HUTT VALLEY DHB

Annual Report 2013

HUTT VALLEY DISTRICT HEALTH BOARD

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 2012/13

From the Chair and Chief Executive

This has been an extraordinary year for Hutt Valley DHB, as we have moved from vision to reality on our journey towards more streamlined services across Wairarapa, Hutt Valley and Capital & Coast DHBs.

In response to our three Annual Plans last year, the Minister required a plan to achieve greater clinical sustainability and improved financial performance across the sub-region. The Board-commissioned Health Partners report built on the work of the sub-regional Clinical Leadership Group and provided a blueprint for this. An action plan based on the Health Partners report was subsequently signed off by the three Boards.

As a result of this, a single Chief Executive across Wairarapa and Hutt Valley DHBs was appointed in December 2012, and a single Executive Leadership Team was largely in place by April 2013. It is our clear direction that administrative changes are made to support the development of more joined-up services across our sub-region. There is still work to be done in aligning structures in Wairarapa and Hutt Valley DHBs to support the increasing level of clinical collaboration, but the basics of directorate structure and clinical and administrative accountabilities have been worked through over the remainder of the 2012/2013 year.

We recognise that our future lies in forging strong subregional and regional relationships and implementing sustainable arrangements to continue to deliver safe, high quality affordable services in the Hutt Valley over the forthcoming years.

While we have had a good track record for managing our resources well over recent years, our relatively small size accentuates vulnerabilities in cover for some specialist services, and creates clinical and administrative inefficiencies relative to the size of the population we serve. Therefore, the partnership model offered in the 3DHB Programme offers the best viable solution to continued clinical and financial viability.

In 2012/13 Hutt Valley DHB met and exceeded many of the expectations that have been placed on it, and continued to deliver and fund high quality care. We are particularly proud of our achievements against the health targets, where our new buildings and processes, and our developing relationship with the primary care sector have supported improved results. A particularly pleasing highlight was meeting and exceeding the ED 6hr wait target in the final quarter of the year, following commissioning of our new building and significant work on hospital-wide processes to ensure availability of beds for acute admissions. The collaborative effort between primary care and the DHB has also seen a good result achieving an immunisation rate of 92% for 8 month old babies including 89% of Maori children and 93% for Pacific children and 94% of 2 year olds; offering 96% of inpatients and 51% smokers attending primary care advice to help quit. This is an increase from 19% in the 2011/2012 year, and equates to and additional 3,550 patients being provided advice and support to quit.

The increased pace of integration work can be seen not just with our neighbouring DHBs but also with local health providers. The Primary Secondary Strategy Group (now renamed Hutt Integrated Care Network (Hutt INC) programme is a collaborative integration programme across the DHB and Primary Care, and is on track to become the Alliance Leadership Team for the Hutt Valley in the 2013/14 year. Building these relationships has supported the

development of clinical pathways in the sub-region for ENT, cellulitus and gastroenterology. A joint project around reducing hospital bed days related to cellulitus has resulted not only in a drop of admissions and bed days, but also better information to help people manage their skin infections in the community.

Some of the successes of working in a partnership relationship with our neighbouring DHBs include progressing discussions on opportunities for single rosters in the sub-region, purchase of a single tilt table and having joint lists and clinics, progress on policy alignment between the 3DHBs, smoother process between CCDHB, Hutt Valley DHB and Wellington Free for acute Cardiac management during daylight hours, and a joint approach to the Starship children's renal clinic, where staff from Hutt and Wellington jointly attend, and Wairarapa and Hutt children can now be seen at Hutt Hospital.

Other notable successes include no Central Line Associated Bacteraemia (CLAB) infections for 365 days at Hutt Hospital. This is significant because CLAB infections are potentially fatal and entirely preventable through meticulous infection control practices. Moving in to the new Theatre and Emergency building has enabled new work processes. Late theatre starts have been reduced and the number of cancelled operations has been reduced by 1/3, while day of surgery admissions have risen from 45% to 95%.

This year has also seen the successful implementation of digital mammography at BreastScreen Central, and establishment of the 'Operations Centre' at Hutt Hospital, enabling effective use of real-time data, including recently implemented TrendCare data, to make best use of staffing and bed resources. We have also rolled out the 'uBook' online system that enables people to book their own outpatient appointments to six specialities, with a pleasing reduction in 'Did Not Attends'. We also now have six of the eleven community dental hubs fully commissioned, with planning and construction of the remaining five all underway.

We acknowledge the collective and individual contribution of our dedicated staff, which as also been recognised externally. The Child and Adolescent Mental Health Service was awarded for outstanding work in Multi Systemic Therapy, achieving top results in Australasia. Mental Health staff also successfully implemented the recommendations of a s95 report, resulting in praise from the Ministry of Health's Director of Mental Health, who said "I have been very impressed with the way the DHB has conducted itself during the inquiry process and I commend the DHB for its responsible and thorough approach to this inquiry". In addition, Hutt Hospital was noted as an 'exemplar site for physician training in NZ' during accreditation, and a high percentage of medical registrars passing their RACP exam this year.

Hutt Valley DHB shows its commitment to developing capacity and capability in many ways, and this is particularly well demonstrated through the Manu Tipuranga Scholarships, aimed at developing Maori and Pacific current and future workforce. 28 Scholarships were awarded, including support for 2 students from Wainuiomata and Pomare studying toward medical qualifications, 2013 will see first Manu Tipuranga Maori Dentist completing Year 5 in the Bachelor Dental programme as well as our first Physiotherapy student completing Year 4 of his studies.

We expect the achievements of this year to be a firm foundation for the 2013/14 year, as we move from a 2DHB to an increasingly 3DHB model for service planning and delivery.

Dr Virginia Hope
Chair
Hutt Valley District Health Board

Graham Dyer
Chief Executive
Hutt Valley District Health Board

Our Key Priorities for 2012/13

A sustainable health system for the Hutt Valley will be characterised by strong integration between services and clinicians, co-operation and joint work with our neighbouring DHBs, and a focus on finding more efficient ways of delivering our services, while retaining our focus on improved patient care and better health outcomes. (2012/13 Annual Plan)

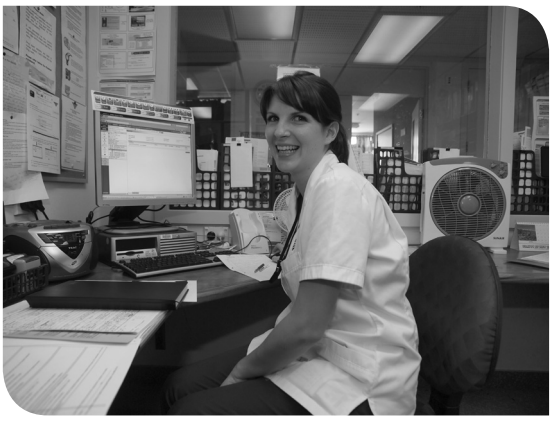
These characteristics were reflected in our Annual Priorities for 2012/13:

- Integrating health services into a more unified system
- Improving our processes and culture
- Government Priorities and Health Targets
- Financial sustainability
- Working with our neighbours, and
- Prevention and earlier intervention.

We also have an ongoing focus on reducing disparities and inequalities, on improving the quality of the services we provide and fund, and on collective clinical and non-clinical leadership.

Our priorities will help us in providing the best possible service in the following ways:

- • An integrated whole of Hutt Valley approach to make health and efficiency gains in how long term conditions are managed and prevented, and how and when hospital care is accessed
- • Co-operation with other DHBs and the wider health sector is also integral to our success – we cannot “go it alone”:



- The Central Regional Services Plan that has been developed between Hutt Valley, Mid Central, Capital and Coast, Hawke’s Bay, Whanganui and Wairarapa DHBs is an important starting point for greater efficiency in service provision, to be secured through collaboration.
- Sub-regionally, we have a particularly close relationship with Capital & Coast and Wairarapa DHBs. We are planning collaboratively for the future development of our clinical services. As we move forward we, expect this co-operation to be reflected in increasingly common approaches to accountability and planning approaches and documents.
- Within the wider health sector, we will work with organisations such as Health Benefits Limited and the Health Safety and Quality Commission to provide high quality services more efficiently and effectively.
- In 2012/13 we will continue improving our hospital processes and culture, which will complement the redevelopment of our Emergency Department and theatres
- Delivering on the Government’s Health Targets and Priorities
- Financial sustainability means that we are using our public funding efficiently, and gives us a stable platform for planning and delivering services to our population.
- Prevention and earlier intervention is critical to developing a sustainable health service, and to improving the overall health of the Hutt Valley population. This will also assist in addressing inequalities, as Maori and Pacific people in the Hutt Valley have a higher risk of developing long term conditions such as diabetes and Heart disease.

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 (around 25,585 people). 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, and experiences higher levels of deprivation than non-Maori.

An estimated 27,000 (17%) Hutt Valley residents have some form of disability and around 16,000 of those people are younger than 65 years. Most disabled people live in the community, with only 13% of older disabled people in residential care and less than 1% of disabled people under the age of 65 in residential care.

Our population's rates for health risk factors are broadly similar to the national rates, i.e. for smoking prevalence, physical activity, hazardous drinking, obesity, high cholesterol, and high blood pressure. Worse or significantly worse rates, when compared with national figures, occur for consumption of fruit and vegetables and breastfeeding.

When compared with national figures, our population has:

- Similar leading causes of hospitalisation, with the exception that asthma is a leading cause of hospitalisation for Maori, Pacific and Asian children aged 0 to 4 years, and diabetes is a leading cause of hospitalisation for Maori and Pacific people 65 years and over
- Significantly higher rates of avoidable hospitalisation, in particular for diabetes,
- cardiovascular disease – especially ischaemic heart disease, and asthma
- Significantly higher rates for prescriptions in the last 12 months
- Significantly higher rates for emergency department attendances
- Lower number of GPs per 10,000 population.

When compared with national figures, our population experiences higher population rates of chronic conditions; diabetes prevalence, asthma prevalence, chronic obstructive pulmonary disease prevalence, and chronic mental health disorder prevalence.

Hutt Valley people experience similar leading causes of mortality, with the addition of stroke.

These factors indicate that our existing activities in the following areas need to continue and increase in emphasis:

- Working closely with primary care to address long term conditions and avoidable hospitalisation, and to reinforce education and prevention, particularly amongst Maori and

Pacific and people with higher needs.

- Continuing our positive engagement with our community providers, including through the cluster of Whanau Ora providers, with a focus on education, prevention and outreach services particularly amongst Maori and Pacific people
- Continuing our emphasis on undertaking actions to better link our hospital with our primary care providers; and
- Positioning ourselves to meet the changed demand for services which will result from an aging population.

Our Hutt Valley DHB annual budget is $442.9 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. (See the directory at the end of this report.) 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.

In the 2012/13 year, the DHB committed 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.

Key Measures - Health Targets

For the year ended 30 June 2013

Key Measures - Health Targets

Quarter four (April to June) Results

Shorter stays in Emergency Departments

		Quarter four performance (%)	95%	Change from previous quarter
1	West Coast	100		-0.2
2	Wairarapa	97		0.0
3	Whanganui	97		0.1
4	Nelson Marlborough	97		0.4
5	Hutt Valley	97		1.4
6	South Canterbury	96		-0.6
7	Waitemata	96		-1.3
8	Counties Manukau	96		-0.8
9	Taranaki	96		-0.8
10	Canterbury	95		1.3
11	Auckland	95		0.6
12	Tairawhiti	95		-0.3
13	Hawke's Bay	93		0.1
14	Northland	92		-1.8
15	Lakes	92		-2.2
16	Southern	91		-1.1
17	Bay of Plenty	90		0.1
18	Waikato	88		-0.6
19	Capital & Coast	87		-1.0
20	MidCentral	86		-3.3
	All DHBs	93		-0.5

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

From next quarter, some level two emergency department facilities will be included in the target.

Improved access to Elective Surgery

		Quarter four performance (%)	100%	Progress against plan (discharges)
1	Northland	124		1546
2	Hawke's Bay	117		949
3	Lakes	115		548
4	Waikato	115		1916
5	Taranaki	112		504
6	Counties Manukau	111		1704
7	Bay of Plenty	108		632
8	MidCentral	106		381
9	Canterbury	106		956
10	South Canterbury	106		156
11	West Coast	106		94
12	Hutt Valley	105		262
13	Tairawhiti	105		100
14	Southern	102		157
15	Capital & Coast	101		88
16	Waitemata	101		112
17	Auckland	101		91
18	Nelson Marlborough	100		25
19	Wairarapa	100		1
20	Whanganui	100		1
	All DHBs	107		10,223

Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4000 discharges per year. DHBs planned to deliver 148,259 discharges for the 2012/13 year, and have delivered 10,223 more.

