HUTT VALLEY DHB

Hutt Valley District Health Board

Annual Report 2015

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CHAIR & CHIEF EXECUTIVE'S FOREWORD

We are pleased to present Hutt Valley District Health Board's (HVDHB) Annual Report for the year 1 July 2014 to 30 June 2015 which highlights the important gains we have made in a number of areas across community and hospital health services. The report also includes a detailed account of how our funding has been spent.

We have made good progress against the national health targets, in particular the three preventive targets. More children have been immunised against childhood diseases, more smokers are being offered support to quit and more people are being checked to see if they are at risk of developing heart disease or diabetes.

We are committed to providing quality and innovative care which improves the health of our people. This year by changing the way we do things we have been able to reduce the average length of time older people spend in hospital, more Maori people are attending their outpatient appointments and more preschool children are enrolled with our oral health service.

Providing care closer to people's home is one of our core focusses and we continue to work closely with our community and primary care colleagues on initiatives to achieve this. We are also strengthening our relationships with other social services in the region, such as Police, Corrections, and the Ministry of Social Development to ensure we are not duplicating services and are focussed on our community's health and social needs.

We continue to see benefits for our patients and staff by working with our neighbouring DHBs. This year the mental health, addiction and intellectual disability services combined across the Greater Wellington region. By integrating the service, our communities now have better access to the specialist care they need. It also improves staff recruitment and retention.

While our financial position continues to be a challenge we believe we are on the right path to reduce our deficit while continuing to provide our communities with high quality and safe clinical care. As part of this work we are strengthening the role our clinical leaders have in the decision making process for the organisation. It is very important for effective stewardship of our health services that we have strong clinical governance and this will be a focus for the year ahead.

We would like to thank all our staff and community providers for their hard work throughout the year. The professionalism and dedication of these people makes a tremendous difference to our patients, their families and the entire community.

Dr Virginia Hope
BOARD CHAIR

Dr Ashley Bloomfield
CHIEF EXECUTIVE

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

OUR PEOPLE

GOOD EMPLOYER OBLIGATIONS REPORT

The DHB takes its obligations to be a good employer very seriously. The Good Employer elements as prescribed by the EEO Commissioner 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 applies appropriate processes to meet the seven key elements of 'the Good Employer' as prescribed by the EEO Commissioner. It also has specific plans to further build practice in these elements.

A consistent recruiting and selection procedure is followed to ensure fairness and equal opportunity. Training and development opportunities are considered for all staff, and development plans are included as part of the annual performance review process.

Several forums are in place to consider workplace practices. Topics include health and safety, and professional practices for relevant staff.

As a good employer the DHB values professionalism through leadership and unacceptable employee behaviour is not tolerated. We have updated our suite of HR policies and guidelines related to discipline, performance, code of conduct, bullying, harassment, victimisation and discrimination prevention this year. Professional leads and executive managers have taken a lead in the launch of the new code and policy as part of a proactive approach to reducing the incidence of bullying and harassment within our organisation.

Approximately 92% of employees are covered by Collective Employment Agreements (CEA). All the CEAs have remuneration, recognition and conditions clauses. We also take a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the organisation.

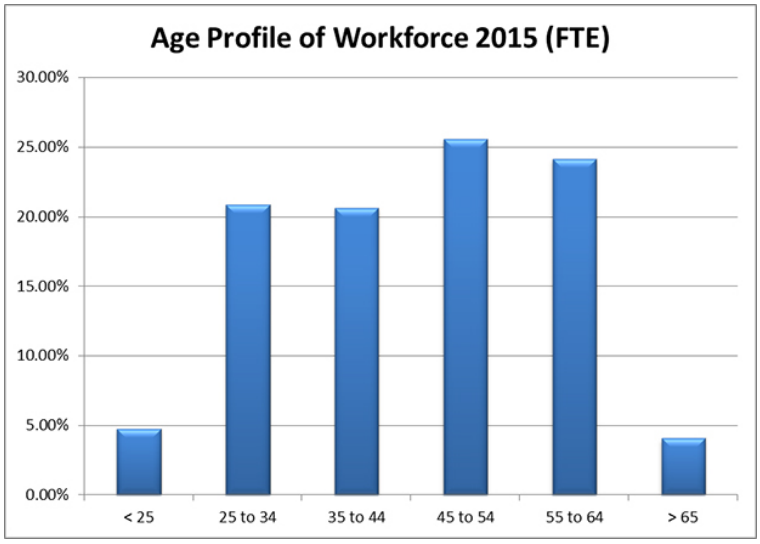
The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation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

