Welcome Mihi

Tihei Mauriora

He honore he kororia ki te Atua

He maungarongo ki te whenua

He whakaaro pai ki nga tangata katoa

E mihi ana tenei ki a Te Atiawa otira ki nga iwi o te motu e noho mai nei i roto i te rohe o Awakairangi ara Te Upoko o te Ika.

Tenei te karanga, te wero, te whakapa atu ki a tatou katoa kia horapa, kia whakakotahi o tatou nei kaha ki te whakatikatika o tatou mauiui. Hei aha Hei oranga mo te tangata

Welcome

All honour and glory to our maker

Let there be peace and tranquillity on Earth

Goodwill to Mankind

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

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

Contents

Highlights in 2011/12

From the Chair and Chief Executive

We are pleased to present the Hutt Valley DHB Annual Report for 2011/2012.

This year Hutt Valley DHB has focused on creating a sustainable and flexible base from which to meet future challenges. We have made major changes to our management structure to embed clinical leadership and align our structure with neighbouring DHBs. We have built on our reputation for innovation, fostering 'whole of health system' thinking and planning. We have worked with Capital and Coast and Wairarapa DHBs in designing and delivering health services to our wider sub-regional population.

Collective Leadership

Our continued commitment to clinical leadership has, through practical application, evolved into mature relationships demonstrating collective leadership. This is now firmly embedded as part of our culture.

A particularly pleasing example of this has been the growing leadership of the Hutt Valley Primary Secondary Strategy Group (PSSG), made up of community and hospital based clinicians. This group strives to break down barriers between primary and secondary health care where they affect patient flows, information flows or patient outcomes. For example, a collective approach between primary care, secondary care and Regional Public Health to better prevent and manage cellulitis has seen a reduction of 385 bed days, the introduction of consistent protocols, and the availability of IV antibiotic therapy at two local practices, rather than returning to the ED for repeat treatment.

The Sub-regional Clinical Leadership Group, hosted monthly at Hutt Valley DHB, has grown to include relevant non-clinical leaders and has initiated a series of service reviews under the '3DHB' programme. These reviews focus on improving the patient experience, improving health outcomes, and making best use of our resources in the sub-region.

Collective leadership and integration are demonstrated at many levels of the organisation. Our executive team includes our lead medical, nursing and allied leaders, as well as the Chief Executive of Te Awakairangi Health, the Hutt Valley Primary Health Organisation (PHO). A significant restructure over the past year has also formalised collective leadership in the 'diamond' of Allied Health, Medical, Nursing and Operations expertise in the shared leadership of the newly created Directorates.

A final example is the consistent representation of Hutt Valley DHB staff in both clinical and non-clinical membership of regional and national groups focused on improving the quality, efficiency and safety of healthcare.

We will continue to invest in our staff, building on the successful Xcelr8 leadership training programme, which is helping staff to find new and innovative ways to continue to improve the services we provide.

Health Targets

Overall we have made good progress towards meeting and exceeding the national health targets this year.

The dedication of our staff was clear in the achievement of the electives target and the 6 month wait-time, with extra clinics arranged, weekend surgery performed and processes and systems examined and updated. Staff commitment has also been shown in their innovative work to improve the journey for patients, like the development of *ubook* - an online system for people to book outpatient appointments at a time that best suits them. *ubook* succeeded in reducing the 'Did Not Attend' from 5% to 0.5% in the 6 services of the initial trial. It has been estimated that *ubook* reduces administration time by at least 6 hours for every 50 patients who

book online. Wider rollout to more areas is now underway, following a successful trial with 6 specialties.

While we have made strong gains on meeting the Emergency Department target for patient waiting times, we still have work to do. The purpose-built design of our new facility, which opened in September 2011, significantly helped us improve our Emergency Department performance and we now need to build on these gains to meet the target.

Meeting the cancer target was achieved through working with Capital and Coast DHB. We made strong gains in our immunisation coverage and now need to step up our efforts to meet the new target for immunisation of 8 month old babies.

Our Smokefree advisor is passionate about educating both staff and patients about their options for quitting - by working with other clinical staff, he has enabled the DHB to achieve the target of providing better help for smokers to quit.

Achieving the target around the risks of cardiovascular disease has proved more elusive. While we have made strong progress against existing targets, the new target will require a change of approach. The DHB is working well with our colleagues in primary care to make rapid gains but this remains an area for improvement.

Working with our neighbours

There is no doubt that the pace and extent of collaborative work is picking up. There are a range of clinically-led projects underway that will improve the experience patients have of health services by removing unnecessary steps, reducing duplication or offering better access and communication.

The Regional Services Plan provides a framework for us to work with our neighbours on areas that will most benefit from a regional approach. The most significant gains to date have been made in the sub-region, among the three lower North Island DHBs (Wairarapa, Hutt Valley and Capital and Coast). We are working to find joined-up clinical approaches between the DHBs, as well as administrative and procedural efficiencies. We will continue to focus on this over the next year.

In these tight economic times working together will be increasingly important. We are committed to keeping our focus on improving the patient experience while managing our resources better.

For example the Sub-regional Clinical Leadership Group has supported clinically-led teams to complete reviews of ENT and Child Health and there are a growing number of other workstreams who will report back over the next year.

Sub-regional initiatives have also included sharing some support functions - for example, Hutt Valley DHB processes payroll functions for Wairarapa DHB and we will continue to look for other ways we can collaborate.

During the year we have participated in a major review of our planning functions with a view to finding a solution that strengthens our ability to think and act sub-regionally.

Work has also progressed to align and share policies between the 3 DHBs to avoid unnecessary duplication and make it easier for the increasing number of staff who move between campuses. A practical example is the pre-employment Health and Safety screening, which no longer has to be repeated by staff who work in more than one DHB.

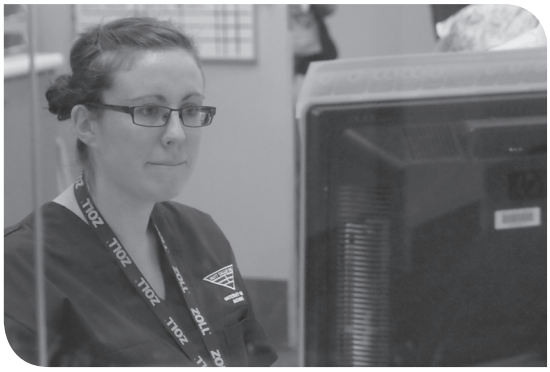
We want to particularly draw note to the work of the paediatric team to bring Starship clinics to Hutt Hospital next year and their initiative to share expertise with their Wellington counterparts around children's renal clinics.

Impressive work has also been done by the Hutt and Wellington respiratory teams, to give patients from across the region access to the same quality of service, at times and places more convenient to the patients. Our physiologist now has 'special staff' status at Wellington Hospital and shares clinics there - as do two Wellington-based physiologists at Hutt Hospital.

These types of collaboration and partnership initiatives will be an area of increasing focus in 2012/13, and will help improve all three DHBs financial position.

Better, sooner, more convenient healthcare

Hutt Valley DHB has a history of working to support primary health, as seen in the initiatives to recruit and retain primary care providers in the Hutt Valley. A major achievement this year was the consolidation of 4 PHOs into a single entity (Te Awakairangi Health). By the end of the financial year the merger of Te Awakairangi Health PHO and its management service organisation, Kowhai Health, was well advanced.



Since the PHOs merged we have built even stronger links with primary care. We have developed clinical pathways, promoted greater integration of hospital and community-provided services and early identification of conditions that lead to otherwise avoidable hospitalisations. Much of this work would not have been possible without the support of the Primary Secondary Strategy Group (PSSG).

The PSSG has sponsored the development of clinical pathways across the primary/secondary continuum, addressing the prevention of conditions which result in avoidable hospitalisation.

Many people were involved in the Cellulitis Project, which created a standard pathway and dovetailed with preventative, educational work undertaken by primary care nurses and Regional Public Health. This produced a saving of 385 bed days, compared with the previous financial year. The cellulitis initiative received recognition in the award of Primary Nurse Innovation funding to support a pilot of Primary Care IV antibiotic therapy.

Another area of collaboration is the radiology clinical criteria trial, where primary and secondary clinicians revised the criteria for access to public funding for community-referred radiology.

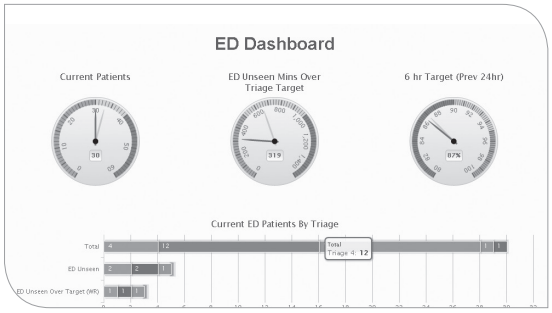
Hospital-based and community-based clinicians have worked together to explore more effective medicine management, with initiatives including medicine synchronisation – where prescriptions are synchronised to end on the same date, reducing the number of patients visits to doctors and pharmacists and supporting a new model of pharmacist care for people with long-term conditions.

Hutt Valley DHB has worked with Te Awakairangi Health to investigate establishing Integrated Family Health Centres and supported services to move to community-based locations, including the physiotherapy clinic at the Pomare medical centre.

Improving our hospital

The completion of our new Theatre and Emergency Department buildings (on time and on budget) has enabled us to make significant process improvements and efficiency gains.

Initiatives like *ubook* and eTree (enabling clinicians to view patient records located on our neighbour's computer systems) have improved quality and safety and saved considerable time and frustration and reduced unnecessary costs.



These and a series of other process improvements to manage patient pathways have enabled us to meet the waiting list target of waiting less than 6 months for elective surgery.

Our IT department has a reputation for innovation, and new systems like the ED Whiteboard enable clinicians to work more efficiently and enable patients to spend less time in the department. We are also trialling electronic patient tracking in the Operating Theatre suite to help us manage our resources more efficiently.

Sustainability

We had an excellent financial result 2011/12 with a breakeven position, thanks to significant effort by all our staff. However, in planning for the 2012/13 year we acknowledge that there is plenty of hard work to be done before we will be able to live within our means and contribute to an improved sub-regional position with our neighbouring Wairarapa and Capital and Coast DHBs.

With ongoing sustainability in mind, we have begun a series of 'Better Healthcare Systems' initiatives, firmly focused on the 'triple aim' of improving the patient journey, improving the health of our population, and making best use of our resources. We also want to achieve a greater understanding of the potential for earthquake damage to our buildings, having completed an initial survey and requested in-depth analysis of our options.

Our ongoing sustainability requires emphasis on increased work with our neighbours coupled with strong clinical leadership and community support, which have always been fundamental to Hutt Valley DHB culture.

Looking ahead

The 2012/13 year will bring major challenges, as we seek to live within our means and further explore sub-regional and regional planning and capacity and service improvements.

Every board and staff member has an active part in designing and implementing changes to meet our triple aim.

We are working closely with neighbouring DHBs in the region to plan consistent service pathways, with a particular focus on joining up clinical approaches and finding efficiencies by minimising duplication. It is increasingly important that health services are seamless and integrated throughout the region and particularly between Wellington, Wairarapa and Hutt Valley DHBs. This sub-regional approach extends beyond clinical to our back office functions, including procurement, shared infrastructural services (including communications centres). It is not just about sharing systems, but about creating coherence by sharing policies.

The 2011/12 year has given us a firm foundation on which to build, and we are confident that our staff will rise to meet the challenges.

We would like to thank the staff of the DHB for their commitment and effort during a year in which we have acquired a better understanding of our sub-regional and regional opportunities, while making an excellent job of managing our local responsibilities. It is this commitment and passion that will help us achieve our vision of 'healthy people, healthy families, healthy communities' both locally, and within our region.

Dr Virginia Hope
Chair
Hutt Valley District Health Board

Graham Dyer
Chief Executive
Hutt Valley District Health Board

Our Key Priorities for 2011/12

Our 2011/14 Statement of Intent set out our key priorities for 2011/12. They were as follows:

1. **Collective leadership**
   Improved collective leadership between clinical and non-clinical staff leading to:
   - Safer, better, higher quality and more sustainable services
   - More effective mechanisms for implementing change
2. **Financial sustainability**
   Greater financial security will help us to invest in new or improved services.
3. **Working with our neighbours**
   Working with our neighbours creates the potential for smarter use of our shared resources and for better service delivery.
4. **Better sooner more convenient (BSMC) primary health care**
   Consolidating PHOs will create an environment more conducive to service integration, and to improving patient experience. Improved primary/secondary integration will lead to better prevention and management of long term conditions, and reduced health inequalities.
5. **Government Priorities and Health Targets (with a focus on ED and Electives)**
   a. Reduced length of stays in EDs, which leads to better clinical outcomes for people using services.
   b. Elective services will be delivered more efficiently across the region, assisting all DHBs within the region to meet targets and expectations.
6. **Improving our Hospital infrastructure and processes**
   Infrastructure: Completing our ED/Theatre redevelopment

   Processes: Improved performance against ED target, improved patient experience, better productivity and efficiency of hospital, and enhanced clinical job satisfaction.

In establishing these priorities we have been guided by the particular health needs of people in the Hutt Valley. We have also chosen priorities which help us to meet Government Policy expectations and Health Targets, as set out below:

Policy priorities

- Improving services and reducing waiting times
- The next steps in the implementation of the Primary Health Care Strategy
- Delivery of agreed financial results
- Strengthened clinical leadership
- Greater regional cooperation
- Creating a more unified health system.

Health Targets

- Shorter stays in emergency departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services (target changed to 'more heart and diabetes checks' on January 1, 2012).

Our local priorities for 2011/12 reflect the Board's commitment to ensuring ongoing sustainability of our services for our community.

Statement of Purpose

Vision Mission and Values

The following vision, mission and values govern the Health Board's 2006-2011 Strategic Plan.

Our Vision

Whanau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities.

Our Mission

Working together for health and well-being

We commit to work cooperatively, as an active part of the health sector and the Hutt Valley community.

Our Values

'Can do' – leading, innovating and acting courageously

Hutt Valley DHB leads the New Zealand health sector. We are committed to quality and innovating to improve the health of our people.

Working together with passion, energy and commitment

We are passionate about our work. We direct our energy to doing the best for our clients and the community.

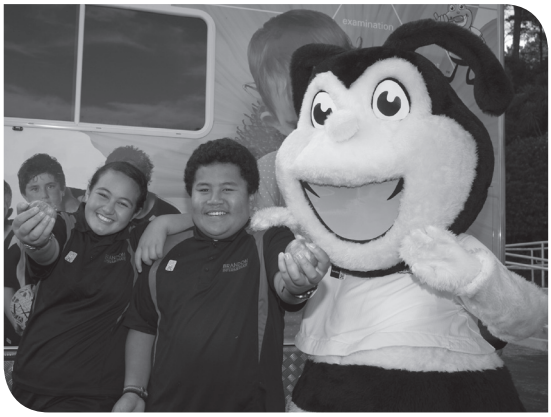
Trust through openness, honesty, respect and integrity

We regard trust as essential to success. The people we serve must have confidence in us. We are open, honest, and respectful. We act with integrity.

Striving for excellence

We aim for excellence, individually and as an organisation. This commitment defines us, the services we provide, the way we work with each other and how we shape our systems.

Hutt Valley DHB Profile



The Hutt Valley District Health Board plans, funds and provides government-funded healthcare and disability support services for 145,000 people in the Hutt Valley. Of these 104,000 people live in Hutt City and 41,000 live in Upper Hutt City.

Around 17% the Hutt Valley population is Maori. 8% are Pacific people. We also have sizeable Asian and refugee populations.

Most Maori and Pacific people live in Hutt City. The Maori and Pacific population is younger than other ethnic groups with around half under 25 years old.

