999	1	0	1
Grand Total	**171**	**172**	**123**

Notes to the Financial Statements

For the year ended 30 June 2011

Key Personnel Remuneration

Key personnel comprise Chief Executive Officer, Chief Financial Officer, Director Planning and Funding, Chief Operating Officer, General Counsel, General Manager Communications, General Manager Human Resources, Chief Medical Officer and Director of Nursing. A total of $1,334,380 (2010: $1,743,786) was paid in short term benefits. Long-term benefits amounted to $17,123 (2010: $16,179). Termination benefits totalled $176,505 (2010: $104,824). Total: $1,528,008 (2010: $1,864,789).

Board members were also paid an annual fee and expenses totalling $312,846 (2010: $281,731); see Note 20.

Employee Benefits

Retirement gratuities, in lieu and special leave and other employment settlement payments of $1,152,261 were paid to 93 staff in the year ended 30 June 2011 (2010: $659,680 to 75 staff).

Good Employer Obligations

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

Employee Management

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

Performance Management

Hutt Valley DHB has fair and equitable performance management systems in place that are supported by policy.

The need to maintain strong relationships with employees and unions are reinforced by the Employment Relations Act and Health and Safety in Employment Amendment Act 2002, and considerable effort is put into these relationships.

Employee Training and Professional Development

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

Health and Safety

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

Productivity

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

Capital Management

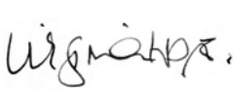
The DHB's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.

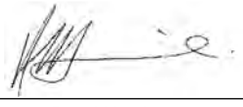
The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

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

Statement of Responsibility

1. The Board and management of Hutt Valley District Health Board accept responsibility for the preparation of the financial statements and statement of service performance and judgements used in them;
2. The Board and management of Hutt Valley District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting; and
3. In the opinion of the Board and Management of Hutt Valley District Health Board, the financial statements and statement of service performance for the year ended 30 June 2011 fairly reflect the financial position and operations of Hutt Valley District Health Board.





Board Member	Board Member	28 October 2011

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report

To the readers of Hutt District Health Board's financial statements and statement of service performance for the year ended 30 June 2011

The Auditor General is the auditor of Hutt District Health Board (the Health Board). The Auditor General has appointed me, Andy Burns, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and statement of service performance of the Health Board on her behalf.

We have audited:

- The financial statements of the Health Board on pages 54 to 84, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies; and
- The statement of objectives and service performance of the Health Board on pages 16 to 53.

Opinion

In our opinion:

- The financial statements of the Health Board on pages 54 to 84:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board's:
    - financial position as at 30 June 2011; and
    - financial performance and cash flows for the year ended on that date; and
- The statement of service performance of the Health Board on pages 16 to 53:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board's service performance for the year ended 30 June 2011, including:
    - its performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
    - its revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 28 October 2011. This is the date at which our opinion is expressed.

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

Basis of opinion

We carried out our audit in accordance with the Auditor General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and statement of service performance that fairly reflect

the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board's financial position, financial performance and cash flows; and
- fairly reflect its service performance achievements.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

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

Responsibilities of the Auditor

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

Independence

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

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

Andy Burns
Audit New Zealand
On behalf of the Auditor-General, Christchurch, New Zealand

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and statement of service performance of Hutt District Health Board (the Health Board) for the year ended 30 June 2011 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 28 October 2011 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.

Hutt Valley DHB Directory

As at 30 June 2011

Head Office

Hutt Valley District Health Board
Private Bag 31-907
Pilmuir House, Pilmuir Street
Lower Hutt
www.huttvalleydhb.org.nz

Bankers

Bank of New Zealand

Auditor

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

Board Members

The Board consists of eleven members, seven elected and four appointed by the Minister of Health including a chair and a deputy chair.
Virginia Hope, Chair
Wayne Guppy, Deputy Chair
Katy Austin
David Bassett
Peter Douglas
Peter Glensor
Keith Hindle
Ken Laban
David Ogden
Iris Pahau
John Terris

Crown Monitor

Debbie Chin

Maori Partnership Board Members

Keriata Stuart, Chair
Shamia Shariff, Deputy Chair
Janis Awatere
Millie Hawiki
Lizzy Kepa-Henry
Catherine Love
Muriel Tunoho

Executive Management Team

Graham Dyer, Chief Executive
Bridget Allan, Director Planning, Funding and Public Health
Stephanie Chapman, Project Manager
Pete Chandler, Chief Operating Officer
Liz Fitzmaurice, Primary Care Liaison
Cheryll Graham, Community Liaison
Peter Gush, Service Manager Public Health
Michele Halford, Acting Director of Nursing
Peter Kennedy, Chief Financial Officer
Siloma Masina, Pacific Health Advisor
Kuini Puketapu, Maori Health Advisor
Russell Simpson, Director of Allied Health
Dr Iwona Stolarek, Chief Medical Advisor
Jill Stringer, Communications Manger
Glen Willoughby, Chief Information Officer