WORKFORCE PROFILE

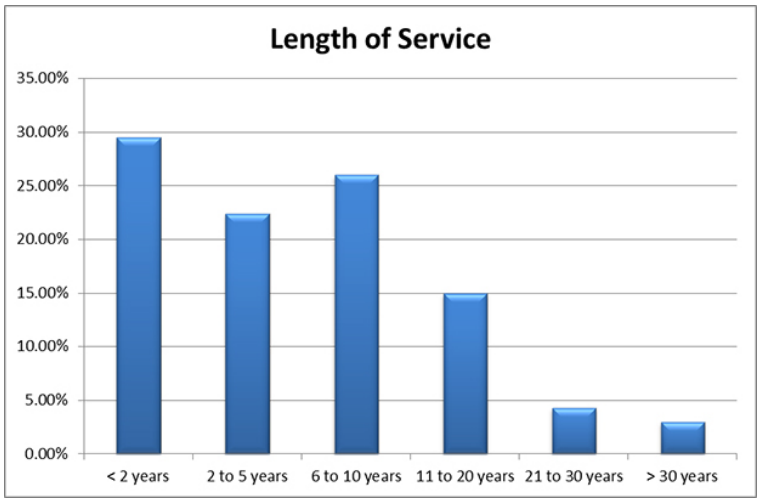
Full Time Equivalent Staff Numbers

	2015	2014	2013	2012	2011	2010	2009
Medical	246	232	232	238	233	217	213
Nursing	755	717	708	712	699	685	713
Allied Health	440	428	435	422	396	383	392
Other	442	434	467	480	481	489	470
Total	1,883	1,811	1,841	1,851	1,809	1,773	1,788

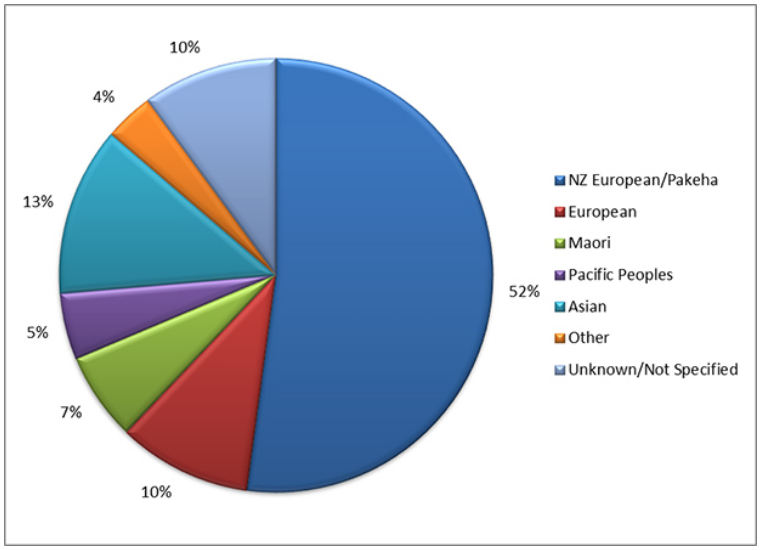
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2015	2014	2013	2012	2011	2010	2009
Female	81.65%	81.89%	82.41%	81.95%	81.16%	81.76%	82.24%
Male	18.35%	18.11%	17.59%	18.05%	18.84%	18.24%	17.76%

