HUTT VALLEY DHB

Hutt Valley District Health Board

Annual Report 2014

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FOREWORD

ABOUT HUTT VALLEY DISTRICT HEALTH BOARD

Hutt Valley District Health Board plans, funds, and provides government-funded healthcare and disability support services for 146,000 people in the Hutt Valley[1]. Of these people, 104,000 live in Lower Hutt and 42,000 live in Upper Hutt.

The Hutt Valley population has a slightly higher proportion of Māori and Pacific people compared to the national average. Around 18% (25,700 people) of the Hutt Valley population are Māori, and about 8% (12,200 people) are Pacific people. We also have sizeable Asian and refugee populations. Most Māori and Pacific people live in Lower Hutt. The Māori and Pacific populations are younger than other ethnic groups, with around half younger than 25 years. The Māori and Pacific populations also experience higher levels of deprivation than other ethnic groups.

An estimated 19% (27,000 people) of the Hutt Valley population have some form of disability[2]. Of these people, around 11% (16,000 people) are younger than 65 years old. 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.

When compared with national figures, our population has:

- Similar rates for health risk factors: smoking, low physical activity, fruit and vegetable intake, hazardous drinking, obesity, high cholesterol and high blood pressure[3]
- A higher rate of asthma, but similar rates of other chronic conditions: diabetes, chronic obstructive pulmonary disease and chronic mental health disorders[3]
- Higher rates of hospitalisation for cardiovascular disease[4]
- Similar leading causes of avoidable hospitalisations and mortality[4]
- Lower rates of unintentional injury hospitalisation[4]
- Higher rates for prescriptions
- Higher rates for emergency department attendances
- Lower number of GPs per 10,000 population

The health status of our population shows that we need to continue to increase our activity in the following areas:

- Working closely with primary care to address long-term conditions and avoidable hospitalisation, and to reinforce education and prevention, particularly amongst Māori, Pacific and people with higher needs;

[1] Population figures based on Statistics New Zealand population projections (2006 Census base). Census 2013 projections not yet available.
[2] 2006 Disability Survey. DHB breakdown of 2013 Disability Survey not yet available.
[3] NZ Health Survey 2011-13.
[4] Hutt Valley DHB Health Needs Assessment, Centre for Public Health Research, Massey University, 2012.

- Continuing our positive engagement with community providers, including the cluster of Whānau Ora providers, with a focus on education, prevention and outreach services, particularly amongst Māori and Pacific people;
- Continuing our emphasis on better linking our hospital services with our primary care providers; and
- Positioning ourselves to meet the changing demand for services, particularly those resulting from an ageing population.

Our Hutt Valley DHB annual budget in 2013/14 was $447.6 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. The Board has seven members elected by the community, 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 that our DHB meets our local and national health objectives. Board elections were held in 2013, with three new members taking up roles from December.

We also share our Board Chair with Capital & 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 of the three sub-regional DHBs.

The Planning & Funding arms of Wairarapa, Hutt Valley and Capital & Coast DHBs amalgamated to form the 3DHB Service Integration and Development Unit (SIDU). On behalf of the three DHBs they plan, contract, monitor and evaluate health and disability services run by the DHBs and their contractors. SIDU strives to maintain and improve the Hutt Valley community's health within available funding. They also consult the community on significant changes to services and ensure any advice given to the Board is consistent with national strategies and Government policy.

In the 2013/14 year, priority activity areas for the DHB were:

- Improve, promote and protect the health of communities within the Hutt Valley
- Reduce health disparities and improve the health of Māori 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.

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)
- Māori and Pacific health providers
- Aged residential care and home support services
- Mental health providers
- Pharmacies
- Laboratory and radiology providers

- Local, regional and national hospitals.

ROLE OF THE BOARD

The Board's governance responsibilities include:

- Communicating with the Minister and other stakeholders to ensure their views are reflected in the DHB's planning
- Delegating responsibility for achievement of specific objectives to the Chief Executive
- Monitoring organisational performance towards achieving objectives
- Reporting to stakeholders on plans and progress against them
- Maintaining effective systems of internal control.

STRUCTURE OF THE DHB

DHB Operations

The Board appointed the Chief Executive to manage all DHB operations. All other employees of the DHB have been appointed by the Chief Executive either directly or via the Chief Executive's delegated authority. The Board directs the Chief Executive by delegating responsibility and authority for the achievement of objectives through setting policy.

Quality Assurance

Hutt Valley District Health Board has numerous processes to ensure the quality of the governance, funder and provider outputs.

GOVERNANCE PHILOSOPHY

In December 2013, all three Boards endorsed a statement agreeing to support a whole of health system approach, by working towards operating as one organisation, as one team over multiple sites.

They agreed that the three Boards will continue to provide governance, ensuring local accountability.

The shared goal is to develop integrated service approaches to improve:

- Preventative health and empowered self-care
- Provision of relevant services close to home; and
- Quality hospital care, including highly complex care, for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

VISION, MISSION & VALUES

The following vision, mission and values govern the planning and activity of Hutt Valley DHB and contribute to 3DHB planning, alongside the highly congruent vision, mission and values of Wairarapa and Capital & Coast DHBs.

Our Vision

Whānau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities.

Our Mission

Working together for health and wellbeing

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

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FROM THE CHAIR AND CHIEF EXECUTIVE

This has been a stretch year for Hutt Valley DHB, as we have implemented more streamlined services across Wairarapa and Hutt Valley DHBs, within the context of 3DHB initiatives.

We ended the year on a high note, performing well against the national health targets and continuing the trend of reducing our deficit. An unplanned increase in Inter District Flow (IDF) outflow late in the year meant we couldn't reach our planned deficit, but an across-the-board efficiency drive was well supported by staff and meant our year-end position was better than the previous year.

Our hospital services have continued to perform well, with many staff-driven quality initiatives improving the health journey for patients. A nurse-led virtual clinic for rheumatology patients means many patients no longer have to take time off work to attend hospital clinics; improvements in line with the national Early Recovery After Surgery (ERAS) initiative have meant a more streamlined process for patients requiring joint replacement; newborn hearing screening processes have been thoroughly reviewed and improved and a new screening process for malnutrition in older patients introduced. The gains created through the introduction of the Operations Centre continue to accrue and an electronic whiteboard system which tracks patient progress has been rolled out to the Medical wards, following successful implementation in the Emergency Department.

From the patient's perspective, one of the most popular initiatives has been granting access to hospital-provided Wifi that is automatically activated when they are admitted and disabled when they are discharged.

FOCUS ON COMMUNITY CARE

Four Hutt Valley PHOs merged during 2011/12, forming the Te Awakairangi Health Network (TeAHN). 2013/14 has been about growing and developing the relationship between Hutt Valley DHB and TeAHN, who have steadily built confidence and capability.

Highlights for the year include:

- Health targets – excellent progress was made with more people having heart checks and we are confident the Network will meet the target in 2014/15. We are continuing to do well nationally with very high rates of child immunisation in the Hutt Valley and we will be looking to maintain and build on this result. We are making good progress with the smoking cessation target and the year ahead is about making these gains sustainable. We reached our local target for the number of people having an annual diabetes checks but need to do more as we aim for the national target in 2014/15.
- Preventing rheumatic fever – a number of sore throat clinics in community pharmacies and general practices in the Hutt Valley were established in the latter part of the year to treat and prevent the spread of rheumatic fever. They saw a considerable number of people in the first month of operation.

- Primary care sustainability – led by primary care and endorsed by Hutt INC, the 'Hutt 2020' integrated strategy has been developed to ensure that the whole health system across the Hutt Valley is sustainable in the future. Hutt 2020 covers the viability of primary care services and business models; the integration of primary and DHB community services; and linkages with enabling initiatives. The Hutt 2020 strategy was well received and implementation will begin in the first half of 2014/15.
- Pharmacy, health promotion, community nursing, primary mental health and community health worker teams in TeAHN are supporting each other and general practices in caring for patients, preventing ill health and empowering communities.
- Continued and enhanced collaboration across the health sector especially under the Hutt INC umbrella; sub-regionally and inter-sectorally with prevention projects – such as Health4Life, Pasifika Choice and Enjoy NRT; and in community development initiatives – such as Healthy Families NZ.

INTEGRATION

A single Chief Executive was appointed across Wairarapa and Hutt Valley DHBs in December 2012, and a single Executive Leadership Team was largely in place by April 2013. Over the last year we have implemented a shared Directorate structure across Wairarapa and Hutt Valley DHBs, which closely mirrors the structure in Capital & Coast DHB. This has supported increased dialogue and clinical collaboration between services across our sub-region.

As part of this streamlining, we have included the Chair of TeAHN and the TeHei Wairarapa (PHO) programme manager to be part of the single executive leadership team for the two DHBs. Their contribution has greatly strengthened the links between community and hospital based services, and encourages whole-of-system thinking preceding decision making.

From a governance perspective, we have joined with our neighbouring Wairarapa and Capital & Coast district health boards to form single sub-regional sub-committees for the Community and Public Health Advisory Committee (CPHAC); and the Hospital Advisory Committee (HAC) since January 2014. This has enabled better consideration of the needs of our combined population when making decisions about how best to use our resources.

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 continues to offer the best viable solution to continued clinical and financial viability.

We recognise that our future lies in forging strong sub-regional and regional relationships and implementing sustainable arrangements to continue to deliver safe, high quality affordable services in the Hutt Valley over the forthcoming years. Examples of this partnership in action include supporting Wairarapa DHB when a fire disabled their Central Sterilising Unit in late 2013. Our Central Sterile team at Hutt Valley DHB swung into action to support Wairarapa Hospital's Theatre services, while a team of clinical and operations experts from the three DHBs explored how standardisation and continued partnership could strengthen local services.

Many of our successes have stemmed from staff making the shift in thinking and owning their contribution to improving the patient journey – right across the spectrum of health care from home, through hospital, and back out into the community.

We believe the best approach to continue this work is to design the way we want to deliver services in the future to guide further structural changes to our services. For the past two years, the sub-regional Clinical Leadership Group has progressed integrated activity in a number of specialties including Ear, Nose and Throat, Gastroenterology, Child Health and Palliative Care. We are also progressing partnership in a single Mental Health, Addictions and Intellectual Disability Directorate for the sub-region. At Kenepuru Community Hospital a new 24-chair purpose-built Satellite Dialysis Unit opened in March and will be used by patients from across the three DHBs, boosting capacity in the sub-region to meet the growing demand for this service.

Done right, all three Boards believe that greater integration will remove many of the artificial boundaries and barriers that hamper effective health care delivery that at times frustrates both patients and clinical staff alike. It will enable our experienced and capable staff to use their time and expertise to better meet the needs of our regions' population; and help ease the financial pressures we are all experiencing as we create services that are sustainable.

Most importantly, we believe this partnership approach will make a material difference to fundamentals such as reducing waiting times and providing better and equitable access to diagnostic and elective services.

INVESTING IN THE FUTURE

3DHealthPathways began this year and is designed to provide GPs with quick access to relevant information about how to manage common conditions and how and when to refer to hospital. This is another integrated project across the three DHBs and local pathways have already been developed for cellulitis, deep vein thrombosis, diabetes, nutrition, dementia, frailty, vulnerable pregnant women, and obesity. This is a significant piece of work will continue to be a priority for the coming year as we step up our exploration of new ways of shifting the healthcare emphasis towards prevention, empowerment and health maintenance services close to home.

Improved access to services and waiting times for patients has been a major focus for all staff with many successful results including elective surgery and orthopaedic service. The elective surgery team also delivered an additional 280 discharges in 2013/14, which again exceeded our elective surgery discharge target.

Our increased immunisation rates have remained consistently high over the past few years and as of July 1, 93% of 8-month-old babies were fully immunised in our region. This achievement reflects effective collaboration between PHOs, primary health care/general practices, Plunket, Well Child/Tamariki providers and Regional Public Health, as well as local Lead Maternity Carer and Midwife teams. It also demonstrates an important investment in the future health of our children.

The increasing trend of 'never having smoked' reported by year 10 students in the Hutt Valley also reflects a multi-agency approach to reducing the harm caused by tobacco.

We have sustained a decrease in the number of children who have decayed, missing or filled teeth at the age of 12, with the rates for Pacific children showing the greatest improvement. However, over the next year we will be working closely with LMCs, early childhood centres and medical centres to improve the early enrolment of children of all ethnicities to Oral Health services.

Looking ahead to the next year, our focus will continue to be on preventing ill health and implementing the Hutt 2020 strategy. We will be developing new approaches to acute patient demand and long-term conditions. The latter will see increasing integration of the many different programmes into a flexible system that identifies conditions early and then assists the people with long-term conditions to manage them well. We expect greater collaboration between TeAHN and local organisations and providers, and between primary and secondary care health professionals as initiatives to promote service integration and community development are progressed.

As we work towards a healthier population, our staff are critical to successfully achieving our outcomes. Over the 2013/14 year we have worked with our neighbouring DHBs to formulate consistent policy and practice that will support the concept of a positive work environment for our staff, many of whom work between DHBs. The resulting 3DHB plan draws together actions that will support this goal.

Finally, we would like to thank the Board and the staff for their continued support and commitment to the people of the region. We recognise that all these achievements are part of a wider change in our approach that is also seeing us working more collaboratively to change the way we do things to optimise the use of our resources to ensure a more sustainable, safer and more convenient patient journey for the people of our region.

We expect the achievements of this year to be a firm foundation for the 2014/15 year, as we move from a 2DHB to an increasingly 3DHB model for service planning and delivery.

Dr Virginia Hope
Board Chair

Graham Dyer
Chief Executive

FROM THE CLINICAL LEADERS

We have written this annual report together as part of our vision of inter-professional collaboration driving continuous quality improvement for the people and families that we work with. We are passionate about improving and leading the way we deliver health care, so that it is truly patient-centred and meets the needs of communities. We realise for patients it is about receiving the right care, at the right time and in the right place.

In striving to provide seamless care, we recognise that patients today require support from a multitude of different services and health professionals. Improving the patient journey, and partnering with our primary care colleagues so that we can look holistically at the care we provide, is helping to help reduce treatment delays and length of hospital admission overall. We recognise that shorter patient journeys are safer, as well as being more convenient for our patients.

WHOLE OF SYSTEM THINKING

An important initiative we have begun this year with our primary care partners and Capital & Coast DHB has been the 3DHealthPathways project. 3DHealthPathways is a collection of online 'care pathways' which describe the best agreed-upon route for the patient to take as they move from primary care through the health system. By standardising clinical practice and the best way to access it, we expect to see significant gains for the patient and health organisations alike. We have already finished 48 pathways with many more in the development phase.

Similarly, the Alliance Leadership Teams consisting of Primary Health Organisations (PHOs) and DHB staff have also embedded a 'whole of system' approach to health across the lower North Island.

Evidence of this approach in action includes the way in which Hutt Valley DHB specialist nurses and Nurse Practitioners are working alongside and mentoring nurses in the community. Examples include a case review mentoring programme established across a number of facilities in aged residential care; DHB-employed Clinical Nurse Specialists (CNS) Diabetes mentoring and coaching nurses in primary care to upskill and enable them to provide a greater range of services in primary care; and Te Omanga Hospice specialist nurses providing mentoring, consultation as well as a clinical load for patients needing end of life care, enabling 'on the spot' teaching for nurses working in aged residential care.

Wairarapa examples of 'whole of system' thinking include the review of community-based mental health services and the transfer of some community mental health nurses from the DHB to the PHO; extension of the availability of the primary Shared Care record for Emergency Department clinicians, collaborative work around maternal and child health, allied health services being made available at Integrated Family Health Centres, and falls prevention initiatives spanning secondary and aged care facilities.

Across the two DHBs we have increased the number of new graduate nurses employed from 26 to 39, compared to the previous year. This includes 11 nurses employed in primary and aged residential care, but supported by the DHB provided Nursing Entry to Practice (NETP) programme. This increase met the required

financial modelling criteria, while recognising the importance of developing our next generation of nurses across the sector.

FOCUS ON QUALITY AND SAFETY

We are working together to ensure that change initiatives are focused on quality and safety, so that we can measure the impact of change through variables like readmission rates, surgical harm or reported medication incidents.

We continue to support and promote the Health Quality & Safety Commission campaigns, which have targeted key areas including inpatient falls, healthcare-associated infections and hand hygiene compliance as well as surgical safety checks.

Acknowledging the value of improvement work by individuals and teams is important and alongside our annual local Nursing and Midwifery Awards, this year we launched the inaugural 3DHB Allied Health, Technical & Scientific Awards. The awards recognise the key role Allied Health professions play in healthcare delivery. This year we are also launching the 3DHB Quality Awards.

The ongoing commitment to training our workforce, both present and future, remains a key driver to our success. This year we have opened our multidisciplinary Xcel8 training programme to Capital & Coast DHB colleagues so that we continue to encourage innovation and practice improvement to benefit our combined populations.

As teaching hospitals, our commitment to research and to training a wealth of undergraduate and post graduate students is well-established and we work closely with the Wellington universities and polytechnics, as well as across New Zealand.

We value and appreciate the array of involvement from clinical staff at all levels across the DHBS and primary and community care to ensure we all practice safe, high-quality and effective healthcare.