Shorter waits for Cancer Treatment

		Quarter four performance (%)	100%	Change from previous quarter
1	Northland	100		0.0
1	Waitemata	100		0.0
1	Auckland	100		0.0
1	Counties Manukau	100		0.0
1	Waikato	100		0.3
1	Lakes	100		0.0
1	Bay of Plenty	100		0.0
1	Tairawhiti	100		0.0
1	Hawke's Bay	100		0.0
1	Taranaki	100		0.0
1	MidCentral	100		0.0
1	Whanganui	100		0.0
1	Capital & Coast	100		0.0
1	Hutt Valley	100		0.0
1	Wairarapa	100		0.0
1	Nelson Marlborough	100		0.0
1	West Coast	100		0.0
1	Canterbury	100		0.0
1	South Canterbury	100		0.0
1	Southern	100		0.0
	All DHBs	100		0.0

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. Six regional cancer centre DHBs provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin. Medical oncology services are provided by the majority of DHBs.

Increased Immunisation

		Quarter four performance (%)	85%	Change from previous quarter
1	Whanganui	96		3.5
2	Hawke's Bay	95		1.2
3	Southern	95		1.7
4	MidCentral	94		0.7
5	West Coast	93		15.4
6	Wairarapa	93		-3.2
7	Canterbury	92		-0.3
8	Capital & Coast	92		1.0
9	Waitemata	92		1.3
10	Hutt Valley	91		-2.1
11	Auckland	90		-0.8
12	Counties Manukau	90		3.4
13	Taranaki	89		0.9
14	Tairawhiti	89		4.1
15	Bay of Plenty	89		0.9
16	South Canterbury	88		-3.9
17	Nelson Marlborough	87		0.1
18	Lakes	86		1.0
19	Waikato	83		2.0
20	Northland	83		-0.4
	All DHBs	90		1.2

Increased immunisation

The national immunisation target is 85 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between April and June 2013 and who were fully immunised at that stage.

Better help for Smokers to Quit

	Change from previous quarter	95%	Hospitals
	0.2		97
	-0.3		98
	0.9		99
	-0.5		99
	0.3		98
	-0.2		90
	-0.5		95
	1.9		97
	0.4		96
	2.0		95
	2.3		96
	4.2		98
	4.4		96
	-0.7		95
	3.5		95
	4.6		95
	-0.3		97
	0.1		96
	0.1		97
	2.4		93
	1.0		96

		Primary care	90%	Change from previous quarter
1	Wairarapa	96		32.6
2	Hawke's Bay	80		-11.8
3	South Canterbury	76		-6.3
4	Bay of Plenty	74		-8.0
5	Northland	72		16.4
6	MidCentral	67		13.7
7	Capital & Coast	66		11.4
8	Taranaki	65		2.2
9	Whanganui	62		20.1
10	Nelson Marlborough	61		2.5
11	Waikato	61		9.8
12	Lakes	61		6.7
13	Southern	56		-4.5
14	Counties Manukau	56		10.8
15	West Coast	55		1.4
16	Tairawhiti	54		6.9
17	Hutt Valley	51		16.6
18	Auckland	48		6.7
19	Waitemata	43		3.6
20	Canterbury	35		3.8
	All DHBs	57		5.9

Better help for smokers to quit

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.

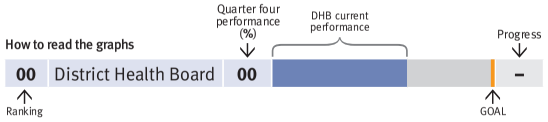
More Heart and Diabetes Checks

		Quarter four performance (%)	75%	Change from previous quarter
1	Auckland	81		17.5
2	Wairarapa	81		11.6
3	Capital & Coast	76		16.0
4	Counties Manukau	76		14.9
5	Northland	74		5.1
6	Taranaki	73		3.0
7	Waikato	73		5.7
8	Hawke's Bay	72		5.0
9	Whanganui	72		8.8
10	Bay of Plenty	72		3.1
11	Waitemata	71		6.4
12	Tairawhiti	68		4.7
13	MidCentral	68		12.4
14	Lakes	66		4.0
15	South Canterbury	64		5.6
16	Southern	63		3.5
17	West Coast	58		0.6
18	Nelson Marlborough	57		1.3
19	Hutt Valley	49		6.8
20	Canterbury	32		3.2
	All DHBs	67		8.2

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved in stages by July 2014. The current stage is to achieve 75 percent by July 2013.

How to read the graphs



Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.

This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

New Zealand Government

Statement of Objectives & Service Performance

For the year ended 30 June 2013

Statement of Objectives & Service Performance

For the year ended 30 June 2013

The Statement of Service Performance describes the DHB's non-financial performance and provides an indication of how well activity over the past year contributed to improving the health and well-being of the local population. The Statement of Service Performance also measures operational performance, ensuring the DHB is delivering sustainable and quality services effectively and efficiently. The Statement of Service Performance reports against targets outlined in the DHB's Statement of Forecast Service Performance in the Annual Plan and Statement of Intent. One of the functions of the Statement of Service Performance, as stated in the Crown Entities Act (s142) is to show how what Hutt Valley DHB did in 2012/13 is measured. These performance measures, targets and milestone are subject to annual audit by auditors appointed by the Office of the Auditor General.

The performance measures include national measures, which are consistent across all 20 DHBs, along with local measures and associated targets. The measures presented are intended to provide a picture of access to services, timeliness of service provision and the quality of care being provided, in order to enable evaluation of performance over time. In determining the set of performance measures, we have focused on our identified health gain priorities, the transformation we are seeking to achieve and the expectations of the Minister of Health. The national 'Health Targets' are the measures that reflect the Minister of Health's expectations for 2012/13, and these are mixed through the Statement of Service Performance.

While the DHB is a provider of hospital and specialist services, we are also the funder of services for our community and work in partnership with other health and disability service providers, external agencies and organisations to collectively improve the health of our community. As the funder, we are often reliant on a third party to deliver the outputs needed to achieve the desired outcomes or objective, and our role is in influencing and enabling change through partnership, leadership and supportive contracting. A number of the associated performance measures in the 2012/13 Statement of Forecast Service Performance were chosen to provide an indication of the success of that collective and collaborative approach.

In the performance tables, each measure has a "key" which indicates the type of measure: coverage (C), Timeliness (T), Quality (Q) or Volume (V). 2011/12 comparative information is provided with measures where available.

Performance Interpretation

The tables on the following pages have the achievements against targets for each of these output classes. These have been categorized according to the table below:

Achievement	Definition
Achieved	Target has been achieved
Partially Achieved	For targets with multiple components, some targets have been met but not all.
Not Achieved	Target has not been met.

This Statement of Service Performance has been grouped into four output classes. These groupings enable us to provide an overview of the services for which the DHB is responsible or accountable. The four output classes applied across all 20 DHBs are outlined below.

Prevention Services (Public Health Services)

Public health services are publicly funded services that protect and promote population health or identifiable subpopulations, comprising services designed to enhance the health status of the population as distinct from curative services which repair/support health and disability dysfunction.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and equality in health status is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protection services such as immunisation and screening services.

Early Detection and Management (Primary and Community Health Services)

Primary and community health care services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. It includes general practice, community and Maori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

Intensive Assessment and Treatment (Hospital Services)

The hospital services output class comprises services that are delivered by a range of secondary, tertiary and quarternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable collocation of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

Rehabilitation and Support (Support Services)

Support services comprise services that are delivered following a 'needs assessment' process and coordination input by Needs Assessment Service Co-ordination Services for a range of services including palliative care services, home-based support services and residential care services.

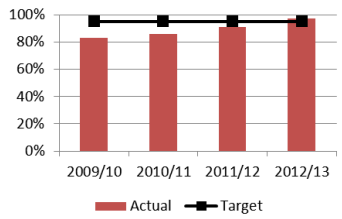
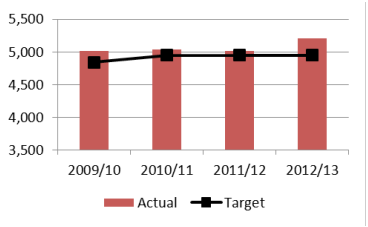
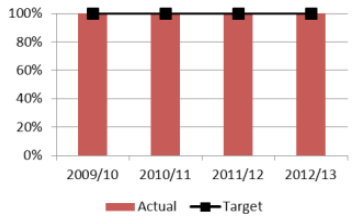
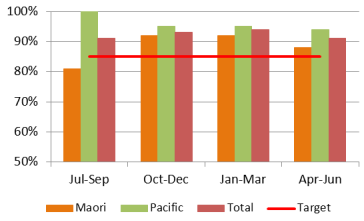
Revenue	2011/12	2012/13 Budget	2012/13 Actual
Prevention	21,626	21,300	20,742
Early Detection and Management	116,592	116,410	118,697
Intensive Assessment and Treatment	237,891	244,180	245,584
Rehabilitation and Support	58,229	58,019	57,910
Total	**434,338**	**439,909**	**442,933**

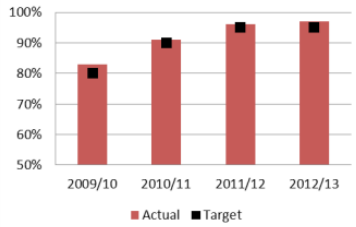
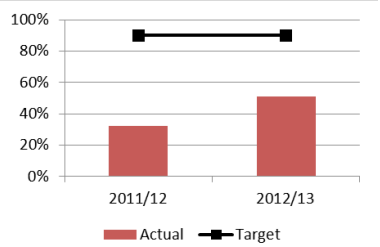
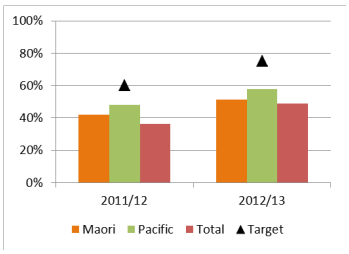
Expenditure	2011/12	2012/13 Budget	2012/13 Actual
Prevention	21,072	21,908	20,744
Early Detection and Management	111,976	112,589	112,628
Intensive Assessment and Treatment	241,631	246,751	253,527
Rehabilitation and Support	59,555	58,661	58,995
Total	**434,234**	**439,909**	**445,894**

Performance Highlights

In 2012/13 Hutt Valley DHB maintained high performance in areas of achievement and progressed work to improve the health of the Hutt Valley population.

- 92% of eight month olds had received their scheduled immunisations in 2012/13. Immunisation rates are 89% for Maori, 93% for Pacific and 90% for children living in deprived areas, exceeding the national target of 85%.
- HVDHB also continues to perform well for immunisation at two years, with 94% of children fully immunised for the total population, 94% for Maori and 97% for Pacific.
- HVDHB provided advice to help quit to 97% of people who smoke and were admitted to hospital in 2012/13. Te Awakairangi Health Network and Ropata Medical Centre provided advice to 51% of smokers attending primary care in the Hutt Valley. For primary care, this is an increase of 19% from 2011/12, which equates to an additional 3,550 patients being provided advice and support to quit smoking.
- As at 30 June 2013 49% of the total eligible population had a cardiovascular risk assessment in the last five years. This includes 51% of the eligible Maori population and 58% of the eligible Pacific population. This represents a total increase of 15% from 2011/12, and 8,160 risk assessments completed in 2012/13. This is a large volume for primary care and reflects the hard work of Te Awakairangi Health Network and Ropata Medical Centre.
- People in the Hutt Valley are less likely to be admitted to hospital for an avoidable condition compared to in 2011/12. Avoidable hospitalisation rates have improved for some population groups, particularly children and Maori, in 2012/13.
- Hutt Valley has improved performance in and progressed to exceeding the 95% target for the percentage of patients discharged or transferred from ED within six hours. For the April – June quarter, 97% of patients were discharged or transferred within six hours, placing Hutt Valley fifth nationally.
- 5,208 elective surgeries were delivered to the DHB population in 2012/13, 262 above what was planned and 188 more than in the previous year.