REMUNERATION OF EMPLOYEES

Annual remuneration	2015	2014	2013
100,000-109,999	37	31	29
110,000-119,999	24	28	24
120,000-129,999	17	12	13
130,000-139,999	8	10	9
140,000-149,999	8	9	12
150,000-159,999	16	9	11
160,000-169,999	9	9	13
170,000-179,999	9	6	6
180,000-189,999	7	9	5
190,000-199,999	12	3	3
200,000-209,999	1	2	5
210,000-219,999	2	9	6
220,000-229,999	5	3	8
230,000-239,999	10	7	11
240,000-249,999	6	11	4
250,000-259,999	6	9	3
260,000-269,999	9	6	4
270,000-279,999	6		
280,000-289,999	1	1	5
290,000-299,999	1	2	2
300,000-309,999	2	3	1
310,000-319,999	3	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	1		
370,000-379,999		1	1
380,000-389,999		1	
390,000-399,999	1		2
400,000-409,999	1		
410,000-419,999			
420,000-429,999		2	
620,000-629,999			
Grand Total	**202**	**185**	**181**

TERMINATION PAYMENTS

During the year ended 30 June 2015, 4 (2014: 12) employees received compensation and other benefits in relation to cessation totalling $138,395 (2014:$205,343). The payments were in the nature of redundancy or retirement gratuities.

PERFORMANCE HIGHLIGHTS

Hutt Valley DHB continues to provide high quality and timely services for our population. In 2014/15:

- Hutt Valley DHB met the health target for the percentage of eight month olds fully vaccinated. Our performance was ranked fourth highest out of twenty DHBs.
- Regional Public Health exceeded the targets for the percentage of school children receiving Boostrix immunisation and HPV vaccination.
- Hutt Valley DHB continues to meet the smoking cessation health target for hospitalised smokers, with 95% of hospitalised smokers receiving smoking cessation advice.
- Hutt Valley DHB continues to meet 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 5,405 elective surgeries delivered to the DHB population, 391 more surgeries than the target.
- All Hutt Valley residents with long-term support needs received a comprehensive clinical [InterRAI] assessment and a completed care plan.

MINISTER'S HEALTH TARGETS

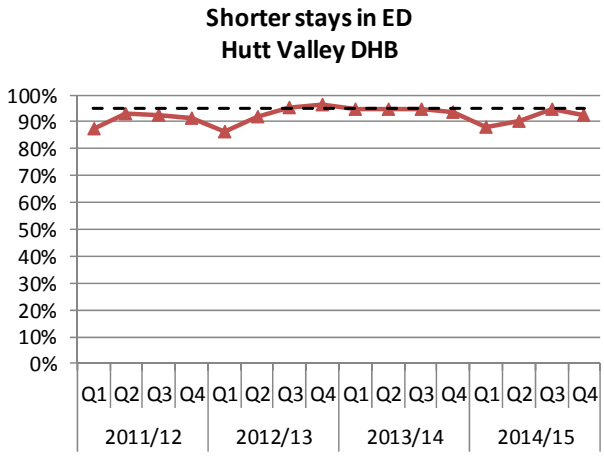
Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. They provide a focus for action.[1]

Shorter stays in Emergency Departments

95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Target: 95%

2014/15 Performance: 91%

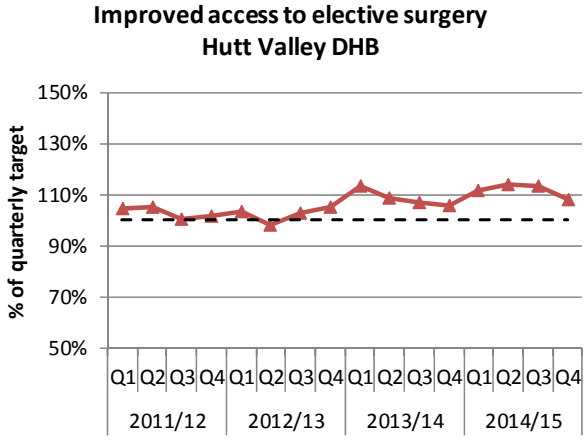


Improved access to elective surgery

More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.