INTEGRATED SERVICES

Through the sub-regional (3DHB) programme, Service Level Alliances have been set up in areas such as Child Health and Health of the Older Person where we have identified that by working collaboratively, we can deliver better services more quickly to our patients.

This year has also seen the coming together over the three DHBs of the Māori Health Service and Mental Health, Addictions and Intellectual Disability Service directorates, respectively.

With all this activity underway, we must acknowledge the commitment and professionalism of our staff and those of other DHBs and primary and community settings who have developed partnerships across teams and services, to enable gains for patients.

Iwona Stolarek
Chief Medical Officer

Helen Pocknall
Executive Director of Nursing and Midwifery

Russell Simpson
Executive Director of Allied Health, Scientific and Technical

COLLABORATION HIGHLIGHTS

3DHB INTEGRATION PROGRAMME

The past year has seen a continued commitment to partnership between Wairarapa, Hutt Valley and Capital & Coast DHBs as we focus on providing sustainable services, both clinically and financially. The three DHBs believe that the best health gains for patients can be achieved through a joined-up approach to service delivery across the sub-region, and that by removing artificial boundaries decisions can be made in the collective interest of the sub-region's population. This includes improving equity of access to services for the combined population.

The 3DHB Health Service Delivery programme has continued to focus on specific clinical service projects identified as critical services for integration along with the key enablers required to support these. Service design has been clinically led, with representation from across the individual sub-regional services as appropriate.

To enable our progress towards fully integrated sub-regional services, we developed a clear framework that identified the stages of integration for this programme. This included the definition of the agreed sub-regional approach at each integration stage for governance, clinical leadership, management, responsibility, accountability, funding, service delivery, operational activity and employment.

A report outlining the considerations needed to progress service design was informed by the outcome of sub-regional workshops with clinical and management representation from services across the DHBs. These workshops gave many staff the opportunity to see the benefits integration provides and for them to influence areas where they felt careful consideration is needed.

Information from this report and framework is now used by all services progressing sub-regional integration design.

Integrated service design continues with Child Health, Radiology and Gastroenterology services, linking directly into local primary secondary integration where appropriate through Primary Care Alliance Leadership Teams.

A PATHWAY TO GOOD HEALTH

The 3DHealthPathways project was launched in February 2014. This collaboration between General Practice and DHBs sees care pathways developed to take the uncertainty out of patient care by ensuring a clear and consistent treatment regime for patients to be referred along.

In doing so, health professionals from across different sectors and organisations must agree upon best practice treatment guidelines and discuss any existing barriers to implementation.

The implementation team includes sub-regional specialists, SIDU programme manager and five general practitioners as clinical editors. A further editor with a dedicated focus on faster cancer treatment is

currently being finalised. The governance group comprises clinical and corporate members from the Wairarapa, Hutt Valley and Capital & Coast DHB executive teams and primary care across the sub-region.

There are currently 95 pathways on the work programme. An example of the co-design approach is the local pathway under development to treat carpal tunnel syndrome, a disabling condition that causes wrist pain and numbness. CCDHB's orthopaedic department has agreed to accept surgical treatment referrals directly from GPs, provided the treatment steps outlined in the pathway are first followed. This means patients can go to their GP, who will perform the appropriate treatment steps, and, if surgical treatment is necessary, give certainty that they will receive it.

"That's a really powerful thing - to say 'I'm referring you for an operation', not 'I'm referring you to see a specialist first'," said Lower Hutt GP Dr Chris Masters, who is one of five clinical editors who have been appointed to work with hospital and community-based specialists as part of the integrated approach.

"While hospital treatment may be necessary for some complex conditions, people don't want to go to hospital when they can come and see their local family doctor or medical centre to get treatment that is closer to home and more convenient," Dr Masters said.

The new general practice model recognises that long-term conditions require coordinated care from different health services. Practice nurses and community health providers such as physiotherapists are seen as key to this.

While the project is still in its initial stages it is seen as a priority for the coming year. Pathways in development include: diabetes nutrition, frail elderly patients, gastroenterology, cellulitis, older persons health, orthopaedics, haematology, general surgery and rheumatic fever.

APPOINTMENTS

In the past year new joint appointments have been created that will continue to build on the work of the integration programme. To date these positions have been for corporate service delivery. We are excited to report the development of the first 3D clinical service position with the agreement to progress a 3DHB General Manager of Mental Health and Addiction Services. The appointment of this position will enable the general manager to lead the staff involved in the delivery of Mental Health and Addictions Services across the sub-region to develop a single approach to service design and delivery.

Corporate Service appointments have progressed with the appointment of a 3DHB Executive Director Corporate Services Group, a 3DHB Chief Information Officer and a 3DHB Facilities Management structure. The focus of these positions in the short-term is to support the 3DHB development to keep us on the pathway toward sustainability and strengthening the back office systems and functions that underpin the way we do business.

These positions will provide strategic advice and direction for Wairarapa, Hutt Valley and Capital & Coast DHBs in relation to financial management, information communications technology, facilities management and payroll and to ensure that the strategic direction translates into tactical and operational activity supporting all DHBs' wider goals as well as individual service goals.

MĀORI HEALTH

There are different views on what a 3DHB Māori health approach will look like, but the focus remains on improving each DHB's performance against the national Māori health targets. Having a collaborative approach will provide the framework for the wider teams to learn from each other.

The 3DHB sub-region is home to 438,345 people, equivalent to nearly 11% of New Zealanders in 2013. The Māori populations of the Wairarapa and Hutt Valley districts are higher than the 15% national average, at 16% and 18% respectively, while 11% of people in the Capital & Coast district identify as Māori.

Additionally, the Māori population of all three DHBs is expected to grow within an overall sub-regional growth rate projected at 0.6% per year to 2026.

Each of the three DHB Māori health teams is unique and has strengths that we can collectively learn from. For example, Wairarapa leads the country for screening 80% of Māori women for cervical cancer checks.

LABORATORY

Hutt Valley and Capital & Coast DHB's laboratories combined into a single service, OneLab, in March 2014 with a Laboratory Manager appointed across the sites. Work is underway to align processes and protocols as far as possible and to utilise opportunities as they present to continuously improve service delivery for patients.

The combined laboratories installed a new combined laboratory information system, Sysmex Delphic, across both DHBs. The implementation was completed in November 2013 in Capital & Coast and April 2014 in Hutt Valley. The project required the two laboratory teams and ICT to work closely together to create a single system that could be used by both DHB laboratories. This has successfully occurred and, except where required for technical reasons, the system is configured the same in both laboratories.

The Anatomic Pathology portion of the system is ahead of the rest of the DHB laboratories in the country. At least four other laboratories have been to visit the system and Canterbury DHB laboratory has just gone live with a similar system with many of the configurations learnt from our system.

NEW SATELLITE DIALYSIS UNIT

Based on current and projected demand in the sub-region, a new satellite dialysis unit at Kenepuru Hospital was officially opened by Minister of Health Tony Ryall on 20 March 2014. The unit provides services for patients from Wairarapa, Hutt Valley and Capital & Coast DHBs.

The new purpose built unit is more accessible and spacious and has plenty of natural light. Feedback received from patients has been overwhelmingly positive with everyone appreciating the state-of-the-art facility that is not just aesthetically pleasing but also comfortable.

The unit is operational seven days a week with up to 32 patients receiving treatment each day. In addition to the patients who attended the previous Porirua satellite unit, a significant number of patients have transferred from the Wellington Hospital unit out to Kenepuru. Patients have adapted well to the change in environment with many patients embracing the opportunity to become more actively involved in aspects of

their treatment. Feedback from patients includes one saying: “I enjoy being able to do things for myself – learning is good for me.”

The opening of the new larger unit has given the renal service the capacity to provide patients with dialysis treatment in the most appropriate facility based on the level of care they require. With 16 of the available 24 dialysis stations currently commissioned for use, the unit will be able to cope with additional demand over the coming years.

OPHTHALMOLOGY

This year Capital & Coast started an opthalmologists’ minor operations session each week at Hutt Hospital, meaning patients from the Hutt and Wairarapa no longer have to travel to Wellington for minor surgical procedures.

The plan is to extend this to a full day outpatient department session at Hutt, so staff can continue to help clear the backlog of children awaiting operations for squints. This will mean that paediatric patients who live in the Hutt and Wairarapa will no longer have to travel to Wellington for outpatient appointments.

EAR, NOSE & THROAT (ENT)

The sub-regional ENT steering group formally disbanded during 2013/14 following completion of its work programme, which included the development and implementation of management and referral pathways and agreement on workforce strategies. The members of the group continue to take a sub-regional approach to achieving targets and developing the workforce.

DISABILITY SERVICES

Great progress has been made during 2013/14 in improving health services for people who experience long-term impairments/disability in the wider Wellington region.

In December 2013 the first sub-regional New Zealand Disability Service Implementation Plan was agreed by the Wairarapa, Hutt Valley and Capital & Coast Boards at their first combined meeting. To support the roll out and to provide a voice at governance level the Sub-Regional Disability Advisory Group was formed.

The group produced its first newsletter in May 2014 providing a means to enable a mechanism for community engagement across all sectors, including mental health, older people, primary care and young peoples’ networks.

A sub-regional Disability Forum was held, which provided an opportunity for people with disabilities to give their feedback on the implementation of the sub-regional disability plan. The key themes that arose from the forum correspond with the determinants of the Triple Aim approach which, in relation to disability, means the need to balance patient experience; visibility of disability (within population health initiatives) through more robust data collection; and through efficient and financially sustainable systems that enable all to access services they need.

Other Disability Service highlights include:

- The launch of the Health Passport in Wairarapa, Hutt Valley and Capital & Coast DHBs. The Health Passport will assist health providers to better understand the care and communication needs of people who experience long-term impairments / disability.
- The Disability Alert Icon was launched at Capital & Coast and Hutt Valley. The icon will alert staff to patients' particular needs when using health services, including what they need to be kept safe.
- An eLearning module for all Capital & Coast staff was launched. This gives basic education and specific instructions on the use of the Disability Alert Icon, and the link to the Health Passport.
- A disability champion/facilitator network made up of staff across all three Sub-Regional District Health Boards and community services was launched to help improve services and information to health staff and people with disabilities.

RHEUMATIC FEVER PREVENTION

In 2013/14 a sub-regional rheumatic fever plan was developed that built on the Rheumatic Fever Prevention Programme operating in Porirua. The aim of the sub-regional plan is to reduce the incidence of rheumatic fever in the region through a programme of work focussed on prevention, treatment and follow-up of rheumatic fever. The plan is part of the Government's Rheumatic Fever Prevention Programme which is working to improve outcomes for vulnerable children and achieve the goal of reducing the incidence of rheumatic fever in New Zealand by two thirds to a rate of 1.4 cases per 100,000 people by June 2017.

The plan's goals are to prevent the transmission of Group A streptococcal throat infections in the Wairarapa, Hutt Valley and Capital & Coast DHB region.

This will be achieved through:

- The development and implementation of a pathway to identify and refer high-risk children to comprehensive housing, health assessment and referrals services, in 2014/15
- The development of the Housing and Health Capability Building Programme and implementation of insulation referral process for high-risk patients, in 2014/15
- Raising community awareness.

To ensure Group A streptococcal infections are treated quickly and effectively there has been increased training and information for primary care providers, and an algorithm tool for the treatment of sore throats in primary care has been developed. A review of the sore throat swabbing in schools model will happen in the coming year. In 2013/14 the total number of throat swabs was 7,180, with 11.2% positive swabs.

Results for 12/13 and 13/14 for Porirua, 4-19 year olds:

	2013/14	2012/13
Positive	802	791
Negative	6378	5890
Total swabs	7180	6681
% positive	11.2%	11.8%

Hutt Valley and Capital & Coast are steadily reducing the rate of first episode rheumatic fever hospitalisation (per 100,000 total population), with Capital & Coast achieving 1.7 (per 100,000 total population) in 2013/14, which is better than the target for the year.

Rapid response clinics were opened in Porirua, with ongoing review and refinement of the services as required. Engagement with the Pacific Health and Wellbeing Collective continued to ensure key messages are reaching Pacific families. This collaborative approach will continue with ongoing engagement with local providers in Porirua East through the Porirua Kids Group and Porirua Social Sector Trial.

At Hutt Valley, walk-in sore throat treatments clinics were commenced from June 2014 at three pharmacies, three general practices and one after-hours medical centre.

INFORMATION, COMMUNICATION & TECHNOLOGY (ICT)

ICT has had a significant year of achievements as we continue to enhance the 3DHB ICT integration. The three pillars of work being progressed are:

- Convergence of platforms, systems and processes
- One approach in areas of commonality
- Intellectual property sharing.

This collaborative approach was formalised in May 2013 with the development of a 3DHB ICT service. A senior management structure and 3DHB ICT Governance Group was implemented to drive and support the next level of changes to occur over the coming financial year.

The area of security will continue to be a key focus for the organisation and the formation of the Information, Privacy and Security Group has provided structure and support to the management of key security matters.

During the past year a number of ICT projects have been completed to support the Minister's initiative of 'Better, Sooner, More Convenient' healthcare delivery, including significant input in supporting the Central Region Information Systems Plan (CRISP). The key projects include:

- Electronic results sign-off
- Occupancy at a glance

- Clinical audit tool
- Laboratory system upgrade
- The Referral Management Module for Outpatients and Allied Health which offers a number of benefits including more accurate data capture and reporting, ability to view and better manage a patient's full episode of care and management of referrals in real time.

During the past year the Department of Internal Affairs (Government Chief Information Officer) released the Whole of Government Direction for ICT Functional Leadership of District Health Boards in respect of:

- ICT strategic planning and investment
- ICT procurement
- ICT assurance

These directives are to be effective from 1 July 2014. As a result of this initiative there are a number of 3DHB ICT activities planned to align current processes to this approach.

A number of Ministry of Health (National Health IT Board) projects, including National Patient Flow, Maternity and e-Pharmacy have either been implemented or are underway in conjunction with other projects.

Sub-regionally a number of activities are underway to integrate IT systems across the three DHBs. Convergence work completed includes the implementation of a Microsoft 3DHB Outlook service, enabling all staff to electronically communicate with ease.

The Common Operating Environment Programme of work, which included the migration of XP Microsoft to Windows 7, is well underway. This significant activity has been a driver in progressing and engaging the teams across the three DHBs and will result in having the sub-region under the Citrix environment, providing the platform for other convergence work.

Other collaborative work includes:

- A standardised single time sheeting process for projects across the 3DHBs has been implemented. This has enabled more accurate and timely reporting to support the financial and resource management of projects and business-as-usual activities.
- Work to collaboratively manage risk across the three DHBs is underway. In support, Audit NZ has been engaged in a common audit review process across the sub-region.
- Building on the existing quality control and compliance activities, ICT have commenced a programme of independent quality audits on key projects which will continue through the next financial year.
- Wairarapa DHB service calls are now managed by the Capital & Coast Service Desk. This enhances the capture of data and enables the Wairarapa ICT team to focus on project and business as usual activities.
- The establishment of a single 3DHB ICT structure is to commence in the first quarter of 2014/15. This will support integration activities and enable both effectiveness and efficiency gains across the three DHBs.

OUR PEOPLE

A skilled, supported and responsive workforce is essential for sustainable service delivery. The DHB needs the right mix of trained and qualified people in sufficient supply and working in partnership with each other. Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues to be a key priority for the DHB.

The DHB supports clinical governance based on the following six principles:

- Quality and safety will be the goal of every clinical and administrative initiative
- The most effective use of resources occurs when clinical leadership is embedded at every level of the system
- Clinical decisions at the closest point of contact will be encouraged
- Clinical review of administrative decisions will be enabled
- Clinical governance will build on successful initiatives
- Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

Hutt Valley DHB is committed to continuing to support and grow clinical leadership by supporting clinical governance of the patient journey across primary and secondary services.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level; controlling the growth of hospital labour costs; maintaining and where possible, improving hospital productivity; and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians.

The DHB continues to ensure local clinicians take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and optimal clinical arrangements for securing specialised hospital capacity with neighbouring DHBs. This strengthened clinical leadership was assisted through the activity of the Alliance Leadership Team, the Clinical Board and involvement of clinicians in the development of collaborative service models at a sub-regional and regional level.

The Clinical Board is responsible for providing clinical leadership; leading the development of clinical governance across all of the services provided by the DHB; overseeing the quality and safety of services delivered by DHB providers and the clinical quality programme; and providing advice and recommendations to the DHB Board, Chief Executive and management.

Meanwhile, the Alliance Leadership Team 'Hutt INC' (formerly the Primary Secondary Strategy Group) has clinical representation from across the Hutt Valley health system, including Te Awakairangi Health Network (PHO). It is the key driver in the development of integrated services and the implementation of their work programme.

The DHB focuses on the needs of each employee through individual performance planning and development. This ensures all staff have performance objectives that align to the DHB's strategy, goals and

values. This individualised performance development framework will reduce staff turnover and improve staff retention.

GOOD EMPLOYER

A key value of Hutt Valley DHB is to be a good employer. The DHB embraces the '7 key elements of being a good employer' as prescribed by the Equal Employment Opportunities Commissioner. The elements are:

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

Hutt Valley DHB has an equal employment opportunities focus within the relevant policies. A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity. Training and development opportunities are offered to all staff, and personal performance and development plans are a requisite for all employees.