Health Target	Description and 2012/13 Result	Trend
Shorter stays in Emergency Departments 	95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours. 2012/13 Result: 92% **Output Class: Intensive Assessment and Treatment**	
Improved access to elective surgery 	More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year. HVDHB's target was 4,946 discharges in 2012/13. 2012/13 Result: 5,208 (105%) **Output Class: Intensive Assessment and Treatment**	
Shorter waits for cancer treatment 	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. 2012/13 Result: 100% **Output Class: Intensive Assessment and Treatment**	
Increased immunisation 	85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014. 2012/13 Result 92% **Output Class: Prevention Services**	

Better help for smokers to quit 	95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. 2012/13 Result Hospital: 97% Primary Care: 51% **Output Class: Prevention Services**	**Hospital**  **Primary Care** 
Better diabetes and cardiovascular services 	75 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. 2012/13 Result: 49% **Output Class: Early Detection and Management**	

[1] This is no longer measured by Regional Public Health.

Prevention Services

Smoking Cessation Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: Percentage of smokers hospitalised and given advice to quit	C	96%	95%	97%	Achieved
Health Target: Percentage of enrolled patients who smoke and are seen in General Practice will be provided with advice and help to quit	C	32%	90%	51%	Not Achieved

Commentary

The DHB continues to provide advice to quit to over 95% of smokers who are hospitalised. In 2012/13 the percentage of enrolled patients who smoke and are seen in General Practice receiving advice to quit did not reach the 90% target; however rates did increase by 19% which equates to 3,550 more patients being provided advice and help to quit.

Health Promotion

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of schools and early childhood services receiving health promotion visits (Hutt Valley and Capital & Coast populations)	V	142	138	290	Achieved
Number of education and training sessions provided	V	929	906	N/A[1]	
Number of opportunities taken to provide strategic public health input and expert advice to inform policy and public health programming	V	39	60	31	Not Achieved

Commentary

Regional Public Health (RPH) has completed 150 visits to Early Childhood Services across HVDHB and CCDHB, with a health promotion focus. These have been with a focus on the assistance in translating the healthy skin tool, to promote the Pacific workshops, First Aid course and the Professional Development Day and to assist with outbreaks of vomiting and diarrhoea. A further 140 visits were made to schools across HVDHB and CCDHB by the 'health promoting schools' public health advisors. Some projects that they have been involved with are road safety, nutrition, nutrition surveys, starting up lunch time physical education and bullying.

Thirty-one written submissions were made by Regional Public Health to territorial local authorities, central government agencies, as well as central government committees such as the social service select committee. It is important to note data collection is limited to prepared written submissions and that these are demand-driven based on local/regional/national government consultation requirements.

Population based screening programmes

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Breast screening 50-69 – Total	V	11,883 (77%)	11,113 (70%)	10,972 (67%)	Not Achieved
Maori	V	1,083 (69%)	1,183	1,026 (58%)	Not Achieved
Pacific	V	576 (70%)	606	534 (60%)	Not Achieved

Commentary

Target was not achieved for breast screening. The screening service is working to identify any issues and to raise awareness of the importance of breast screening, particularly with Maori and Pacific population groups.

Well Child, Well School Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of visits to schools by health nurses - HVDHB	V	733	1,632	1,355	Not Achieved
CCDHB	V	1,154	3,363	2,369	Not Achieved
Number of Before School Checks	V	1,761	1,778	2,223	Achieved

Commentary

There has been improved practice around data capture and a new system has been implemented to ensure data quality. Within the total 3,724 visits occurring across Hutt Valley and Capital and Coast, there were 491 home visits and 960 visits relating to the Rheumatic Fever Programme in Porirua. Home visits are based on school referrals and require a large time investment from the nurses. This measure has been changed for 2013/14 to better reflect what is accurately captured in data systems.

Statutory and Regulatory Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Communicable disease notifications investigated	V	2,679	2,733	2,541	Achieved
Number of environmental health investigations	V	824	1,281	684	Not Achieved
Number of controlled purchase operations	V	21	29	439	Achieved

Commentary

In 2012/13 there has been a decrease in the number of communicable disease notifications investigated. Pertussis notifications have decreased over the past 12 month period; this is a positive impact of increased immunisation.

The number of tobacco and alcohol controlled purchase operations is much higher than the target due to changes in how this is measured. Each premise visited is now classed as a controlled purchase operation.

Immunisation Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: The percentage of children fully immunised at 8 months old	C	New measure in 2012/13	90%[2]	92%	Achieved
Percentage of Year 7 children vaccinated in schools	C	65%	75%	73%	Not Achieved
Percentage of Year 8 girls (birth cohort 1998) vaccinated against Human Papillomavirus	C	58%	65%	58%	Not Achieved
Over 65 year olds flu vaccinated	C	9,574	9,791	12,594	Achieved

Commentary

Hutt Valley DHB has exceeded the Ministry of Health target of 85% of children fully immunised by 8 months by June 2013. Performance as at 30 June 2013 is 92% total, 89% Maori and 93% Pacific. HVDHB also continues to perform well for immunisation at two years, with 94% of children fully immunised for Total and Maori, and 97% coverage for Pacific.

While the school programme for Year 7 children has fallen shy of the DHB target, it is important to note the high rates of students already vaccinated, and those that prefer to receive vaccinations from the GP. Overall, if students vaccinated by GPs are included the rate of Year 7 students immunised is 82%.

[2] Due to Hutt Valley DHB's strong historical performance for immunisation at two years, the DHB chose to have a stretch target of 90% in the Statement of Forecast Service Performance rather than 85% national health target.

Early Detection and Management

Primary and Community Care

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of people accessing programmes	V	28,803	19,986	14,683	Not Achieved
Number of Hutt Valley people enrolled in a Primary Healthcare Organisation	V	140,400	140,320	140,137	Not Achieved
Number of people enrolled in CarePlus[3]	V	3,502	3,050	6,950	Not Achieved
Health Target: CVD risk assessment	C	34%	75%	49%	Not Achieved

Commentary

While target for Hutt Valley people enrolled in a Primary Healthcare Organisation was not achieved, a 97% enrolment rate has been maintained. 80% of the Hutt Valley enrolled population is enrolled with Te Awakairangi Health Network, 13% with Cosine Primary Health Network, and 7% with Capital & Coast DHB's PHOs. Currently it is estimated that there are 4,748 people from the Hutt Valley not enrolled with any PHO.

Te Awakairangi Health Network and Ropata Medical Centre have increased the percentage of the eligible population having had a cardiovascular disease (CVD) risk assessment in the last five years. As at 30 June 2013, 14,636 (49%) people had had a CVD risk assessment, an increase of 8,160 (72%) from 2011/12. The percentage increase between 2011/12 and 2012/13 results has only increased 15% due to the increase in the eligible population.

Pharmacist Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of dispensed items	V	2,289,068	2,466,618	2,286,848	Achieved

Commentary

On 1 July 2012 the new national Community Pharmacy Services Agreement (CPSA) was introduced. One of the key changes to this national agreement was the shift towards a capped funding model for pharmacy services based on patient need, rather than reimbursement based on dispensing volumes. The result of this can be seen in 2012/13 results, with volumes being lower than expected.

[3] This measure is for HVDHB and CCDHB combined as services, contracted jointly.

[4] Results for the year to 31 July 2013.

Community Referred Test/Diagnostic Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of laboratory tests	V	2,167,000	2,280,000	2,284,189[3]	Achieved
Number of radiological examinations	V	9,646	10,500	9,160	Not Achieved
Total number of community mental health clients seen	V	4,879	5,000	3,905	Not Achieved
Total number of occupied bed days	V	16,695	17,806	14,418	Not Achieved

Commentary

There has been a decrease in the number of clients due to improved data collection methods which prevent the duplicate counting of servicer users who attend multiple services.

There has been a decrease in the number of occupied bed days as there has been lower utilisation of regional alcohol and other drug residential services in 2012/13.

Oral Health Services[5]

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of enrolled pre-school and school children (HVDHB and CCDHB)	V	55,048	58,137	57,620	Not Achieved
Total number of school dental service examinations for pre-school children (HVDHB and CCDHB)	V	7,554	10,461	8,025	Not Achieved
Number of adolescents examined	V	6,399 (67% of cohort)	7,600 (80% of 9,500 cohort)	6,318 (68% of cohort)	Not Achieved

Commentary

The target for the number of enrolled pre-school and school children was an ambitious target. While target has not been attained, the number of enrolled children has increased by 2,572 (5%) in 2012. There are number of planned actions under development for 2013/14 to improve enrolment of eligible children into the Bee Healthy Regional Dental Service, for example:

- Enrolment from birth. Once in place parents will be invited to "opt-out" of the service if they choose rather than the current "opt-in" process of enrolment.
- Increase options for the public to enrol such as web site, when visiting the doctor and when engaging with other child services.
- Targeted enrolment initiatives.

The number of school dental service examinations for pre-school children was also an ambitious target, based on large growth in enrolment. The number of examinations for pre-school children has increased by 471 (6%) in 2012. Preschool children receive examinations at the new dental hubs; presently three are open in Hutt Valley and three in Capital and Coast. Plans are underway for the construction of five more sites, which will further improve access for children across the two DHBs.

[5] Measured on a calendar year basis to align with the school year.

68% of Hutt Valley adolescents received dental examinations in 2012. It is hoped that improvement on this result will be achieved in 2013/14 through working closely with the colleges where utilisation of dental services is lower. Further, a proposed "opt-out" Adolescent Oral Health transfer system has been developed and is due to be implemented mid-September 2013, which will improve the transition from the Regional Dental Service to a community dentist.

Intensive Assessment and Treatment

Mental Health Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Total number of clients seen	V	2,977	2,500	2,492	Not Achieved
Total number of occupied bed days	V	8,894	6,935	8,560	Achieved
Percentage of people who have up to date crisis prevention plans	Q	97%	95%	93%	Not Achieved

Commentary

There has been a decrease in the number of clients due to improved data collection methods which prevent the duplicate counting of servicer users who attend multiple services.

Elective Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: Elective services provided by Hutt Hospital and by other DHBs for the Hutt Valley population	V	5,020	4,946	5,208	Achieved
First specialist assessments (medical & surgical) provided at any public hospital for the Hutt Valley population	V	16,585	18,614	16,203	Not Achieved
Elective services provided by Hutt Hospital for the Hutt Valley and other DHB populations	V	6,412	6,722 (CWD)	6,748	Achieved
First specialist assessments (medical & surgical) provided by Hutt hospital for the Hutt Valley and other DHB populations	V	15,764	15,721	13,599	Not Achieved
Percentage of day case discharges	T, Q	58.1%	58%[6]	56%	Not Achieved

Commentary

Hutt Valley DHB continues to achieve the elective surgery health target, with 5,208 discharges in 2012/13. Hutt Hospital completed 6,748 case-weighted discharges, an increase of 336 from 2011/12.

[6] The Ministry of Health revised the methodology for this measure part way through the year and therefore updated DHBs' targets.

Fertility Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of fertility cycles	V	280	244	298	Achieved

Acute Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of Emergency Department (ED) attendances	V	41,044	43,320	46,105	Not Achieved
Number of inpatients	V	19,466	12,968	13,779[7]	Not Achieved
Health Target: The percentage of patients discharged or transferred from ED within six hours	T, Q	91%	95%	92%	Not Achieved
Average length of stay (days)	T	3.95	4.01	3.73	Achieved
Reducing acute readmission rate[8]	Q	10.02		10.67	Not Achieved

Commentary

For the April to June quarter, 97% of patients were discharged or transferred from ED within six hours. Several initiatives have been undertaken during 2012/13 to improve performance, and saw the 95% target achieved for the second half of the year.

Maternity Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of deliveries	V	2,015	≥2,000	1,880	Not Achieved
Average postnatal length of stay (days)	T	2	≥1.9	2.1	Achieved
Average neo-natal length of stay (days)	T	7.1	≤9.0	10.82	Not Achieved

Commentary

The number of deliveries is demand-driven, and there have been less births in the Hutt Valley than anticipated. The average neo-natal length of stay has increased, however this depends on the complexity of treatment for neonates.

The average postnatal length of stay has increased, allowing women to establish breastfeeding and gain confidence in caring for their new infant before returning home.