Our annual budget is $448.4 million and the DHB employs over 2,200 staff. Most work in our "provider arm" – at Hutt Hospital or for community or regional health services.

A governance board oversees the DHB. It has seven community-elected members and four members appointed by the Minister of Health (including the Chair) and a Crown Monitor. The Board ensures the DHB will meet our local and national health objectives.

We share our board Chair with Capital and Coast DHB. Our advisory committees also reflect this joint approach: the Community and Public Health Advisory Committee and Disability Services Advisory Committee share members from each DHB.

The DHB commits to:

- Improve, promote and protect the health of communities within the Hutt Valley.
- Reduce health disparities and improve the health of Maori and Pacific people.
- Enable the community to take part in improving healthcare and planning health services changes.
- Ensure anyone who needs health services or disability support gets effective help.
- Supporting people with disabilities to take part in the community.
- Ensure that health services in the Hutt Valley are seamless and coordinated.

To meet the wide range of needs in our community we buy services from health and disability service providers. These include:

- Primary healthcare providers (including general practices and youth health services).
- Maori and Pacific health providers
- Aged residential care and home support services
- Mental health providers
- Pharmacies
- Laboratory and radiology providers
- Local, regional and national hospitals.

Hospital Service Indicators

	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012
Inpatient discharges	17,835	17,687	17,678	17,546	17,568
Day case discharges	9,365	10,114	10,960	10,783	11,649
Total discharges (Inc Newborns)	27,200	27,801	28,638	28,329	29,217
Discharges per day	74.3	76.0	78.2	77.6	80.0
Available bed days	95,526	102,565	102,565	102,565	103,613
Occupied bed days	85,183	81,961	82,115	82,008	83,243
Average occupancy	89.2%	80.0%	80.0%	80.0%	80.0%
Inpatient operations	5,535	5,637	5,936	5,925	5,904
Daypatient operations	2,549	2,642	3,509	3,279	3,250
Total operations (theatre cases)	8,084	8,279	9,445	9,204	9,154
Elective operations	4,136	4,337	4,793	4,658	5,077
Acute operations	3,948	3,942	4,652	4,546	4,077
Total operations (theatre cases)	8,084	8,279	9,445	9,204	9,154
Inpatient Waiting List (total 30 June)	1,312	1,585	1,834	1,783	1,788
Outpatient attendances					
- surgical	43,687	47,461	44,895	46,231	46,171
- medical	22,455	30,779	32,663	34,743	36,517
- paediatric	5,918	9,226	10,763	11,389	11,469
Emergency attendance	39,360	40,356	40,331	42,453	44,173
Births - hospital	2,182	2,208	2,248	2,038	1,953
Radiology examinations	52,833	61,156	61,229	57,265	65,639
Laboratory tests performed	901,154	934,346	967,112	994,722	996,156

Key Measures - Health Targets

For the year ended 30 June 2012

Key Measures - Health Targets

For the year ended 30 June 2012

The DHB has cemented the gains made in elective surgery over recent times. The result for the year for elective discharges was above the target (101.6%). At the same time we were successful in keeping waiting times for patients to 6 months. This means the DHB is providing more timely access to elective services to more patients. Elective surgery is important to New Zealanders as these are essential services to improve quality of life by reducing pain or discomfort and improve independence and well-being. The Minister of Health recognised this achievement with an award for the DHB for outstanding performance.

We have made good progress towards the *Shorter Stays in Emergency Department* Health target. In 2011/12, 91% of the DHB's patients were seen within 6 hours, compared with 86% of patients in 2010/11. During periods in the year, the DHB reached 95%, usually under normal hospital conditions, which demonstrates that meeting the target is very much an achievable goal when patient flow is maintained throughout the hospital. It also underlines the work underway to develop clinically-integrated pathways to reduce avoidable hospital admissions.

The DHB continues to perform well with the secondary care *Better Help for Smokers to Quit* (Hospital) health target and slightly exceeded the increased target this year. A primary care component was introduced in 2011/12. The results are below what the DHB is aiming for and the DHB and Regional Public Health are working with Te Awakairangi Health Network and primary care to prioritise smoking cessation and lift performance.

The DHB did well with immunisation achieving only slightly under the increased target in 2011/12. We were very pleased to reach targets for our Maori and Asian populations. In 2012/13 the target will change to 85 percent of eight-month-olds to have their primary course of immunisations by six weeks, three months and five months before July 2013. The DHB has prepared well for this change.

The DHB exceeded the *Diabetes Annual Review* target, thanks greatly to the efforts of our primary care partners. We achieved just below the Diabetes Management target for the total population but were pleased to reach the target for our Maori and Pacific populations. This is the last time the Ministry will be reporting on diabetes indicators as part of the health target measures. However the DHB will continue this focus with the diabetes care improvement package.

This is the second quarter that we have formally reported on the new target for *More Heart and Diabetes Checks*. This target measures the proportion of enrolled people in PHOs within the eligible population who have had a cardiovascular disease (CVD) risk assessment recorded within the last 5 years. Some issues remain with data collection processes at both the national and local levels as we move to the new target. Significant work has been done in Hutt Valley primary care to ensure that all cardiovascular risk assessments are reported correctly. General Practices are working hard to increase the rate of cardiovascular assessments completed among the target population. We acknowledge that achieving this target has been challenging for the DHB and primary care and the DHB will continue to work closely with Te Awakairangi Heath Network to make progress with the target in 2012/13.

Government Target	Impact or strategic priority (as applicable)	2011/12 Target	Result	2010/11 Result	Output Class
	Health risk is reduced; people are healthy; able to self manage; live longer.	95% (Hospital) 90% (Primary Care)	Hospital: 96.03% Primary Care: 32.04%	N/A	Prevention Services
			Comment: The DHB continues to achieve the hospital target. The primary care target was introduced this year. The result is below what the DHB is aiming for and a programme of work is underway to prioritise and help lift performance in primary care.	N/A. The primary care smoking cessation target was introduced in 2011/12.	
	95% of patients will be assessed, treated and referred/ discharged within 6 hours.	95%	91%	86%	Intensive Assessment and Treatment Services
			Comment: Good progress has been made this year. The DHB saw 91% patients within 6 hours in 2011/12 compared to 86% in 2010/11. The DHB will continue to prioritise progress on this target.		
	95% of two-year-olds are fully immunised by July 2011; and 95% by July 2012.	95% (reported/ assessed by ethnicity)	94%	91%	Prevention Services
			Comment: the DHB, along with its primary care and NGO partners, attained 94% overall. Immunisation is an area where the Hutt Valley historically performs very well and we were pleased to reach equity for our Maori and Asian population groups by achieving coverage of 95% and 96% respectively.		
	Elective Services Standardised Intervention Rate	308 per 10,000 population	354.17 per 10,1000 population	342 per 10,000 population	Intensive Assessment and Treatment Services
			Comment: the DHB also achieved the 2011/12 *Improved Access to Elective Surgery* national target (101.6%).		

Government Target	Impact or strategic priority (as applicable)	2011/12 Target	Result	2010/11 Result	Output Class
More Heart and Diabetes Checks		Diabetes Annual Review (annual check / group of tests): 72%	Diabetes Annual Review (annual check / group of tests): 79%[1] **Comment**: the DHB has, mainly through its primary care partners, exceeded the target for the total population (72%) by 7%. We also made good progress in achieving health equity with performance exceeding target by 4% for our Maori and Pacific populations, and 8% for 'Other'.	74%	Early Detection and Management Services
		Diabetes Management (annual HbA1C test): 75%	Diabetes Management (annual HbA1C test): 73%.[2] **Comment**: we achieved just 2% below the *Diabetes Management* target for the total population, but again made good ground in improving equity by achieving the target for our Maori and Pacific populations	74.11%	
		Cardiovascular disease risk assessment: 60% (reported/ assessed by ethnicity)	CVD risk assessment: 34%[3] **Comment**: there are issues with data collection processes as we transition into the new target, primarily concerning the way the data is collected to provide a DHB result. Significant work underway to ensure that all cardiovascular risk assessments are correctly reported. General Practices are also working hard to increase the rate of cardiovascular assessments completed amongst the target population.	N/A. The CVD risk assessment target was introduced in 2012.	

1,2,3 Source: Te Awakairangi Health Network Trust

Government Target	Impact or strategic priority (as applicable)	2011/12 Target	Result	2010/11 Result	Output Class
	Everyone needing radiation treatment will have this within four weeks.	100%	100% **Comment**: The DHB, mainly through the excellent service provided by Capital and Coast DHB, achieved the 100% target	100%	N/A

Non-health Targets

The DHB's 2011-14 Statement of Intent includes a group of strategic priorities and key performance measures which the DHB has used to establish an operational emphasis. The strategic priorities, action areas and our performance against them are set out in the table below. The broader priorities are included in the *Statement of Objectives and Service Performance*.

The DHB has achieved a lot in this area, with particular success in our work with primary care partners to address diabetes and in our efforts in improving access to our community mental health services and ensuring that a reduced number of people experience a mental health crisis.

We remain concerned about avoidable hospitalisations, with Ambulatory Sensitive Hospitalisation (ASH) rates continuing to be too high. Patients need earlier intervention to prevent unnecessary hospital admissions. A programme of work is underway to bring the intervention forward. We are developing clinical pathways for primary and secondary clinicians, patient resources to help with self-management and recovery, and developing new models of care where it makes sense for our top ASH conditions: cellulitis, childhood gastroenteritis, respiratory, stroke, and dental. The DHB expects to see the results of this work take effect over the next 12 months.

Strategic Intent	Impact	2011/12 Target/impact	Result	2010/11 Result	Output Class
Health protection is enhanced, public trust, confidence and security	Disease outbreaks are controlled	100%	100%	100%	Prevention Services

Strategic Intent	Impact	2011/12 Target/impact	Result	2010/11 Result	Output Class
Health risk is reduced, people are healthy, and live longer	Percentage of infants breastfed at 6 weeks[4]	58%	DHB NGO providers: 87% Plunket (national contract): 58% Combined: 72.5% **Note**: a new Ministry database has enabled the DHB to report on both Plunket DHB NGO provider results. Data is for the 2011 calendar year. DHB NGO numbers are very low (27).	N/A	Prevention Services
	Proportion of people in the population who are obese	<25%	N/A. 2011 Census not held.	N/A. 2011 Census not held.	Prevention Services
Intervention is early; people who are at risk of injury of illness are diagnosed and managed earlier	Breast cancer screening - percentage of eligible population screened every 2 years[5]	70% (reported / assessed by ethnicity)	Total: 15,623 (74.45%) Maori: 1,516 (64.51%) Pacific: 775 (64. 85%) The DHB is pleased to have met the target for the total population. A specific set of actions are underway to raise Maori and Pacific women's screening rates.	Total: 75% Maori: N/A Pacific: N/A	Prevention Services

4 Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy and childhood. The Ministry of Health has identified targets for the proportion of infants exclusively and fully breastfed: 85% at discharge from maternity unit, 74% and above at six weeks; 57% and above at three months; 27% and above at six months.

5 The Ministry of Health sets breast screening coverage target rates based on targets for reduced mortality (breast cancer). For example if 70% of eligible women are screened for breast cancer then we can expect a 30% reduction in mortality amongst the screened population.

<table>
<tr><th>Strategic Intent</th><th>Impact</th><th>2011/12 Target/impact</th><th>Result</th><th>2010/11 Result</th><th>Output Class</th></tr>
<tr><td></td><td>Improved oral health in children – children caries free at 5 years of age[6]</td><td>70% (reported/ assessed by ethnicity)</td><td>Total: 62%

Maori: 54%
Pacific: 41%
Other: 67%

Comment: to help reach this target, the DHB is moving from 100% population enrolment to a targeted approach in 2012/13 for high risk children. Implementation of an Early Engagement Strategy from 1 July 2012 should see significant improvements in the next 3 - 4 years as work to prevent caries developing in children under 5 years old takes affect.</td><td>N/A</td><td>Early Detection and Management Services</td></tr>
<tr><td></td><td>Reduced avoidable hospitalisations – rates of ambulatory sensitive hospitalisations expressed as ratio of observed to expected for each aged group where 100 is benchmark[7]</td><td colspan="3"><table>
<tr><th>Baseline</th><th>Baseline</th><th>2011/12 Result</th><th>2010/11 Result</th></tr>
<tr><td>Children Maori 0-4</td><td>< 140.8</td><td>134</td><td>160.32</td></tr>
<tr><td>Pacific 0-4</td><td><160.2</td><td>163</td><td>136.99</td></tr>
<tr><td>Other 0-4</td><td><155.8</td><td>153</td><td>169.34</td></tr>
<tr><td>Adults Maori 45-64</td><td><103.6</td><td>97</td><td>111.7</td></tr>
<tr><td>Pacific 45-64</td><td><93.9</td><td>90</td><td>103.15</td></tr>
<tr><td>Other 45-64</td><td><107.6</td><td>105</td><td>105.02</td></tr>
<tr><td>Maori 0-74</td><td>< 112</td><td>121</td><td>134.14</td></tr>
<tr><td>Pacific 0-74</td><td>< 112.9</td><td>118</td><td>117.8</td></tr>
<tr><td>Other 0-74</td><td>< 108.29</td><td>111</td><td>116.79</td></tr>
</table>
Comment: Patients need early intervention to prevent unnecessary hospital admissions. A programme of work is underway to bring the intervention forward, addressing our top ASH conditions.</td><td></td></tr>
</table>

6 The number of 'caries free' children at 5 years of age 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 and other child oral health providers are influencing the oral health status of children.

7 Avoidable hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings. Ambulatory sensitive admissions are the largest contributor to avoidable hospitalisations. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors. If there is good access to effective primary health care for all population groups then it is reasonable to expect that there will be lower levels of ambulatory sensitive hospital admissions. This indicator will highlight disparities between different population groups.

<table>
<tr><th>Strategic Intent</th><th>Impact</th><th>2011/12 Target/impact</th><th colspan="2">Result</th><th>2010/11 Result</th><th>Output Class</th></tr>
<tr><td rowspan="2">Access to services is improved; people with early conditions are treated and managed earlier and illness progression is reduced.</td><td>Improved access to mental health services.[8]</td><td colspan="4"><table><tr><th>Baseline</th><th>Baseline</th><th>2011/12 Result</th><th>2010/11 Result</th></tr><tr><td>0-19 Maori</td><td>2.7%</td><td>4.0%</td><td rowspan="4">N/A in the 2010/11 Annual Report</td></tr><tr><td>0-19 Total</td><td>2.55%</td><td>3.5%</td></tr><tr><td>20-64 Maori</td><td>5.3%</td><td>7.6%</td></tr><tr><td>20-64 Total</td><td>3.35%</td><td>4.2%</td></tr></table></td><td rowspan="2">Early Detection and Management Services

Intensive Assessment and Treatment Services</td></tr>
<tr><td>Reduced number of people experiencing a mental health crisis - % of people with crisis prevention plan.[9]</td><td>95%
(reported/ assessed by ethnicity)</td><td>Total: 97%
Maori: 98%
Pacific: 94%

Comment: the DHB continues to make progress having moved from a 2009/10 result of 65% to 92% in 2010/11, and now to 96% in 2011/12. Even more pleasing, we have maintained the excellent improvements for Maori (98%) and Pacific (94%) clients.</td><td>Total: 92%
Maori: n/a in the 2010/11 Annual Report
Pacific: n/a in the 2010/11 Annual Report</td></tr>
</table>

8 The percentage of population accessing mental health services for different ethnic groups and by age group compared to the 3% of the population that are estimated to have severe mental health disorders provides a measure of access and availability of mental health services.