Several forums are in place comprising a selection of employees from across Hutt Valley DHB. These forums meet to consider workplace practices. Flexibility and work design are among the many topics these forums consider. Other topics include health and safety, and professional practices, for example nursing, clerical and administration.

Hutt Valley DHB has a zero tolerance policy to bullying and harassment. This is supported by a Harassment and Bullying Policy and frequent training sessions for all employees on dealing with bullying and harassment.

Approximately 96 per cent of employees are covered by collective employment agreements (CEA). All the CEAs have prescribed remuneration, recognition and conditions clauses. Hutt Valley DHB has a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the DHB.

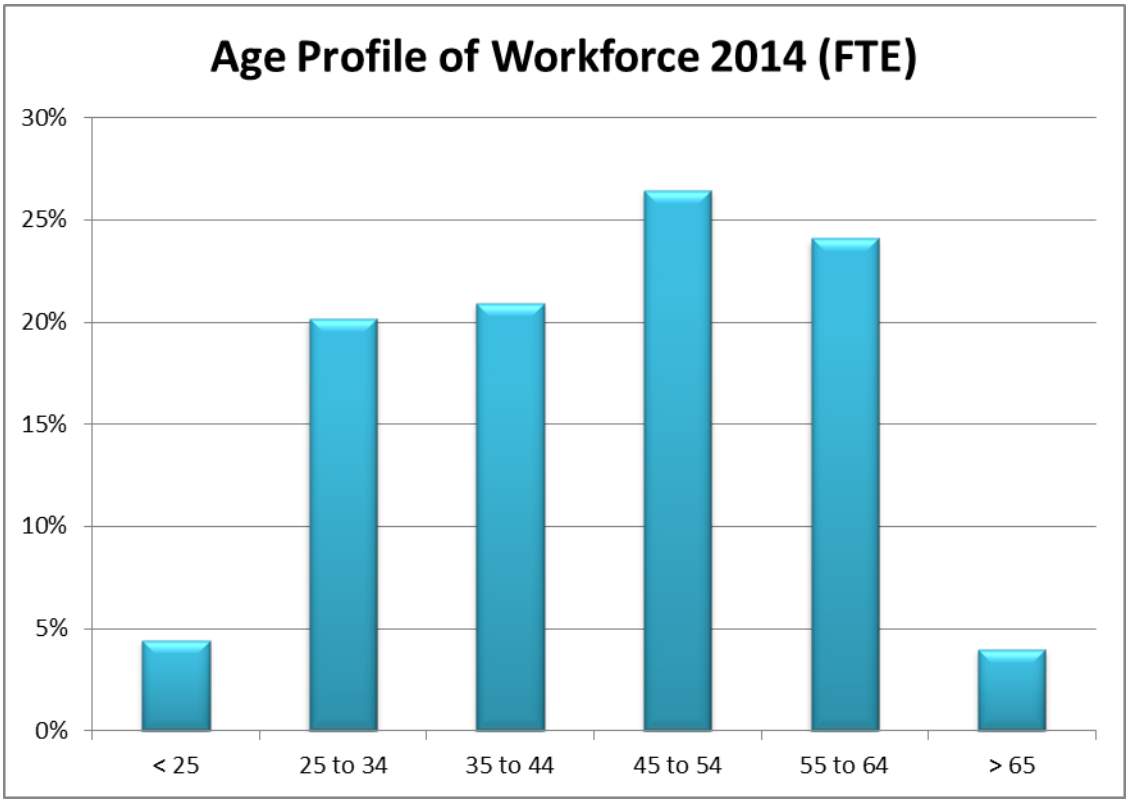
The Protected Disclosure Act 2000 and the Board's related policy protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the Employee Assistance Programme.

WORKFORCE PROFILE

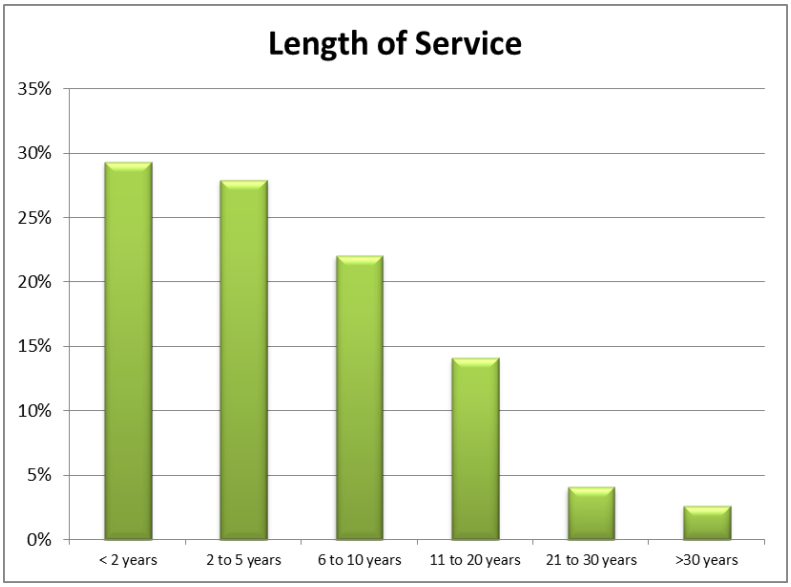
Full Time Equivalent Staff Numbers

	2014	2013	2012	2011	2010	2009
Medical	232	232	238	233	217	213
Nursing	717	708	712	699	685	713
Allied Health	428	435	422	396	383	392
Other	434	467	480	481	489	470
Total	1,811	1,841	1,851	1,809	1,773	1,788

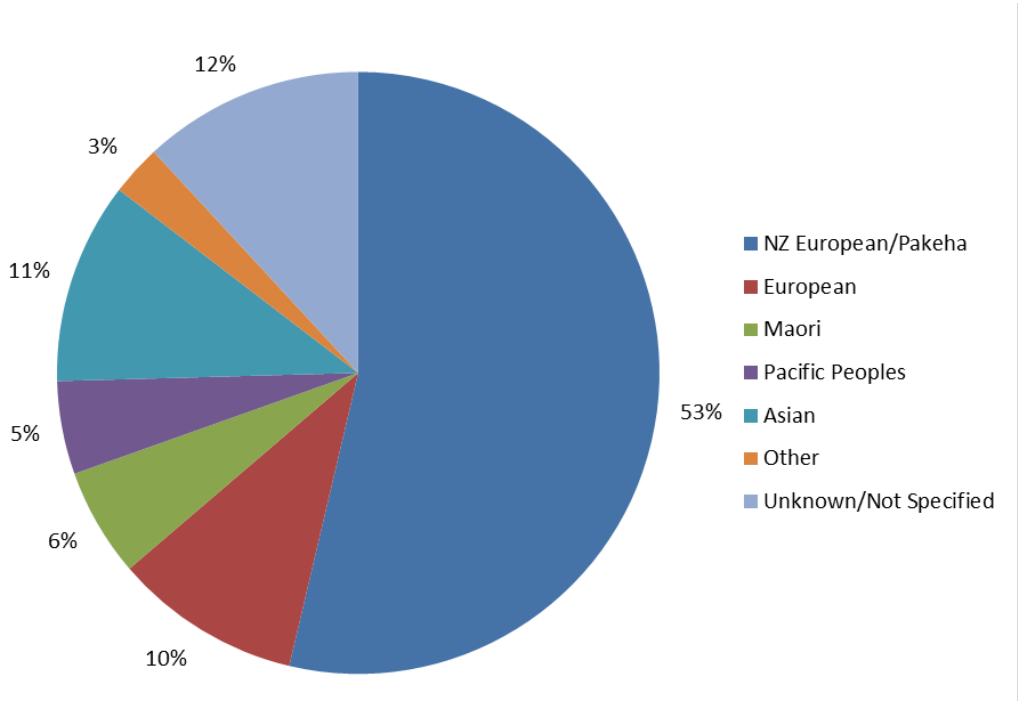
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2014	2013	2012	2011	2010	2009
Female	81.89%	82.41%	81.95%	81.16%	81.76%	82.24%
Male	18.11%	17.59%	18.05%	18.84%	18.24%	17.76%

REMUNERATION OF EMPLOYEES

Employees (excluding board members), including management and medical staff, receiving remuneration in excess of $100,000 per annum are shown in the table below.

Annual remuneration	2014	2013
100,000-109,999	31	29
110,000-119,999	28	24
120,000-129,999	12	13
130,000-139,999	10	9
140,000-149,999	9	12
150,000-159,999	9	11
160,000-169,999	9	13
170,000-179,999	6	6
180,000-189,999	9	5
190,000-199,999	3	3
200,000-209,999	2	5
210,000-219,999	9	6
220,000-229,999	3	8
230,000-239,999	7	11
240,000-249,999	11	4
250,000-259,999	9	3
260,000-269,999	6	4
270,000-279,999		
280,000-289,999	1	5
290,000-299,999	2	2
300,000-309,999	3	1
310,000-319,999	2	1
320,000-329,999		1
330,000-339,999		1
340,000-349,999		1
350,000-359,999		
360,000-369,999		
370,000-379,999	1	1
380,000-389,999	1	
390,000-399,999		2
400,000-409,999		
410,000-419,999		
420,000-429,999	2	
620,000-629,999		
Grand Total	**185**	**181**

Of the employees shown above, 130 are clinical employees (2013: 129) and 55 are non-clinical employees (2013: 52).

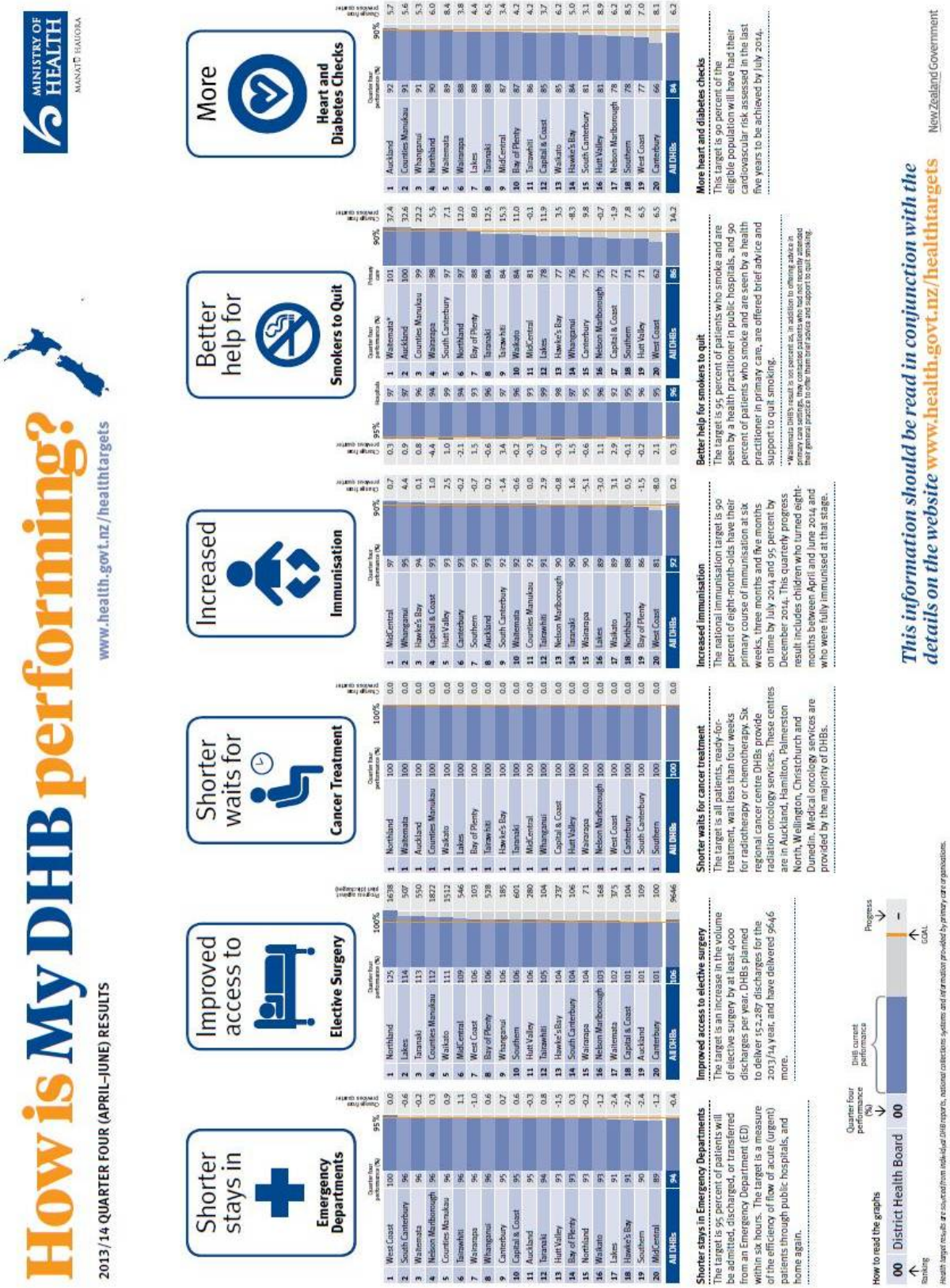
Only staff on the Hutt payroll are included in the table above.

TERMINATION PAYMENTS

During the year ended 30 June 2014, 12 (2013: 19) employees received compensation and other benefits in relation to cessation totalling $205,343 (2013: $281,056). The payments made were in the nature of redundancy or retirement gratuities.

KEY MEASURES – HEALTH TARGETS

Quarter Four (April – June) Results



IMPACTS AND OUTCOMES

As the major funder and provider of health, wellbeing, and disability services in our district, we work to make and maintain positive changes in the health of our population. Our decisions about which services to fund and deliver have a significant impact on the health of our population and contribute to the effectiveness of our entire health system.

We can measure our progress toward improving the health of our population on three different timescales: long-term outcomes (5-10 years), medium-term impacts (3-5 years), and shorter-term outputs (1 year). When we make progress on our short-term outputs (described in the following Statement of Service Performance), over time we can expect to see improvement in our medium-term impacts, which in the long-term will lead to progress toward our outcomes.

In 2013/14, the three sub-regional DHBs agreed to focus on four long-term outcomes:

- Reduction of health disparities/improved health equity
- People are healthier and taker greater responsibility for their own health
- Improving the health and wellbeing of our region's children
- Optimising the health, wellbeing, and independence of our region's older people.

We can measure our progress toward these outcomes by monitoring our population's health status and the environment in which they live. As such, in our 2013/14 Statement of Forecast Service Performance we identified impact measures related to each outcome, and we now report against these below. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas the DHB is making a positive difference and in which areas the DHB should seek to improve.

It is important to note that these outcomes are progressed not just through the work of the DHBs, but also through the work of all of those across the health system and wider health and social services.

Measures that also appear in the Māori Health Plans for the sub-regional DHBs are denoted with a [†].

Population health outcome: Reduction of health disparities/improved health equity

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and the current models of care. Māori and Pacific have consistently worse health outcomes, and patients can find it hard to access services or to know how to manage their health if services are not culturally competent. We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

Patients experiencing disability can also have trouble finding services that are accessible and responsive to their needs. With an ageing population, the number of patients experiencing disability will increase and we need to deliver services that meet patients' needs. Low income and poor housing also contribute to poor health outcomes, so those living in deprived areas require services that are low-cost and easily accessible.

Measures – The DHB measures progress through:

A reduction in ambulatory sensitive hospitalisations (ASH) rates[†]

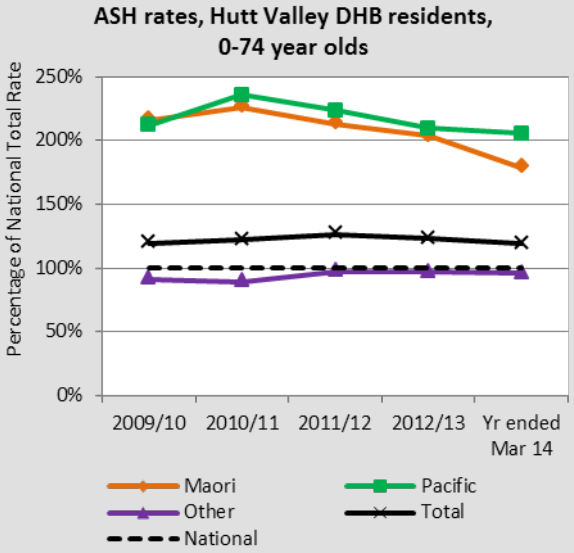
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include skin infections, dental conditions, asthma, pneumonia, cardiovascular disease, and diabetes.