Target: 5,226 (graph - 100%)

2014/15 Performance: 5,405



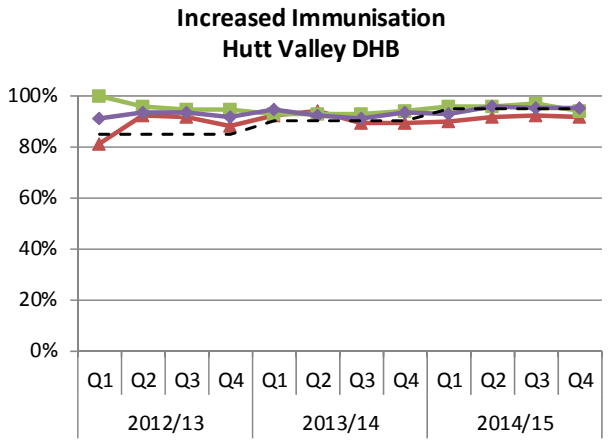
[1] Quoted from the Ministry of Health, http://www.health.govt.nz/new-zealand-health-system/health-targets

Increased immunisation

85 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.

Target: 95%

2014/15 Performance: 95%

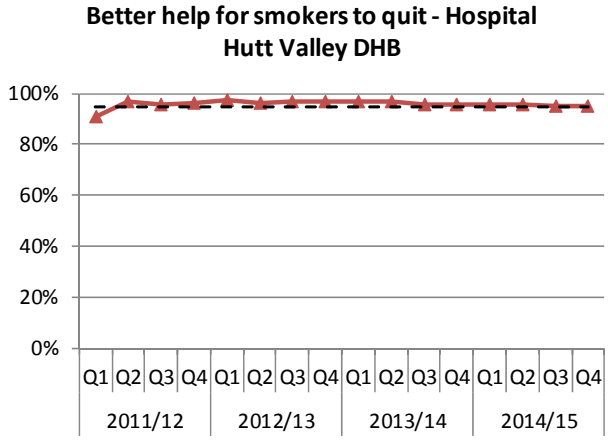


Better help for smokers to quit – Hospital

95 percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.