9 All clients with enduring mental illness should have up-to-date crisis prevention/resiliency plans (NMHSS criteria 16.4). Crisis prevention/resiliency planning has been shown to be a key component of service delivery that ensures the medium to longer impacts of a serious mental illness to be minimised. Effective prevention planning can be expected to contribute materially to improved outcomes for clients.

Statement of Objectives & Service Performance

For the year ended 30 June 2012

Statement of Objectives & Service Performance

For the year ended 30 June 2012

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 our service performance. In this section the performance of Hutt Valley DHB for the year ended 30 June 2012 is measured against undertakings made in the our Statement of Intent for 2011/12-2013/14. The Auditor-General has audited this performance report.

Prevention Services

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.

The DHB continues to perform well with the secondary care *Better Help for Smokers to Quit* (Hospital) health target and slightly exceeded this target this year, which was increased to 95%. This was in no small way due to the dedicated and committed effort by our staff to achieve these results. Within the target a specialised identified group in 2012/13 will include progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

The primary care component of the smoking cessation target is new and was introduced this year. The results are below what the DHB is aiming for and a programme of work underway to help Te Awakairangi Health Network primary care prioritise smoking cessation and lift performance. We expect progress over the next 12 months.

The DHB did well with immunisation, achieving only slightly under the increased target in 2011/12. We were very pleased to reach or exceed the target for our Maori and Asian populations. In 2012/13 the target will change to 85 percent of eight-month-olds have their primary course of vaccinations at six weeks, three months and five months on time by July 2013. The DHB is well prepared for this change.

The smoking cessation and immunisation targets are important population health areas. The conditions associated with smoking and childhood diseases are both significant health issues for individuals and their families, but they also impose significant avoidable costs on our health system.

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.[10] The Government has set a health target of 95% of hospitalised smokers are provided with advice and help to quit. It has also introduced a new target of 90% of enrolled patients who smoke and are seen in General Practice are provided with advice and help to quit.

10 Ministry of Health DHB Performance Monitoring Framework 2010/11

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>Hospital
95%</td><td>96.03%</td><td rowspan="3">Intended impact:
The reduced number of smokers in the population reduce health risk of cancer and heart disease.

Impact Result:
Change in percentage of Smokers in Population. Results not available as the 2011 Census not held.

Baseline (male/female):[11]
Maori: 37% 42%
Pacific: 31% 20%
Other: 18% 16%
Asian: 15% 4%</td></tr>
<tr><td>General Practice
90%</td><td>32.04%</td></tr>
<tr><td colspan="2">Comment: the DHB is pleased to have exceeded the new hospital target of 95% by July 2012. The primary care target was introduced this year, and the results are below what the DHB is aiming for. A significant cause was the restructuring of the four PHOs and support agencies resulting in a limited capacity to prioritise the new target. The DHB and Regional Public Health and Te Awakairangi Health Network are working with primary care to lift performance including establishment of a primary / secondary collective leadership group, roll-out of ABC training to health professionals in primary care, development of tools for General Practice to identify patient smoking status, development of personalised ‘QuitCards’ for general practices to make life easier for health professionals, and community education activities to promote smoking cessation. The DHB expects to see progress made over the coming months.</td></tr>
</table>

Number of education and training sessions provided

Public health leadership input into working groups included (but was 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 reintegration, family violence, built environment, and illicit drugs. (Hutt Valley, Capital and Coast, and Wairarapa DHB populations).

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>Number of education sessions: 855</td><td>929</td><td rowspan="3">Intended impact:
Reduced number of smokers in the population reduces health risk of cancer and heart disease. Increased breastfeeding rates to support health development and reduces risk factors (e.g. obesity).

Impact Result:
See above regarding smoking rates.

Breastfeeding rates increase (6 weeks)
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>58%</td><td>72.5%</td></tr></table>DHB NGO providers: 87%
Plunket: 58%
Combined: 72.5%

Comment: a new Ministry database has enabled the DHB to report on both Plunket and DHB NGO provider results. Data is for the 2011 calendar year. DHB NGO numbers are very few (27). Plunket services are provided through a nationally-held contract by the Ministry of Health.</td></tr>
<tr><td>Number of working groups: 64</td><td>71</td></tr>
<tr><td colspan="2"></td></tr>
</table>

11 2006/07 15+ years of age daily, standardised per 100000

	Breast feeding rates increase (6 months) **Baseline** 36% **Result** 24%	**Comment:** as above **DHB NGO providers:** 45% **Plunket :** 24% **Combined:** 24%

Number of schools and early childhood services receiving health promotion visits

(Hutt Valley and Capital and Coast DHB populations only)

Target	2011/12	Intended impact and impact results
138	142	**Intended impact**: Health risk reduced by increased education. Education is assumed to contribute to increase awareness, and awareness is assumed to contributed to increasing the likelihood of healthy lifestyle choices. **Impact Result**: No measure developed yet. It is assumed that health promotion impacts awareness and decision-making around health issues. See above regarding the smoking target for proxy measure.

Number of opportunities taken to provide strategic public health input and expert advice to inform policy and public health programming including (but not limited to): Housing; Tobacco; Urban environment; Alcohol; Transport; Physical Activity; Nutrition; and Mental Health (Hutt Valley, Capital and Coast, and Wairarapa DHB populations)

Target	2011/12	Intended impact and impact results
73	39	**Intended impact**: Health protection is enhanced, health risk is reduced through policy and decision-making processes are informed about health perspectives, reducing risk that negative health impacts will flow from decisions and polices. **Impact Result**: No measure developed yet. However the DHB has received positive feedback from stakeholders about the quality and comprehensiveness of submissions and there are examples of impacts on decisions, eg liquor license not given to a specific outlet. See above regarding smoking rates as a proxy impact result.
Comment: this includes preparing submissions, which is demand-driven based on local government consultation requirements, as well as engagement with policymakers in other agencies.		

Population-based screening programmes

Provided by Regional Screening Services based at Hutt Valley DHB to Capital and 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.[12]

Number of women screened for breast cancer (Hutt Valley, Capital and 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%. 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.[13]

Target (For 24 months from 01/07/10 to 30/06/12)	2011/12	Intended impact and impact results
All: 12,663 (70%) **Maori**: 1,645 (70%) **Pacific**: 837 (70%) Target population is 45-69 year olds	15,623 (74.45%) 1,516 (64.51%) 775 (64.85%)	**Intended impact**: Health risk is reduced; people live longer, they are healthier and more able to live independently. Reduced impact and mortality from breast cancer due to early detection. **Impact Result**: Incidence of breast cancer reduces (regionally or nationally)[14] Breast cancer registration baseline: 510

Number of Registrations					
Year	**2005**	**2006**	**2007**	**2008**	**2009**
Capital and Coast	160	179	163	188	204
Hutt Valley	91	82	92	80	111
Wairarapa	29	36	28	41	28
Grand Total	280	297	283	309	343

Comment: the DHB is pleased to have achieved the target for the total population. We did not reach the target for Maori and Pacific women and are working to identify and raise awareness of the importance of breast screening with these population groups. A specific set of actions are underway:

- screening and ensure access across the region
- data matching with primary care
- activation of the regional coordination group to ensure closer collaboration with DHBs and Maori and Pacific providers
- progressing the digital mammography project to future proof the service.

Comment:
The DHB's regional BreastScreen Aotearoa service also provides for Capital and Coast DHB and Wairarapa DHBs as below:

Capital and Coast DHB			
Ethnicity	Age	Target	Actual
All	45-69	70%	66.87%
Maori	45-69	70%	58.55%
Pacific	45-69	70%	59.15%

Wairarapa DHB			
Ethnicity	**Age**	**Target**	**Actual**
All	45-69	70%	74.74%
Maori	45-69	70%	74.73%
Pacific	45-69	70%	70.00%

12 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.
13 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.
14 This information will not be collected by the DHB, and utilising this measure is dependant on a national or regional organisation or grouping confirming collection and availability of data.

Well Child, School Health Services

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

School and pre-school health services are 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 and 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, young people to maximise their physical, mental and emotional health potential, thereby establishing a strong foundation for ongoing healthy development.[15]

The B4 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.[16]

Number of School Health visits by school health nurses

Target	2011/12	Intended impact and impact results
Hutt Valley DHB: 1,632 **CCDHB**: 3,363	**Hutt Valley DHB**: 733 **CCDHB**: 1,154	**Intended impact**: Early detection and treatment of health and development issues will impact on a child's learning. Intervention is early - reduced avoidable hospitalisations, as earlier identification and treatment of issues will reduce acute attendances. **Impact Result**: Reduced ambulatory sensitive (avoidable) hospitalisations (ASH rate), as earlier identification and treatment of issues will reduce acute attendances.
Comment: The health service focus and school nurse visit delivery model has changed. The B4 School check has replaced the New Entrant School Check which has altered the intervention pattern. Single schools health nurse visits have been replaced by a delivery model of working intensively with high need schools and providing follow up with individual families.		

Baseline	Result
Maori 0 - 4: < 140.8	134
Pacific 0 - 4: < 160.2	163
Other 0 - 4: < 155.8	153
Maori 45 - 64: < 103.6	97
Pacific 45 - 64: < 93.9	90
Other 45 - 64: < 107.6	105
Maori 0 - 74: < 112.9	121
Pacific 0 - 74: < 112.9	118
Other 0 - 74 : < 108.29	111

Comment: Patients need earlier intervention to prevent unnecessary hospital admissions. The four top conditions affecting children aged 0-4 years have been identified: respiratory, dental, gastroenteritis, and skin conditions. DHB and Regional Public Health are collaborating to develop primary and secondary care clinical pathways, patient / parent resources and new models of care where it makes sense. The DHB hopes to see sustained improvement over the next 12 months.

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

Number of Before School Checks (Hutt Valley DHB population only)

Target	2011/12	Intended impact and impact results
1,754 (high needs = 388)	1,761 (high needs = 406)	**Intended impact**: As above. **Impact Result**: Greater contact with health professionals at any early age allows issues to be identified and treated earlier. See above regarding ASH rates as the proxy measure.
Comment: the DHB is pleased to continue to meet this target.		

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

Number of communicable disease notifications investigated Including but not limited to tuberculosis, meningococcal disease, vaccine-preventable and enteric illness (Hutt Valley, Capital and Coast, and Wairarapa DHB populations)

Target	2011/12	Intended impact and impact results
2,530	2,929	**Intended impact**: Health protection is enhanced; Disease outbreaks are controlled through investigations, which provides opportunity to control outbreaks. **Impact Result**: Qualitative reporting on issues Healthier Communities identified and severity of outbreaks (see below). **Comment**: There were 60 outbreaks in a variety of settings in 2011/2012, compared with 78 outbreaks in the previous year. There were 826 Pertussis notifications (suspect, probable or confirmed cases) in the last 12 months compared to 125 in 2010/11. Pertussis notifications significantly increased from October 2011 and peaked in November 2011. Numbers continue to be high across the Wellington region. There is a spectrum of illness from classical severe whooping cough to mild symptoms, particularly in partial or fully vaccinated people. This contributes to difficulty in diagnosing mild cases. The number of notified cases is an under estimate of the true extent of Pertussis in the community. A significant number of measles notifications were received. The first case of confirmed measles in the greater Wellington region was notified on 28 September 2011. Since that date there have been 15 confirmed cases in the region. Thirteen of these cases had a history of either a trip to Auckland or contact with a confirmed measles case from Auckland. Effective and timely case and contact follow up by the Public Health Nurses ensured measles did not circulate in the Wellington region. There have been no confirmed measles cases since 20 January 2012.
Comment: In this twelve month period we investigated a total of 2,679 suspect, probable and confirmed disease notifications. An additional 250 disease notifications were denotifed post public health follow-up.		

Number of environmental health investigations

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

Target	2011/12	Intended impact and impact results
1,281	824	**Intended impact**: As above. **Impact Result**: As above regarding qualitative reporting on issues Healthier Communities identified and severity of outbreaks. Health protection has been enhanced through investigation and control of infectious diseases.
Comment: The level of work is demand-driven. There have been no notifications not investigated.		

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

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

Target	2011/12	Intended impact and impact results
35 (controlled purchase operations)	21 (covering 284 operations)	**Intended impact**: Health risk is reduced; reduced illegal supply of tobacco; and alcohol health protection is enhanced. **Impact Result**: No measure developed yet. 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.
Comment: this measure will be updated in 2012/13 to reflect the way we capture data on Control Purchase Operations [CPOs]. We report the number of premises visited as part of a control purchase operation. Each "operation" could include several premises. This gives a more accurate reflection of the level of work and regulation being undertaken. The 21 COPs covered 284 premises. Of these, some 256 were visits to alcohol premises and 28 were to tobacco retailer premises.		

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.[17]

17 Ministry of Health DHB Performance Monitoring Framework 2010/11

% of 2 year old children fully vaccinated (Hutt Valley DHB population only) – *health target*

Target	2011/12	Intended impact and impact results
95%	94%	**Intended impact**: Health risk is reduced; intervention is early - reduced incidence of vaccine preventable diseases among children and older adults. **Impact Result**: Reduced or static notifiable disease rates (MMP) vaccine preventable.
Comment: taking into account the combined opt-off decline rate of 3.1% and coverage of 94% it suggests that nearly everyone in the community (97%) has considered immunising. Immunisation is an area where the Hutt Valley historically performs very well and we were pleased to reach equity for our Maori and Asian population groups by achieving coverage of 95% and 96% respectively. The DHB and our primary care and NGO partners are working hard to promote and educate parents about vaccination to help reduce the number of parents who decline vaccination, and to maintain and improve our results for Maori and Pacific.		

Baseline cases: 17	Result
Meningococcal Disease > 5	12
Mumps > 5	3
Pertussis: 53	826

Comment: There was an outbreak of Pertussis in 2011/12. Notifications significantly increased from October 2011 and peaked in November 2011. Numbers continue to be high across the Wellington region.

Number of Year 7 children (cohort) vaccinated in Schools (Hutt Valley and Capital and Coast DHB populations only)[18]

Target	2011/12	Intended impact and impact results
HVDHB 1,985	2,397	**Intended impact**: As above. **Impact Result**: As above.
Comment: this is a pleasing result.		

Number of over 65 years flu vaccinated[19] (Hutt Valley population)

Target	2011/12	Intended impact and impact results
Total: 14,154 High needs: 2,497 Other: 11,656	Total: 9,574 High needs: 2,218 Other: 7,356	**Intended impact**: Health risk is reduced; Percentage of target population immunised **Impact Result**: Reduced hospital admissions for respiratory conditions of people 65+
Comment: The target was not achieved due to forecasts including an allowance for a high demand based on previous years H1N1 concerns. This did not eventuate as expected.		**Comment**: there was an increase in ED and Medical and Assessment Planning patients where respiratory admissions went from 15 in 2010/11 to 50 in 2011/12.

Baseline cases	Result
171 cases	198

18 Measured on a calendar year basis
19 Measured on a calendar year basis

Number of HPV vaccinated 12 year old girls (Hutt Valley and Capital and Coast School Health Service)[20]

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>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>764</td><td>419</td><td rowspan="2">Intended impact:
As above.

Impact Result:
Incidence of cervical cancer reduces (regionally or nationally).[21]
<table><tr><th>Baseline cases</th><th>Result</th></tr><tr><td>The rate of cervical abnormalities will only become clear over time and at a national level.</td><td>N/A</td></tr></table></td></tr>
<tr><td colspan="2">Comment: note that 2011/12 covers two cohorts: 419 girls have received all three doses (HV only) and 1551 total doses were administered.
In terms of the variance between the target and result, 56 girls were absent, 27 were referred to their GP, 8 left school, 5 refused vaccination and 1 withdrew consent. All girls who were absent had left their schools or refused the vaccination were also referred back to their GP to complete the programme.</td></tr>
</table>

Early Detection and Management Services Output Class

Primary Health Care

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, mainly through its primary care partners, exceeded the *Diabetes Annual Review* target. We achieved just below the *Diabetes Management* target for the total population but were pleased to reach it for our Maori and Pacific populations. This is the final time the Ministry will be reporting on diabetes indicators as part of the health target measures, however the Ministry will continue to monitor performance through the measures in the 2012/13 DHB monitoring framework. The DHB will continue to maintain a focus through the Diabetes Care Improvement package.