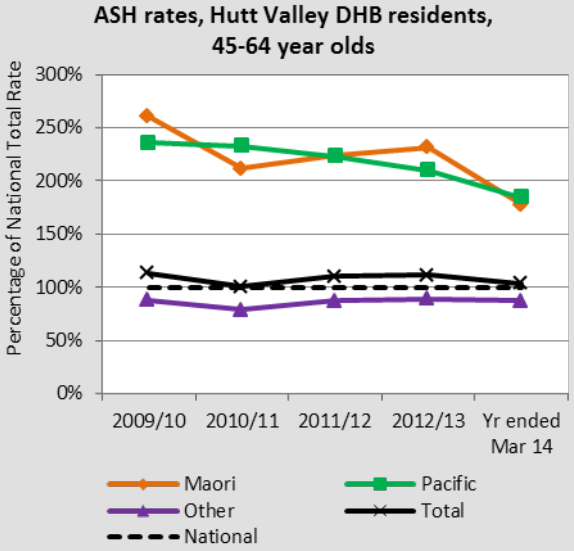
ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

Although our overall ASH rate is higher than the national average, Māori and Pacific rates relative to the national ASH rate have been decreasing since 2010/11. Notably, the ASH rates for Māori and Pacific have decreased relative to other ethnicities. However, Māori and Pacific continue to have higher ASH rates than other ethnicities.

ASH rates are affected by a wide range of services and programmes in the social sector, including housing and education. In addition to the outputs described in the following Statement of Service Performance, recent initiatives in the sub-region that will reduce ASH rates include:

- A sub-regional equity report, which contains a suite of equity indicators, including ASH rates. By improving our monitoring of disparities, we will be able to more effectively plan activities and reduce existing disparities.
- A project that aims to reduce the number of people who do not attend (DNA) outpatient appointments, as Māori and Pacific have higher DNA rates than other ethnicities.
- Regional Public Health's (RPH) housing





programmes, which aim to reduce overcrowding, provide education about healthy housing, and improve access to health and social services.

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

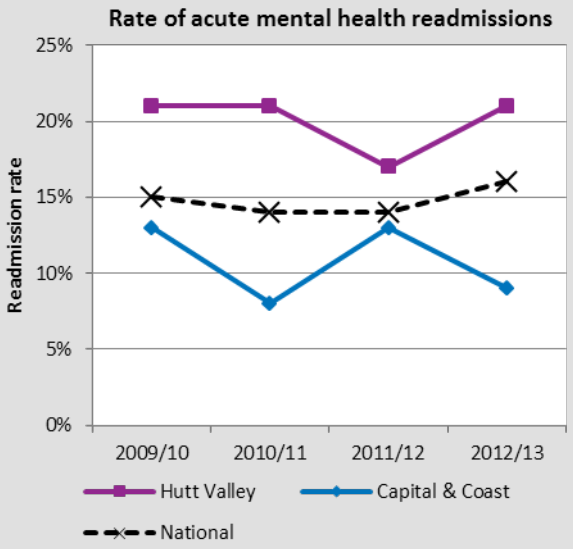
A reduction in the rate of acute mental health readmissions

Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to support the person out of hospital.

A decrease in the rate of acute mental health readmissions reflects good continuity of care across the health system.

Hutt Valley DHB's rate of acute mental health readmissions is higher than the national average. Because the readmission rate is affected by small changes in the number of yearly readmissions, four years is not enough data to establish a trend.

This measure links to the Intensive Assessment and Treatment Services output class.



Note: Wairarapa DHB is not shown as it does not operate an inpatient unit. 2013/14 data not available at time of publication.

Population health outcome: People are healthier and taker greater responsibility for their own health

Hutt Valley DHB and our partners, including Regional Public Health and local PHOs, continue to advocate for healthy lifestyles. By investing in preventative measures and promoting positive health choices, we expect that people's health will improve over time, which will reduce pressure on healthcare services and reduce hospital admissions.

Measures – The DHB measures progress through:

An increase in the proportion of "Never Smoked" responses from Year 10 students

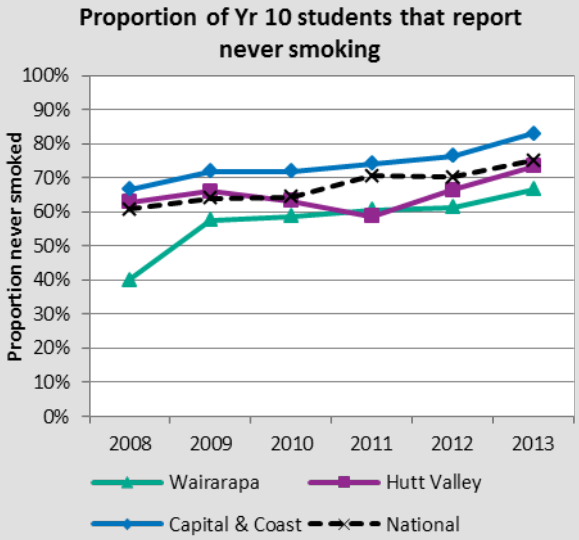
Over 95% of smokers have started smoking by 18 years of age, so reducing the number of young people taking up smoking will greatly reduce smoking rates in the future.

An increase in the number of young people that have never smoked is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risky behaviour.

Nationally, the number of Year 10 students who report never smoking has increased. In 2013, Hutt Valley DHB's rate is similar to the national rate.

The smoking cessation advice provided in primary care and hospitals helps to reduce smoking rates. Smoking education in RPH's school visits can increase the number of young people who have never smoked.

This measure links to the Prevention Services output class.

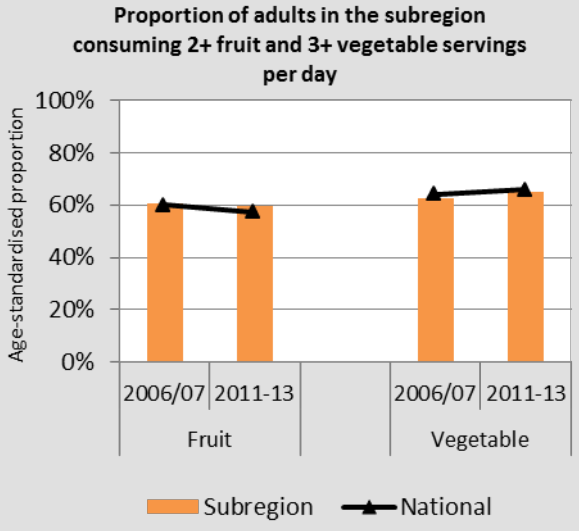


Source: Action on Smoking and Health Survey, www.ash.org.nz

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 a number of risk factors and conditions, including high cholesterol, high blood pressure, obesity, CVD, and diabetes. These nutrition-related risk factors jointly contribute to two out of every five deaths each year.

Fruit and vegetable intake in the sub-region is not significantly different from the national



Source: NZ Health Survey

average, and has not significantly changed from 2006/07 to 2011-13.

Regional Public Health school visits include nutrition education and RPH also runs a school vegetable garden programme. These initiatives will help to increase the consumption of fruit and vegetables in the sub-region.

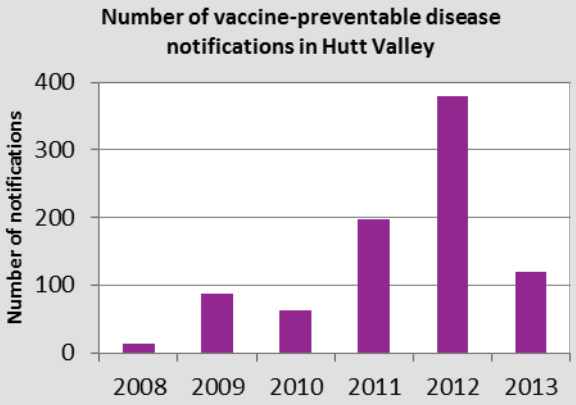
This measure links to the Prevention Services output class.

A decrease in the number of vaccine-preventable disease notifications

In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

Pertussis outbreaks in the region in recent years have caused an increase in vaccine preventable disease notifications. However, the number of notifications is beginning to return to normal in 2013. In the longer term, with increased immunisation, we expect that the number of vaccine preventable disease notifications will decrease.

This measure links to the Prevention Services output class.



Source: Environmental Science & Research, **www.esr.cri.nz**

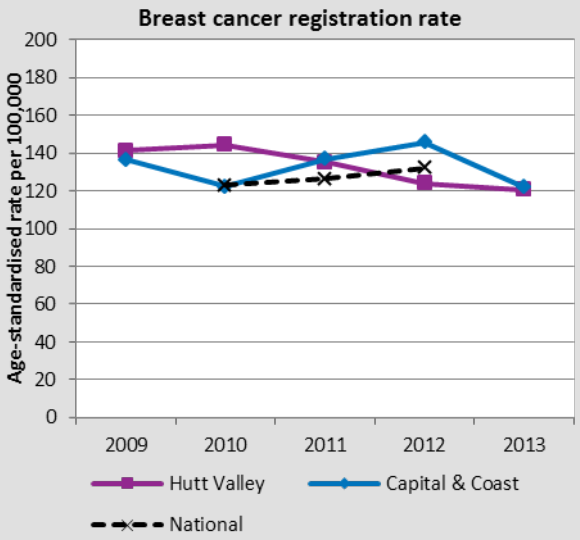
A decrease in the breast and cervical cancer registration rate (rate per 100,000)

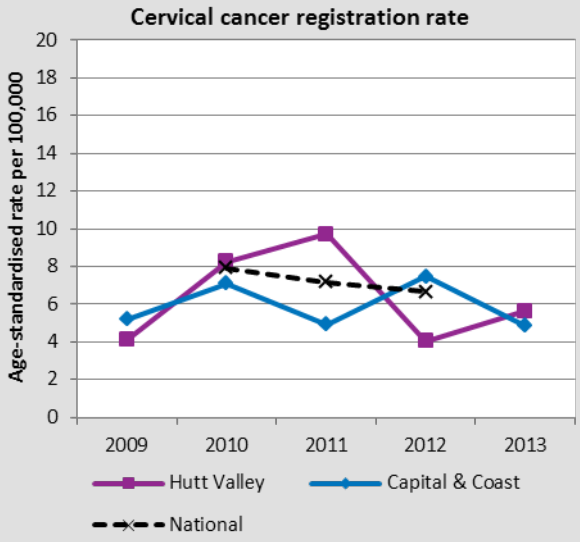
Breast screening for women over the age of 40 years significantly reduces their chance of dying from breast cancer[5]. Increased accessibility of breast screening services may increase breast cancer registration rates but will reduce breast cancer deaths.

Cervical screening reduces the chance of developing cervical cancer by about 90%. Increased accessibility of cervical screening services will reduce cervical cancer registration rates.

To achieve equity in screening rates, the screening service runs 'Priority Women Days' on Saturdays when Māori and Pacific women and women who are overdue for screening are booked in.

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





Source: NZ Cancer Registry, provisional data

Note: Wairarapa DHB is not shown as the number of cancer registrations is very low and therefore the rate is unreliable.

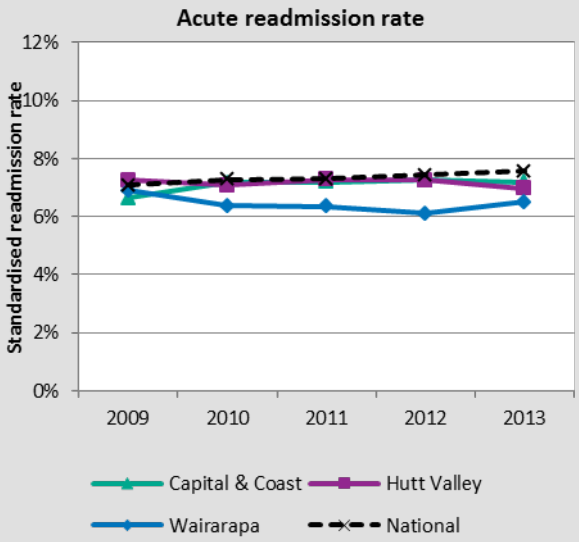
[5] Nelson HD, Tyne K, Naik A, et al. Screening for Breast Cancer: Systematic Evidence Review Update for the US Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (US); 2009 Nov. (Evidence Syntheses, No. 74.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK36392/

A reduction in the rate of acute readmissions, Total

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital.

Nationally, there has been a reduction in the rate of acute readmissions since 2011/12. Hutt Valley residents have a lower rate of readmission to hospital than the national average. This result is in conjunction with the average length of stay in Hutt Hospital decreasing, which shows that the effectiveness and efficiency of hospital treatment is increasing.

This measure links to the Intensive Assessment and Treatment Services output class.



Population health outcome: Improving the health and wellbeing of our region's children

Healthy behaviours in childhood and the teenage years can affect health outcomes in adulthood. Health promotion and prevention can be particularly focussed on children and youth to ensure long-term health gains for our population.

Measures – The DHB measures progress through:

Oral health measures:

- An increase in the proportion of children caries free at age 5
- A decrease in the mean number of decayed, missing, or filled teeth (DMFT) at age 12

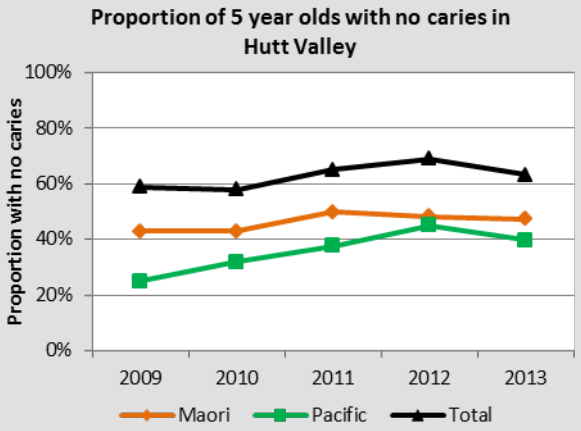
Regular dental care has lifelong benefits for improved health. Māori and Pacific children are more likely to have decayed, missing, or filled teeth, and improved oral health is an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need.

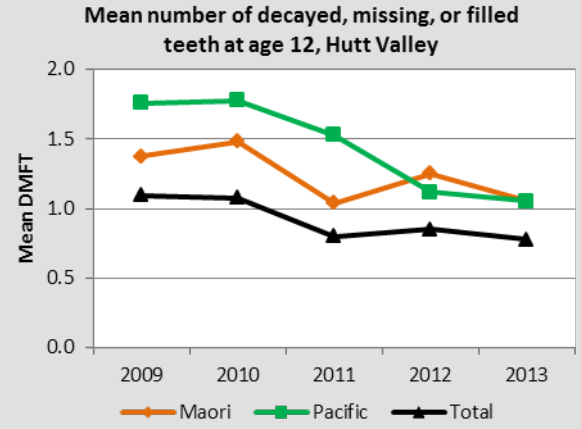
Water fluoridation helps to maintain oral health, prevents tooth decay, and reduces health inequalities. There is evidence of this within our sub-region; Māori children in non-fluoridated areas of Kapiti have twice as many decayed, missing, or filled teeth, as Māori children living in areas with community water fluoridation. For this reason, the sub-regional DHBs and Regional Public Health supported community water fluoridation in 2013/14.

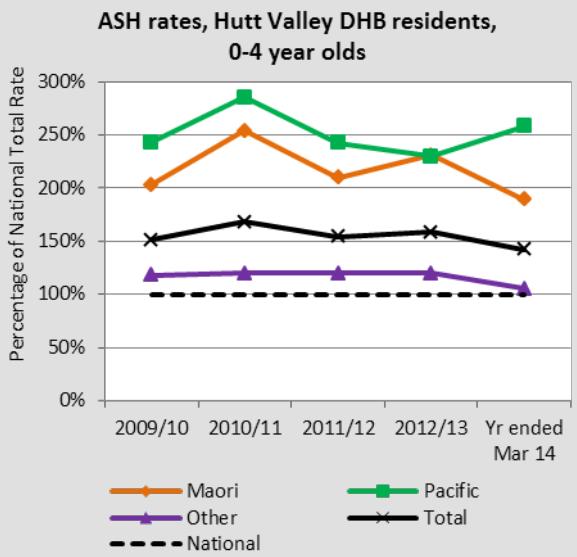
The mean number of decayed, missing or filled teeth is decreasing in Hutt Valley, which is good. However, disparities between Māori and Pacific and other ethnicities still exist.

The oral health team is working closely with early childhood services and medical centres to find and enrol children younger than five years to the school dental service, which should improve oral health outcomes.

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





An increase in the percentage of children immunised at 8 weeks	Immunisation rates for this age group are currently not reported by the National Immunisation Register.
A reduction in ambulatory sensitive hospitalisations (ASH) rates[†] Hutt Valley DHB's 0-4 year olds ASH rate is higher than the national average. Although Māori have higher ASH rates than other ethnicities, it is promising that this disparity has decreased in 2013/14. However, Pacific rates have increased since 2012/13 and needs to be a focus moving forward. The local newborn enrolment project is currently developing a single system in each of the three DHBs that enables enrolment of newborns to primary care, oral health and Well Child Tamariki Ora services. The project also includes the development of information for parents and providers about the importance of newborn enrolment and the process for enrolling. In addition, following the government policy to provide free after-hours care to children under six from July 2012, consultations for under sixes across all general practices in the sub-region have been made free. This measure links to the Prevention Services and Early Detection & Management output classes.	

Population health outcome: Optimising the health, wellbeing, and independence of our region's older people

It is important to ensure that health services meet the increasing need of our ageing population. The proportion of Hutt Valley DHB residents who are 65 years or older is projected to increase from 14% in 2014 to 19% in 2025. Thus, it is important that the DHB provides services that are responsive to older people's needs.

By ensuring that health services are responsive to the needs of our older population, we can help older people to maintain their independence and to remain at home for longer.