Target: 95%

2014/15 Performance: 95%

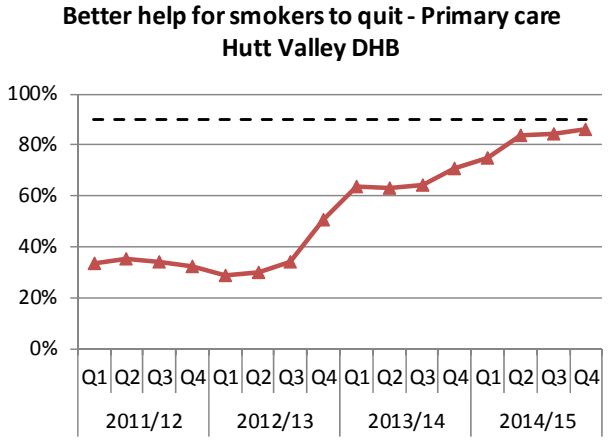


Better help for smokers to quit – Primary Care

90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

Target: 90%

2014/15 Performance: 86%

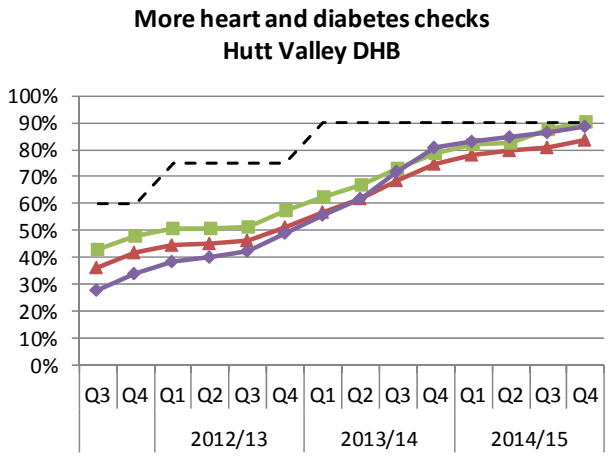


More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Target: 90%

2014/15 Performance: 89%

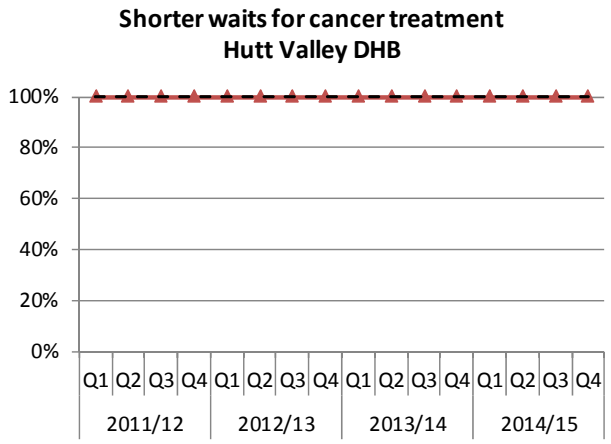


Shorter waits for cancer treatment

All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. The Ministry of Health has transitioned from this target to the 'Faster cancer treatment' Health Target.

Target: 100%

2014/15 Performance: 100%

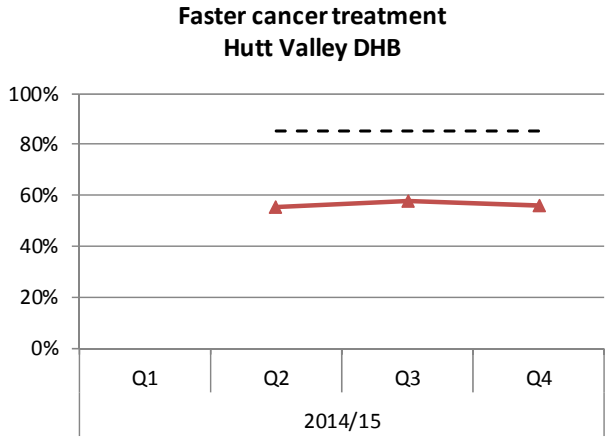


Faster cancer treatment

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.

Target: 85% by July 2016

2014/15 Performance: 56%



IMPACTS & 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.

In the following section, we present our six intended outcomes and their associated impact measures. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas our DHB is making a positive difference and in which areas our DHB should seek to improve. It is important to note that these outcomes are progressed not just through the work of DHBs, but also through the work of all of those across the health system and wider health and social services.

POPULATION HEALTH OUTCOME: IMPROVED HEALTH EQUITY

What difference will we make for our population?

Overarching across the three components of our strategy is a focus on patient-centred care. This incorporates an outcome of improved health equity, to ensure the gains in health of our population are across all groups. Inequalities in access to and decisions over resources are the primary cause of health inequalities. Differential access to health services – and in the quality of care provided to patients – also contribute to unequal health outcomes. These structural inequalities may explain more of ethnic inequalities in health than is often recognised.

Although the overall Wellington sub-region has a relatively affluent, healthy population, there are pockets of deprivation concentrated in parts of Porirua, the south eastern suburbs of Wellington, parts of the Hutt Valley such as Naenae and Wainuiomata, and parts of Masterton. Over half of the Pacific population and 29 per cent of Māori live in the most deprived areas.

Māori and Pacific people die on average 10 to 15 years earlier than non-Māori non-Pacific, and experience significantly higher acute admission and avoidable mortality rates. Although access to some health care services has improved, outcomes often remain worse for Māori and Pacific people.

We acknowledge our responsibility to design and deliver services that are accessible and responsive to all of our population’s needs.

Impact measures – The DHB measures progress through:

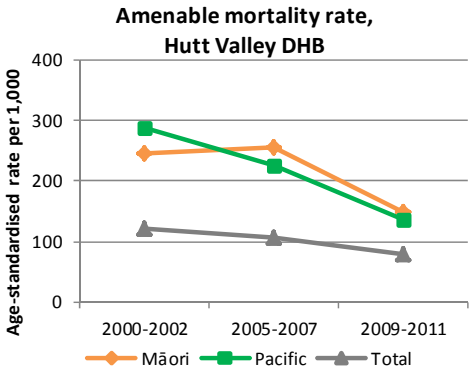
A reduction in amenable mortality rates for Māori & Pacific

'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them.

Māori and Pacific amenable mortality rates are more than 2.5 times higher than other ethnicities, indicating that Māori and Pacific are not receiving equitable coverage or quality of healthcare.

This measure links to the Early Detection & Management and Intensive Assessment & Treatment output classes.