This is the second quarter that the new target, *More Heart And Diabetes Checks*, has been formally reported. This target measures the proportion of enrolled people in the PHOs within the eligible population who have had a cardiovascular disease (CVD) risk assessment recorded within the last five years. The new target is that 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years, to be achieved in stages by 1 July 2014. The first stage is to achieve 60 percent by July 2012, and 75 percent by July 2013. The DHB achieved a final result of 34% in 2011/12, up 6% over the last quarter. Data for this target is sourced from the PHO Performance Programme and PHO enrolment registers. At a national level there remain some issues with data collection processes as DHBs transition into the new target, primarily concerning the way PHO data is collated and mapped to a DHB result. Consequently the Ministry acknowledges the results are provisional. We have also had data issues at a local level with the way cardiovascular risk assessment data is recorded. Significant work has been undertaken in Hutt Valley primary care to ensure that all cardiovascular risk assessments are correctly

20 Measured on a calendar year basis

21 This information will not be collected by the DHB and utilising this measure is dependant on a national or regional organisation or grouping confirming collection and availability of data.

reported. General Practices are also working hard to increase the rate of cardiovascular assessments completed amongst the target population. We acknowledge achieving this target is challenging for the DHB and primary care and the DHB will continue to closely with Te Awakairangi Heath Network to make progress with the target in 2012/13.

We remain concerned about avoidable hospitalisations, with the rates of Ambulatory Sensitive Hospitalisation (ASH) being too high. Patients need earlier intervention to prevent unnecessary hospital admissions. A programme of work is underway to bring the intervention forward. We are developing clinical pathways for primary and secondary clinicians, patient resources to help with self-management and recovery, and developing new models of care where it makes sense for our top ASH conditions: cellulitis, childhood gastroenteritis, respiratory, stroke, and dental. The DHB expects to see the results of this work take effect over the next 12 months and onwards.

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 preventive services, including health education, counselling, 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 establishing PHOs, set a new direction and vision for primary health care services in New Zealand.[22] Primary Health Care Services are subsidised via a national contract between DHBs and PHOs based on the number of people enrolled.

Number of Hutt Valley people enrolled with a Primary Healthcare Organisation (PHO)

Primary Health Care Services are subsidised via a national contract between DHBs and PHOs based on the number of people enrolled.

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>136,165</td><td>140,400</td><td rowspan="2">Intended impact:
Intervention is early, Access to services is improved, Services are better integrated:
• Early detection and reduced impact of disease.
• Better management of long term conditions in the community.
• Reducing growth in demand for acute medical services.

Impact Result:
Reduced ASH rate as above.

Reduced rate of non-admitted triage 4 and 5 Emergency Department self-presentations
<table><tr><th>Baseline cases</th><th>Result</th></tr><tr><td>39%</td><td>40%</td></tr></table>
Comment: it is too early to assess the impact of changes to the ED and formation of the PHO. The new policy of free after hours for under 6's may have an impact in future years. The DHB will continue to monitor.</td></tr>
<tr><td colspan="2">Comment: This is a pleasing result as at June 2012, 97% (140,400) Hutt residents were enrolled in a PHO. Some 78% are enrolled in Te Awakairangi Health Network and 13% are enrolled with Cosine Primary Health Network. Some 6% are enrolled with Capital and Coast PHOs other than Cosine Primary Health Network.
99.98% of Hutt Valley residents are enrolled with either Te Awakairangi Health or one of Capital and Coast DHB's PHOs. Only 303 people are enrolled elsewhere.
Currently we estimate that there are 4,340 people that are not enrolled in any PHO.</td></tr>
</table>

22 Ministry of Health http://www.moh.govt.nz/primaryhealthcare

Primary and community care programmes

Provided by Hutt Hospital, Primary Care, and NGOs. Includes CarePlus, Health Promotion, Services to Improve Access, Diabetes Annual Review, Cardiovascular Disease 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 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 (see above)

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>23,002</td><td>28,803</td><td rowspan="2">Intended impact:
Early detection and reduced impact of disease; intervention is early, access to services is improved:
• Better management of long term conditions in the community.
• Reducing growth in demand for acute and planned medical services.

Impact Result: ASH rates as above.
Proportion of people who have satisfactory or better diabetes management (defined as having an HbA1c of equal to or less than 8%) at the time of their free annual diabetes check). This is also a national health target.
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>75%[23]</td><td>73%</td></tr></table></td></tr>
<tr><td colspan="2">Comment: A greater number of patients received a CVD Risk assessment than expected. More patients also accessed cardiac services.</td></tr>
</table>

23 Q2 2010/11

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td></td><td></td><td>Diabetes management target by ethnicity
<table>
<tr><th>Ethnicity</th><th>2011/12 Target</th><th>Result</th></tr>
<tr><td>Maori</td><td>66%</td><td>60%</td></tr>
<tr><td>Pacific</td><td>53%</td><td>54%</td></tr>
<tr><td>Other</td><td>82%</td><td>77%</td></tr>
<tr><td>Total</td><td>75%</td><td>73%</td></tr>
</table>
Comment: The data shows that for the 2011/12 year we have not achieved the target for the total population or for “Other” and Maori. However, we are pleased to report that we have achieved 1% above the target for Pacific people.</td></tr>
</table>

Number of people enrolled in Care Plus

Care Plus is a primary health care initiative targeting people with high health needs 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	2011/12	Intended impact and impact results
3,024	3,502	**Intended impact**: As above **Impact Result**: N/A

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.

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>4,639</td><td>4,655</td><td>Intended impact: As above

Diabetes “free annual check” Target by ethnicity
<table>
<tr><th>Ethnicity</th><th>2011/12 Target</th><th>Result</th></tr>
<tr><td>Maori</td><td>65%</td><td>69%</td></tr>
<tr><td>Pacific</td><td>64%</td><td>65%</td></tr>
<tr><td>Other</td><td>75%</td><td>87%</td></tr>
<tr><td>Total</td><td>72%</td><td>79%</td></tr>
</table>
Comment: The data shows that for the 2011/2012 year we have achieved 7% above the target for the total Population. We have achieved above target for all ethnicities, in particular 4% above the target for Maori and 12% above the target for “Other”.</td></tr>
</table>

Note: The Diabetes Annual Review target printed in the 2011/12 Annual Plan was incorrect. The correct target agreed by Hutt Valley District Health Board and the Ministry of Health is in the table above.

The incorrect targets published in the 2011/12 Annual Plan are below.

Ethnicity	2011/12 Target	Result
Maori	67.4%	69%
Pacific	65.2%	65%
Other	77%	87%
Total	74%	79%

Percentage of CVD risk assessments undertaken

This is the percentage of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years.

Target	2011/12	Intended impact and impact results
60%	34.2%	**Intended impact**: As above **Intended result**: N/A

Comment: The result for quarter four indicates that 34.2% of the eligible enrolled population have received a CVD risk assessment. This is an increase of 6.3% from last quarter (2,227 actuals).

During the last quarter of 2012 quarter Te Awakairangi Health identified a number of issues with the way in which Cardiovascular Risk screening was recorded. As a consequence, significant work has been undertaken to identify the CV risk screening terms used in General Practice and ensuring that all CV risk assessments are correctly reported. This work also identified a number of patients who had been screened in Predict but had not had their results reported in Medtech. The cause of this error has since been fixed and the patient records are in the process of being updated. Further work is continuing on improving the data records.

Also, in May 2012 Valley PHO identified that approximately 1700 patients had known Cardiovascular Disease but had not yet had a CVD Risk Assessment. According to the Primary Care Guidelines Handbook 2012 the cardiovascular risk rating for these patients will always be "clinically high risk". The Clinical Governance Committee therefore agreed that these patients would be identified as clinically high risk and the CV risk screening code would be entered automatically in MedTech for these patients with the risk percentage noted as clinically high. This work was completed in June 2012. A follow up process is underway with the CV risk Programme Manager working with practices to ensure that all clinically high risk Patients are having their heart health regularly monitored by their general practice.

% of CVD risk assessment by ethnicity

Ethnicity	New 2011/12 Target	Result (Jan - June 2012)
Maori	60%	41.7%
Pacific	60%	47.9%
Other	60%	31.0%
Total	60%	34.2%

Note: the Ministry of Health revised CVD target during 2011/12 so that from January 2012 the intervention measured changed. The former measures are above. The new measure is the number of people in the eligible population who have had CVD risk assessment in primary care recorded in the last 5 years / the number of people in the eligible population.

Target 2011/12	Intended impact and impact results
Comment: At the same time, practices are working hard to increase the rate of cardiovascular assessments completed amongst the target population, resulting in 749 risk assessments being recorded in the Predict database over this quarter. One practice ran very successful heart check clinics after hours targeted at their high needs population, which resulted in a number of hard to reach patients being CV risk assessed. We acknowledge achieving this target is very challenging for the DHB and primary care and we will keep working closely with Te Awakairangi Heath Network to make progress in this area in 2012/13.	

Pharmacy 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 that: 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; ensures people's safety.[24]

Number of dispensed items

Target	2011/12	Intended impact and impact results
2,308,000	2,289,068	**Intended impact**: Access to services is improved, (people's conditions are managed better with hospital attendances reduced) as people receive a wider range and volume of pharmaceuticals, better meeting their health needs. **Impact Result**: See ASH rates above.
Comment: The volume of dispensed items is demand-driven, based on prescribing of health professionals.		

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 and Coast DHB population. 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.[25]

24 Nationwide Service Framework; Service Specifications; Community Pharmacy Services, Ministry of Health 2010/11
25 Nationwide Service Framework; Service Specifications; Community Laboratory Services, Ministry of Health 2010/11

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.[26]

Number of laboratory tests

Target	2011/12	Intended impact and impact results
2,121, 815	2,167,000	**Intended impact**: Intervention is early, as improved access to diagnostics allows earlier identification of issues. **Intended result**: See ASH rates above.
Comment: the number of laboratory tests is demand-driven, based on referrals by health professionals.		

Number of radiological examinations

Target	2011/12	Intended impact and impact results
10,660	9,646	**Intended impact**: Access to services is improved, (people's conditions are managed earlier and better with hospital attendances reduced). **Intended result**: See ASH rates above.
Comment: the reduction is due to the January to June 2012 period being the initial phase of a project to improve access where clinically appropriate.		

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.[27] Note that these services are regional and include services provided to non-Hutt Valley residents.

26 Nationwide Service Framework; Service Specifications; Community Radiology Services, Ministry of Health 2010/11

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

Total number of community mental health clients seen[28]

Target	2011/12	Intended impact and impact results
4,421	4,879	**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. **Intended result**: Reduced rate of ED self-presentations for mental health issues.
Comment: the results include Te Waireka, a new youth Alcohol and Drug residential rehabilitation service, and Unique Alcohol and Other Drug beds, which were not included in baseline figures.		

Baseline	Result
2%	1.8%

Total number of occupied bed days

Target	2011/12	Intended impact and impact results
13,851	16,695	**Intended impact**: See above
Comment: as above		**Intended impact result**: See above

Oral Health Services

Oral Health Services include services provided by Hutt Hospital, based at Hutt Valley DHB to Capital and 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 and Coast DHB populations)[29]

Target	2011/12	Intended impact and impact results
64,416	55,048	**Intended impact**: Intervention is early, as improved access allows earlier identification of issue access to services is improved, (people's conditions are managed better with hospital attendances reduced). Children are proactively managed so they do not develop caries. Early caries among children and adolescents is stopped before damage to teeth occurs.[30] **Impact result**: Increased percentage of children caries free at age 5.
Comment: This target was always seen as ambitious. We have worked closely with the Ministry of Health to define the target cohort for pre-school children. We will be moving from 100% population enrolment to a targeted approach in 2012/13 for those children at risk. Implementation of an Early Engagement strategy from 1 July 2012 should see significant improvements in the next 3-4 years.		

Baseline	Result
58.27%[31]	62%

28 Clients see 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

29 Measured on a calendar year basis

30 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.

31 2010 calendar year

Target	2011/12	Intended impact and impact results
Comment: From 1 July 2012 we will be implementing an 'opt-out' enrolment in the Bee Healthy Regional Dental Service. Through our DHB patient management system we can identify and enroll every child under 5 years up to and including new births daily. Families will be contacted and given an opportunity to 'opt-out' of the service. Special focus will be applied to Maori, Pacific and lower socioeconomic children and also introducing an 18 month recall for the lowest risk children.		**Impact result**: Oral Health DMFT Score at year 8 **Baseline**: 0.93[32] **Result**: 0.8 Reduced Avoidable Hospital Admissions rate (dental) **Baseline**: 140.0[33] **Result**: 119.6

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

Target	2011/12	Intended impact and impact results
59,343	42,462	**Intended impact**: See above.
Comment: during 2011 a large number of staff transitioned to the new hub clinics. The change in work practices and the required on-going training with new equipment meant a large drop in numbers of examined children. We expect this to return to normal volumes for the 2012 year.		**Impact result**: See above.

Number of adolescents examined (Hutt Valley DHB population)[34]

Target	2011/12	Intended impact and impact results
7,136 (75% of 9,515 cohort)	6,399 (67.3% of 9,515 cohort)	**Intended impact**: See above.
Comment: although we did not achieve the target of 75% it was pleasing to see an improvement on the 59% achieved in 2010. An additional 786 Hutt Valley adolescents utilised dental services in 2011.		**Impact result**: See above.

Intensive Assessment and Treatment Services Output Class

This section outlines the Intensive Assessment and Treatment Services we intend to deliver to our population. Some of these services are provided directly by the Hutt Valley DHB while others are funded through contracts with NGOs (in particular some Mental Health services). The outputs are aggregated into Mental Health Services, Elective Services, Acute Services, Maternity Services, and Assessment, Treatment and Rehabilitation Services.

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

32 2010 calendar year

33 Hutt Valley DHB ASH data for 12 months to March 2011

34 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)

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

Our hospital has performed well in 2011/12, 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.

Good progress towards the *Shorter Stays in ED* health target has been made. In 2011/12, 91% of the DHB's patients were seen within 6 hours in 2011/12, compared with 88% of patients in 2010/11. During certain periods in the year, the DHB reached 95%, usually under normal hospital conditions, which demonstrates that meeting the target is very much as achievable goal when patient flow throughout the hospital is maintained. It also underlines the work underway to develop clinically integrated pathways to reduce avoidable hospital admissions. We will continue to prioritise the *Shorter Stays* target in 2012/13.

Mental Health Services

Mental Health includes services provided at Hutt Hospital and in the community, including by contracted providers. It also includes 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 3% 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.[35] 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, provided in the least restrictive environment.[36]

35 Nationwide Service Framework; Service Specifications; Mental Health and Addiction Specialist Services Tier One Service Specification Ministry of Health 2010/11
36 Ministry of Health Performance Monitoring Framework, 2010/11

Total number of clients seen[37]

Target	2011/12	Intended impact and impact results
2,308	2,977	**Intended impact**: Improved access to services (people are managed earlier and better) • Reduce the impact of crisis or acute episodes of unwellness. • Fewer people remain in a specialist mental health service for long periods and have better mental and physical health outcomes. **Intended impact result**: Reduced readmission rates to adult inpatient mental health services. **Baseline**: 21%[38] **Result**: 13% **Comment**: focus on setting up clients appropriately for discharge through medication management and a focus on family support and longer term living arrangements have resulted in lower readmission rates. The Transition/liaison team works closely with clients on ensuring a smooth transition from inpatient to community care. **Reduced average length of stay for inpatient mental health services** **Baseline**: 13.4 days **Result**: 16.9 days **Comment:** an increase in acute presentations and better preparation for clients discharging back into the community has impacted on our length of stay. Planning is underway to introduce a Home Based Treatment team in the 2012/13 year that will help reduce ALOS in the coming year. **No more than 30 days waiting time for alcohol and drug services** **Baseline**: <30 **Result**: The DHB does not collect this data
Comment: There has been a substantial increase in the number of clients seen by our Crisis, Assessment and Treatment team over the past year. Better monitoring and follow up combined with a more responsive service has resulted in this increase in volumes.		