[8] Excludes CAU and Maternity

[9] A target was not agreed with the Ministry of Health for this measure in 2012/13

Rehabilitation and Support

Needs Assessment Services Coordination

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of total assessments (including new, reviews and reassessments)	V	2,329	≥3,600	2,714	Not Achieved
Number of client complaints to DHB	Q	3	<5	6	Not Achieved
Percentage of new assessments completed within agreed timeframes	T	99%	≥95%	99%	Achieved

Commentary

The number of total assessments has increased in 2012/13 to 2,714 from 2,329 in 2011/12. Despite the increase, target has not been met due to less new assessments being required than expected, however more reviews and reassessments were completed than in the previous year.

Home Based Support

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of home based support unique clients	V	1,860	≥1,920	1,882	Not Achieved
Number of home based support hours	V	239,802	≥224,850	255,768	Achieved

Commentary

While the number of home based support clients did not grow as much as anticipated, the number of home based support hours has exceeded target. This is due to an increase in the level of care required per patient.

Aged Residential Care Bed Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Total number of subsidised aged residential care bed days	V	273,720	310,250	310,359	Achieved
Number of providers audited	V	13	12	12	Achieved
Number of residential/aged dementia bed days	V	28,212	33,580	32,367	Not Achieved

Commentary

The number of subsidised aged residential care bed days has increased in line with trend data, resulting in target being achieved. The number of residential/aged dementia bed days did not achieve target, however has increased 4,155 (15%) in 2012/13.

Aged Residential Care Bed Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Total number of subsidised aged residential care bed days	V	273,720	310,250	310,359	Achieved
Number of providers audited	V	13	12	12	Achieved
Number of residential/aged dementia bed days	V	28,212	33,580	32,367	Not Achieved

Commentary

The number of subsidised aged residential care bed days has increased in line with trend data, resulting in target being achieved. The number of residential/aged dementia bed days did not achieve target, however has increased 4,155 (15%) in 2012/13.

Respite and Day Care Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of respite days	V	1,437	3,100	3,203	Achieved
Respite beds utilised	V	4.2	8.5	11.8	Achieved
Number of day service clients	V	158	200	129	Not Achieved

Commentary

The number of day service clients is demand-driven, and uptake was lower than expected in 2012/13. During 2012/13 and 2013/14 there has been a focus on improving information to clients on available services.

Palliative Care Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Number of patients receiving specialist palliative care	V	617	466	295	Not Achieved

The number of patients receiving specialist palliative care is demand-driven and dependent on patient choice and whether it is clinically appropriate

Community Nursing Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Total number of contacts	V	29,249	38,650	37,537	Not Achieved

Commentary

While target was not achieved, there has been an increase of 8,288 (28%) during 2012/13.

Social Work Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Total number of contacts	V	1,468	1,900	2,331	Achieved

Community Mental Health Support Services

Measure	Key	2011/12 performance	2012/13 Target	2012/13 Performance	Achievement
Total number of clients seen	V	464	500	490	Not Achieved
Total number of occupied bed days	V	16,695	12,720	9,796	Not Achieved

Commentary

While target was not achieved for the total number of clients seen, there was an increase of 26 clients in 2012/13.

Impacts & Outcomes Report

For the year ended 30 June 2013

Impacts and Outcomes

For the year ended 30 June 2013

Long-term outcomes are progressed not just through our work alone, but through the combined effects of all working across the health system and wider health and social services. Evidence about the state of our population's health and the environment in which they live helps us monitor progress towards our intended outcomes. As such, we identified performance indicators related to each outcome in our Statement of Intent 2012-2015, and report against these below. Given the long-term nature of these outcomes, the aim is to make a measurable change over time rather than achieve a specific target. The information provided is the latest available at the time of publication; where possible this pertains to the 2012/13 year with a trend view.

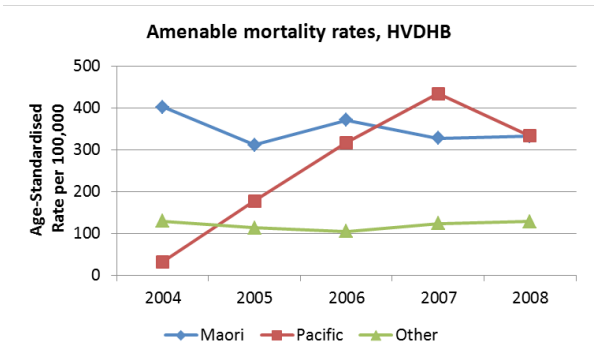
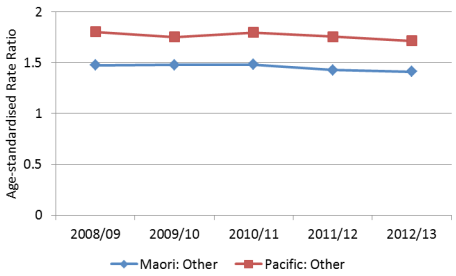
Due to increasing collaboration across Wairarapa, Hutt Valley and Capital & Coast DHBs in 2012/13, the high level impact measures have been aligned across the three DHBs. The strategic visions of the three DHBs were similar for 2012/13, and have been combined into a single set of joint operating priorities in 2013/14. As the 2012/13 strategic visions were similar, many of the outcomes and impacts align. The original wording as in the 2012/13 Statement of Intent has been used for the outcome measures.

Population health outcome: Improved health equity

What difference have we made for our population?

Reducing disparities in our district is a focus for Hutt Valley DHB. In 2012/13 an Equity Report was developed for the three DHBs. This report uses measures where results are available quarterly, and the headline indicators are preschool oral health enrolment, cardiovascular risk assessments, and the rate of outpatient "did not attend" (DNA) appointments. It is anticipated that through improved monitoring of disparities, the DHBs will be able to more effectively plan activities and reduce the disparities which exist.

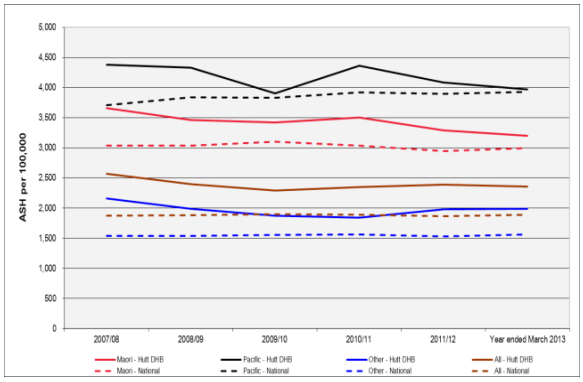
The current level of amenable mortality can be thought of as potential for population health gain through improvements in the health system. It is defined as premature deaths from those conditions for which variation in mortality rates reflects variation in the coverage and quality of health care. Similarly, ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that may be prevented or treated by appropriate interventions in a primary or community setting. It is a shorter term measure than amenable mortality. There have been improvements in ASH rates for Hutt Valley DHB since 2010/11, however rates remain above the national average. Work will continue to be undertaken in 2013/14 to improve these rates. Acute admission rates are influenced by a broader set of strategies including prevention and treatment in primary care as well as alternative models of care.

Measures – The DHB measures progress through:	
A reduction in amendable mortality rates for Maori & Pacific • Amendable mortality captures risks of dying from conditions (diseases and injuries) that are either preventable or treatable. Avoidable mortality includes deaths occurring under age 75 years that could potentially have been avoided through population-based interventions, or through preventive and curative interventions at an individual level. • Maori and Pacific in the Hutt Valley experience avoidable mortality rates that are approximately three-and-a-half times the rate for non-Maori non-Pacific (2008 year). • 2012/13 results are not presently available due to delays in mortality data, therefore the latest has been provided. This measure links to the Early Detection & Management and Intensive Assessment & Treatment output classes.	
A reduction in acute admissions for Maori & Pacific • Maori are about one-and-a-half times more likely to be admitted acutely to hospital than non-Maori non-Pacific. • Pacific are one point seven times as likely to be admitted acutely to hospital than non-Maori non-Pacific. This measure links to the Prevention Services and Early Detection & Management Output Classes.	

A reduction in the ambulatory sensitive hospitalisation (ASH) rates

- There are a number of admissions to hospital which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention, and the continuum of care across the system.
- The rate of preventable hospitalisations in Hutt Valley is higher than the national rate, but is declining. This represents a substantial and avoidable burden on the health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment across the whole system.

This measure links to the Prevention Services and Early Detection & Management output classes.



Source: Ministry of Health, 2013

Population health outcome: Health risk is reduced

What difference have we made for our population?

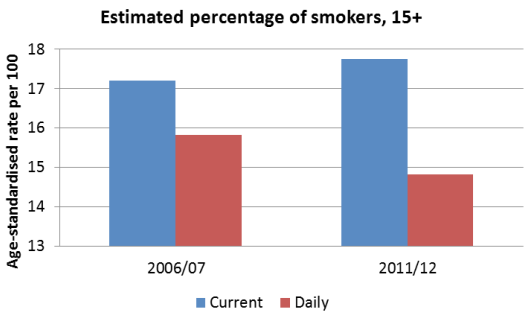
We are pleased to see a continued increase in the proportion of year 10 students who report never smoking in the annual Action on Smoking and Health Survey. While we were disappointed to see a rise in the estimated percentage of current smokers 15+ in the area covered by Regional Public Health, it is positive that there has been a decline in those who smoke daily. There has been an increase in the percentage of the population consuming 2+ fruit and 3+ vegetable servings daily, showing an improvement in healthy eating. However, there has been an increase in the estimated prevalence of obesity. Hutt Valley DHB and Regional Public Health and their partners such as local PHOs continue to advocate for healthy lifestyles, which will see long term gains for our population.

Measures – The DHB measures progress through:

A reduction in smoking rates for the 15+ population

- Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care.
- While the estimated prevalence of current smokers has increased, the rate of daily smokers has decreased. This is positive as it means those who smoke are smoking less frequently. It is anticipated over time, with reduced uptake of smoking as teenagers, that overall smoking rates will decrease.

This measure links to the Prevention Services output class.

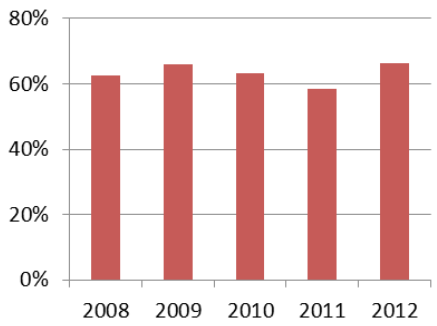


Source: NZ Health Survey, results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs

A reduction in the proportion of young people who take up tobacco smoking

- Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.
- A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.

This measure links to the Prevention Services output class.

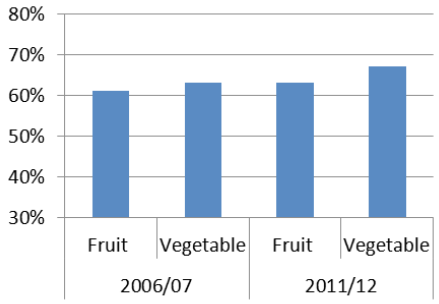


Source: ASH Yr 10 Survey

An increase in the percentage of adults consuming 2+ fruit and 3+ vegetable servings daily

- Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect people against obesity, CVD, diabetes and some common cancers and contributes to maintaining and healthy body weight.
- Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.

This measure links to the Prevention Services output class.

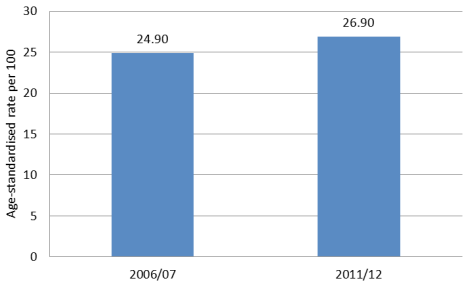


Source: NZ Health Survey, results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs

A reduction in obesity prevalence amongst the population 15+

- Obesity prevalence estimates are obtained from the New Zealand Health Survey, and reflect results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs.
- Obesity rates are increasing across New Zealand. With effective preventative measures, including people being more active and eating more healthily, obesity rates can be reduced. Reducing obesity rates will reduce the incidence of related preventable diseases, including diabetes and cardiovascular disease.

This measure links to the Prevention Services output class.



Source: NZ Health Survey, results for the area covered by Regional Public Health, which covers Wairarapa, Hutt Valley and Capital & Coast DHBs

Population health outcome: Healthier communities, families and individuals

What difference have we made for our population?