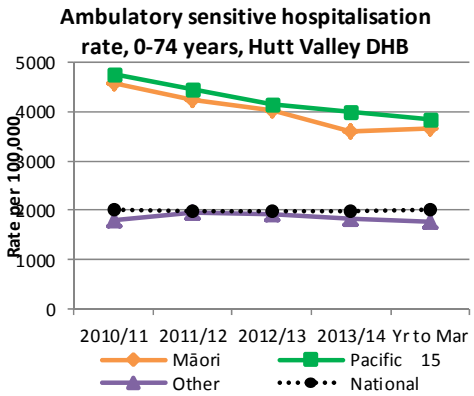
A reduction in the ambulatory sensitive hospitalisation (ASH) rates (0-74)

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.

In Hutt Valley DHB, the ASH rate for Maori and Pacific has decreased over the last four years, but is still approximately twice the rate for other ethnicities.

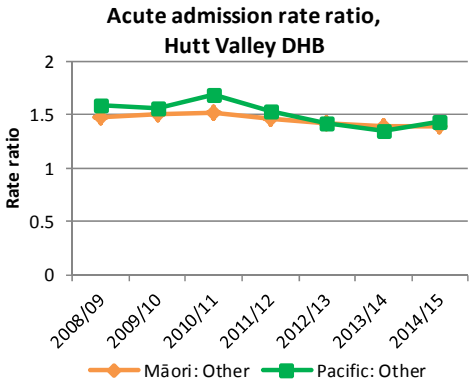
This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in the rate of acute admissions for Māori & Pacific compared to non-Māori non-Pacific

Māori and Pacific are at least one-and-a-half times more likely to be admitted acutely to hospital than non-Māori non-Pacific. This disparity reflects both social and economic inequities and inequities in access to health services.

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

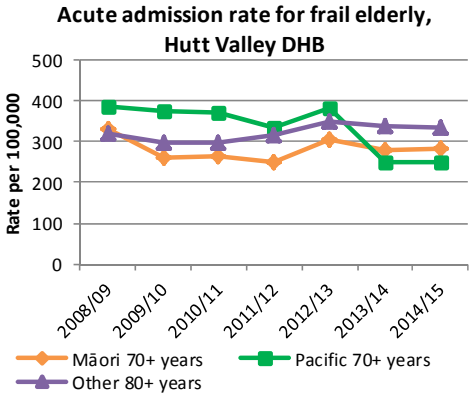


A reduction in acute medical admission rates for Māori and Pacific frail elderly[2]

Rates of acute medical admissions are high across all groups and particularly for Pacific people. Rates for Māori 70+ are declining, which is positive.

By improving the clinical management of frail elderly in the community, we expect that acute admission rates for frail elderly will decrease.

This measure links to the Rehabilitation & Support output class.



POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH

What difference will we make for our population?

Preventative health services provide the population with health literacy, or an understanding of how their daily choices affect their health, and protect the population to keep them healthy. Healthy eating, active living, and not smoking are some of the factors which can prevent diseases or poor health in the longer term.

Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disorder, heart disease and strokes. Supporting the population to say no to tobacco smoking is an important opportunity to target improvements in the health of populations with high need and to improve Māori health.

[2] Age groups have been set based definitions used in current programmes of work for frail elderly.

Current trends indicate sustained increases in obesity in New Zealand's adult population. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy. Supporting the population to maintain healthier body weight through improved nutrition and physical activity levels is fundamental to improving the health and wellbeing of the population and to the prevention of chronic conditions and disability at all ages.

Measures – The DHB measures progress through:

An increase in the percentage of adults 15+ consuming 2+ fruit and 3+ vegetable servings daily

Good nutrition is fundamental to health and the prevention of disease and disability.