Total number of occupied bed days

Target	2011/12	Intended impact and impact results
6,935	8,894	**Intended impact**: As above **Impact result**: As above
Comment: pressure on our inpatient unit demonstrated by the increase in occupied beds has been of concern in the past year. The traditional peaks and troughs have not occurred, however a focus on getting the client well by keeping them in slightly longer on average than previously has impacted on this measure, ALOS and readmission rates.		

37 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

38 2009/10

95% 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. 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.[39]

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>95%</td><td>97%</td><td rowspan="2">Intended impact: As above

Impact result: As above

95% of people with up to date crisis intervention plans by ethnicity
<table>
<tr><th>Ethnicity</th><th>Result</th></tr>
<tr><td>Maori</td><td>98%</td></tr>
<tr><td>Pacific</td><td>94%</td></tr>
<tr><td>Total</td><td>97%</td></tr>
</table></td></tr>
<tr><td colspan="2">Comment: the DHB continues to make sustained improvement, moving from 65% to 92% between 2009/10 - 2010/11, rising to 97% in 2011/12. Even more pleasing, we have maintained the excellent improvements for Maori (98%) and Pacific (94%) clients.

The increased performance is a result of a specific service focus on crisis prevention planning.</td></tr>
</table>

Elective (Inpatient and Outpatient) 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. There are eight Elective Services Performance Indicators that are specified as measures of performance for elective services. They measure quality, timeliness and effectiveness

39 Ministry of Health Performance Monitoring Framework, 2010/11

Elective services provided by Hutt Hospital and by other DHBs for the Hutt Valley population – *health target*

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>Elective services provided by Hutt Hospital and by other DHBs for the Hutt Valley population:
4,946</td><td>5,020</td><td rowspan="4">Intended impact: Improved access to services (people are managed better)

Impact result: See above.

Day of surgery admission rate[40]
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>77%</td><td>93.6%</td></tr></table>
Minimise outpatient DNAs
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>11,010[41]</td><td>14,086</td></tr></table>
Comment: the next stage of the project has been implemented to allow patients to book directly into available appointments via the internet. This has been implemented across a first tranche of services including Diabetes, Gastroenterology, General Surgery, Dermatology, Rheumatology and Gynaecology with a further roll out plans for another six hospital services underway. To date only one patient had failed to attend out of 197 appointments.

Patients given a commitment to treatment but not treated within six months
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>>5%[42]</td><td>0</td></tr></table>
Less than 2% of patients will wait longer than 6 months for first specialist assessment (FSA)
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>2%</td><td>0</td></tr></table></td></tr>
<tr><td>Elective services Provided by Hutt Hospital for the Hutt Valley and other DHB Populations:
6,722 (CWD)</td><td>6,412</td></tr>
<tr><td>First Specialist Assessments (FSA) Provided by Hutt Hospital for the Hutt Valley and other DHB Populations:
15,721</td><td>15,764</td></tr>
<tr><td>First Specialist Assessments (FSA) Provided by Hutt Hospital and by other DHBs for the Hutt Valley population:
18,614</td><td>16,585

Comment: work to improve the surgical pathway commenced in 2011/13. This involves providing patients with greater certainty of the timing of their surgery. and referring back to GPs when certainty cannot be given, which has resulted in fewer FSA than target.</td></tr>
</table>

40 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 necessitated is relatively small.

41 2009/10

42 Performance target for 2010/11 - target was achieved

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>Percentage of day case discharges 62%.</td><td>58.1%</td><td rowspan="2">30 Day mortality[43]
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>1.53%[44]</td><td>1.18</td></tr></table>
Comment: Hutt Valley DHB had the lowest mortality rate in the country in 2011/12.</td></tr>
<tr><td colspan="2">Comment: the results are to the year ending March 2012. A new 23 hour day surgery unit opened in January 2012 with staff and an area dedicated to day surgery that we expect to impact positively on future results.</td></tr>
</table>

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.[45]

Number of deliveries

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>2,200</td><td>2,015</td><td rowspan="2">Intended impact: Access to services is improved; Length of stay reflects best practice. Women are confident to return home with their baby.

Impact result: Reduced readmissions for neonates.
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>10%[46]</td><td>10%</td></tr></table></td></tr>
<tr><td colspan="2">Comment: the result is demand driven.</td></tr>
</table>

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.[47]

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>2.45 days</td><td>2 days</td><td rowspan="2">Intended impact: See above.

Impact result: See above.</td></tr>
<tr><td colspan="2">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. Capacity was increased to allow longer stays due to a lower number of births. However many women are choosing to go home early.</td></tr>
</table>

43 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.

44 Below national average

45 Nationwide Service Framework; Service Specifications; Maternity Services Tier One Service Specification, Ministry of Health 2010/11

46 Readmitted within 28 days of discharge as a neonate; Averaged rate 2007/08 to 2009/10

47 Government priorities, District Annual Plan 2009/10

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, parental nutrition, specialist medical care, and failure to thrive).[48]

Target	2011/12	Intended impact and impact results
12 days	7.1 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. The reduction in length of stay relates partly to a change in practice. Management of babies with complex social issues who had been previously admitted to the Special Care Baby Unit are now managed in maternity. There is now an emphasis on identifiying high risk factors during pregnancy and putting a plan in place before the baby is born.		

Acute services

Includes 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.[49]

Target	2011/12	Intended impact and impact results
43,640	41,044	**Intended impact**: Improved access to services; Better service integration • Decreased ambulatory sensitive ("avoidable") hospital admissions (ASH) through effective primary care and ED intervention • Reduction of presentations better managed in primary care settings **Impact result**: **Improving number of ED attendances with an ED length of stay less than 6 hours – 95%**[50] **(National health target)**

Baseline	Result
88%	91%

48 Nationwide Service Framework; Service Specifications; Specialist Neonates Services Tier One Service Specification, Ministry of Health 2010/11

49 Nationwide Service Framework; Service Specifications; Emergency Department Services Tier One Service Specification, Ministry of Health 2010/11

50 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.

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td></td><td></td><td>Comment: good progress towards the Shorter Stays in ED health target has been made. In 2011/12, 91% of the DHB's patients were seen within 6 hours in 2011/12, compared with 86% of patients in 2010/11. During periods in the year, the DHB reached 95%, usually under normal hospital conditions, which demonstrates that meeting the target is very much as achievable goal when patient flow throughout the hospital is maintained. It also underlines the work underway to develop clinically integrated pathways to reduce avoidable hospital admissions.

Reduced ASH rate
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>See above</td><td>See above</td></tr></table>
Reduced number of non-admitted triage 4 and 5 ED self presentations
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>See above</td><td>15,040</td></tr></table></td></tr>
</table>

Number of in-patients

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.[51]

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>13,889</td><td>19,466</td><td rowspan="2">Intended impact: See above
Impact result: See above</td></tr>
<tr><td colspan="2">Comment: since the target was set two new services have been introduced: the Medical Assessment and Planning Unit and the Child Assessment Unit Together they have seen approximately 5,000 inpatients.</td></tr>
</table>

Average length of stay

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.[52]

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>4.00</td><td>3.95</td><td rowspan="2">Intended impact: See above
Impact result: See above</td></tr>
<tr><td colspan="2"></td></tr>
</table>

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

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 are correlated with 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.[53] Morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia, and hospital-acquired infections in patients.[54]

Target[55]	2011/12	Intended impact and impact results
9.15	10.02	**Intended impact**: See above
Comment: A new unit to support Emergency Department known as the Medical Assessment and Planning Unit (MAPU) was opened in 2011/12 to enable the assessment and treatment of non-complex patients. This increased the count of admitted cases and also the count for readmission.		**Impact result**: See above

Fertility treatment

Includes services provided under contract by Fertility Associates for the populations of the Hutt Valley DHB, Capital and 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.[56]

Number of fertility cycles

Target	2011/12	Intended impact and impact results
280	280	**Intended impact**: Improved access to services. People continue to have appropriate access to fertility services. **Impact result**: N/A Delivery of service improves access.

Rehabilitation and 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.

In 2012/13 the DHB will implement a series of actions to develop a comprehensive respite service for the Hutt Valley by:

- promoting and raising awareness of the benefits of respite and day care
- ensuring people understand the increased eligibility and options available
- offering assistance to help people find respite that works for them
- improve access remains so it is simple and easy
- monitoring the usage of our two dedicated respite beds, in place from February 2012.

53 Ministry of Health Performance Monitoring Framework, 2010/11

54 Ministry of Health Performance Monitoring Framework, 2010/11. In terms of standardisation, as DHBs have different mixes of acute cases, the Ministry of Heath has increased weighting around Hutt Valley DHB's results to take into consideration that different hospitals specialise in different areas.

55 The rate given is the percentage of patients readmitted within 28 days for the same reason as their initial admission. The result for the year end is based on data for the 12 months ending 31 March. The current rules applied by the Ministry of Health will change in 2012/13 as they currently penalise the wrong DHB, for example, if a patient is released by CCDHB and is readmitted to Hutt Valley, the latter will incur the readmission even though they did not discharge the patient. In 2012/13, the rules will change so the discharging DHB picks up the count for the readmission.

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

While uptake of some respite services is below forecast but the DHB has not had feedback from the community that it is not meeting the respite needs of our population.

Needs assessment services coordination

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 maximize independence and participation in society. Service coordination 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 coordination 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 total assessments (including new, reviews and reassessments) completed on time and accurate

Target	2011/12	Intended impact and impact results
2,683	2,329	**Intended impact**: Improved access to services, Better service integration – improved care coordination: • Older people referred for a comprehensive support needs assessment will receive timely assessments. • Access for support needs assessment will be equitable. **Impact result**: Improved average waiting time from receipt of referral to assessment.
Comment: this variance predominately represents that this service is demand driven. Every client requiring long term support is assessed using interRAI tools. The average waiting time from receipt of referral to assessment is 4 days, which is below the baseline.		

Baseline	Result
6 days	4 days

% of new assessment completed within agreed timeframes

Target	2011/12	Intended impact and impact results
95%	99%	**Intended impact**: See above **Impact result**: Improved % of new assessments completed within agreed timeframes.
Comment: this variance predominately represents that this service is demand driven. Every client requiring long term support is assessed using interRAI tools. The average waiting time from receipt of referral to assessment is 4 days, which is below the baseline.		

Baseline	Result
90%	99%

Number of client complaints

Target	2011/12	Intended impact and impact results
<10	3	**Intended impact**: See above **Impact result**: See above

Home-based support services

Includes contracted services provided for the Hutt Valley population. The purpose of the home support services 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	2011/12	Intended impact and impact results
1,960	1,860	**Intended impact**: Improved access to services, Better service integration – improved care coordination, Older people with complex needs able to remain living in their home for longer. **Impact result**: Percentage of people aged 65 and over living in home (not in full time ARC) Baseline: 92.9% — Result: 94% Reduced percentage of people 75yrs and older hospitalised for falls domiciled in the DHB region, per year. Baseline: 4.7% — Result: Measure removed by the Ministry of Health.
Comment: while the total number of home based support clients has decreased, the number of complex clients with low-moderate to high needs has increased, and the number of non-complex clients with low needs has decreased.		

Number of home based support hours

Target	2011/12	Intended impact and impact results
224,850	239,802	**Intended impact**: See above. **Impact result**: See above.

Aged residential care bed services

Aged residential care includes contracted services provided by Hutt Hospital 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 subsidised resident's representative, to be involved in decisions affecting the subsidised resident's life; and acknowledge the significance of each subsidised resident's family/whanau and chosen support networks.[57]

Number of subsidised bed days

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>301,700</td><td>273,720</td><td rowspan="2">Intended impact: Improved access to services, support services are appropriate - Confidence in quality of service provision and quality improvement systems
Impact result:
All providers required to hold certification are certified for three years (excluding new providers who are initially certified for one year).
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>100%</td><td>87%
Comment: This is an improvement from the 2009/10 result of 69%.</td></tr></table>
Reduced number of care quality complaints to DHB
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>6</td><td>2</td></tr></table></td></tr>
<tr><td colspan="2">Comment: the DHB's policy is to enable people to age in place, remaining in their home environment for as long as they choose. The number of beds required is driven by demand with each client assessed using interRAI tools.</td></tr>
</table>

Number of providers audited (actual number depends on Ministry of Health certification timetable and length of certification of providers)

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>4</td><td>13</td><td rowspan="2">Intended impact: See above

Impact result: See above</td></tr>
<tr><td colspan="2">Comment: the DHB may need to revisit this target to more accurately reflect our audit schedule.</td></tr>
</table>

Number of residential / aged dementia bed days

Target	2011/12	Intended impact and impact results
32,000	28,212	

57 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 coordinators 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.[58]

Number of respite days

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>3,100</td><td>1,437</td><td rowspan="2">Intended impact: Improved access to services; support services are appropriate.

Impact result: Increased utilisation of respite services.<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>1,899 respite days</td><td>1,437</td></tr></table></td></tr>
<tr><td colspan="2">Comment: as the figures show, people are not fully utilising available respite services. The DHB is addressing this with information and awareness raiding, ensuring that:
• caregivers understand that they can arrange emergency respite and this time will not be taken out of their normal respite care allocation
• offering assistance to help people find respite that works for them
• reinforcing the message that respite is an important component to maintain care over time.</td></tr>
</table>

Respite beds utilised

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>8.5</td><td>4.2</td><td rowspan="2">Intended impact: See above

Impact result: See above</td></tr>
<tr><td colspan="2">Comment: as above</td></tr>
</table>

Number of day service clients

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>200</td><td>158</td><td rowspan="2">Intended impact: See above

Impact result: See above</td></tr>
<tr><td colspan="2">Comment: DHB is seeking to raise utilisation, ensuring that:
• at assessment, people understand the emergency respite does not reduce eligibility for respite care
• offering assistance to help people find respite that works for them
• reinforcing the message that respite is an important component to maintain care over time.

In addition, some providers are actively the allocation increase and advertising their day care service to communities.

The DHB is in the process of signing a new contract with Alzheimers Wellington for day care services.</td></tr>
</table>

58 Nationwide Service Framework; Service Specifications; Day Care Services and Respite Care 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 multidisciplinary team, and is aimed at improving the quality of life for people who are dying and their families/whanau.[59]

Number of patients receiving specialist palliative care

Target	2011/12	Intended impact and impact results
609	617	**Intended impact**: Support services are appropriate (appropriate support and services are provided to people whose conditions are terminal). **Impact result**: N/A

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 MOH.[60]

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

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>30,733</td><td>29,249</td><td rowspan="2">Intended impact: Support services are appropriate. Access to services is improved - the care provided reflects the need for services which, in accordance with best practice, allow people to remain in their homes/ communities for longer. Intervention is early - prevent avoidable admission to, or enable early discharge from, hospital.
Impact result:
Reduced avoidable hospitalisation rate
<table>
<tr><th>Baseline</th><th>Result</th></tr>
<tr><td>Cellulitis 0-74: 133.3</td><td>154.7
Comment: the new Ministry rule to count ED patients with a stay of over 3 hours as admitted has impacted on the result. Note, however, that the increase in admissions by 7% 2011/12, is less than the 13% increase in 2010/11.</td></tr>
<tr><td>Respiratory 0-74: 136.6</td><td>113.3</td></tr>
</table>
</td></tr>
<tr><td colspan="2">Comment: contacts as a measure does not reflect complexity of patient or number of procedures required at each contact. Increasing complexity of patients leads to increased time spent per contact.</td></tr>
</table>

59 Nationwide Service Framework; Service Specifications; Palliative Care Services Tier Two Service Specifications, Ministry of Health 2010/11
60 Nationwide Service Framework; Service Specifications; Specialist Community Nursing Services Tier Two Service Specifications, Ministry of Health 2010/11

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 (people who have a disability) or other health professional appropriate to the need of the client.