Many lifelong habits are established in childhood, and health promotion for children and their parents influences long term outcomes. By keeping children healthy, the DHB aims to ensure not only a healthy start but also a healthy life. Oral health results for children are recognised as an indicator of lifelong health. Hutt Valley DHB has some of the best performance nationally for the rate of children caries free at five years and the average number of decayed, missing or filled teeth at Year 8. However, disparities are evident at these ages. Improved preschool enrolment in and early engagement with the dental service will help all families to have good oral health.

ASH rates provide a 'real time' view of whether children are receiving appropriate treatment at the right level. This provides a proxy for access and health literacy, as well as an indication of the burden of preventable disease. ASH rates for Hutt Valley children 0-4 have declined in 2011/12 and in the year to March 2013. Activities to reduce admissions for top conditions, such as gastroenteritis, will continue in 2013/14 and the DHB looks to continue to reduce avoidable admissions for children.

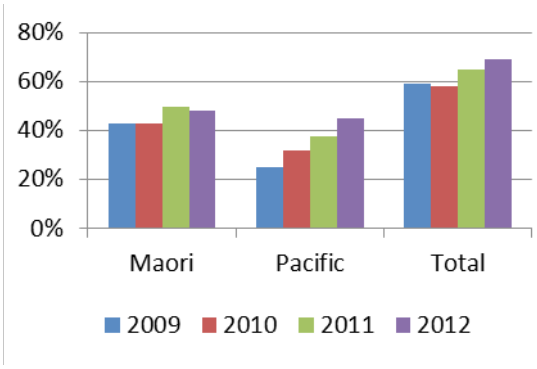
Rheumatic fever mostly affects children and adolescents and is a consequence of a throat infection caused by streptococcus bacteria. It can result in chronic heart disease with reduced life expectancy. Rheumatic fever is the leading cause of childhood heart disease in New Zealand, contributing to poor child health outcomes. Maori and Pacific children are disproportionately represented in terms of disease incidence and rheumatic fever outcomes in New Zealand. A sub-regional rheumatic fever plan is being developed to address the incidence of rheumatic fever in Wairarapa, Hutt Valley and Capital & Coast DHB areas.

Measures – The DHB measures progress through:

Increased proportion of children caries free at five years

- Regular dental care has life-long benefits for improved health. While water fluoridation can significantly reduce tooth decay across all population groups, prevention and education initiatives are essential to good oral health.
- Oral health outcomes are a good proxy measure of early contact with effective health promotion and prevention services. It also serves as an indicator of risk factors, such as poor diet, and therefore can provide other benefits in terms of improved nutrition and healthier body weights.
- There is an improving trend and the rate of children caries free at five years is above the national (59%).

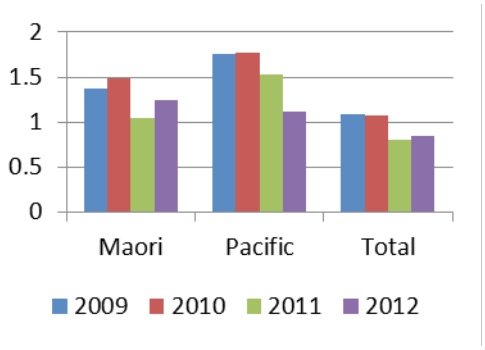
This measure links to the Early Detection & Management output class.



Decrease in the mean number of decayed, missing or filled teeth (DMFT) at Year 8

- Maori and Pacific children are more likely to have decayed, missing or filled teeth, and improved oral health is a good proxy measure of equity of access to services and the effectiveness of mainstream services in targeting those most in need.
- HVDHB has a declining trend in the mean number of decayed, missing or filled teeth, which is good. The 2012 mean DMFT for Total and Pacific populations is below the national mean of 1.16.

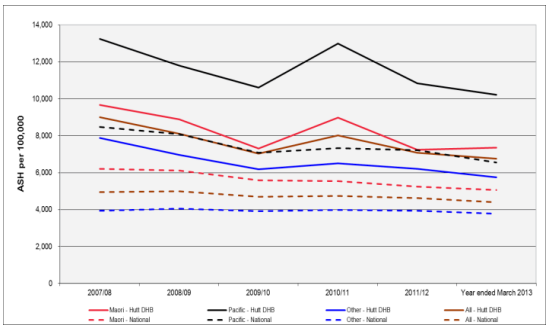
This measure links to the Early Detection & Management output classes.



A reduction in ambulatory sensitive hospitalisations of children (0-4)

- Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. 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.

This measure links to the Prevention Services &Early Detection & Management output classes.

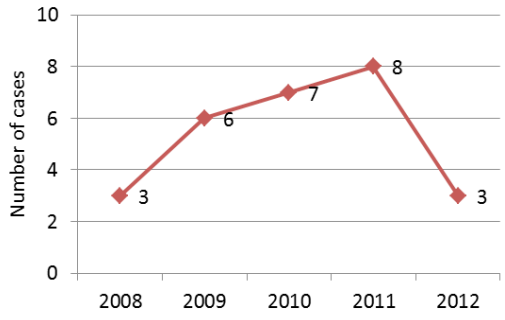


Source: Ministry of Health, 2013

Reduced incidence of rheumatic fever in vulnerable children

- Rheumatic fever is a serious illness which affects the young and can damage their health for life. New Zealand has very high rates of this preventable disease compared to other developed countries. The rates are particularly high amongst M ori and Pacific people.
- A subregional rheumatic fever plan is being developed in 2013/14 to further reduce the incidence of rheumatic fever in Hutt Valley, Capital & Coast, and Wairarapa DHBs.

This measure links to the Prevention Services &Early Detection & Management output class.



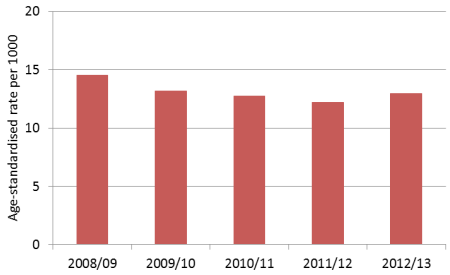
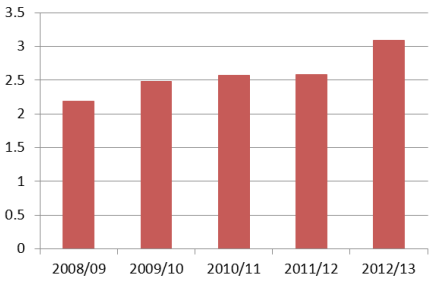
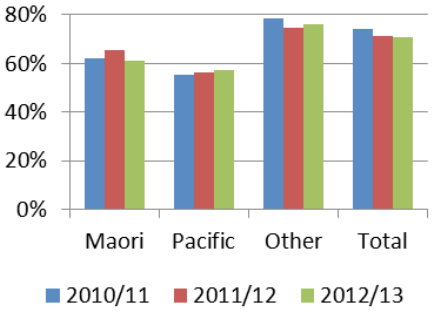
Source: ESR surveillance reports

Population health outcome: Reduced avoidable hospitalisations

What difference have we made for our population?

There is an increasing burden of long term conditions, seen in the continued increase in diagnosis of cardiovascular disease and diabetes. By better managing the health of people with long term conditions, the DHB can help them lead longer, healthier lives and prevent unneeded hospital admissions. Improved screening for and detection of cardiovascular disease and diabetes helps management occur earlier, reducing the likelihood of complications. Since 2010/11 there has been a reduction in the rate of hospital admissions for cardiovascular disease, however there has been growth in diabetes hospitalisation rates.

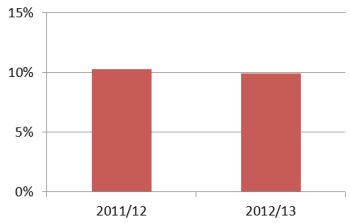
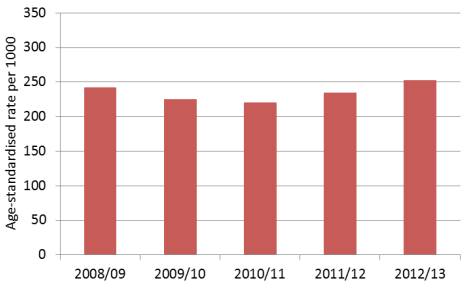
Another measure of the management of long term conditions is the percentage of diabetics with satisfactory blood glucose control. In Hutt Valley DHB, rates for Other and Total populations remain high, while there have been improvements in the rate for Pacific. Through the Diabetes Care Improvement Plan, it is hoped to make further gains in diabetes management in the Hutt Valley.

Measures – The DHB measures progress through:	
A reduction in the cardiovascular disease (CVD) hospitalisation rate • Cardiovascular disease (CVD) includes heart attacks and strokes - which are both substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. This measure links to the Prevention Services and Early Detection & Management output classes.	 Source: National Minimum Dataset
A reduction in diabetes hospitalisation rate • Diabetes is defined by the body's inability to control blood glucose. Diabetes is a chronic condition, which can cause kidney failure, eye disease, foot ulceration and a higher risk of heart disease if not well managed. • Supporting people to manage their diabetes well will reduce acute admissions to hospital. This measure links to the Prevention Services and Early Detection & Management output classes.	 Source: National Minimum Dataset
Increased proportion of diabetics checked with satisfactory or better blood glucose control (HbA1c less than or equal to 64 mmol/mol) • Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as lower limb amputation, kidney failure and blindness, and will improve people's quality of life. This measure links to the Early Detection & Management output classes.	 Source: National Minimum Dataset

Population health outcome: Better length and quality of life

What difference have we made for our population?

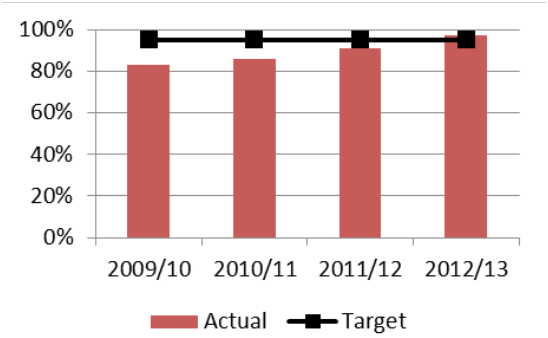
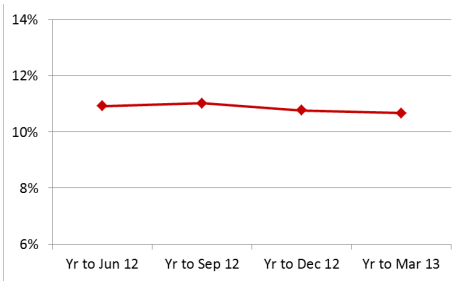
When people are supported to remain in their own homes, they live healthier, more independent lives. The DHB provides home-based support services to those who require them, so that people are able to remain in their own home. In 2012/13 the proportion of older people 65+ supported to live at home has been maintained. There has been an increasing rate of unplanned acute admissions for people 65+ in 2011/12 and 2012/13. Activities are planned for 2013/14 to improve these rates, and support people to lead longer, healthier lives.

Measures – The DHB measures progress through:	
An increase in the proportion of older people 65+ years supported to live at home • When people receive the adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. This measure links to the Early Detection & Management and Rehabilitation & Support output classes.	
A reduction in the unplanned acute admission rate for people aged 65+ years • By supporting older people to remain at home and maintaining functional level for longer, the DHB seeks to reduce the unplanned acute admission rate for people aged over 65 years.	

Population health outcome: People access integrated, sustainable, quality services

What difference have we made for our population?

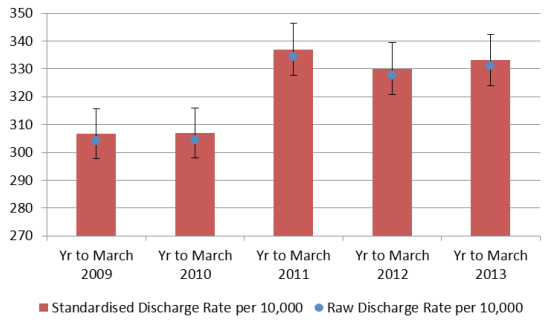
Patient-focused, clinically driven pathways of care provide flexibility for early intervention and planned readmission where clinically appropriate, and support improvements in care across the whole continuum. In 2012/13, Hutt Valley DHB achieved 95% in the Shorter Stays in Emergency Departments Health Target, and the DHB continues to work to improve patient flow. Quality patient care and integration with primary care continue to be prioritised, with improvements in the rate of acute hospital readmissions within 28 days. Patients who require elective services are receiving them appropriately, with Hutt Valley DHB's performance matching the national target of 333.00 per 10,000. These measures indicate that patients accessing Hutt Valley DHB services are receiving integrated, sustainable, quality services.