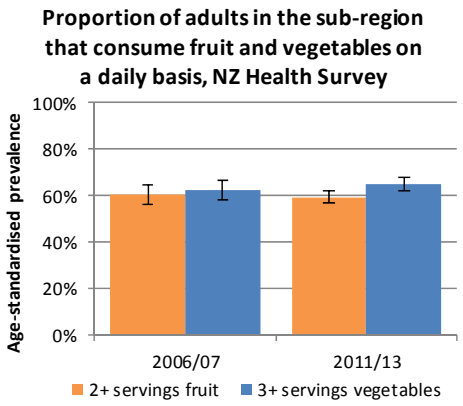
Appropriate fruit and vegetable consumption helps to protect people against obesity, CVD, diabetes and some common cancers and contributes to maintaining a healthy body weight.

Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.

By providing education and support for people to live healthily, we expect that the consumption of fruit and vegetables will increase.

The number of adults consuming fruit and vegetables on a daily basis has not changed significantly over the last five years.

This measure links to the Prevention Services output class.



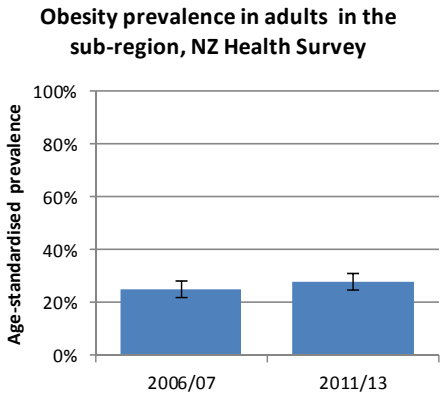
A reduction in obesity prevalence amongst the population 15+

Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of overweight and obesity in developed countries has increased so quickly that is has been described as an epidemic.

The most recent NZ Health Survey shows that there is no significant difference in obesity rates between the three DHBs. Adults have a much higher obesity rate than children in all three.

By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

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



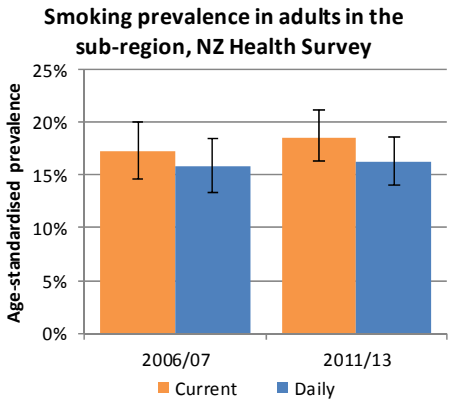
A reduction in smoking rates for the sub-region's 15+ population

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smoke free by 2025. Our DHB is working towards this goal by providing smoking advice and cessation support to patients when they visit their general practice or visit the hospital.

Census 2013 data shows that in our sub-region, smoking prevalence in Māori (30%) and Pacific (24%) are higher than the average smoking prevalence (14%) in our sub-region.

By providing smoking cessation advice and support, we expect that the percentage of people who smoke will decrease.

This measure links to the Prevention Services output class.



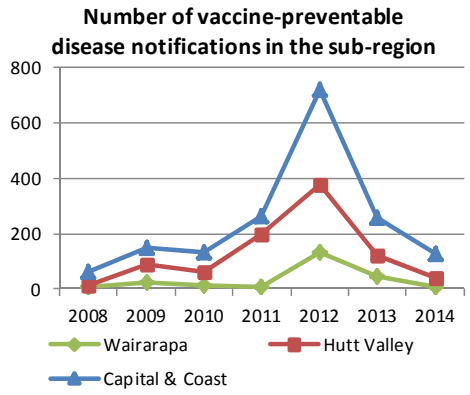
A decrease in the number of vaccine preventable disease notifications

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.

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications has returned to previous levels in 2014.

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 and Early Detection & Management output classes.



Source: Environmental Science & Research surveillance reports

POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH: IMPROVED CHILD AND YOUTH HEALTH

What difference will we make for our population?

Outcomes for the current generation of children and young people will determine the future success or failure of the community and society as a whole. The relatively short periods of time which gestation, infancy, childhood and adolescence occupy have more power to shape the individual than much longer periods of time later in life.

The health status of young people and expectant mothers is most strongly influenced by environmental determinants of health outside of the services the DHB provides. However the DHBs have a focus on influencing change that supports healthier environments; on ensuring younger populations have a healthy start to life; and on addressing the inequalities between population groups to improve overall population outcomes.