Total number of contacts (face to face meeting with either the client or their family)

Target	2011/12	Intended impact and impact results
2,042	1,468	**Intended impact**: Access to services is improved; Support services are appropriate. **Impact result**: N/A
Comment: The gap between target and the actual reflects a change in social work practice. Many contacts are now provided over the phone. These phone contacts replace a visit in many cases, and constitute assessment and management of patients. Currently these phone contacts which can range from 20 minutes to 1 hour long, are not part of the outpatient statistics but are being collected in a 'virtual' clinic scenario to show changing models of patient delivery.		

Community Mental Health Support Services

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.[61] Note that this is a regional service and that delivery is also to non – Hutt Valley residents.

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

Total number of clients seen

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>485</td><td>464</td><td rowspan="2">Intended impact: Access to services is improved; intervention is early; support services are appropriate. Reduce number of people experiencing a mental health crisis.

Impact result:
Reduced acute mental health inpatient admissions
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>543[62]</td><td>468
Comment: This is a pleasing trend downwards on the number of acute admissions.</td></tr></table>
Reduced acute mental health inpatient readmissions
<table><tr><th>Baseline</th><th>Result</th></tr><tr><td>21%[63]</td><td>13%</td></tr></table></td></tr>
<tr><td colspan="2">Comment: the DHB's policy is to enable people to age in place, remaining in their home environment for as long as they choose. The number of beds required is driven by demand with each client assessed using interRAI tools.</td></tr>
</table>

Total number of occupied bed days

<table>
<tr><th>Target</th><th>2011/12</th><th>Intended impact and impact results</th></tr>
<tr><td>14,704</td><td>16,695</td><td rowspan="2">Intended impact: See above

Impact result: See above</td></tr>
<tr><td colspan="2">Comment: this includes new services and Alcohol and Other Drug beds that were not included in baseline figures.</td></tr>
</table>

62 2010/11. The baseline was reset in 2010/11 due to more accurate data collection rather than services delivered.
63 2009/10

Financial Report

For the year ended 30 June 2012

Statement of Comprehensive Income

For the year ended 30 June 2012

	Note	2012 Actual $000	2012 Budget $000	2011 Audited $000
Income				
Operating Income	2	433,866	432,744	419,898
Interest		472	400	459
Total Income		**434,338**	**433,144**	**420,357**
Expenditure				
Personnel Costs	3	153,240	154,536	149,487
Depreciation, Amortisation & Impairment expense	10-11	11,031	11,140	10,079
Outsourced Services		5,874	4,952	6,670
Clinical Supplies		25,322	24,380	23,996
Infrastructure and non-clinical expenses		14,849	16,096	17,043
Other District Health Boards		79,348	75,182	73,241
Non-Health Board Providers		133,322	135,154	133,169
Capital Charge	4	4,966	5,248	4,987
Interest expense	5	2,903	3,230	1,243
Other expenses	6	3,379	3,226	3,316
Total Expenditure		**434,234**	**433,144**	**423,231**
Net surplus / (Deficit)		**104**	**0**	**(2,874)**
Other comprehensive income				
Revaluation of Land and Buildings		0	0	0
Total Comprehensive Income for the Year		**104**	**0**	**(2,874)**

The notes to accompany these financial statements start on page 57, including explanations for major variances against budget in note 27.

Statement of Changes in Equity

For the year ended 30 June 2012

	Note	2012 Actual $000	2012 Budget $000	2011 Audited $000
Equity as at 1 July		64,088	66,902	65,317
Capital Contributions from the Crown		4,323	3,303	1,852
Repayment of equity to the Crown		(207)	(207)	(207)
Total Comprehensive Income for the Year		104	0	(2,874)
Equity as at 30 June	17	**68,308**	**69,998**	**64,088**

The notes to accompany these financial statements start on page 57, including explanations for major variances against budget in note 27.

Statement of Financial Position

As at 30 June 2012

	Note	2012 Actual $000	2012 Budget $000	2011 Audited $000
Assets				
Current Assets				
Cash and cash equivalents	7	29,217	2,462	4,122
Debtors and other receivables	8	12,680	10,915	16,111
Inventories	9	1,431	1,240	1,264
Total Current Assets		**43,328**	**14,617**	**21,497**
Non Current Assets				
Property, Plant and Equipment	10	177,774	190,237	166,583
Intangible Assets	11	3,999	5,051	2,296
Investment in Joint Ventures	12	223	0	0
Trust and bequest funds	13	997	900	902
Total Non Current Assets		**182,993**	**196,188**	**169,781**
Total Assets		**226,321**	**210,805**	**191,278**
Liabilities				
Current Liabilities				
Creditors and other payables	14	47,229	23,303	40,743
Employee entitlements and provisions	15	20,751	25,520	24,491
Borrowings	16	3,051	2,000	0
Total Current Liabilities		**71,031**	**50,823**	**65,234**
Non Current Liabilities				
Employee entitlements and provisions	15	6,846	2,084	4,154
Borrowings	16	79,139	87,000	56,900
Trust and bequest funds	13	997	900	902
Total Non Current Liabilties		**86,982**	**89,984**	**61,956**
Total Liabilities		**158,013**	**140,807**	**127,190**
Equity				
Crown equity	17	44,285	46,180	40,169
Revaluation reserves	17	50,368	50,368	50,368
Retained earnings	17	(26,345)	(26,550)	(26,449)
Total Equity	17	**68,308**	**69,998**	**64,088**
Total Equity and Liabilities		**226,321**	**210,805**	**191,278**

The notes to accompany these financial statements start on page 57, including explanations for major variances against budget in note 27.

For, and on behalf of, the Board

Board Member | Board Member | 21 November 2012

Statement of Cash Flow

As at 30 June 2012

	Note	2012 Actual $000	2012 Budget $000	2011 Audited $000
Cashflows from Operating Activities				
Cash receipts		449,687	453,084	430,807
Payments to providers		(225,720)	(226,741)	(217,712)
Payments to suppliers & employees		(195,671)	(204,127)	(196,835)
Goods and Services Tax (net)		1,205	(460)	(711)
Capital charge paid		(5,425)	(5,532)	(4,927)
Net cash flows from Operating Activities	18	**24,076**	**16,224**	**10,622**
Cashflows from Investing Activities				
Interest Received		472	396	459
Proceeds from sale of property, plant and equipment		27	0	16
Purchase of property,plant and equipment		(25,297)	(35,541)	(39,924)
Investments		(223)	0	0
Net cash flows from Investing Activities		**(25,021)**	**(35,145)**	**(39,449)**
Cashflows from Financing Activities				
Equity Contribution		4,323	3,096	1,853
Loans raised		25,600	22,100	24,900
Interest paid		(3,366)	(8,812)	(2,090)
Payment of Finance Leases		(310)	0	0
Repayment of Equity		(207)	0	(207)
Net cash flows from Financing Activities		**26,040**	**16,384**	**24,456**
Net Increase / (Decrease) in Cash Held		25,095	(2,537)	(4,371)
Cash and cash equivalents at beginning of year	7	4,122	4,999	8,493
Cash and Cash Equivalents at end of year		**29,217**	**2,462**	**4,122**

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

Equipment totalling $3.5m was acquired by means of finance leases during the year.

The notes to accompany these financial statements start on page 57, including explanations for major variances against budget in note 27.

Notes to the Financial Statements

For the year ended 30 June 2012

1 Statement of Accounting Policies

Reporting Entity

The Hutt Valley District Health Board (Hutt Valley DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is located in New Zealand. Hutt Valley DHB reports to the New Zealand Crown.

Hutt Valley DHBs primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, Hutt Valley DHB has designated itself and the group as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

Hutt Valley DHB has a 16.67% share of a joint venture company Central Regional Technical Advisory Services Limited which is incorporated and domiciled in New Zealand.

The financial statements for Hutt Valley DHB are for the year ended 30 June 2012, and were approved by the Board on 19 October 2012.

Basis of Preparation

Statement of Compliance

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

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement Base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, buildings, and forward foreign exchange contracts at fair value.

Functional and Presentation Currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of Hutt Valley DHB and its joint venture is New Zealand dollars ($NZ).

Changes in Accounting Policies

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

Hutt Valley DHB has adopted the following revisions to accounting standards during the financial year, which have only had a presentation or disclosure effect:

- Amendment to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item. Hutt Valley DHB has decided to present this analysis in note 17.
- FRS-44 *New Zealand Additional Disclosure and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments)* – The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on Hutt Valley DHB is that certain information about property valuations is no longer required to be disclosed. Note 10 has been updated for these changes.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to Hutt Valley 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

Notes to the Financial Statements

For the year ended 30 June 2012

following three main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 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 the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied to public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Hutt Valley DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Hutt Valley DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Hutt Valley DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Significant Accounting Policies

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Ministry of Health (MoH) revenue
Hutt Valley DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of Hutt Valley DHB meeting its objectives.
Revenue from the MoH is recognised as revenue when earned.

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

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

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

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

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

Notes to the Financial Statements

For the year ended 30 June 2012

Donations and bequests
Donations and bequests to Hutt Valley DHB are recognised 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.

Capital charge

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

Interest expense

Hutt Valley DHB has elected to defer the adoption of the revised NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, borrowing costs are recognised as an expense in the financial year in which they are incurred except to the extent they are directly attributable to the acquisition or construction of a qualifying asset.

Leases

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

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

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

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

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straightline basis over the lease term.
Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Foreign currency transactions

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

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.
Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

Debtors and other receivables

Debtors and other receivables are recorded at their face value, less any provision for impairment.
A receivable is impaired when there is objective evidence that Hutt Valley DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, 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. 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 surplus or deficit. 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 (that is, not past due).

Investments

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

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

Notes to the Financial Statements

For the year ended 30 June 2012

A bank deposit is impaired when there is objective evidence that Hutt Valley DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories

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

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

Property, plant, and equipment

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

- land;
- site improvements;
- building service fitout;
- plant and equipment (includes computer equipment);
- leased assets; and
- motor vehicles.

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

Revaluations

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

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

Revaluation movements are accounted for on a class-of-asset basis.

All other asset classes are carried at depreciated historical cost.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

Additions

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

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

Disposals

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

Subsequent costs

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

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Notes to the Financial Statements

For the year ended 30 June 2012

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

Site Improvements	4 to 80 years
Building Services Fit-out	2 to 36 years
Plant and equipment	2 to 9 years
Computer equipment	3 to 5.5 years
Leased assets	3 to 8 years
Motor vehicles	5.5 to 12.5 years

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

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

Intangible assets

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

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

Staff training costs are recognised as an expense when incurred.

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

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

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

Impairment of property, plant, and equipment and intangible assets

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

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

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at 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 other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

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

Creditors and other payables

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

Notes to the Financial Statements

For the year ended 30 June 2012

Borrowings

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

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

Employee entitlements

Short-term employee entitlements
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.
These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, long service leave, retiring gratuities, continuing medical education leave and expenses, and other entitlements for example sick leave.

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

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

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

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

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

Superannuation schemes

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

Defined benefit schemes
Hutt Valley DHB is a participating employer in the 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 an increased share of the 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 surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be

Notes to the Financial Statements

For the year ended 30 June 2012

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.

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

Equity

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

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

Revaluation reserves
These reserves are related to the revaluation of land and buildings to fair value.

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

Notes to the Financial Statements

For the year ended 30 June 2012

and liabilities within the next financial year are discussed below:

Land and buildings revaluations
Note 10 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. The DHB minimises the risk of this estimation uncertainty by physical inspection of assets and an asset replacement programme.

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 judgements in applying accounting policies:

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

2 Operating Income

	2012 Actual $000	2011 Actual $000
Ministry of Health contract funding	373,237	360,167
ACC Contract revenue	4,419	4,487
Other Government	1,977	1,559
Revenue from other District Health Boards	49,267	48,465
Other patient care related revenue	4,229	4,363
Other Income:		
Gain on Sale of Fixed Assets	27	12
Donations and bequests received	605	287
Donated property, plant and equipment	0	397
Rental income and services	105	161
Total Operating Income	**433,866**	**419,898**

3 Personnel Costs

	2012 Actual $000	2011 Actual $000
Salaries and wages	154,219	146,334
Contributions to defined contribution schemes	69	17
Increase/(decrease) in liability for employee entitlements	(1,048)	3,136
Total Personnel Costs	**153,240**	**149,487**

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

4 Capital Charge

Hutt Valley DHB pays a capital charge to the Crown every six months. The charge is now based on the actual closing equity balance. The capital charge rate for the year ended 30 June 2012 was 8% (2011: 8%).

5 Interest Expense

Interest costs are recognised as an expense in the financial year 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 the Crown Health Financing Agency directly attributable to the Theatre and Emergency Department building project have been capitalised to the project in accordance with IAS23. This policy will apply until such time as the developments are ready for use. This capitalisation policy has been approved by the Hutt Valley DHB's Board. The amount capitalised during the period is $515k (2011: $1.04m)

6 Other Expenses

	2012 Actual $000	2011 Actual $000
Audit Fees for financial statement audit	115	109
Audit-related fees for internal audit services	110	73
Operating lease expense	2,800	2,817
Impairment of debtors	(11)	(17)
Board member fees	329	313
Loss on disposal of property, plant and equipment	36	21
Total Other expenses	**3,379**	**3,316**

7 Cash and cash equivalents

	2012 Actual $000	2011 Actual $000
Cash at bank and on hand	1,169	198
Call deposits	23,031	3,924
Term deposits with maturities less than 3 months	5,017	0
Total cash and cash equivalents	**29,217**	**4,122**
Bank overdrafts	0	0
Cash and cash equivalents for the purposes of the statement of cash flows	**29,217**	**4,122**

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

8 Debtors and other receivables

	2012 Actual $000	2011 Actual $000
Ministry of Health receivables	7,348	4,332
Trade debtors - other	5,072	11,692
Provision for doubtful debts	(305)	(371)
	12,115	**15,653**
Prepayments	565	458
Total Debtors and other receivables	**12,680**	**16,111**

The carrying value of receivables approximates their fair value.
The ageing profile of receivables at year end is detailed below:

	2012			2011		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	11,427	(42)	11,385	15,354	(19)	15,335
Past due 1-30 days	671	(6)	665	42	(3)	39
Past due 31-60 days	71	(6)	65	13	(1)	12
Past due >60 days	251	(251)	0	615	(348)	267
Total	**12,420**	**(305)**	**12,115**	**16,024**	**(371)**	**15,653**

All receivables greater than 30 days are considered to be past due.

The provision for impairment has been calculated based on a review of significant debtor balances and a collective assessment of all debtors (other than those determined to be individually impaired) for impairment. The collective impairment assessment is based on an analysis of past collection history and write-offs.

Individually impaired receivables are assessed as impaired due to the significant financial difficulties being experienced by the debtor and management concluding that the likelihood of the overdue amounts being recovered is remote.