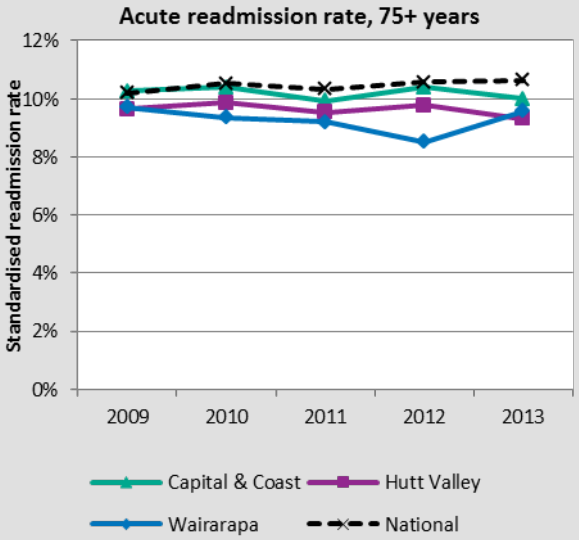
Measures – The DHB measures progress through:

A reduction in the rate of acute readmissions, 75+

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported once they are out of hospital.

Nationally, there has been a slight increase in the rate of acute readmissions of people 75+ years over the past four years. Hutt Valley DHB's rate has decreased slightly over the last four years and is lower than the national average.

This measure links to the Intensive Assessment and Treatment Services output classes.



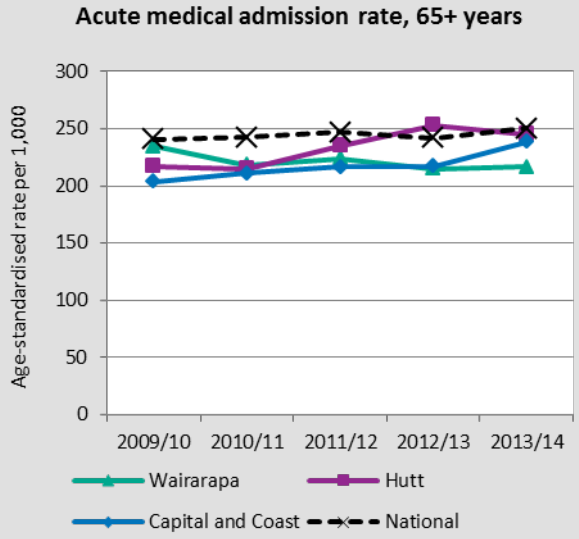
A reduction in the rate of acute medical admissions for 65+

Acute admission rates are influenced by a broad set of strategies, including prevention and treatment in primary care, and alternative models of care.

Unplanned acute admissions are an indicator of the quality of acute care (in the hospital and/or the community), and access to and the quality of health and disability services.

Hutt Valley DHB's rate of acute medical admissions has increased in recent years, and is now comparable to the national rate. However, the recent establishment of 3DHealthPathways, which describe the route a patient takes as they move through the health system and receive healthcare, should reduce the acute admission rate in future years. 3DHealthPathways will increase collaboration between health services which will result in better quality of care for our population.

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

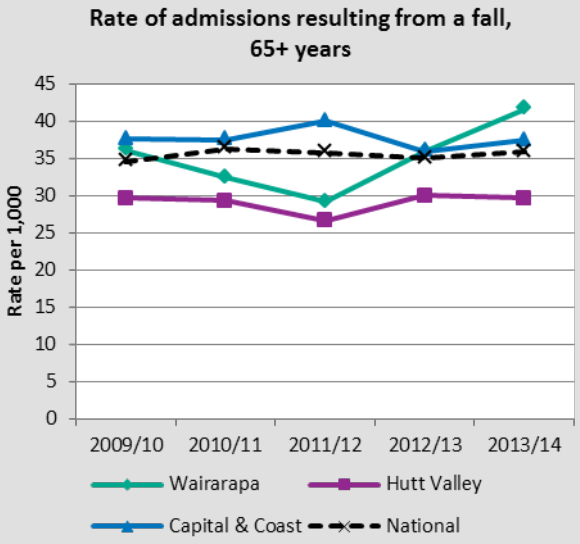


A reduction in the rate of admissions as a result of a fall, 65+

Falls are a common indicator in the health of older persons sector, both nationally and internationally. Reducing the rate of falls will promote and protect good health and independence, as older people will be able to do more things for themselves and remain in their own homes for longer. It will also reduce the demand on other services that provide treatment or interventions for falls.

The three DHBs joined with the Health and Safety Quality Commission in 2013/14 to implement a Falls Collaborative (as part of the Commission's Reducing Harm from Falls programme) with aged care facilities across the subregion. This programme supported aged care to introduce and implement Quality Improvement projects to reduce the incidence of falls within facilities. The formal programme has finished. It has been independently evaluated and as a result the Commission is developing a set of tools and templates to support best practice in falls risk assessment and individualised care planning. The three DHBs will be involved in the promotion of these resources.

This measure links to the Rehabilitation & Support output class.

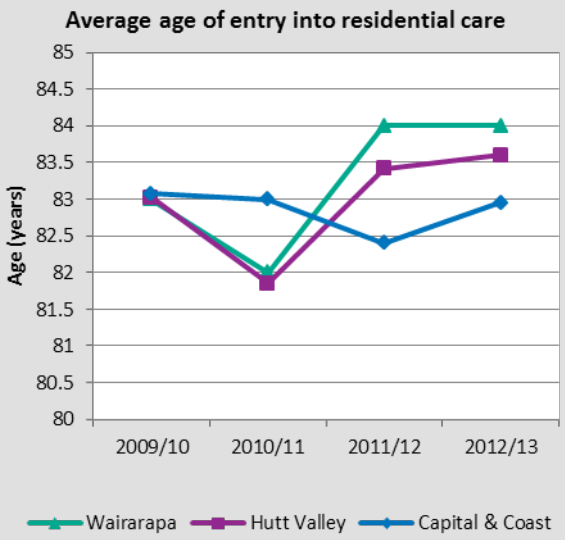


An increase in the average age of entry into residential care

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[6] found that "home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy". This shows the importance of helping older people to maintain their independence.

Increasing the average age of entry into aged residential care indicates that our health services are providing for our older population's needs. There has been an increase in the age at which people are entering aged residential care in Hutt Valley DHB.

This measure links to the Rehabilitation & Support output class.



Source: Regional benchmarking. 2013/14 data not available at time of publication.

[6] Hambleton, Penny, Sally Keeling, & Margaret McKenzie (2008). "Quality of Life is…:The Views of Older Recipients of Low-Level Home Support." *Social Policy Journal of New Zealand (33).*

STATEMENT OF SERVICE PERFORMANCE

For the year ended 30 June 2014

In the Statement of Service Performance, we evaluate our performance (outputs) against the targets that we set in our 2013/14 Statement of Forecast Service Performance. We choose outputs that make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes that we are seeking to achieve over the longer term. These outputs also cover areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. They reflect a picture of health service activity across the whole of the Hutt Valley health system.

To give a representative picture of our performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care and are applicable to all DHBs:

- Prevention Services;
- Early Detection and Management Services;
- Intensive Assessment and Treatment Services; and,
- Rehabilitation and Support Services.

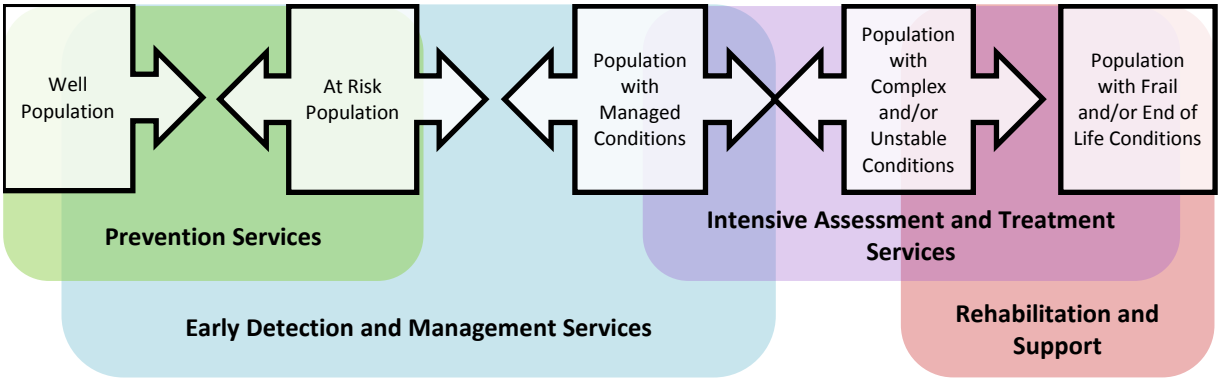


Figure 1: Scope of DHB Operations – Output Classes in the Continuum of Care

1. Prevention Services (Public Health Services)

Public health services are publicly funded to protect and promote the health of our population or of identifiable subpopulations (e.g., Māori, or children under 5). Public health services improve and maintain the health and wellbeing of the population through population-wide physical and social environment interventions, and enabling and empowering community resiliency. Notably, public health services are different to 'curative' services which repair health dysfunction and disability and support rehabilitation.

Public health services include:

- health promotion to prevent illness and to achieve equity in health status;
- statutorily-mandated health protection services to protect the public from toxic environmental risks and communicable diseases; and,

- individual health protection services, including immunisation and screening services.

2. Early Detection and Management (Primary and Community Health Services)

Primary and community healthcare services are delivered by a range of health and allied-health professionals in various private, not-for-profit, and government service settings. These services include general practice, community, and Māori and Pacific health services, community pharmacy services, and child and adolescent dental and oral health services. These services are usually accessible from multiple health providers and from a number of different locations within the district.

3. Intensive Assessment and Treatment (Hospital Services)

Hospital services are publicly funded and are delivered by a range of secondary, tertiary, and quaternary providers. These services are usually integrated with 'facilities' (hospitals) so that specialised clinical expertise and equipment are conveniently provided in the same place, as hospital services are usually highly complex and provided by a variety of health care professionals that work closely together.

Hospital services 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.

4. Rehabilitation and Support (Support Services)

Support services 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.

Interpreting our Performance

Identifying appropriate measures for each output class is difficult as it is important to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time.

Because of this complexity, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness.

Type of Measure	**Abbreviation**
Coverage	C
Quality	Q
Volume	V

Timeliness	T

The tables on the following pages show our performance against our targets. Our performance has been categorised according to the table below:

Performance	**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.

In addition, we've used the following symbols:

Symbol	**Definition**
†	Appears in the Māori Health Plan for Hutt Valley DHB.
*	New measure in 2013/14. Our 2012/13 performance has therefore not been audited by Audit New Zealand.

Financial Performance ($000s)

Revenue	**2012/13**	**2013/14 Budget**	**2013/14 Actual**
Prevention	20,742	20,172	22,096
Early Detection and Management	118,697	112,640	114,579
Intensive Assessment and Treatment	245,584	255,429	257,424
Rehabilitation and Support	57,910	59,390	59,550
Total	442,933	447,631	453,648

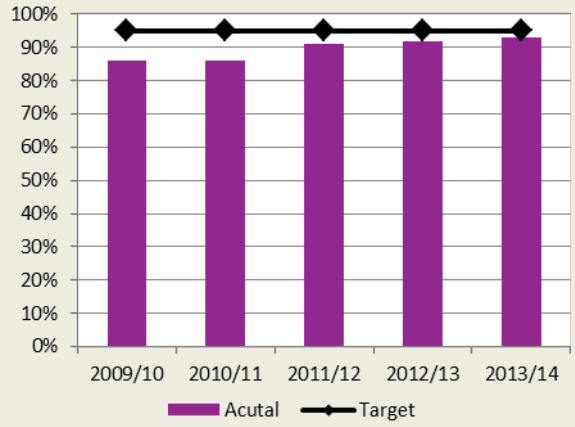
Expenditure	**2012/13**	**2013/14 Budget**	**2013/14 Actual**
Prevention	20,744	20,478	21,539
Early Detection and Management	112,628	108,418	106,488
Intensive Assessment and Treatment	253,527	258,845	267,386
Rehabilitation and Support	58,995	59,890	60,059
Total	445,894	447,631	455,472

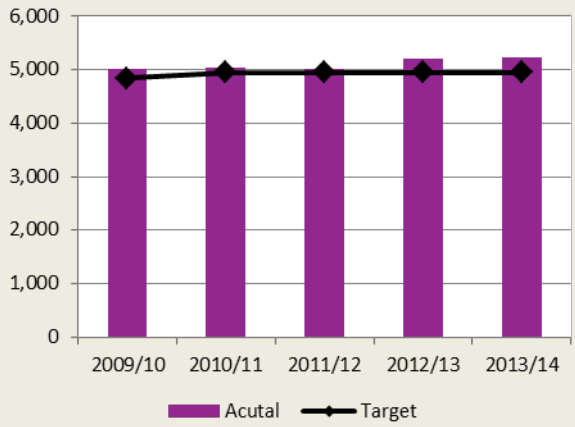
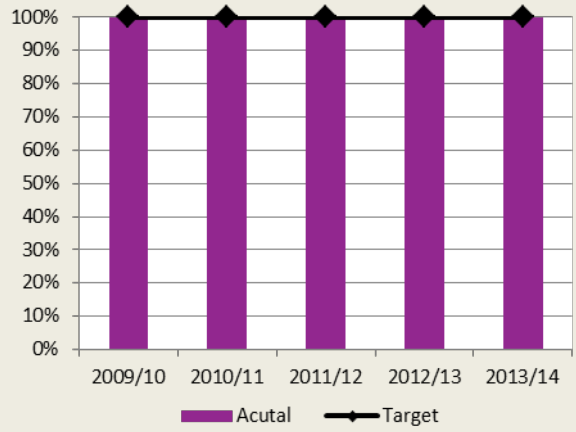
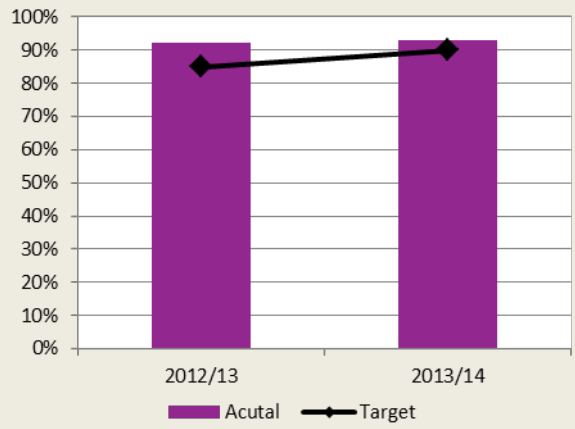
PERFORMANCE HIGHLIGHTS

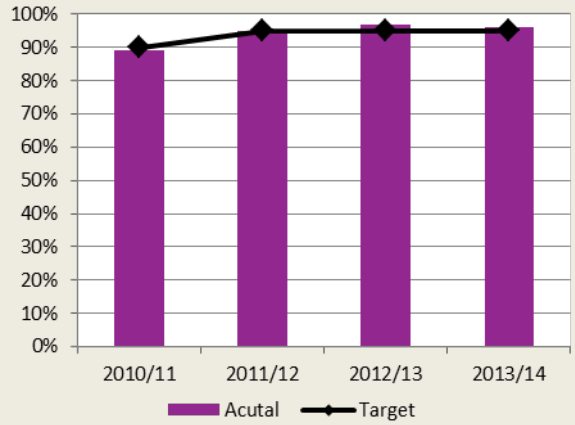
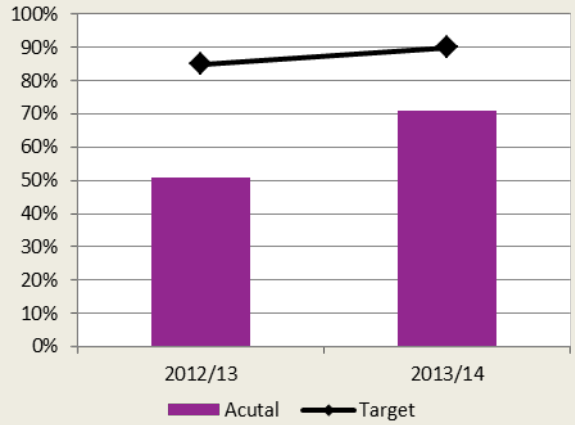
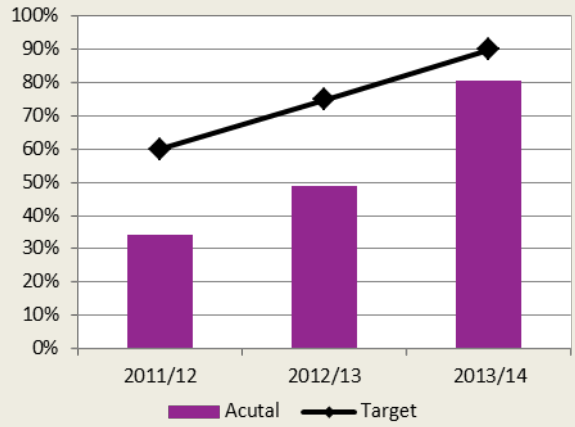
Hutt Valley DHB continues to provide high quality and timely services for our population. In 2013/14:

- Hutt Valley DHB and PHOs met all of the immunisation health targets
- Hutt Valley DHB continues to meet the Better Help for Smokers to Quit hospital health target, with 96% of hospitalised smokers given advice to quit in 2013/14
- Thanks to substantial effort from the PHOs, the percentage of the eligible population receiving a CVD risk assessment within the last five years increased from 49% in 2012/13 to 81% in 2013/14. This increase equates to approximately 12,800 more people receiving an assessment in 2013/14
- Hutt Valley DHB met the Before School Check screening target for both the total population and the high need population, with 90% (of both populations) of children receiving a check
- Hutt Valley DHB exceeded the elective surgery health target with 5,226 elective surgeries delivered to the DHB population, 280 more surgeries than the target
- The Hutt Valley population's access to secondary mental health services continues to increase.