Measures – The DHB measures progress through:	
Shorter stays in Emergency Department (ED) • Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through DHB services. It also demonstrates a commitment to addressing the needs of Hutt Valley DHB patients and valuing their time. • Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through management of acute demand in the community, improved capacity in ED and supported discharge into services in the community. This measure links to the Intensive Assessment & Treatment output class.	
A reduction in the acute hospital 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 countermeasure to average length of stay. This measure links to the Intensive Assessment & Treatment output class.	 Source: Ministry of Health

An increase in standardised intervention rates (SIR) for elective services

- One of the areas of focus for elective services is the level of service being provided to the Hutt Valley population (as measured by Standardised Intervention Rates), and the level of service being provided for identified key conditions, including cardiac procedures, major joint replacement and cataract procedures.

This measure links to the Intensive Assessment & Treatment output class.



The performance story provided is a comprehensive view, and allows for a robust assessment of Hutt Valley DHB's impact and outcome performance. As the impact measures have been aligned across the three DHBs, the following impacts originally listed in the Statement of Forecast Service Performance are not specifically reported here, although some have been reported through the measures in this section:

- Breastfeeding rates
- Qualitative reporting on issues identified and severity of outbreaks
- Reduced or static notifiable disease rates (meningococcal, mumps, pertussis)
- Reduced hospital admissions for respiratory conditions of people 65+
- Incidence of cervical cancer reduces
- Reduced rate of non-admitted triage 4 & 5 ED self-presentations
- Reduced rate of ED presentations for Mental Health issues
- Reduced avoidable hospital admissions (dental)
- Reduced readmission rate to adult inpatient mental health services
- Reduced acute length of stay (ALOS) for inpatient mental health services
- Day of surgery admission rates
- Minimise outpatient did not attends (DNAs)
- Patients given a commitment to treatment but not treated within six months
- Less than 2% of patients will wait longer than six months for a first specialist appointment (FSA)
- 30 day mortality
- Reduced readmissions for neonates
- Improved NASC average waiting time from receipt of referral to assessment
- All providers required to hold certification are certified for three years
- Reduced number of care quality complaints to the DHB
- Reduced avoidable hospitalisation rate, 0-74 Cellulitis
- Avoidable hospitalisation rate, 0-74 respiratory
- Reduced acute mental health inpatient admissions

The following measures were listed as both outputs and impacts in the Statement of Forecast Service Performance, and are therefore reported in the Statement of Service Performance in the section previous:

- Improved percentage of new assessments completed within agreed timeframes
- Increased utilisation of respite services

Financial Report

For the year ended 30 June 2013

Statement of Comprehensive Income

For the year ended 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Actual $000
Income				
Operating Income	2	441,892	439,537	433,866
Interest		1,041	372	472
Total Income		**442,933**	**439,909**	**434,338**
Expenditure				
Personnel Costs	3	154,155	154,267	153,240
Depreciation, Amortisation & Impairment expense	10-11	11,452	14,642	11,031
Outsourced Services		10,127	5,696	5,874
Clinical Supplies		23,541	23,330	25,322
Infrastructure and non-clinical expenses		15,132	15,661	14,849
Other District Health Boards		80,163	77,614	79,348
Non-Health Board Providers		138,472	135,349	133,322
Capital Charge	4	5,308	5,568	4,966
Interest expense	5	3,859	4,407	2,903
Other expenses	6	3,685	3,375	3,379
Total Expenditure		**445,894**	**439,909**	**434,234**
Net surplus / (Deficit)		**(2,961)**	**-**	**104**
Other comprehensive income				
Revaluation of Land and Buildings		29,439	-	-
Total Comprehensive Income for the Year		**26,478**	**-**	**104**

The notes to accompany these financial statements start on page 43, including explanations for major variances against budget in note 27.

Statement of Changes in Equity

For the year ended 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Audited $000
Equity as at 1 July		68,308	68,089	64,088
Capital Contributions from the Crown		-	-	4,323
Repayment of equity to the Crown		(207)	-	(207)
Revaluation surplus		29,439	-	-
Total Comprehensive Income for the Year		(2,961)	-	104
Equity as at 30 June	17	**94,579**	**68,089**	**68,308**

The notes to accompany these financial statements start on page 43, including explanations for major variances against budget in note 27.

Statement of Financial Position

As at 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Audited $000
Assets				
Current Assets				
Cash and cash equivalents	7	24,650	214	29,217
Debtors and other receivables	8	11,861	15,305	12,680
Inventories	9	1,435	1,289	1,431
Total Current Assets		**37,946**	**16,808**	**43,328**
Non Current Assets				
Property, Plant and Equipment	10	204,037	181,197	177,774
Intangible Assets	11	4,281	10,639	3,999
Investment in Joint Ventures	12	1,280	867	223
Trust and bequest funds	13	1,099	992	997
Total Non Current Assets		**210,697**	**193,695**	**182,993**
Total Assets		**248,643**	**210,503**	**226,321**
Liabilities				
Current Liabilities				
Bank Overdraft		-	2,700	-
Creditors and other payables	14	39,036	17,298	47,229
Employee entitlements and provisions	15	25,453	30,025	20,751
Borrowings	16	11,207	-	3,051
Total Current Liabilities		**75,696**	**50,023**	**71,031**
Non Current Liabilities				
Employee entitlements and provisions	15	6,978	4,570	6,846
Borrowings	16	70,291	86,829	79,139
Trust and bequest funds	13	1,099	992	997
Total Non Current Liabilties		**78,368**	**92,391**	**86,982**
Total Liabilities		**154,064**	**142,414**	**158,031**
Equity				
Crown equity	17	44,078	44,203	44,285
Revaluation reserves	17	79,807	50,368	50,368
Retained earnings	17	(29,306)	(26,482)	(26,345)
Total Equity	17	**94,579**	**68,089**	**68,308**
Total Equity and Liabilities		**248,643**	**210,503**	**226,321**

The notes to accompany these financial statements start on page 43, including explanations for major variances against budget in note 27.

For, and on behalf of, the Board

Board Member | Board Member | 31 October 2013

Statement of Cash Flow

As at 30 June 2013

	Note	2013 Budget $000	2012 Audited $000
Cashflows from Operating Activities			
Cash receipts		455,252	449,687
Payments to providers		(232,317)	(225,720)
Payments to suppliers & employees		(210,038)	(195,671)
Goods and Services Tax (net)		128	1,205
Capital charge paid		(5,308)	(5,425)
Net cash flows from Operating Activities	18	**7,717**	**24,076**
Cashflows from Investing Activities			
Interest Received		1,041	472
Proceeds from sale of property, plant and equipment		301	27
Purchase of property,plant and equipment		(5,215)	(25,297)
Investments		(1,867)	(223)
Net cash flows from Investing Activities		**(5,740)**	**(25,021)**
Cashflows from Financing Activities			
Equity Contribution		-	4,323
Loans raised		(348)	25,600
Interest paid		(5,645)	(3,366)
Payment of Finance Leases		(344)	(310)
Repayment of Equity		(207)	(207)
Net cash flows from Financing Activities		**(6,544)**	**26,040**
Net Increase / (Decrease) in Cash Held		**(4,567)**	**25,095**
Cash and cash equivalents at beginning of year	7	29,217	4,122
Cash and Cash Equivalents at end of year		**24,650**	**29,217**

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 Nil (2012: $3.5m) was acquired by means of finance leases during the year.

The notes to accompany these financial statements start on page 43, including explanations for major variances against budget in note 27.

Notes to the Financial Statements

For the year ended 30 June 2013

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 domiciled in New Zealand. Hutt Valley DHBs ultimate parent is 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 2013, and were approved by the Board on 31 October 2013.

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

TheThe 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.

There have been no revisions to accounting standards during the financial year which have had an effect on the DHB's financial statements.

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 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

Notes to the Financial Statements

For the year ended 30 June 2013

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.

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

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.

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

Notes to the Financial Statements

For the year ended 30 June 2013

value of the leased item or the present value of the minimum lease payments.

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

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

Operating leases

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

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

Foreign currency transactions

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

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held on call with Health Benefits Limited (HBL) and 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.

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

Notes to the Financial Statements

For the year ended 30 June 2013

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.

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	6 to 33 years
Building Services Fitout	2 to 36 years
Plant and equipment	2 to 25 years
Computer equipment	2 to 10 years

Notes to the Financial Statements

For the year ended 30 June 2013

Leased assets	3 to 6 years
Motor vehicles	5.5 to 10 years

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software 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 3-10 years, amortisation rate 10- 33%

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.

Notes to the Financial Statements

For the year ended 30 June 2013

Creditors and other payables

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

Borrowings

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

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

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

Notes to the Financial Statements

For the year ended 30 June 2013

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 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, buildings and site improvements to fair value.

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

The budget figures are derived from the statement of 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.

Notes to the Financial Statements

For the year ended 30 June 2013

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 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

	Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Ministry of Health contract funding	379,690	377,217	373,237
ACC Contract revenue	4,414	4,555	4,419
Other Government	1,419	1,700	1,977
Revenue from other District Health Boards	50,808	49,997	49,267
Other patient care related revenue	4,838	5,861	4,229
Other Income:			
Gain on Sale of Fixed Assets	301	-	27
Donations and bequests received	350	126	605
Donated property, plant and equipment	-	-	-
Rental income and services	72	81	105
Total Operating Income	**441,892**	439,537	433,866

3 Personnel Costs

	Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Salaries and wages	150,979	154,267	154,219
Contributions to defined contribution schemes	3,308	-	69
Increase/(decrease) in liability for employee entitlements	(132)	-	(1,048)
Total Personnel Costs	**154,155**	**154,267**	153,240

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 2013 was 8% (2012: 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 (administered by the Ministry of Health after the disestablishment of 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 $185k (2012: $515k)

6 Other Expenses

	Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Audit Fees for financial statement audit	121	111	115
Audit-related fees for internal audit services	149	114	110
Operating lease expense	2,939	2,721	2,800
Impairment of debtors	124	36	(11)
Board member fees	349	390	329
Loss on disposal of property, plant and equipment	3	3	36
Total Other expenses	**3,685**	**3,375**	**3,379**

7 Cash and cash equivalents

	Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Call Deposits with Health Benefits	19,077	-	-
Cash at bank and on hand	7	-	1,169
Other call deposits	5,566	198	23,031
Term deposits with maturities less than 3 months	-	-	5,017
Total cash and cash equivalents	**24,650**	**198**	**29,217**
Bank overdrafts	-	(2,700)	-
Cash and cash equivalents for the purposes of the statement of cash flows	**24,650**	**(2,502)**	**29,217**

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

The Hutt Valley DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue used in determining working capital limits, and is defined as one-twelve of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For the Hutt Valley DHB that equates to $15.9million.

The New Zealand International Financial Reporting Standards (NZIFRS 7) requires disclosure of the credit quality of the financial assets. The money with HBL is classified under "counterparties without credit rating"(Note 25: Credit quality of financial assets).

8 Debtors and other receivables

	2013 Actual $000	2012 Actual $000
Ministry of Health receivables	5,735	5,922
Other DHBs	1,336	1,212
PHARMAC	2,559	2,571
Trade debtors - other	2,004	2,715
Provision for doubtful debts	(342)	(305)
	11,292	**12,115**
Prepayments	569	565
Total Debtors and other receivables	**11,861**	**12,680**

The carrying value of receivables approximates their fair value.