Movements in the provision of impairment of receivables are as follows:

	2012 Actual $000	2011 Actual $000
Opening Balance	(371)	(484)
Additional Provisions made	11	17
Receivables Written Off	55	96
Closing Balance	**(305)**	**(371)**

9 Inventories

	2012 Actual $000	2011 Actual $000
Pharmaceuticals	141	125
Surgical and medical supplies	1,300	1,149
	1,441	**1,274**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,431**	**1,264**

All inventories are distributed to operating areas in the normal course of business and recognised as an expense at the time of distribution. The write-down of inventories held for distribution amounted to $nil (2011: nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2011: nil) however some inventories are subject to retention of title clauses.

10 Property, Plant and Equipment

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

	Land $000	Site Improvements $000	Building Services Fitout $000	Plant & Equipment $000	Leased Assets $000	Motor Vehicles $000	Total $000
Cost or valuation							
Balance at 1 July 2010	13,020	1,195	120,758	42,752	98	609	178,432
Additions	-	56	9,390	4,163	4	220	13,833
Work in Progress	-	-	30,169	(150)	-	(59)	29,960
Revaluations	-	-	-	-	-	-	-
Disposals	-	(6)	(1,053)	(554)	-	(18)	(1,631)
Impairment provision	-	-	-	(563)	-	-	(563)
Balance 30 June 2011	13,020	1,245	159,264	45,648	102	752	220,031
Balance 1 July 2011	13,020	1,245	159,264	45,648	102	752	220,031
Additions	-	1,995	44,981	2,412	3,249	1,653	54,290
Work in Progress	-	-	(32,134)	-	-	-	(32,134)
Revaluations	-	-	-	-	-	-	-
Disposals	-	(1)	(645)	(2,486)	-	(26)	(3,158)
Impairment provision	-	-	-	-	-	-	-
Balance 30 June 2012	13,020	3,239	171,466	45,574	3,351	2,379	239,029
Accumulated depreciation and impairment losses							
Balance at 1 July 2010	-	251	16,107	28,470	98	486	45,412
Depreciation expense	-	70	5,032	3,141	1	24	8,268
Depreciation on disposals	-	-	-	(214)	-	(18)	(232)
Balance 30 June 2011	-	321	21,139	31,397	99	492	53,448
Balance at 1 July 2011	-	321	21,139	31,397	99	492	53,448
Depreciation expense	-	133	6,496	3,426	100	177	10,332
Depreciation on disposals	-	(1)	(333)	(2,172)	-	(20)	(2,526)
Balance 30 June 2012	-	453	27,302	32,651	199	649	61,254
Carrying Amounts							
At 30 June 2011	13,020	924	138,125	14,251	3	260	166,583
At 30 June 2012	13,020	2,786	144,164	12,923	3,152	1,730	177,775

The net carrying amount of assets held under finance leases is $3.15m (2011: nil) for plant and equipment.

Valuation

The most recent valuation of land and buildings was performed by an independently contracted registered valuer, Matt Snelgrove, BBS, SPINA, ANZIV of CB Richard Ellis. The valuation is effective as at 30 June 2012. 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 market based evidence.

Seismic Status of Building

Eleven of Hutt Valley DHB's 15 buildings have been assessed against the earthquake standards. Of the assessed buildings all but one meet the current minimum standards of the Building Code for existing buildings. The one building that doesn't is undergoing strengthening to stairwells to meet those minimum standards.

The Hutt City Council reviewed its local regulations for existing buildings late in 2011. The standards were increased from the same level as the building code (33% of new building strength) to a level of twice the Building Code minimum (67% of new building strength). The council also requires existing buildings to meet the higher standard by 2018.

A number of the buildings on the Hutt Hospital campus fall between the building code minimum and new council minimum standard. These include the Heretaunga Block, Clock Tower building, Pilmuir House and the Kitchen/ learning centre block. Indicative estimates have been received for a number of these buildings as well as the building that is below the minimum building code standard, with indicative repair costs of circa $21M. These repair costs have not been tested in the market, and do not cover all buildings. The remedial work could be extremely disruptive, especially to the Heretaunga Block, which is the main patient accommodation on campus. These are preliminary estimates only and are subject to significant uncertainty and actual costs may differ from the estimate in either direction.

The Hutt Valley DHB is continuing to gather information on the status of the current building stock, and will undertake a campus planning exercise in 2013. The exercise will also be influenced by sub-regional and regional capacity planning. Following the campus planning exercise, decisions will be made whether to undertake remedial work, or to look at a process of demolition and rebuilding on site to replace the patient accommodation. The demolition and rebuilding options may allow a change of purpose for the Heretaunga Block, resulting in a lower 'importance level' for the building, and therefore potentially making remedial work unnecessary.

Given the current level of uncertainty of both remedial work costs and future campus planning, the Hutt Valley DHB has chosen not to book an impairment on current building values. However given the material size of the initial remedial work estimates the Hutt Valley DHB is disclosing the situation.

11 Intangible Assets

Movements for each class of intangible asset are as follows:

	2012 Actual $000	2011 Actual $000
Computer Software		
Cost		
Opening Balance	10,258	9,624
Additions	1,605	212
Work in progress	791	594
Disposals	(24)	(172)
Closing Balance	**12,630**	**10,258**
Accumulated Amortisation		
Opening Balance	7,962	7,262
Amortisation expense	699	811
Disposals	(30)	(111)
Closing Balance	8,631	7,962
Net Carrying amounts	**3,999**	**2,296**

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

12 Investments in Joint Ventures

	2012 Actual $000	2011 Actual $000
Carrying Amount of Investment		
Uncalled ordinary share capital	0	0
Advance on redeemable preference shares	223	0
Investments in Joint Ventures	**223**	**0**

Other investments comprise the 16.67% (2011: 16.67%) 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 DHBs share is $100. At balance date all share capital remains uncalled.

As at 30 June 2012, a further investment in CRTAS includes an advance, for the acquisition of Class B Redeemable Preference Shares. The advance will convert to Redeemable Preference Shares after all terms of the issue, compliance with the applicable law and requirements of the Ministry of Health are complied with.

	2012 Actual $000	2011 Actual $000
Summary of DHBs Interest in Joint Venture		
Assets	1,387	176
Liabilities	1,212	52
Revenue	1,934	696
Expenditure	1,882	676
Surplus / (deficit)	52	20
Share of contingent liabilities incurred jointly with other investors	0	0
Contingent liabilities that arise because of several liability	0	0

13 Trust and Bequest Funds

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

	2012 Actual $000	2011 Actual $000
Opening balance	902	778
Funds received	226	331
Interest received	37	37
Funds disbursed	(167)	(244)
Closing Balance	**997**	**902**

14 Creditors and other payables

	2012 Actual $000	2011 Actual $000
Trade payables	4,486	5,524
Accrued expenses	25,872	25,583
Income in advance	7	342
Other payables	14,448	5,777
GST and other taxes payable	2,033	823
Capital charge due to the Crown	0	459
Fixed assets payable	383	2,235
Total Creditors and other payables	**47,229**	**40,743**

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

15 Employee entitlements and provisions

	2012 Actual $000	2011 Actual $000
Current Liabilities		
Salary and Wages Accrued	1,937	3,530
Annual leave	14,672	13,880
Long Service Leave	1,265	1,039
Retirement Gratuities	519	251
Continuing Medical Education Leave and Expenses	905	3,528
Other Entitlements	1,453	2,263
Total Current Liabilities	**20,751**	**24,491**
Non-current Liabilities		
Long Service leave	1,851	2,450
Retirement Gratuities	1,162	1,320
Continuing Medical Education Leave and Expenses	2,727	0
Other Entitlements	1,106	384
Total Non-current Liabilities	**6,846**	**4,154**
Total of Employee Entitlements and Provisions	**27,597**	**28,645**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 2.28% (2011:2.84%) and an inflation factor of 2.5% has been used.

16 Borrowings

	2012 Actual $000	2011 Actual $000
Current portion		
Finance Lease	1,051	0
Crown Health Financing Agency	2,000	0
	3,051	**0**
Non-current portion		
Finance Lease	2,139	0
Crown Health Financing Agency	77,000	56,900
	79,139	**56,900**
Total borrowings	**82,190**	**56,900**
Borrowing facility limits		
Crown Health Financing Agency	79,000	79,000
Overdraft facility	6,000	6,000
	85,000	**85,000**

	2012 Actual $000	2011 Actual $000
CHFA Loans repayable		
Within one year	2,000	0
One to two years	10,500	2,000
Two to five years	16,450	20,950
More than five years	50,050	33,950
Total CHFA Loans	**79,000**	**56,900**

Crown Health Financing Agency loans

The Crown Health Financing Agency (CHFA) loans are secured by a negative pledge. Without the CHFA's prior written consent, Hutt Valley DHB cannot perform the following actions:

- create any security over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature and scope of its business as presently conducted;
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value; or
- provide or accept services other than for proper value and on reasonable commercial terms.

Hutt Valley DHB is not required to meet any covenants.

The fair value of CHFA borrowings is $86.4m (2011: $62.2m). Fair value has been based on the Government bond rate plus 15 basis points based on mid-market pricing.

Overdraft Facility

Hutt Valley DHB has an overdraft facility with the Bank of New Zealand. The facility is secured by a negative pledge. Without the bank's written approval, Hutt Valley DHB cannot perform the following actions:

- create any security over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature and scope of its business as presently conducted; or
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value.

Finance Leases

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

The fair value of finance lease is $3.19m (2011: nil). Fair value is estimated at the present value of future cash flows.

	2012 Actual $000	2011 Actual $000
Minimum lease payments payable:		
Not later than one year	1,199	0
Later than one year and not later than five years	2,521	0
Later than five years	0	0
Total mimimum lease payments	3,720	0
Future finance charges	(530)	0
Present value of minimum lease payments	3,190	0
Present value of minimum lease payable		
Not later than one year	1,051	0
Later than one year and not later than five years	2,139	0
Later than five years	0	0
Total present value of minimum lease payments	3,190	0

Description of finance leasing arrangements

Hutt Valley DHB has entered into a finance lease for $3.5m for a period of 5 years. There are no restrictions placed on Hutt Valley DHB by any of the finance leasing arrangements.

17 Equity

	Crown Equity $000	Land* $000	Non-Residential Buildings* $000	Other Assets* $000	Retained Earnings $000	Total Equity $000
Balance at 1 July 2010	38,524	8,659	43,105	(1,396)	(23,575)	65,317
Contribution from the crown	1,852	-	-	-	-	1,852
Repayment of equity	(207)	-	-	-	-	(207)
Total comprehensive income for the year	-	-	-	-	(2,874)	(2,874)
Balance 30 June 2011	**40,169**	**8,659**	**43,105**	**(1,396)**	**(26,449)**	**64,088**
Balance 1 July 2011	40,169	8,659	43,105	(1,396)	(26,449)	64,088
Contribution from the crown	4,323	-	-	-	-	4,323
Repayment of equity	(207)	-	-	-	-	(207)
Total comprehensive income for the year	-	-	-	-	104	104
Balance 30 June 2012	**44,285**	**8,659**	**43,105**	**(1,396)**	**(26,345)**	**68,308**

* Revaluation Reserves

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

	2012 Actual $000	2011 Actual $000
Reconciliation of net operating surplus/deficit with net cash inflow from operating activities		
Net operating surplus	104	(2,874)
Add / (less) non-cash items		
Depreciation and amortisation expense	11,031	10,079
Increase / decrease in provisions	(1,114)	3,136
Total non-cash items	**9,917**	**13,215**
Add / (less) items classified as investing or financing activity		
(Gains) / losses on sale of property, plant and equipment	9	9
Net interest paid	2,431	784
Total items classified as investing or financing activity	**2,440**	**793**
Add / (less) movements in statement of financial position items		
Debtors and other receivables	3,497	(3,283)
Inventories	(167)	91
Capital charge payable	(459)	60
Creditors and other payables	8,744	2,620
Net movements in Working Capital items	**11,615**	**(512)**
Net cash flow from Operating Activities	**24,076**	**10,622**

19 Commitments

	2012 Actual $000	2011 Actual $000
Capital commitments	18,368	18,952
Non-cancellable operating lease commitments		
Less than one year	1,812	1,578
One to two years	1,133	1,208
Two to five years	694	871
Over five years	78	0
Total non-cancellable operating lease commitments	**3,717**	**3,657**

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

For the year ended 30 June 2011 additional information was provided regarding provider funding commitments (2011: $36.302m) and other demand driven costs (2011:$97.711m). This information is no longer required to be reported so has been removed from these financial statements. Details of the budgeted expenditure for 2012/13 financial year have been published in the Annual Plan.

20 Contingencies

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2012 (2011: Nil).

21 Related Party Transactions

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

Significant transactions with government-related entities
Hutt Valley DHB has received funding from the Ministry of Health of $373.24m (2011: $360.17m) to provide health services to the population of the Hutt Valley. The amount owing to Hutt Valley DHB at the end of the financial year was $6.60m (2011: $7.96m), and the amount owed by Hutt Valley DHB to the Ministry of Health was $63k (2011: $162k).

Hutt Valley DHB has received funding from the Accident Compensation Corporation (ACC) of $4.42m (2011: $4.49m) to provide health services to the population of the Hutt Valley. The amount owing to Hutt Valley DHB at the end of the financial year was $467k (2011: $411k), and the amount owed by Hutt Valley DHB to the Accident Compensation Corporation was nil (2011: nil).

Revenue earned from other DHB's for the care of patient's outside the Hutt Valley amounted to $49.27m (2011: $48.47m). Expenditure to other DHB's for their care of patients from the Hutt Valley amounted to $79.35m (2011:$73.24m). The amount owing to Hutt Valley DHB at the end of the financial year was $1.95m (2011: $4.65m), and the amount owed by Hutt Valley DHB to other DHBs was $5.28m (2011: $4.10m).

Collectively, but not individually, significant transactions with government-related entities
In conducting its activities, Hutt Valley DHB 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. Hutt Valley DHB is exempt from paying income tax.

Hutt Valley DHB 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 2012 totalled $1.91m (2011: $1.66m). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post.

Related party transactions with Hutt Valley DHBs joint venture company
During the year Hutt Valley DHB transacted with Central Regional Technical Advisory Service Ltd, a joint venture company. Services provided to Hutt Valley DHB cost $0.95m (2011: $1.06m), and services provided by Hutt Valley DHB cost $1k (2011: $1k). There were no amounts outstanding at the end of the financial year.

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

	2012 Actual $000	2011 Actual $000
Salaries and other short-term employee benefits	1,614	1,334
Post-employment benefits	0	0
Other long-term benefits	0	17
Termination benefits	9	177
Total key management personnel compensation	**1,623**	**1,528**

During the year Hutt Valley DHB transacted with Capital and Coast DHB on normal inter-DHB terms. Both DHB's share some board members and also hold combined Community Public Health Advisory Committee meetings. The total value of the revenue was $43.79m (2011: $27.79m), with total expenditure of $71.60m (2011: $64.46m). The amount owing to Hutt Valley DHB by Capital and Coast DHB at the end of the financial year was $1.12m (2011: $2.13m), and the amount owing to Capital and Coast DHB was $4.03m (2011: $5.57m).

During the year Hutt Valley DHB transacted with Greater Wellington Regional Council in which Board member Peter Glensor is a Deputy Chair. These services cost $5k (2011: $1k) and were incurred on normal commercial terms. There were no amounts outstanding at the end of the financial year.

During the year Hutt Valley DHB transacted with Upper Hutt City Council in which Board member Wayne Guppy is the Mayor. These services cost $10k (2011: $48k) and were incurred on normal commercial terms. There were no amounts outstanding at the end of the financial year.

During the year Hutt Valley DHB transacted with Hutt City Council in which Board member David Bassett is the Deputy Mayor, and Ken Laban is a Councillor. These services cost $197k (2011: $315k) and were incurred on normal commercial terms. At the end of the financial year $48k was outstanding.