Minister's Health Targets

Health Target	Description and 2013/14 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. 2013/14 Result: 94% **Output Class: Intensive Assessment and Treatment**	

Health Target	Description and 2013/14 Result	Trend
Improved access to elective surgery	More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year. Target was 4,946 discharges in 2013/14. 2013/14 Result: 5,226 **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. 2013/14 Result: 100% **Output Class: Intensive Assessment and Treatment**	
Increased immunisation	90 percent of eight month 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. 2013/14 Result: 93% **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	

Health Target	Description and 2013/14 Result	Trend
	brief advice and support to quit smoking. 2013/14 Result: Hospital: 96% Primary Care: 71% **Output Class: Prevention Services**	Hospital:  Primary care: 
Better diabetes and cardiovascular services More heart and diabetes checks	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. 2013/14 Result: 81% **Output Class: Early Detection and Management**	

PREVENTION SERVICES

Immunisation Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of eight month olds fully vaccinated†	C	92%	**90%**	93%	Achieved
The percentage of Yr 7 children vaccinated in schools[7]	C	73%	**70%**	70%	Achieved
The percentage of Yr 8 girls vaccinated against HPV[8]	C	58%	**60%**	69%	Achieved
The percentage of enrolled people over 65 years vaccinated against flu[9†]	C	68%*	**66%**	68%	Achieved
High need		67%*	**64%**	67%	Achieved

Hutt Valley DHB has achieved all immunisation targets this year. In addition to school vaccinations, approximately 13% of the combined HVDHB and CCDHB Year 7 population were vaccinated in primary care.

Smoking Cessation

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of hospitalised smokers receiving advice and help to quit†	C	97%	**95%**	96%	Achieved
Health Target: The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking†	C	51%	**90%**	71%	Not Achieved

Hutt Valley DHB continues to provide advice to quit to over 95% of smokers who are hospitalised. Although the general practice target was not met, our performance increased by 20% which equates to approximately

[7] Performance aligned to school year: January to December 2012 (2012/13) and January to December 2013 (2013/14)
[8] Fully vaccinated Dose 3
[9] As flu vaccinations are seasonal, result is as at July 2013 (for 2012/13) and July 2014 (for 2013/14)

3,800 more patients being provided advice to quit. Te Awakairangi Health Network continues to work with its general practices to increase smoking cessation support.

Health Promotion Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The number of schools and early childhood services receiving health promotion visits[10]	V	290	**138**	186	Achieved
Minimum number of housing assessments	V	217*	**200**	34[11]	Not Achieved
The percentage of infants exclusively and fully breastfed at 6 months[12†]	C	25%*	**27%**	22%	Not Achieved
The number of diseases investigated	V	2538*	**< 2700**	1797[13]	Achieved
The number of environmental health investigations	V	684	**550**	587	Achieved
The number of new client referrals to school health nurses[14]	V	Unavailable[15]	**650**	948	Achieved

Regional Public Health service (RPH) visited 153 Early Childhood Services and 33 schools across Hutt Valley and Capital & Coast DHBs in 2013/14. These visits included health promotion topics such as skin infections, gastroenteritis, oral health, nutrition, physical activity, bullying, and road safety.

A new Housing Assessment and Advice Service began in March 2014. In this service, public health nurses provide housing and health assessments for at-risk groups and referrals to other providers. The service also provides advice for health professionals, as well as workforce development and support to primary health care staff to directly address the housing needs of their clients.

[10] Hutt Valley and Capital & Coast populations.

[11] RPH's housing programme was disrupted by the national Healthy Housing Programme (HHP) formally ending in September 2013. From July to October 2013, Housing NZ advised RPH not to undertake any joint assessments. Therefore no assessments were undertaken for this programme for the 13/14 year. Referrals to the new Housing Assessment and Advice Service programme were received from March 2014. Thirty four assessments were completed from 57 referrals received.

[12] Plunket data.

[13] Sub-regional total.

[14] This measure was originally "The number of new client referrals *by* school health nurses". This wording has since been revised as we are measuring referrals to the public health nursing service, not volume of referrals by the nursing service to other providers.

[15] This measure changed in 2013/14 from the number of *visits* to the number of *referrals*. The 2012/13 number of *visits* was 1355. In 2013/14, the average number of visits per open referral was 4.93.

In 2013/14 there was a decrease in the number of diseases investigated, which is a positive result and reflects the impact of increased immunisation. Pertussis notifications have decreased significantly in 2013/14, returning to baseline levels before the outbreak in 2012/13. Enteric infections continue to dominate disease notifications.

EARLY DETECTION AND MANAGEMENT

Primary Care Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The number of DHB domiciled population enrolled in a PHO[16]	V	140,137	**≥140,859**	140,369	Not Achieved
Māori†		21,635*	**≥21,879**	21,872	Not Achieved
The percentage of the PHO enrolled population enrolled in Care Plus	C	5.1%*	**≥4.5%**	5.3%	Achieved
The ratio (high need: non high need) of standardised GP and nurse utilisation rate	V	1.05*	**≥1.03**	1.12	Achieved
Health Target: The percentage of eligible people assessed for CVD risk within the last five years†	C	49%	**≥90%**	81%	Not Achieved
The percentage of diabetics receiving an annual check	C	71%*	**≥75%**	77%	Achieved

While the target for Hutt Valley people enrolled in a PHO was not achieved, a 97% enrolment rate has been maintained. Of the Hutt Valley enrolled population, 80% are 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 approximately 4,750 people from the Hutt Valley not enrolled with any PHO.

Although the CVD health target was not met, performance increased by 32%, which equates to approximately 12,800 more people receiving a check in 2013/14. The PHOs made a concerted effort to achieve the target with substantial gains each quarter, with DHB performance improving from 19th to 7th of the 20 DHBs. There have been substantial investments in IT and workforce support to improve the visibility of patients who are overdue for assessments to practitioners.

[16] PHO enrolment as at 1 July 2013 (for 2012/13) and 1 July 2014 (for 2013/14).

Screening Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of eligible children receiving a Before School Check	C	83%*	**≥90%**	90%	Achieved
High need		83%*	**≥90%**	90%	Achieved
The percentage of eligible women (25-69) having cervical screening in the last 3 years[17†]	C	80%*	**≥80%**	79%	Not Achieved
Māori		64%*	**≥80%**	64%	Not Achieved
Pacific		67%*	**≥80%**	64%	Not Achieved
The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years[†]	C	67%*	**≥70%**	73%	Achieved
Māori		58%*	**≥70%**	64%	Not Achieved
Pacific		60%*	**≥70%**	64%	Not Achieved

Hutt Valley DHB has achieved the Before School Check target for both the total population and high need population. Part of the cervical screening service involves following up people who have not had a cervical screen in the last five years. Focused initiatives to support primary care include data matching and priority women days in which Māori and Pacific women and those overdue for screening are booked into a Saturday clinic for breast screening and/or cervical screening. A current shortage of Medical Radiology Technologists (MRT) is placing strain on breast screening services, and we are actively recruiting for MRTs.

Oral Health Services

Measure	Type of Measure	2012 Performance	Target[18]		2013 Performance	Achievement
			2013	2014		
The percentage of children under 5 years enrolled in DHB funded dental services	C	47%*	**≥65%**	**≥85%**	47%	Not Achieved

[17] National Screening Unit data. Note that in 2013/14 the National Screening Unit revised the original measure from 20-69 year olds to 25-69 years old to align with international best practice. The national targets (to which our targets are aligned) have remained the same.

[18] Oral health measures are reported on a calendar year, so the Ministry of Health requests that we specify targets for each year.

Measure	Type of Measure	2012 Performance	Target[18]		2013 Performance	Achievement
			2013	2014		
The total number of dental examinations by the dental service for children 0-12, Hutt Valley population	V	17,403*	**≥17,822**	**≥18,210**	16,876	Not Achieved
The percentage of adolescents accessing DHB funded dental services	C	69%*	**≥85%**	**≥85%**	69%	Not Achieved

The oral health team are working closely with early childhood services and medical centres to find and enrol children younger than five years to the school dental service. A lack of clinical resource in the service currently contributes to the shortfall in dental examinations. An open recruitment drive is in place to employ staff to the service. The service continues to prioritise examinations for the children most overdue.

INTENSIVE ASSESSMENT AND TREATMENT

Medical and Surgical Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	92%	**≥95%**	94%	Not Achieved
Health Target: The number of surgical elective discharges	V	5,208	**≥4,946**	5,226	Achieved
The average length of stay for inpatients (days)[19] – Acute	T	3.73	**4.60**	4.06	Achieved
Elective		3.20*	**3.21**	3.15	Achieved
Number of fertility treatments provided for the Central Region	V	302	**≥303**	275	Not Achieved

Hutt Valley DHB met the shorter stays in ED health target in all quarters except for the final quarter, when unforeseen increases in the number of ED visits increased waiting times. A number of initiatives are in place to improve performance during these unforeseen increases.

[19] Standardised rate. Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).

Hutt Valley DHB continues to achieve the elective surgery health target, with 5,226 discharges in 2013/14. The average length of stay remains substantially lower than it was in 2011/12. This decrease is related to a recent initiative of regular reviews to identify possible delays in a patients' treatment.

Quality Measures

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of "DNA" (did not attend) appointments for outpatients	Q	9%*	**<7%**	9%	Not Achieved
Māori		18%*	**<7%**	17%	Not Achieved
Pacific		18%*	**<7%**	19%	Not Achieved
The ratio of first specialists assessments (medical & surgical) to follow up appointments	Q	1:2.9*	**1:2.6**	1:3.1	Achieved
The percentage of mothers breastfeeding on discharge[20]	Q	79.7%*	**≥77.8%**	80.7%	Achieved
The number of central line acquired bacteraemia infections in ICU	Q	0*	**0**	0	Achieved
The rate of falls per 1000 bed days causing patient harm[21]	Q	1.9*	**<7.2**	2.2	Achieved
The rate of medication errors per 1000 bed days	Q	2.7*	**<4.48**	3.3	Achieved

Although the DNA rate for Māori has decreased in 2013/14, there is still inequity between Māori and other ethnicities. To reduce DNA rates, Māori and Pacific teams are using a range of culturally-specific approaches, including engagement with patients and whanau prior to appointments, coordinating appointments, providing assistance to attend appointments, linking with community services, and responding to referrals from clinics following a DNA.

Hutt Valley DHB continues to provide high quality and timely care to patients. In 2013 the Health Quality & Safety Commission (HQSC) introduced a campaign that focusses on improving patient safety in medications, falls, health acquired infections, and perioperative harm. Our medication error and fall rates are now significantly lower than they were in 2011/12.

[20] Fully or exclusively breastfeeding.

[21] This measure was originally "The rate of falls per 1,000 bed days" in the 2013/14 Annual Plan and has since been revised.

Cancer Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	100%	Achieved

Mental Health and Addictions Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of people accessing secondary mental health services [22]	C	4.04%*	**≥4.10%**	4.16%	Achieved
The percentage of people accessing secondary mental health services, 0-19[23]		4.23%*	**≥3.84%**	4.20%	Achieved
Māori		5.33%*	**≥3.84%**	5.20%	Achieved
The percentage of people accessing secondary mental health services, 20-64[24]		4.40%*	**≥4.14%**	4.63%	Achieved
Māori		7.55%*	**≥4.14%**	7.70%	Achieved
The percentage of long-term clients who have up-to-date relapse prevention plans	Q	93%	**≥95%**	89%	Not Achieved
The percentage of patients referred to non-urgent mental health services who are seen within eight weeks	T	88%*	**≥95%**	94%	Not Achieved

[22] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
[23] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
[24] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).

The percentage of patients referred to non-urgent addictions services who are seen within eight weeks	T	91.5%*	**≥90%**	91.7%	Achieved

There has been increasing collaboration between the Mental Health and Addiction Services in the sub-regional DHBs in 2013/14. We will continue to work with our Alcohol and Drug facilities and NGO providers to increase the access to and timeliness of mental health services.

REHABILITATION AND SUPPORT

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of people 65+ who have received long-term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan[25]	Q	100%*	**≥95%**	100%	Achieved
The number of total assessments (including new and review)	V	2,714	**2,500**	3,405	Achieved
The number of people receiving home and community support services	V	1,917*	**1,880**	1,987	Achieved
The number of home based support hours	V	255,768	**254,000**[26]	257,002	Achieved
The number of respite days[27]	V	3,203	**1,895**[28]	2,317	Achieved
The number of subsidised aged residential care bed days	V	310,359	**313,531**[29]	309,233	Not Achieved

[25] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
[26] These targets are based on historic trends and are not aspirational. There are no assumptions around whether an increase/decrease is desirable or not. Performance on these targets will vary from year to year depending on a number of factors (e.g., socio-demographic and economic profiles).
[27] Excluding bulk-funded beds (3 beds).
[28] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
[29] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).

The percentage of residential care providers meeting three year certification standards[30]	Q	93%*	**≥90%**	87%	Not Achieved
The number of Disability Forum meetings (sub-regional and local)	V	2*	**2**	2	Achieved

Regional benchmarking shows that Hutt Valley DHB has the highest percentage of people in aged residential care over the age of 80+ years. Fewer subsidised aged residential care days is positive given the numbers of people receiving support to stay at home, as it indicates that people are able to stay at home for longer.

The three sub-regional DHBs collaborated in a disability plan in 2013. As a result of this collaborative approach, the first 3DHB inter-sectoral forum around disability issues was held in 2013/14.

[30] Excluding new providers and facilities as these are required to have a one year certification.

FINANCIAL STATEMENTS

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STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Income				
Operating Income	2	452,509	447,301	441,892
Interest		1,138	330	1,041
Total Income		**453,647**	**447,631**	**442,933**
Expenditure				
Personnel Costs	3	156,571	156,830	154,155
Depreciation, Amortisation & Impairment expense	10-11	10,985	13,793	11,452
Outsourced Services		13,031	8,708	10,127
Clinical Supplies		23,886	23,594	23,541
Infrastructure and non-clinical expenses		14,175	14,391	15,132
Other District Health Boards		81,506	77,184	80,163
Non-Health Board Providers		139,976	140,240	138,472
Capital Charge	4	7,410	5,501	5,308
Interest expense	5	3,969	3,999	3,859
Other expenses	6	3,962	3,390	3,685
Total Expenditure		**455,471**	**447,631**	**445,894**
Net surplus / (Deficit)		**(1,824)**	-	**(2,961)**
Other comprehensive income				
Revaluation of Land and Buildings		-	-	29,439
Total Comprehensive Income for the Year		**(1,824)**	**-**	**26,478**

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

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2014

		2014 Actual $000	2014 Budget $000	2013 Audited $000
Equity as at 1 July		94,579	67,322	68,308
Capital Contributions from the Crown		1,066	-	-
Repayment of equity to the Crown		(207)	-	(207)
Revaluation surplus		-	-	29,439
Total Comprehensive Income for the Year		(1,824)	-	(2,961)
Equity as at 30 June	17	**93,614**	**67,322**	**94,579**

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	23,623	9,201	24,650
Debtors and other receivables	8	15,641	13,042	11,861
Inventories	9	1,466	1,389	1,435
Total Current Assets		**40,730**	**23,632**	**37,946**
Non-Current Assets				
Property, Plant and Equipment	10	197,639	178,338	204,037
Intangible Assets	11	8,823	6,914	4,281
Investments in Joint Ventures	12	2,744	5,424	1,280
Trust and bequest funds	13	1,288	1,063	1,099
Total Non-Current Assets		**210,494**	**191,739**	**210,697**
Total Assets		**251,224**	**215,371**	**248,643**
Liabilities				
Current Liabilities				
Bank Overdraft		-	-	-
Creditors and other payables	14	40,970	32,601	39,036
Employee entitlements and provisions	15	26,996	25,748	25,453
Borrowings	16	8,991	4,992	11,207
Total Current Liabilities		**76,957**	**63,341**	**75,696**
Non-Current Liabilities				
Employee entitlements and provisions	15	6,440	6,847	6,978
Borrowings	16	72,925	76,798	70,291
Trust and bequest funds	13	1,288	1,063	1,099
Total Non-Current Liabilities		**80,653**	**84,708**	**78,368**
Total Liabilities		**157,610**	**148,049**	**154,064**
Equity				
Crown equity	17	44,937	45,817	44,078
Revaluation reserves	17	79,807	50,368	79,807
Accumulated deficit	17	(31,130)	(28,863)	(29,306)
Total Equity	17	**93,614**	**67,322**	**94,579**
Total Equity and Liabilities		**251,224**	**215,371**	**248,643**

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

STATEMENT OF CASH FLOW

For the year ended 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Cashflows from Operating Activities				
Cash receipts		463,954	447,262	455,252
Payments to providers		(234,992)	(217,474)	(232,317)
Payments to suppliers & employees		(209,752)	(206,004)	(210,038)
Goods and Services Tax (net)		(168)	-	128
Capital charge paid		(7,410)	(5,496)	(5,308)
Net cash flows from Operating Activities	18	**11,632**	**18,288**	**7,717**
Cashflows from Investing Activities				
Interest Received		1,137	330	1,041
Proceeds from sale of property, plant and equipment		-	-	301
Purchase of property, plant and equipment		(9,650)	(11,498)	(5,215)
Investments		(1,464)	(2,904)	(1,867)
Net cash flows from Investing Activities		**(9,975)**	**(14,072)**	**(5,740)**
Cashflows from Financing Activities				
Equity Contribution		1,066	-	-
Loans and finance lease raised/(paid)		1,312	-	(348)
Interest paid		(3,960)	(3,997)	(5,645)
Payment of Finance Leases		(895)	-	(344)
Repayment of Equity		(207)	-	(207)
Net cash flows from Financing Activities		**(2,684)**	**(3,997)**	**(6,544)**
Net Increase / (Decrease) in Cash Held		**(1,027)**	**219**	**(4,567)**
Cash and cash equivalents at beginning of year	7	24,650	8,982	29,217
Cash and Cash Equivalents at end of year		**23,623**	**9,201**	**24,650**

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

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2014

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 DHB's ultimate parent is the New Zealand Crown.