The ageing profile of receivables at year end is detailed below:

	2013			2012		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	10,367	(12)	10,355	11,427	(42)	11,385
Past due 1-30 days	160	(24)	136	671	(6)	665
Past due 31-60 days	191	(35)	156	71	(6)	65
Past due >60 days	916	(271)	645	251	(251)	0
Total	**11,634**	**(342)**	**11,292**	**12,420**	**(305)**	**12,115**

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:

	2013 Actual $000	2012 Actual $000
Opening Balance	(305)	(371)
Additional Provisions made	(124)	11
Receivables Written Off	87	55
Closing Balance	**(342)**	**(305)**

9 Inventories

	2013 Actual $000	2012 Actual $000
Pharmaceuticals	121	141
Surgical and medical supplies	1,324	1,300
	1,445	**1,441**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,435**	**1,431**

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 (2012: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2012: 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 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)
Balance 30 June 2012	13,020	3,239	171,466	45,574	3,351	2,379	239,029
Balance 1 July 2012	13,020	3,239	171,466	45,574	3,351	2,379	239,029
Additions	-	745	16,614	5,219	156	287	23,021
Work in Progress	-	-	(13,806)	(1,722)	-	-	(15,528)
Disposals	-	-	(1,610)	(84)	-	-	(1,694)
Adjustments	-	-	(59)	(7,620)	(855)	(29)	(8,563)
Revaluation increase/ (decrease)	605	(1,817)	(3,086)	-	-	-	(4,298)
Balance 30 June 2013	13,625	2,167	169,519	41,367	2,652	2,637	231,967
Accumulated depreciation and impairment losses							
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
Balance at 1 July 2012	-	453	27,302	32,651	199	649	61,254
Depreciation expense	-	178	7,518	2,861	271	277	11,105
Depreciation on disposals	-	-	(1,610)	(82)	-	-	(1,692)
Adjustment	-	-	(106)	(8,958)	91	(29)	(9,002)
Elimination on revaluation	-	(631)	(33,104)	-	-	-	(33,735)
Balance 30 June 2013	-	-	-	26,472	561	897	27,930
Carrying Amounts							
At 30 June 2012	13,020	2,786	144,164	12,923	3,152	1,730	177,774
At 30 June 2013	13,625	2,167	169,519	14,895	2,091	1,740	204,037

The net carrying amount of assets held under finance leases is $3.04m (2012: $3.15m) for plant and equipment.

A detailed reconciliation between the fixed assets register and the general ledger has revealed that the fixed asset cost amounts in the general ledger are higher than the fixed assets register cost by $9.7m. Also, the general ledger accumulated depreciation amounts are higher than the accumulated depreciation amount in the fixed assets register by $9.7M. However, the total written down value (WDV) is the same in both records. As the fixed assets register is traditionally the detailed repository for all asset details, including cost and accumulated depreciation, with the general ledger typically holding summary transaction amounts and totals, the appropriate fixed assets costs and corresponding accumulated depreciation balances in the general ledger have been adjusted and aligned with the balances in the fixed assets register. Given that the WDV is the same in both records and this adjustment in the general ledger involves only the reduction in the fixed assets costs and a reduction in the fixed assets accumulated depreciation balances, there is no impact in the statement of financial position.

Valuation

The most recent valuation of land and buildings was performed by an independently contracted registered valuer, Peter Schellekens, ANZIV, SPINZ of CBRE Limited. The valuation is effective as at 30 June 2013. Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Seismic Status of Building

Hutt Valley DHB's buildings have been assessed against the earthquake standards. Of the assessed buildings, all meet the current minimum standards of the Building Code for existing buildings, except that one building (garages at one end of the campus) has a rating of below 33%. Strengthening work of some sort will be required for that building

Given the low level of remedial work anticipated, the Hutt Valley DHB has chosen not to book an impairment on current building values.

11 Intangible Assets

Movements for each class of intangible asset are as follows:

	Computer Software	FPSC Shared Services Rights	Total
Cost or valuation			
Balance 1 July 2011	10,258	-	10,258
Additions	1,605	-	1,605
Work in Progress	791	-	791
Disposals	(24)	-	(24)
Balance 30 June 2012	**12,630**	**-**	**12,630**
Balance 1 July 2012	**12,630**	**-**	**12,630**
Additions	**665**	**810**	**1,475**
Work in Progress	**(409)**	**-**	**(409)**
Adjustment	**(1,123)**	**-**	**(1,123)**
Balance 30 June 2013	**11,763**	**810**	**12,573**
Accumulated depreciation and impairment losses			
Balance at 1 July 2011	7,962	-	7,962
Depreciation expense	699	-	699
Depreciation on disposals	(30)	-	(30)
Balance 30 June 2012	**8,631**	**-**	**8,631**
Balance at 1 July 2012	8,631	-	8,631
Depreciation expense	346	-	346
Adjustment	(685)	-	(685)
Balance 30 June 2013	8,292	-	8,292
Carrying amounts			
At 30 June 2012	3,999	-	3,999
At 30 June 2013	3,471	810	4,281

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

Finance, Procurement and Supply Chain (FPSC) shared services project

Health Benefits Limited (HBL) was established in July 2010 and owned by the 20 DHBs across the country. HBL is undertaking a Finance, Procurement and Supply Chain (FPSC) shared services project aimed at reducing costs in administrative support and procurement for the public health sector. The FPSC project is to be funded by the 20 DHBs across the country who will be the beneficiaries of these savings. As at 30 June 2013, the DHB has accrued $0.81million as its share of the project. This funding represents an intangible asset and gives the DHB the right to access shared services.

12 Investments in Joint Ventures

	Actual 2013 $000	Actual 2012 $000
Carrying Amount of Investment		
Advance on redeemable preference shares	1,280	223
Investments in Joint Ventures	**1,280**	**223**

The investment in Central Region's Technical Advisory Services Limited (CRTAS) comprises 16.67% (2012: 16.67%) shareholding in 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 DHBs share is $100. At balance date all share capital remains uncalled.

As at 30 June 2013, 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.

	2013 Actual $000	2012 Actual $000
Summary of DHBs Interest in Joint Venture		
Assets	3,902	1,387
Liabilities	3,728	1,212
Revenue	2,841	1,934
Expenditure	2,844	1,882
Surplus / (deficit)	(3)	52
Share of contingent liabilities incurred jointly with other investors	-	-
Contingent liabilities that arise because of several liability	-	-

The DHB's share in the investment (unrated) of Health Benefits Limited's (HBL) share capital is 2.82%

13 Trust and Bequest Funds

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

	Actual 2013 $000	Actual 2012 $000
Opening balance	997	902
Funds received	215	226
Interest received	40	37
Funds disbursed	(153)	(168)
Closing Balance	**1,099**	**997**

14 Creditors and other payables

	Actual 2013 $000	Actual 2012 $000
Trade payables	2,620	4,486
Other DHBs	4,647	4,829
Accrued expenses	18,969	21,042
Income in advance	-	7
Other payables	10,143	14,448
GST and other taxes payable	2,175	2,033
Capital charge due to the Crown	-	-
Fixed assets payable	482	384
Total Creditors and other payables	**39,036**	**47,229**

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

	Actual 2013 $000	Actual 2012 $000
Current Liabilities		
Salary and Wages Accrued	4,087	1,937
Annual leave	15,139	14,472
Long Service Leave	1,461	1,265
Retirement Gratuities	524	519
Continuing Medical Education Leave and Expenses	975	905
Other Entitlements	3,267	1,453
Total Current Liabilities	**25,453**	**20,751**
Non-current Liabilities		
Long Service leave	1,863	1,851
Retirement Gratuities	1,059	1,162
Continuing Medical Education Leave and Expenses	2,620	2,727
Other Entitlements	1,436	1,106
Total Non-current Liabilities	**6,978**	**6,846**
Total of Employee Entitlements and Provisions	**32,431**	**27,597**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 4.07% (2012: 2.28%) and an inflation factor of 2.5% (2012: 2.5%) has been used.

16 Borrowings

	Actual 2013 $000	Actual 2012 $000
Current portion		
Finance Lease	707	1,051
Crown Health Financing Agency	10,500	2,000
	11,207	**3,051**
Non-current portion		
Finance Lease	1,791	2,139
Crown Health Financing Agency	68,500	77,000
	70,291	79,139
Total borrowings	**81,498**	**82,190**
Total borrowing facility limits		
Crown Loans – fixed interest	79,000	79,000
Overdraft facility	-	6,000
	79,000	**85,000**

Crown loans

The Crown loans are secured by a negative pledge. Without the Ministry of Health'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 Crown loans borrowings is $83.3m (2012: $86.4m). Fair value has been based on the Government bond rate plus 15 basis points based on mid-market pricing.

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 $2.498m (2012: $3.19m). Fair value is estimated at the present value of future cash flows.

- 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.

	Actual 2013 $000	Actual 2012 $000
Minimum lease payments payable:		
Not later than one year	758	1,199
Later than one year and not later than five years	1,932	2,521
Later than five years	-	-
Total mimimum lease payments	2,690	3,720
Future finance charges	(192)	(530)
Present value of minimum lease payments	2,498	3,190
Present value of minimum lease payable		
Not later than one year	707	1,051
Later than one year and not later than five years	1,791	2,139
Later than five years	-	-
Total present value of minimum lease payments	2,498	3,190

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	Retained Earnings $000	Total Equity $000
Balance 1 July 2011	40,169	8,659	41,709	(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**	**41,709**	**(26,345)**	**68,308**
Balance 1 July 2012	44,285	8,659	41,709	(26,345)	68,308
Contribution from the Crown	-	-	-	-	-
Repayment of Equity	(207)	-	-	-	(207)
Revaluation surplus / (deficit)		605	28,834		29,439
Total Comprehensive Income for the Year	-	-	-	(2,961)	(2,961)
Balance 30 June 2013	**44,078**	**9,264**	**70,543**	**(29,306)**	**94,579**

* Revaluation Reserves

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

	2013 Actual $000	2012 Actual $000
Reconciliation of net operating surplus/deficit with net cash inflow from operating activities		
Net operating surplus	(2,961)	104
Add / (less) non-cash items		
Depreciation and amortisation expense	11,452	11,031
Increase / decrease in provisions	3,885	(1,114)
Total non-cash items	**15,337**	**9,917**
Add / (less) items classified as investing or financing activity		
(Gains) / losses on sale of property, plant and equipment	(298)	9
Net interest paid	2,817	2,431
Total items classified as investing or financing activity	**2,519**	**2,440**
Add / (less) movements in statement of financial position items		
Debtors and other receivables	782	3,497
Inventories	(4)	(167)
Capital charge payable	-	(459)
Creditors and other payables	(7,956)	8,744
Net movements in Working Capital items	**(7,178)**	**11,615**
Net cash flow from Operating Activities	**7,717**	**24,076**

19 Commitments

	2013 Actual $000	2012 Actual $000
Capital commitments - Property, plant and equipment	582	18,368
Non-Cancellable Operating Lease Commitments		
Less than one year	2,095	1,812
One to two years	1,248	1,133
Two to five years	1,943	694
Over five years	74	78
Total non-cancellable operating lease commitments	**5,360**	**3,717**

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

20 Contingencies

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2013 (2012: 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 $379.69m (2012: $373.24m) 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 $5.74m (2012: $6.60m), and the amount owed by Hutt Valley DHB to the Ministry of Health was $108k (2012: $63k).

Hutt Valley DHB has received funding from the Accident Compensation Corporation of $4.41m (2012: $4.42m) 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 $568k (2012: $467k), and the amount owed by Hutt Valley DHB to the Accident Compensation Corporation for health services was nil (2012: nil), and $1.04m for levies payable.

Revenue earned from other DHB's for the care of patient's outside the Hutt Valley amounted to $50.81m (2012: $49.27m). Expenditure to other DHB's for their care of patients from the Hutt Valley amounted to $80.16m (2012: $79.35m). The amount owing to Hutt Valley DHB at the end of the financial year was $1.34m (2012: $1.95m), and the amount owed by Hutt Valley DHB to other DHBs was $4.65m (2012: $5.28m).

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 2013 totalled $1.23m (2012: $1.91m). 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 DHB's 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 $1.85m (2012: $0.95m), and revenue received by Hutt Valley DHB for services provided were $1k (2012: $1k). The amount owed by Hutt Valley DHB at the end of the financial year was $363k.

Key management personnel

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

	2013 Actual $000	2012 Actual $000
Salaries and other short-term employee benefits	2,278	1,614
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	22	9
Total key management personnel compensation	**2,300**	**1,623**

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 $45.14m (2012: $43.79m), with total expenditure of $73.24m (2012: $71.60m). The amount owing to Hutt Valley DHB by Capital and Coast DHB at the end of the financial year was $537k (2012: $1.12m), and the amount owing to Capital and Coast DHB was $4.77m (2012: $4.03m).

During the year Hutt Valley DHB transacted with Wairarapa DHB on normal inter-DHB terms. Both DHB's share an executive management team and also hold combined Community Public Health Advisory Committee meetings. The total value of the revenue was $4.90m (2012: $4.71m), with total expenditure of $922k (2012: $1.13m). The amount owing to Hutt Valley DHB by Wairarapa DHB at the end of the financial year was $263k (2012: $55k), and the amount owing to Wairarapa DHB was $278k (2012: $130k).