During the year Hutt Valley DHB transacted with Te Omanga Hospice in which Board member Ken Laban is a Trustee. These services cost $3.96m and were negotiated on normal commercial terms. At the end of the financial year $330k was outstanding.

There are close family members of key management personnel employed by Hutt Valley DHB or suppliers to Hutt Valley DHB. The terms and conditions of those arrangements are no more favourable than Hutt Valley DHB would have adopted if there were no relationship to key management personnel. No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2011: nil).

22 Board Member Remuneration and Meetings Attended

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

Board Member	Position	2012 Actual $000	2011 Actual $000
Dr Virginia Hope	Board Chair	46	26
Wayne Guppy	CPHAC Chair	30	27
Keith Hindle	FRAC Chair	25	25
Peter Glensor	HAC Chair	29	34
Debbie Chin	Crown Monitor	35	30
David Bassett	Current Member	24	13
David Odgen	Current Member	23	24
Iris Pahau	Current Member	22	13
John Terris	Current Member	23	13
Katy Austin	Current Member	25	26
Ken Laban	Current Member	23	24
Peter Douglas	Current Member	24	13
Sharon Cole	Previous Member	-	13
Sandra Greig	Previous Member	-	10
Catherine Love	Previous Member	-	12
Pat Brosnan	Previous Member	-	10
Total		**329**	**313**

Other payments have been made to Maori Partnership Board members and other co-opted community representatives for attendance at meetings of $29k (2011: $15k).

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

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

No Board members received compensation or other benefits in relation to cessation (2011: nil).

The total number of meetings attended and the number of meetings held during the year was:

		Meetings Attended		Meetings Held	
Board Member	**Position**	**Board Meetings**	**Committee Meetings**	**Board Meetings**	**Committee Meetings**
Dr Virginia Hope	Board Chair	8	25	8	35
Wayne Guppy	CPHAC Chair	8	18	8	20
Keith Hindle	FRAC Chair	7	18	8	20
Peter Glensor	HAC Chair	7	34	8	35
Debbie Chin	Crown Monitor	8	27	8	35
David Bassett	Current Member	8	14	8	15
David Odgen	Current Member	8	14	8	15
Iris Pahau	Current Member	8	9	8	10
John Terris	Current Member	8	13	8	20
Katy Austin	Current Member	7	24	8	35
Ken Laban	Current Member	5	13	8	25
Peter Douglas	Current Member	8	13	8	20
Total		**90**	**222**	**96**	**285**

23 Employee Remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

Position	**2012**	**2011**
$100,000 - 109,999	31	33
$110,000 - 119,999	19	16
$120,000 - 129,999	14	16
$130,000 - 139,999	6	7
$140,000 - 149,999	13	10
$150,000 - 159,999	10	10
$160,000 - 169,999	7	4
$170,000 - 179,999	7	10
$180,000 - 189,999	8	4

Position	2012	2011
$190,000 - 199,999	6	8
$200,000 - 209,999	4	8
$210,000 - 219,999	7	9
$220,000 - 229,999	12	6
$230,000 - 239,999	9	3
$240,000 - 249,999	3	7
$250,000 - 259,999	5	3
$260,000 - 269,999	4	3
$270,000 - 279,999	2	4
$280,000 - 289,999	2	2
$290,000 - 299,999	1	1
$300,000 - 309,999	0	1
$310,000 - 319,999	3	0
$320,000 - 329,999	1	1
$330,000 - 339,999	0	1
$350,000 - 359,999	1	0
$360,000 - 369,999	1	1
$370,000 - 379,999	0	1
$490,000 - 499,999	0	1
$610,000 - 619,999	0	1
$620,000 - 629,999	1	0
Total number of employees	**177**	**171**

During the year ended 30 June 2012, 11 (2011: 18) employees received compensation and other benefits in relation to cessation totalling $145,044 (2011 $795,498). The payments made were in the nature of redundancy payments or retirement gratuities.

24 Events after the balance date

An announcement was made on the 18 October 2012 regarding an accelerated and enhanced partnership process across Hutt Valley, Wairarapa and Capital and Coast DHBs. This will include a change to a single chief executive and executive team across the Hutt Valley and Wairarapa DHBs.

25 Financial Instruments

Fair Values

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

	2012		2011	
	Carrying Amount $000	Fair Value $000	Carrying Amount $000	Fair Value $000
Cash and cash equivalents	29,217	29,217	4,122	4,122
Debtors and other receivables	12,680	12,680	16,111	16,111
Creditors and other payables	47,229	47,229	40,743	40,743
Secured loans	79,000	86,400	56,900	62,230
Finance leases	3,190	3,190	0	0
	129,419	136,819	97,643	102,973

Risks

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

Price Risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Hutt Valley DHBs exposure to cash flow interest rate risk is limited to on-call deposits. At 30 June 2012, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2011/12, as most of the DHBs term debt is at fixed rates, and only the net interest from cash holdings and bank overdraft would be affected.

Currency Risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. Hutt Valley DHB purchases clinical equipment from overseas, which requires it to enter into transactions denominated in foreign currencies. As a result of these activities, exposure to currency risk arises. The effect of a general increase of one percentage point on the value of the NZD against other foreign currencies would have had a minimal impact on earnings.

Credit risk

Credit risk is the risk that a third party will default on its obligations to Hutt Valley DHB, causing it to incur a loss. Due to the timing of its cash inflows and outflows, surplus cash is invested with registered banks. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in statement of financial position.

The amount of credit exposure to any one financial institution for term deposits is limited to no more than 25% of total investments held. Investments are entered into only with registered banks that have a Standard and Poor's credit rating of at least A2 for short term and A- for long term investments. Hutt Valley DHB has not experienced any defaults of interest or principal payments for term deposits.

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

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

Credit quality of financial assets

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

	2012 Actual $000	2011 Actual $000
Counterparties with credit ratings		
Cash and cash equivalents including trust funds		
AA	0	5,024
AA-	30,214	0
	30,214	**5,024**
Maximum exposure for each class of financial instrument		
Cash and cash equivalents	29,217	4,122
Trust and bequest funds	997	902
Debtors and other receivables	12,680	16,111

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

Liquidity Risk
Liquidity risk is the risk that Hutt Valley DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through adequate amounts of committed credit facilities and the ability to close out market positions. Hutt Valley DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

	Carrying Amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2011						
Creditors and other payables	40,743	40,743	40,743	0	0	0
Finance leases	0	0	0	0	0	0
CHFA loans	56,900	75,492	3,189	5,169	31,333	35,801
Total	**97,643**	**116,235**	**43,932**	**5,169**	**31,333**	**35,801**
2012						
Creditors and other payables	47,229	47,229	47,229	0	0	0
Finance leases	3,190	3,967	872	872	2,223	0
CHFA loans	79,000	99,050	5,910	14,245	46,457	32,438
Total	**129,419**	**150,246**	**54,011**	**15,117**	**48,680**	**32,438**

26 Capital management

The Hutt Valley DHBs capital is its equity, which comprises Crown equity, accumulated surpluses and revaluation reserves.

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

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

27 Explanation of major variances against budget

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2012 are provided below.

Statement of Comprehensive Income
The Hutt Valley DHB recorded a surplus of $104k compared with the budgeted breakeven position.

Outsourced services were higher than budget because of contracted staff to cover vacancies.
Clinical supply costs were higher because of costs associated with Child Oral Health services.
Infrastructure and non-clinical expenses were lower than budget because of lower interest and capital charge costs and also lower depreciation because of delays to capital expenditure programmes.

Statement of Financial Position
Major variances were:
Cash and cash equivalents were better because of the lower capital expenditure than planned for the year, and because of funds held by the DHB for the National Haemophiliac Management Group and the National IT Grants Fund which are also reflected in the higher creditors and other payables.

Statement of Cash Flows
The net cash flow was favourable to the budget and the major reasons were:
Capital expenditure was lower than planned for the year, and because of funds held by the DHB for the National Haemophiliac Management Group and the National IT Grants Fund.

28 Cost of Service Statements for Output Classes

$000	Prevention Services			Early Detection & Management Services			Intensive Assessment & Treatment			Rehabilitation & Support Services			DHB Total		
	2012 Actual	2012 Budget	2011 Audited	2012 Actual	2012 Budget	2011 Audited	2012 Actual	2012 Budget	2011 Audited	2012 Actual	2012 Budget	2011 Audited	2012 Actual	2012 Budget	2011 Audited
Revenue															
Operating Income	21,611	21,577	23,051	116,582	116,111	109,590	237,444	238,587	230,771	58,229	56,467	56,486	433,866	432,744	419,898
Interest Revenue	15	0	0	10	0	0	447	400	459	1	0	0	472	400	459
Total Revenue	**21,626**	**21,577**	**23,051**	**116,591**	**116,111**	**109,590**	**237,891**	**238,987**	**231,230**	**58,229**	**56,467**	**56,486**	**434,338**	**433,144**	**420,357**
Expenditure															
Personnel Costs	13,092	13,553	13,078	13,182	14,164	11,957	123,401	123,194	121,118	3,565	3,624	3,334	153,240	154,536	149,487
Depreciation, Amortisation & Impairment Expense	276	305	359	480	528	162	10,266	10,300	9,552	9	5	6	11,031	11,140	10,079
Outsourced Services	853	828	1,091	686	631	433	4,245	3,405	5,053	89	89	93	5,874	4,952	6,670
Clinical Supplies	1,852	1,819	1,882	1,147	677	688	21,095	20,533	20,191	1,227	1,350	1,236	25,322	24,380	23,996
Infrastructure & non-clinical expenses	709	952	1,138	1,272	1,935	2,056	12,762	13,053	13,653	106	157	197	14,849	16,097	17,043
Other District Health Boards	0	0	74	11,834	8,992	7,250	61,913	60,585	60,031	5,601	5,605	5,886	79,348	75,182	73,241
Non-Health Board Providers	1,006	1,007	2,163	79,699	84,663	82,101	4,386	4,341	4,478	48,231	45,144	44,427	133,322	135,154	133,169
Capital Charge	225	0	0	628	480	213	4,105	4,768	4,774	8	0	0	4,966	5,248	4,987
Interest expense	62	0	0	41	0	0	2,798	3,232	1,243	2	0	0	2,903	3,230	1,243
Other expenses	0	0	30	0	0	1	3,379	3,226	3,285	0	0	0	3,379	3,226	3,316
Internal Allocations	2,995	2,988	2,911	3,007	2,999	2,992	(6,718)	(6,705)	(6,648)	716	718	745	0	(0)	0
Total Expenditure	**21,072**	**21,451**	**22,726**	**111,976**	**115,069**	**107,852**	**241,631**	**239,933**	**236,729**	**59,555**	**56,691**	**55,924**	**434,234**	**433,144**	**423,231**
Net Surplus / (Deficit)	**555**	**125**	**324**	**4,615**	**1,042**	**1,738**	**(3,740)**	**(945)**	**(5,499)**	**(1,325)**	**(225)**	**562**	**104**	**(0)**	**(2,874)**

29 Statutory deadline for publishing the Annual Report

In accordance with section 150 of the Crown Entities Act 2004, the annual report is required to be published within 4 months of balance date. The statutory deadline was not met because a position had not been reached on the disclosures and accounting treatment required regarding the seismic status of the Hutt Valley DHB buildings. Discussions with the auditors on this matter were not concluded until 15 November.

Statement of Responsibility

The Board and management are responsible for the preparation of the Hutt Valley District Health Board financial statements and the statement of service performance, and for the judgments made in them.

The Board and management of the Hutt Valley District Health Board have the responsibility of establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operation of the Hutt Valley District Health Board for the year ended 30 June 2012.

Signed on behalf of the Board

Board Member | Board Member | 21 November 2012

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report

To the readers of Hutt Valley District Health Board's financial statements and statement of service performance for the year ended 30 June 2012

The Auditor General is the auditor of Hutt Valley 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 53 to 86, that comprise the statement of financial position as at 30 June 2012, 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 other explanatory information; and
- the statement of objectives and service performance of the Health Board on pages 20 to 51.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 53 to 86:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board's:
    - financial position as at 30 June 2012; and
    - financial performance and cash flows for the year ended on that date; and
- the statement of objectives and service performance of the Health Board on pages 20 to 51:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board's service performance for the year ended 30 June 2012, 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.

Emphasis of matter – significant uncertainties in the carrying value of certain buildings due to earthquake strength issues

Without modifying our opinion, we draw your attention to the disclosures made in note 10 on page 69, which explains the building earthquake strength issues of a number of buildings located on the Hutt Hospital campus. The Health Board has received indicative estimates for the cost to strengthen some of these buildings and it is continuing to gather further information for other affected buildings. The Health Board will undertake a campus planning exercise in 2013 and following this, the Board will make decisions about the affected buildings. Due to the significant uncertainties surrounding both remedial work costs and the outcome of future campus planning, the Health Board has not made any adjustment to the carrying values of those buildings with earthquake strength issues. We consider the disclosures about these uncertainties to be adequate.

Our audit was completed on 21 November 2012. 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

Hutt Valley DHB Directory

As at 30 June 2012

Head Office

Hutt Valley District Health Board
Private Bag 31-907
Lower Hutt 5040

Pilmuir House, Pilmuir Street
Lower Hutt 5010
(04) 566 6999
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 has eleven members. Seven are elected. Four are appointed by the Minister of Health (including the Chair and Deputy Chair).

- Dr 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

Executive Management Team

- Graham Dyer, Chief Executive Officer
- Shayne Nahu, Acting Director Planning and Funding
- Pete Chandler, Chief Operating Officer
- Russell Simpson, Executive Director of Allied Health
- Iwona Stolarek, Chief Medical Officer
- Leanne Spice, Acting Director Corporate Support
- Cheryll Graham, Community Liaison and Acting Manager Pacific Health
- Michele Halford, Executive Director of Nursing
- Kuini Puketapu, Maori Health Advisor
- Jill Stringer, Communications Manager
- Richard Schmidt, Strategic Development Manager
- Peter Gush, Service Manager - Public Health
- Glen Willoughby, Chief Information Officer
- Helen Sinclair, Quality Manager

Maori Partnership Board

The Maori Partnership Board (MPB) operates under a Memorandum of Understanding with the DHB and assists to reduce health inequalities and improve health outcomes for Maori people within the Hutt Valley.

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

Community & Public Health Advisory Committee

The Community & Public Health Advisory Committee advises the board on the health needs and status of our population. This is a joint committee with Capital & Coast District Health Board.

- Wayne Guppy (Chair)
- Judith Aitken (Deputy Chair)
- Katy Austin
- David Choat
- Iris Pahau
- Helene Ritchie
- John Terris
- Muriel Tunoho (Hutt Valley MPB)
- Jack Rikihana (Capital Coast MPB)
- Virginia Hope
- Peter Glensor
- Debbie Chin (Crown Monitor)

Disability Support Advisory Committee

The Disability Support Advisory Committee advises the board on the support needed for people with disability. It is a joint committee with Capital & Coast District Health Board.

- Margaret Faulkner (Chair)
- Ken Laban (Deputy Chair)
- Judith Aitken
- Katy Austin
- David Bassett
- David Ogden
- Helene Ritchie
- Janis Awatere (Hutt Valley MPB)
- Litea Ah Hoi
- Jim Webber (Capital Coast MPB)
- Nathan Bond
- Peter Glensor
- Wayne Guppy
- Virginia Hope
- Debbie Chin (Crown Monitor)

Hospital Advisory Committee

The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Hutt Hospital and its services.

- Peter Glensor (chair)
- Peter Douglas (deputy chair)
- Katy Austin
- Keith Hindle
- Ken Laban
- David Ogden
- Keriata Stuart
- John Terris
- Virginia Hope
- Debbie Chin (Crown Monitor)