Hutt Valley DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. 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 DHB has reported in note 13 on the trust monies and bequests that it administers.

The financial statements for Hutt Valley DHB are for the year ended 30 June 2014, and were approved by the Hutt Valley District Health Board on 31 October 2014.

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 have been prepared in accordance with NZGAAP as appropriate for public benefit entities.

Measurement base

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

Functional and Presentation Currency

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

Changes in Accounting Policies

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

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 that are not yet effective and have not been early adopted

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Hutt Valley DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS)]. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. This means Hutt Valley DHB will transition to the new standards in preparing its 30 June 2015 financial statements.

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.

Hutt Valley DHB anticipates that these standards will have no material impact on the financial statements in the period of initial application. It is likely that the changes arising from this framework will affect the disclosures required in the financial statements. However, it is not practicable to provide a reasonable estimate until a detail review has been completed.

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

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.

Leases

Finance Leases

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

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

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

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

Operating Leases

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

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

Foreign currency transactions

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

Cash and Cash equivalents

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

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 period of the write-down.

Property, plant and equipment

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

- land;
- site improvements;
- building services fit out;
- plant and equipment (includes computer equipment);
- leased assets ; and
- motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation 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 were reviewed during the year and have been estimated as follows:

Site Improvements	6 to 33 years
Building Structure, Services and Fit out	2 to 55 years
Plant and equipment	2 to 25 years
Computer equipment	3 to 10 years
Leased assets	3 to 15 years
Motor vehicles	8 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 and with the development and maintenance of Hutt Valley DHBs website are recognised as an expense when incurred.

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Amortisation

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

Indefinite life intangible assets are not amortised.

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

Computer software	3 to 10 years

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 revalued amounts, the total impairment loss is recognised in the surplus or deficit.

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

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

Creditors and other payables

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

Borrowings

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

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

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, long service leave, retiring gratuities, continuing medical education leave and expenses, and other entitlements for example sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the

unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

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

Long-term entitlements

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

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

Provisions

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

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 deficits; and
- revaluation reserves.

Revaluation reserves

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

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

Land and buildings revaluations

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

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

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

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

Critical judgements in applying accounting policies

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

Classification of Leases

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

2 OPERATING INCOME

	2014 Actual $000	2013 Actual $000
Ministry of Health contract funding	387,968	379,690
ACC Contract revenue	4,279	4,414
Other Government	1,595	1,419
Revenue from other District Health Boards	53,409	50,808
Other patient care related revenue	4,953	4,838
Other Income:		
Gain on Sale of Fixed Assets	-	301
Donations and bequests received	235	350
Rental income and services	71	72
Total Operating Income	**452,509**	**441,892**

3 PERSONNEL COSTS

	2014 Actual $000	2013 Actual $000
Salaries and wages	151,440	150,979
Contributions to defined contribution schemes	4,126	3,308
Increase/(decrease) in liability for employee entitlements	1,005	(132)
Total Personnel Costs	156,571	154,155

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

4 CAPITAL CHARGE

Hutt Valley DHB pays a capital charge to the Crown every six months. The charge is now based on the actual closing equity balance excluding the value of donated assets. The capital charge rate for the year ended 30 June 2014 was 8% (2013: 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 in accordance with IAS23 Qualifying assets are capital projects spanning more than one year and requiring long-term funding.

Interest on Crown borrowings which were directly attributable to the Theatre and Emergency Department building project completed in 2013 was capitalised to the project. The amount capitalised during the period is nil (2013: $185k).

6 OTHER EXPENSES

	2014 Actual $000	2013 Actual $000
Audit Fees for financial statement audit	122	121
Audit-related fees for internal audit services	50	149
Operating lease expense	3,460	2,939
Impairment of debtors	(11)	124
Board member fees	304	349
Loss on disposal of property, plant and equipment	37	3
Total Other expenses	**3,962**	**3,685**

7 CASH AND CASH EQUIVALENTS

	2013 Actual $000	2013 Actual $000
Call Deposits with Health Benefits Ltd	17,624	19,077
Cash at bank and on hand	99	7
Other Call deposits	5,900	5,566
Total Cash and cash equivalents for the purposes of the statement of cash flows	**23,623**	**24,650**

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 $18 million (2013:$15.9m).

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 26: Credit quality of financial assets).

8 DEBTORS AND OTHER RECEIVABLES

	2014 Actual $000	2013 Actual $000
Ministry of Health	5,879	5,735
Other DHBs	2,002	1,336
PHARMAC	2,975	2,559
Trade debtors - other	4,458	2,004

Provision for doubtful debts	(230)	(342)
	15,084	**11,292**
Prepayments	557	569
Total Debtors and other receivables	**15,641**	**11,861**

The carrying value of receivables approximates their fair value.

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

	2014			2013		
	Gross $000	**Impairment $000**	**Net $000**	**Gross $000**	**Impairment $000**	**Net $000**
Not past due	15,789	(2)	15,788	10,367	(12)	10,355
Past due 1-30 days	394	(10)	384	160	(24)	136
Past due 31-60 days	(1,835)	-	(1,834)	191	(35)	156
Past due >60days	964	(218)	746	916	(271)	645
Total	**15,314**	**(230)**	**15,084**	**11,634**	**(342)**	**11,292**

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.

The net balance in the past due 31-60 days is in credit due to refund adjustment.

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

	2014 Actual $000	**2013 Actual $000**
Opening Balance	(342)	(305)
Provisions write back/(made)	11	(124)
Receivables Written Off	100	87
Closing Balance	**(230)**	**(342)**

9 INVENTORIES

	2014 Actual $000	2013 Actual $000
Pharmaceuticals	168	121
Surgical and medical supplies	1,308	1,324
	1,476	**1,445**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,466**	**1,435**

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 (2013: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2013: nil) however some inventories are subject to retention of title clauses.

10 PROPERTY, PLANT AND EQUIPMENT

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

	Land	Site Improve-ments	Building Services Fit out	Plant & Equipment	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance 1 July 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
Balance 1 July 2013	13,625	2,167	169,519	41,367	2,652	2,637	231,967
Additions	-	6	1,123	2,716	1,135	-	4,980
Work in Progress	-	-	409	(1,177)	-	-	(768)
Disposals	-	-	(5)	(719)	7	(186)	(903)
Adjustments	-	-	-	-	-	-	-
Revaluation increase/(decrease)	-	-	-	-	-	-	-
Balance 30 June 2014	13,625	2,173	171,046	42,187	3,794	2,451	235,276

Accumulated depreciation and impairment losses							
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
Balance at 1 July 2013	-	-	-	26,472	561	897	27,930
Depreciation expense	-	124	6,958	2,989	231	262	10,564
Depreciation on disposals	-	-	(4)	(667)	-	(186)	(857)
Adjustment	-	-	-	-	-	-	-
Elimination on revaluation	-	-	-	-	-	-	-
Balance 30 June 2014	-	124	6,954	28,794	792	973	37,637
Carrying Amounts							
At 30 June 2013	13,625	2,167	169,519	14,895	2,091	1,740	204,037
At 30 June 2014	13,625	2,049	164,092	13,393	3,002	1,478	197,639

The net carrying amount of assets held under finance leases is $3.00m (2013: $3.04m) for plant and equipment.

There are no restrictions over the titles of Hutt Valley DHB's property plant and equipment; neither has any of the DHB's property, plant and equipment been pledged as security for liabilities.

Adjustments were made in 2013 to reclassify fixed asset costs and accumulated depreciation balances to align the General Ledger balances with the Fixed Assets register. No such adjustment has been made this year.

Valuation

Land and building valuations are done on a five year cycle. A full valuation was done in 2010 and desktop valuation updates are done in the interim years between full valuations. The most recent valuation update of land and buildings was performed by an independently contracted registered valuer, Peter Schellekens, ANZIV, SPINZ of CBRE Limited. The effective date of the last desktop valuation was 30 June 2014 and the next full valuation will be completed for 30 June 2015. 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. All the assessed buildings met the current minimum standards of the Building Code for existing buildings. This includes the one building (garages at one end of the campus) which did not meet the minimum standard in the previous year which has now been strengthened.

11 INTANGIBLE ASSETS

	Computer Software	FPSC Shared Services Rights	Total
	$000	$000	$000
Cost or valuation			
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
Balance 1 July 2013	11,763	810	12,573
Additions	1,187	736	1,923
Work in Progress	3,041	-	3,041
Adjustment	-	-	-
Balance 30 June 2014	15,991	1,546	17,537
Accumulated depreciation and impairment losses			
Balance at 1 July 2012	8,631	-	8,631
Depreciation expense	346	-	346
Adjustment	(685)	-	(685)
Balance 30 June 2013	8,292	-	8,292
Balance at 1 July 2013	8,292	-	8,292
Depreciation expense	422	-	422
Adjustment	-	-	-

Balance 30 June 2014	8,714		-	8,714
Carrying Amounts				
At 30 June 2013	3,471	810		4,281
At 30 June 2014	7,277	1,546		8,823

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

At 30 June 2014, the DHB had made payments totalling $1.54m (2013: $0.81m) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

It is expected that the final costs of the FPSC programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC programme will proceed as originally planned. In this scenario, the DRC of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC programme is uncertain and any future decision to re-scope or discontinue the FPSC programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

12 INVESTMENTS IN JOINT VENTURES

	2014 Actual $000	2013 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares (JV-CRTAS)	2,744	1,280
Total Investments	**2,744**	**1,280**

The investment in Central Region's Technical Advisory Services Limited (CRTAS) comprises 16.67% (2013: 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.

During 2013 Hutt Valley DHB made a further investment in CRTAS by way of 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 such as compliance with the applicable law and requirements of the Ministry of Health have been met.

	2014 Actual $000		2013 Actual $000
Summary of DHBs Interest in Joint Venture in Central Region's Technical Advisory Services Limited (CRTAS)			
Assets	5,525		3,902
Liabilities	2,276		3,728
Revenue	4,044		2,841
Expenditure	4,024		2,844
Surplus / (deficit)	21		(3)
Share of contingent liabilities incurred jointly with other investors	-	-	-
Contingent liabilities that arise because of several liability	-	-	-

Health Benefits Limited (HBL) is an unlisted company. Accordingly there are no published prices for this investment. Hutt Valley DHB's investment in HBL's 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.

	2014 Actual $000	2013 Actual $000
Opening balance	1,099	997
Funds received	402	215
Interest received	28	40
Funds disbursed	(241)	(153)
Closing Balance	**1,288**	**1,099**

14 CREDITORS AND OTHER PAYABLES

	2014 Actual $000	2013 Actual $000
Trade payables	1,383	2,620
Other DHBs	5,433	4,647
Accrued expenses	22,276	18,969
Income in advance	1,792	-
Other payables	8,097	10,143
GST and other taxes payable	1,989	2,175
Fixed assets payable	-	482
Total Creditors and other payables	**40,970**	**39,036**

See note 25 for liquidity risk

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

15 EMPLOYEE ENTITLEMENTS AND PROVISIONS

	2014 Actual $000	2013 Actual $000
Current Liabilities		
Salary and Wages Accrued	4,872	4,087
Annual leave	15,650	15,139
Long Service Leave	1,290	1,461
Retirement Gratuities	797	524
Continuing Medical Education Leave and Expenses	991	975
Other Entitlements	3,397	3,267
Total Current Liabilities	**26,996**	**25,453**
Non-current Liabilities		
Long Service leave	1,698	1,863
Retirement Gratuities	908	1,059
Continuing Medical Education Leave and Expenses	2,560	2,620
Other Entitlements	1,274	1,436
Total Non-current Liabilities	**6,440**	**6,978**
Total of Employee Entitlements and Provisions	**33,436**	**32,431**

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 4.68% (2013:4.07%) and an inflation factor of 2.5% (2013:2.5%) has been used.

16 BORROWINGS

	2014 Actual $000	2013 Actual $000
Current portion		
Finance Lease	991	707
Crown Loans - fixed interest	8,000	10,500
	8,991	**11,207**
Non-current portion		
Finance Lease	1,925	1,791
Crown Loans - fixed interest	71,000	68,500
	72,925	**70,291**
Total borrowings	**81,916**	**81,498**
Total borrowing facility limits		
Crown Loans - fixed interest	79,000	79,000
	79,000	**79,000**

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 $81.2m (2013: $83.3m). 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 leases is $2.916m (2013: $2.498m). Fair value is estimated at the present value of future cash flows.

Analysis of Finance Lease

	2014 Actual $000	2013 Actual $000
Minimum lease payments payable:		
Not later than one year	1,026	758
Later than one year and not later than five years	2,218	1,932
Later than five years	-	-
Total minimum lease payments	3,244	2,690
Future finance charges	(328)	(192)
Present value of minimum lease payments	2,916	2,498
Present value of minimum lease payable:		
Not later than one year	991	707
Later than one year and not later than five years	1,925	1,791
Later than five years	-	-
Total present value of minimum lease payments	2,916	2,498

Description of finance leasing arrangements

Hutt Valley DHB has entered into three (2013: two) finance leases totalling $4.83 million (2013: $3.5m) for periods ranging from 3 to 5 years ending between July 2014 and June 2019. The finance leases are for medical equipments. There are no restrictions placed on Hutt Valley DHB by any of the finance leasing arrangements.

17 EQUITY

	Crown Equity $000	Land* $000	Buildings* $000	Accumulated Deficit $000	Total Equity $000
Balance 1 July 2012	44,285	8,659	41,709	(26,345)	68,308
Repayment of Equity	(207)	-	-	-	(207)
Revaluation surplus		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**
Balance 1 July 2013	44,078	9,264	70,543	(29,306)	94,579
Contribution from the Crown	1,066	-	-	-	1,066
Repayment of Equity	(207)	-	-	-	(207)
Total Comprehensive Income for the Year	-	-	-	(1,824)	(1,824)
Balance 30 June 2014	**44,937**	**9,264**	**70,543**	**(31,130)**	**93,614**

***Revaluation Reserves**

18 RECONCILIATION OF NET SURPLUS/DEFICIT TO NET CASH FLOW FROM OPERATING ACTIVITIES

	2014 Actual $000	2013 Actual $000
Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities		
Net operating (loss)	(1,824)	(2,961)
Add/(less) non-cash items:		
Depreciation and amortisation expense	10,985	11,452
Increase/(decrease) in Provisions	894	3,885
Total non-cash items	**11,880**	**15,337**
Add/(less) items classified as investing or financing activity:		
(Gains)/losses on sale of property, plant and equipment	37	(298)
Net interest paid	2,830	2,817
Total items classified as investing or financing activity	**2,867**	**2,519**
Add/(less) movements in statement of financial position items:		
Debtors and other receivables	(3,668)	782
Inventories	(30)	(4)
Creditors and other payables	2,408	(7,956)
Net movements in Working Capital items	**(1,290)**	**(7,178)**
Net cash flow from Operating Activities	**11,632**	**7,717**

19 CAPITAL COMMITMENTS AND OPERATING LEASES

	2014 Actual $000	2013 Actual $000
Capital commitments - Property, plant and equipment	1,203	582
Non-Cancellable Operating Lease Commitments		
Less than one year	1,438	2,095
One to two years	908	1,248
Two to five years	1,135	1,943
Over five years	71	74
Total Non-cancellable Operating Lease Commitments	**3,552**	**5,360**

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

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

- the Regional Public Health premises in Thorndon are leased for five years with an expiry date of December 2017
- the Community Mental Health premises in Lower Hutt are leased for fourteen years with an expiry date of September 2015

- Digital mammography equipment is leased for four years with an expiry date of September 2017
- Clinical equipment including the Magnetic Resonance Imaging (MRI) and ultrasound machines are leased for periods ranging from four to seven years, with expiry dates from October 2014 to January 2015.