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 $7k (2012: $5k) 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 $1k (2012: $10k) 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 $228k (2012: $197k) and were incurred on normal commercial terms. At the end of the financial year $1k was outstanding (2012:$48k).

During the year Hutt Valley DHB transacted with Te Omanga Hospice in which Board member Ken Laban is a Trustee. These services cost $4.00m and were negotiated on normal commercial terms (2012: $3.96m). At the end of the financial year $333k was outstanding (2012:$330k).

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 (2012: 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	2013 Actual $000	2012 Actual $000
Dr Virginia Hope	Board Chair	45	46
Wayne Guppy	CPHAC Chair	30	30
Keith Hindle	FRAC Chair	25	25
Peter Glensor	HAC Chair	27	29
David Bassett	Current Member	23	24
David Ogden	Current Member	23	23
Iris Pahau	Current Member	22	22
John Terris	Current Member	24	23
Kathryn Austin	Current Member	24	25
Ken Laben	Current Member	22	23
Peter Douglas	Current Member	22	24
Total		**322**	**329**

Deborah Chin was the Crown Monitor, not a board member.

Other payments have been made to Maori Partnership Board members and other co-opted community representatives for attendance at meetings of $27k (2012: $29k).

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 (2012: 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	9	23	9	32
Wayne Guppy	CPHAC Chair	9	17	9	20
Keith Hindle	FRAC Chair	7	18	9	20
Peter Glensor	HAC Chair	9	25	9	27
David Bassett	Current Member	8	13	9	17
David Odgen	Current Member	9	12	9	12
Iris Pahau	Current Member	7	7	9	10
John Terris	Current Member	9	15	9	15
Katy Austin	Current Member	9	16	9	17
Ken Laban	Current Member	5	9	9	12
Peter Douglas	Current Member	6	7	9	15

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	2013	2012
100,000-109,999	29	31
110,000-119,999	24	19
120,000-129,999	13	14
130,000-139,999	9	6
140,000-149,999	12	13
150,000-159,999	11	10
160,000-169,999	13	7
170,000-179,999	6	7
180,000-189,999	5	8
190,000-199,999	3	6
200,000-209,999	5	4
210,000-219,999	6	7
220,000-229,999	8	12
230,000-239,999	11	9
240,000-249,999	4	3
250,000-259,999	3	5
260,000-269,999	4	4
270,000-279,999		2
280,000-289,999	5	2
290,000-299,999	2	1
300,000-309,999	1	
310,000-319,999	1	3
320,000-329,999	1	1
330,000-339,999	1	
340,000-349,999	1	
350,000-359,999		1
360,000-369,999		1
370,000-379,999	1	
380,000-389,999		
390,000-399,999	2	
620,000-629,999		1
Grand Total	**181**	**177**

During the year ended 30 June 2013, 19 (2012: 11) employees received compensation and other benefits in relation to cessation totalling $281,056 (2012: $145,044). The payments made were in the nature of redundancy or retirement gratuities.

24 Events after the balance date

There are no significant events subsequent to balance date.

25 Financial Instruments

Fair Values

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

	2013		2012	
	Carrying Amount $000	Fair Value $000	Carrying Amount $000	Fair Value $000
Cash and cash equivalents	24,650	24,650	29,217	29,217
Debtors and other receivables	11,861	11,861	12,680	12,680
Creditors and other payables	39,036	39,036	47,229	47,229
Secured loans	79,000	83,334	79,000	86,400
Finance leases	2,498	2,498	3,190	3,190
	157,045	161,379	171,316	178,716

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 2013, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2012/13, 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:

	2013 Actual $000	2012 Actual $000
Counterparties with credit ratings		
Cash and cash equivalents including trust funds		
AA-	-	-
AA-	6,672	-
Unrated (Call Deposits with Health Benefits Ltd)	**19,077**	**30,214**
	25,749	**30,214**
Maximum exposure for each class of financial instrument		
Cash and cash equivalents	24,650	29,217
Trust and bequest funds	1,099	997
Debtors and other receivables	11,861	12,680

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
2012						
Creditors and other payables	47,229	47,229	47,229	-	-	-
Finance leases	3,190	3,967	872	872	2,223	-
Crown Loans-fixed interest	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**
2013						
Creditors and other payables	39,036	39,036	39,036	-	-	-
Finance leases	2,498	3,095	872	872	1,350	-
Crown Loans-fixed interest	79,000	97,195	14,300	7,373	60,932	10,591
Total	**120,534**	**139,326**	**54,208**	**8,246**	**62,282**	**10,591**

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 2013 are provided below.

Statement of Comprehensive Income

The Hutt Valley DHB recorded a deficit of $2,961k compared with the budgeted breakeven position. The major variances were:

- Higher personnel costs due to staffing reductions not being totally achieved, higher overtime and outsourced costs;
- Insurance cost increases;.
- Costs relating to other District Health Boards were higher than budget because of higher Inter District Flows for patients treated at other hospitals; and
- Non-Health Board Providers' costs were higher than budget because of higher Aged Residential Care costs.

The above higher than budgeted costs were partly offset by higher Clinical Training Agency revenue and unbudgeted revenue from Residential Medical Officer (RMO) training, lower depreciation due to delays in capital expenditure programmes, adjustments for extension of the assets' useful lives, lower interest, and capital charge costs.

Statement of Financial Position

Cash and cash equivalents were higher than budget because of:

- lower capital expenditure than planned for the year; and
- funds held by the DHB for the National Haemophiliac Management Group and the National IT Grants Fund that were not budgeted for.

Statement of Cash Flows

The net cash flow was lower than the previous year primarily because of:

- higher disbursements to creditors and contracted staff; and
- lower than planned borrowing draw downs.

28 Cost of Service Statements for Output Classes

Financial Statement by Output Class

For the year ended 30 June 2013

$000	Prevention Services			Early Detection & Management Services			Intensive Assessment & Treatment			Rehabilitation & Support Services			DHB Total		
	2012/13 Actual	2012/13 Budget	2011/12 Audited	2012/13 Actual	2012/13 Budget	2011/12 Audited	2012/13 Actual	2012/13 Budget	2011/12 Audited	2012/13 Actual	2012/13 Budget	2011/12 Audited	2012/13 Actual	2012/13 Budget	2011/12 Audited
Income															
Operating Income	20,723	21,301	21,611	118,685	116,410	116,582	244,574	243,808	237,444	57,910	58,019	58,229	441,891	439,537	433,866
Interest Income	19	-	15	12	-	10	1,010	372	447	-	-	1	1,040	372	472
Total Income	**20,742**	**21,301**	**21,626**	**118,697**	**116,410**	**116,592**	**245,584**	**244,180**	**237,891**	**57,910**	**58,019**	**58,230**	**442,931**	**439,909**	**434,338**
Expenditure															
Personnel Costs	12,441	12,985	13,092	10,409	11,476	13,182	127,957	126,149	123,401	3,348	3,656	3,565	154,156	154,267	153,240
Depreciation	223	718	276	661	952	480	10,557	12,965	10,266	11	8	9	11,452	14,642	11,031
Outsourced Services	1,063	861	853	561	319	686	8,288	4,430	4,245	215	87	89	10,126	5,696	5,874
Clinical Supplies	956	1,067	1,852	731	658	1,147	20,707	20,262	21,095	1,147	1,344	1,227	23,540	23,330	25,322
Infrastructure and Non Clinical Expenses	502	774	709	884	1,056	1,272	13,691	13,753	12,762	55	78	106	15,132	15,661	14,849
Other District Health Boards	-	-	-	11,946	12,214	11,834	63,417	60,537	61,913	4,800	4,864	5,601	80,162	77,615	79,348
Non Health Board Providers	1,712	1,635	1,006	83,595	81,835	79,699	4,565	4,244	4,386	48,600	47,635	48,231	138,472	135,349	133,322
Capital Charge	228	238	225	916	983	628	4,156	4,339	4,105	8	8	8	5,307	5,568	4,966
Interest Expense	62	284	62	41	41	41	3,753	4,079	2,798	2	2	2	3,858	4,407	2,903
Other	494	239	-	459	456	-	2,678	2,622	3,379	55	59	0	3,686	3,375	3,379
Internal Allocations	3,063	3,108	2,995	2,425	2,601	3,007	(6,242)	(6,628)	(6,718)	754	919	716	-	(1)	-
Total Expenditure	**20,744**	**21,908**	**21,072**	**112,628**	**112,589**	**111,976**	**253,527**	**246,751**	**241,631**	**58,995**	**58,661**	**59,555**	**445,894**	**439,898**	**434,234**
Net Surplus / (Deficit)	**(3)**	**(608)**	**554**	**6,069**	**3,821**	**4,615**	**(7,943)**	**(2,571)**	**(3,740)**	**(1,085)**	**(642)**	**(1,326)**	**(2,961)**	**-**	**104**

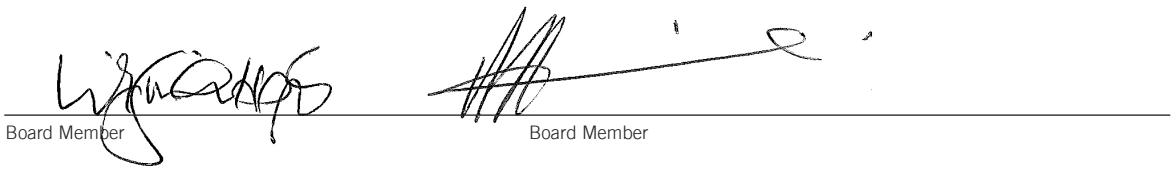
Statement of Responsibility

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 2013.

Signed on behalf of the Board



Board Member | Board Member

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Hutt Valley District Health Board's financial statements and performance information for the year ended 30 June 2013

The Auditor-General is the auditor of Hutt Valley District Health Board (the Health Board). The Auditor-General has appointed me, Kelly Rushton, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and performance information of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 39 to 73 that comprise the statement of financial position as at 30 June 2013, 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 performance information of the Health Board that comprises the statement of service performance on pages 11 to 25 and the report about outcomes on pages 27 to 36.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 39 to 73:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
    - financial position as at 30 June 2013; and
    - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets) rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 10 to 25 and 27 to 36:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2013. 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 performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, 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 performance information 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.

Our audit of the financial statements involved 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; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information 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 and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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 performance information 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 External Reporting Board.

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

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

Hutt Valley DHB Directory

As at 30 June 2013

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
- Pete Chandler, Chief Operating Officer
- Helen Pocknall, Executive Director of Nursing & Midwifery
- Iwona Stolarek, Cheif Medical Officer
- Russell Simpson, Executive Director Allied Health, Scientific & Technical
- Carolyn Cooper (3DHB), Executive Director People & Culture
- Ashley Bloomfield (3DHB), Director Service Integration & Development Unit (SIDU)
- Kelvin Watson (3DHB), Acting Chief Information Officer
- Cate Tyrer, General Manager Quality & Risk
- Judith Parkinson, Finance Manager
- Richard Schmidt, Executive Officer
- Stephanie Turner (Acting, Wairarapa)
- Kuini Puketapu (Acting, Hutt Valley), Maori Health
- Tofa Suafole Gush, Director, Pacific People's Health
- Jill Stringer, Communications Manager
- Justine Thorpe, Programme Director, Tihei Wairarapa
- Bridget Allen (Hutt Valley), Chief Exective, Te Awakairangi Health Network

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.

- Bob Francis (Combined – Chair)
- Virginia Hope (Combined – Chair)
- Judith Aitken
- Margaret Faulkner
- Wayne Guppy
- Keith Hindle
- Ken Laban
- Rick Long
- Iris Pahau
- Leanne Southey
- Janine Vollebregt
- 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.

- Bob Francis (Combined - Chair)
- Virginia Hope (Combined - Chair)
- Judith Aitken
- Margaret Faulkner
- Wayne Guppy
- Keith Hindle
- Ken Laban
- Rick Long
- Iris Pahau
- Leanne Southey
- Janine Vollebregt
- 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)
- Viv Napier (deputy chair)
- Katy Austin
- David Bassett
- Peter Douglas
- Bob Francis
- Virginia Hope
- Rob Irwin
- Helen Kjestrup
- Fiona Samuel
- John Terris
- Debbie Chin (Crown Monitor)