20 CONTINGENCIES

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2014 (2013: Nil).

21 RELATED PARTY TRANSACTIONS

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

Significant transactions with government-related entities

Hutt Valley DHB has received funding from the Ministry of Health of $387.97m (2013: $379.69m) 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 $5.88m (2013: $5.74m), and the amount owed by Hutt Valley DHB to the Ministry of Health was nil (2013: $108k).

Hutt Valley DHB has received funding from the Accident Compensation Corporation of $4.28m (2013: $4.41m) 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 $335k (2013: $568k), and the amount owed by Hutt Valley DHB to the Accident Compensation Corporation for health services was nil (2013: nil), and $1.04m (2013: $1.04m) for levies payable.

Revenue earned from other DHBs for the care of patients outside the Hutt Valley amounted to $53.41m (2013: $50.81m). Expenditure to other DHBs for their care of patients from the Hutt Valley amounted to $81.5m (2013: $80.16m). The amount owing to Hutt Valley DHB at the end of the financial year was $2.00m (2013: $1.34m), and the amount owed by Hutt Valley DHB to other DHBs was $5.40m (2013: $4.65m).

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 2014 totalled $0.794m (2013: $1.23m). These purchases included the purchase of electricity from Meridian and Genesis, 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 $2.53m (2013: $1.85m), and revenue received by Hutt Valley DHB for services provided was nil (2013: $1k). The amount owed by Hutt Valley DHB at the end of the financial year was $2.794m (2013: $363k).

Key management personnel

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

	2014 Actual $000	2013 Actual $000
Salaries and other short-term employee benefits	1,947	2,278
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	22
Total key management personnel compensation	**1,947**	**2,300**

During the year Hutt Valley DHB transacted with Capital & Coast DHB on normal inter-DHB terms. In addition the DHBs share some board members and also hold combined Community Public Health Advisory Committee meetings. The total value of the revenue was $47.5m (2013: $45.14m), with total expenditure of $75.78m (2013: $73.24m). The amount owing to Hutt Valley DHB by Capital & Coast DHB at the end of the financial year was $1.46m(2013: $537k), and the amount Hutt Valley DHB owed to Capital & Coast DHB was $4.62m (2013: $4.77m).

During the year Hutt Valley DHB transacted with Wairarapa DHB on normal inter-DHB terms. In addition the DHBs share an executive management team and also hold combined Community Public Health Advisory Committee meetings. The total value of the revenue was $5.90m (2013: $4.90m), with total expenditure of $1.12m (2013: $922k). The amount owing to Hutt Valley DHB by Wairarapa DHB at the end of the financial year was $466k (2013: $263k), and the amount owing to Wairarapa DHB was $65k (2013: $278k).

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 (2013: 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	2014 Actual $000	2013 Actual $000
Dr Virginia Hope	Chair	47	45
Wayne Guppy	FRAC Chair 2014	29	30
David Bassett	Current Member	23	23
David Ogden	Current Member	23	23
John Terris	Current Member	22	24
Kathryn Austin	Current Member	23	24
Ken Laban	Current Member	22	22
Peter Douglas	Current Member	22	22
Sandra Greig	Member from December 2013	13	0
Ron Mark	Member from December 2013	12	0
Jaimes Wood	Member from December 2013	13	0
Peter Glensor	HAC Chair to December 2013	12	27
Keith Hindle	FRAC Chair to December 2013	11	25
Iris Pahau	Member to December 2013	9	22
Total Board member remuneration		**281**	**287**

Board and committee meeting attendances in the year to 30 June 2014:

Board Member	Position	Meetings Attended		Meetings held during tenure	
		Board	Committee	Board	Committee
Virginia Hope	Board Chair	8	22	9	26
Wayne Guppy	FRAC Chair 2014	9	14	9	18
David Bassett	Current Member	8	9	9	9
David Ogden	Current Member	9	9	9	9
John Terris	Current Member	9	7	9	8
Kathryn Austin	Current Member	9	8	9	8
Ken Laban	Current Member	7	8	9	9
Peter Douglas	Current Member	6	8	9	13
Sandra Greig	Member from Dec 2013	4	3	4	4
Ron Mark	Member from Dec 2013	2	1	4	4
Jaimes Wood	Member from Dec 2013	4	4	4	4
Peter Glensor	HAC Chair to Dec 2013	5	12	5	15
Keith Hindle	FRAC Chair to Dec 2013	4	10	5	10
Iris Pahau	Member to Dec 2013	4	5	5	5

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.

During the year Hutt Valley DHB transacted with the following entities which are related parties to various members of the Hutt Valley DHB Board:

- Greater Wellington Regional Council in which Board member Peter Glensor is a Deputy Chair. These services cost $6k (2013: $7k) and were incurred on normal commercial terms. There were no amounts outstanding at the end of the financial year.
- Upper Hutt City Council in which Board member Wayne Guppy is the Mayor. These services related to the cost of local body elections $47k (2013: $1k). There were no amounts outstanding at the end of the financial year.
- Hutt City Council in which Board member David Bassett is the Deputy Mayor, and Ken Laban is a Councillor. These services related in the main to the local body elections. The total cost incurred was $135k (2013: $228k) those services unrelated to the elections were incurred on normal commercial terms. The amount outstanding to Hutt City Council at the end of the financial year was $30.6k (2013:$1k).
- Environmental Science and Research (ESR) of which the Board Chair is the health programme leader. These services cost $23k and were negotiated on normal commercial terms. There were no amounts outstanding at the end of the financial year.
- Te Omanga Hospice of which Board member Ken Laban is a Trustee. These services cost $4.01m (2013: $4.00m) and were negotiated on normal commercial terms. The amount outstanding at the end of the financial year was $333k (2013:$333k).
- Various Marae and the Māori welfare groups of which Board members Iris Pahau and Wayne Guppy are members or trustees. These transactions came to a total of $2k (2013: nil). There were no amounts outstanding at the end of the financial year.

23 EMPLOYEE REMUNERATION

Details of employee remuneration can be found in the 'Our People' section – please refer to page 23 of this report.

24 EVENTS AFTER THE BALANCE DATE

There are no significant events subsequent to balance date.

25 FINANCIAL INSTRUMENTS

Fair Values

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

	2014		2013	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	$000	$000	$000	$000
Cash and cash equivalents	23,623	23,623	24,650	24,650
Debtors and other receivables	15,640	15,640	11,861	11,861
Creditors and other payables	40,971	40,971	39,036	39,036
Crown loans-fixed interest	79,000	81,200	79,000	83,334
Finance leases	2,916	2,916	2,498	2,498
	162,151	**164,351**	**157,045**	**161,379**

Risks

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

Price Risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Hutt Valley DHBs exposure to cash flow interest rate risk is limited to on-call deposits. At 30 June 2014, it is estimated that a general increase of one percentage point in interest

rates would have a minimal impact on earnings in 2013/14, as most of the DHB's term debt is at fixed rates, and only the net interest from cash holdings would be affected.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. Hutt Valley DHB purchases clinical equipment from overseas, which requires it to enter into transactions denominated in foreign currencies. As a result of these activities, exposure to currency risk arises. This exposure is not considered significant and is not actively managed. The effect of a general increase of one percentage point on the value of the NZD against other foreign currencies would have had a minimal impact on earnings.

Credit risk

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

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

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

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

Credit quality of financial assets

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

	2014 Actual $000	2013 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
A-1+	7,288	-
AA-	-	6,672
Unrated (Call Deposits with Health Benefits Ltd)	17,624	19,077
	17,624	**25,749**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	23,623	24,650
Trust and bequest funds	1,289	1,099
Debtors and other receivables	15,640	11,861

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 through the "DHB Treasury Services Agreement" with Health Benefits Limited as described in Note 7.

	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
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**	**8,245**	**62,282**	**10,591**

	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
2014						
Creditors and other payables	40,971	40,971	40,971	-	-	-
Finance leases	2,916	3,095	872	872	1,350	-
Crown Loans-fixed interest	79,000	93,113	11,828	17,965	58,066	5,254
Total	**122,887**	**137,178**	**53,671**	**18,837**	**59,416**	**5,254**

26 CAPITAL MANAGEMENT

The Hutt Valley DHB's capital is its equity, which comprises Crown equity, accumulated surpluses/deficits and revaluation reserves. Hutt Valley DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that the DHB effectively achieves its objectives and purposes, while remaining a going concern.

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

27 EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2014 are provided below.

Statement of Comprehensive Income

The Hutt Valley DHB recorded a deficit of $1.824m compared with the budgeted breakeven position. The major variances were:

- Higher outsourced costs primarily due to covering medical vacancies and additional costs related to the Central Region Information Systems plan and higher costs in respect of laboratory test and radiology,
- Clinical supplies in respect of pharmaceuticals for immune disorders and blood products,
- A higher than expected number of Hutt Valley District patients received acute specialist tertiary services provided by CCDHB resulting in a higher than budget net Inter-DHB outflow cost.
- Higher capital charge payable to the Ministry due to higher equity as a result of property revaluation increase in June 2013.

The above higher than budgeted costs were partly offset by higher income from the Ministry of Health related to capital charge, elective surgery breast screening and public health and various personal health contracts, and reduced depreciation costs related to lower than budgeted capital expenditure with more equipment being leased rather than purchased.

Statement of Financial Position

Cash and cash equivalents were higher than budget because of lower capital expenditure than planned for the year; and unbudgeted funds held by the DHB for the National Haemophiliac Management Group and the National IT Board Funds. Higher property, plant and equipment balances were due to the 2013 revaluation increase and an extension of useful lives partially offset by lower than budgeted capital spend.

Statement of Cash Flows

The net cash flow improved from the previous year primarily because of increased operating net cashflow largely from increased income from the Ministry of Health partially offset by increased expenditure on large capital projects.

28 COST OF SERVICE STATEMENTS FOR OUTPUT CLASSES

For the year ended 30 June 2014

	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
$000s	**2013\14 Actual**	**2013\14 Budget**	**2012\13 Audited**	**2013\14 Actual**	**2013\14 Budget**	**2012\13 Audited**	**2013\14 Actual**	**2013\14 Budget**	**2012\13 Audited**	**2013\14 Actual**	**2013\14 Budget**	**2012\13 Audited**	**2013\14 Actual**	**2013\14 Budget**	**2012\13 Audited**
Income															
Operating Income	22,039	20,156	20,723	114,541	112,629	118,685	256,382	255,127	244,574	59,548	59,389	57,910	452,509	447,302	441,891
Interest Income	57	16	19	37	11	12	1,042	302	1,010	2	1	-	1,138	330	1,040
Total Income	**22,096**	**20,172**	**20,742**	**114,579**	**112,640**	**118,697**	**257,424**	**255,428**	**245,584**	**59,550**	**59,390**	**57,910**	**453,648**	**447,631**	**442,931**
Expenditure															
Personnel Costs	12,773	11,989	12,441	4,267	5,151	10,409	136,154	136,216	127,957	3,378	3,474	3,348	156,572	156,830	154,156
Depreciation	254	795	223	704	773	661	10,014	12,214	10,557	14	11	11	10,985	13,793	11,452
Outsourced Services	1,133	1,007	1,063	1,083	1,060	561	10,393	6,217	8,288	423	424	215	13,031	8,708	10,126
Clinical Supplies	1,035	1,035	956	407	504	731	21,308	20,795	20,707	1,135	1,260	1,147	23,886	23,593	23,540
Infrastructure and Non Clinical Expenses	577	662	502	590	766	884	12,938	12,730	13,691	70	235	55	14,175	14,393	15,132
Other District Health Boards	62	62	-	14,666	14,570	11,946	63,117	58,891	63,417	3,661	3,661	4,800	81,506	77,184	80,162
Non Health Board Providers	1,281	1,226	1,712	82,059	82,993	83,595	5,993	5,988	4,565	50,644	50,034	48,600	139,978	140,240	138,472
Capital Charge	334	238	228	976	916	916	6,088	4,339	4,156	12	8	8	7,410	5,501	5,307
Interest Expense	62	62	62	41	41	41	3,863	3,893	3,753	2	2	2	3,969	3,998	3,858
Other	955	292	494	122	137	459	2,832	2,908	2,678	53	52	55	3,962	3,390	3,686
Internal Allocations	3,072	3,109	3,063	1,574	1,508	2,425	(5,314)	(5,347)	(6,242)	667	730	754	-	-	-
Total Expenditure	**21,539**	**20,478**	**20,743**	**106,488**	**108,418**	**112,628**	**267,386**	**258,845**	**253,527**	**60,059**	**59,890**	**58,995**	**455,472**	**447,631**	**445,894**
Net Surplus / (Deficit)	**557**	**(306)**	**(2)**	**8,090**	**4,222**	**6,069**	**(9,962)**	**(3,414)**	**(7,943)**	**(510)**	**(501)**	**(1,085)**	**(1,824)**	**-**	**(2,961)**

STATEMENT OF RESPONSIBILITY

The Board and management of Hutt Valley District Health Board accept responsibility for the preparation of the financial statements and the statement of service performance and judgements used in them.

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

In the opinion of the Board and management of Hutt Valley District Health Board the financial statements and the statement of service performance for the year ended 30 June 2014 fairly reflect the financial position and operations of Hutt Valley District Health Board.

Dr Virginia Hope
Board Chair

Wayne Guppy
Deputy Board Chair and Chair of Finance, Risk and Audit Committee

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 2014

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 54 to 91, that comprise the statement of financial position as at 30 June 2014, 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 38 to 52 and the report about outcomes on pages 26 to 37.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 54 to 91:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information because of limited control on information from third-party health provider

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.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

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 38 to 52 and 26 to 37:

- 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 2014, 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 2014. 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 preparation of the Health Board's 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; 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 qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board. 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 the Health Board's 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.

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

DIRECTORY

Head Office Postal Address: Hutt Valley District Health Board Private Bag 31-907 Lower Hutt 5040 Website: www.huttvalleydhb.org.nz Phone: (04) 566 6999	**Head Office Physical Address:** Executive Reception Pilmuir House, Pilmuir Street Hutt Hospital Campus Lower Hutt 5010
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). The Triennial Board elections in 2013 resulted in 3 new members from December 2013.

Dr Virginia Hope, Chair	**John Terris**
Wayne Guppy, Deputy Chair	**Jaimes Wood (from December 2013)**
Katy Austin	**Sandra Greig (from December 2013)**
David Bassett	**Ron Mark (from December 2013)**
Peter Douglas	**Peter Glensor (Chair until December 2013)**
Ken Laban	**Keith Hindle (Until December 2013)**
David Ogden	**Iris Pahau (Until December 2013)**

Crown Monitor: Debbie Chin (Until September 2013)

Executive Leadership Team for Wairarapa and Hutt Valley DHBs as at 31 July 2014

Graham Dyer	Chief Executive Officer	**Cate Tyrer**	General Manager Quality & Risk
Pete Chandler	Chief Operating Officer	**Judith Parkinson**	Finance Manager
Helen Pocknall	Executive Director of Nursing & Midwifery	**Jill Stringer**	Communications Manager
Iwona Stolarek	Chief Medical Officer	**Kuini Puketapu**	Manager, Hutt Valley Māori Health Development Unit
Russell Simpson	Executive Director Allied Health, Scientific & Technical	**Tofa Suafole Gush**	Director of Pacific People's Health
Carolyn Cooper	3DHB Executive Director People & Culture	**Ashley Bloomfield (3DHB)**	Director Service Integration & Development Unit (SIDU)
Bridget Allen	Chief Executive, Te Awakairangi Health Network (PHO)	**Glen Willoughby**	Chief Information Officer
Justine Thorpe	Programme Manager, TeHei Wairarapa	**John Ryan**	3DHB Corporate Services Manager

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 Wairarapa and Capital & Coast District Health Boards.			
Derek Milne (Chair)	Wairarapa	**Wayne Guppy**	Hutt Valley
Dr Virginia Hope (Deputy)	Capital & Coast	**David Choat**	Capital & Coast
Helen Kjestrup	Wairarapa	**Chris Laidlaw**	Capital & Coast
Janine Vollebregt	Wairarapa	**Helene Ritchie**	Capital & Coast
Leanne Southey	Wairarapa	**Keith Hindle (until Dec 2013)**	Hutt Valley
Liz Falkner	Wairarapa	**Iris Pahau (Until Dec 2013)**	Hutt Valley
Peter Douglas	Hutt Valley	**Bob Francis (Until Dec 2013)**	Wairarapa
Ron Mark	Wairarapa / Hutt Valley	**Ken Laban (Until Dec 2013)**	Hutt Valley
Sandra Greig	Hutt Valley		

Hospital Advisory Committee			
The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Hutt Hospital and its services. This was a joint committee with Wairarapa District Health Board until January 2014, when it became a 3DHB committee.			
Dr Virginia Hope (Chair)	Hutt Valley / Capital & Coast	**Katy Austin**	Hutt Valley
Derek Milne (Deputy)	Wairarapa	**John Terris**	Hutt Valley
Alan Shirley	Wairarapa	**Sue Kedgley**	Capital & Coast
Fiona Samuel	Wairarapa	**Nick Leggett**	Capital & Coast
Rob Irwin	Wairarapa		