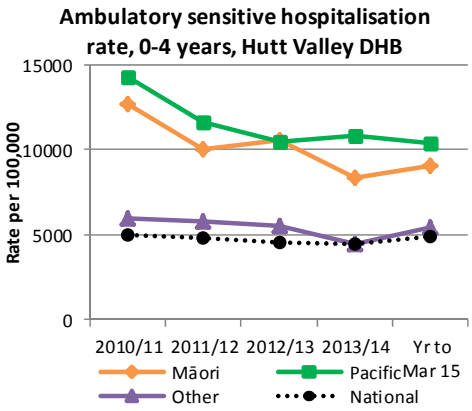
Measures – The DHB measures progress through:

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

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.

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



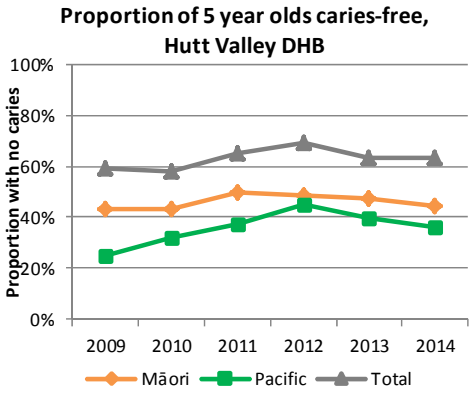
An increase in the proportion of children caries free at five years

Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination, through which children with poor oral health are referred to community oral health services.

By ensuring that every child has access to and is receiving oral health services, we expect that the proportion of five year olds with no caries will increase.

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

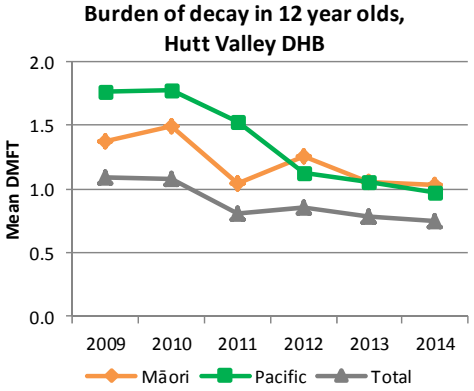


A decrease in the mean number of decayed, missing or filled teeth (DMFT) at Year 8

The burden of tooth decay is measured by the mean number of decayed, missing or filled teeth (DMFT) in twelve year old children. Māori and Pacific children have a higher burden of decay than other ethnicities.

By ensuring that every child has access to and is receiving oral health services, we expect that the burden of decay in twelve year olds will decrease.

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



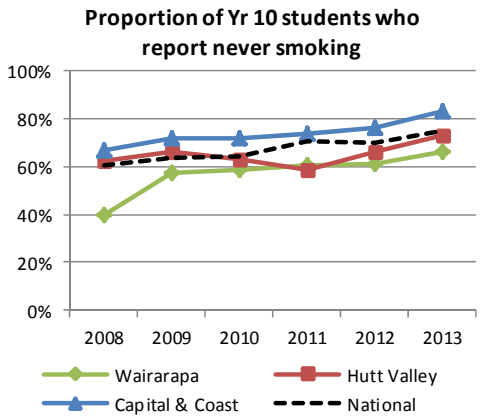
An increase in the proportion of year 10 students who report never smoking

Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.

A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.

The proportion of year 10 students who report never smoking has increased over the last five years across all three DHBs, which is positive.

This measure links to the Prevention Services output class.



POPULATION HEALTH OUTCOME: EMPOWERED SELF-CARE

What difference will we make for our population?

The impact of long-term conditions in terms of quality of life and cost to the health system is significant. Early diagnosis and intervention and improved disease management provide major opportunities for improving health outcomes; particularly for Māori and Pacific people, who have disproportionately higher rates of many long-term conditions.

Empowering people to manage their long-term conditions and seek appropriate intervention early will result in a reduction in the proportion of the population seeking urgent care or requiring acute admission to hospital. Improving access to alternative pathways of care will ensure people are being given the right treatment in the right place, improve health outcomes, reduce pressure on hospital resources and enable investment in other priority areas.

Measures – The DHB measures progress through:

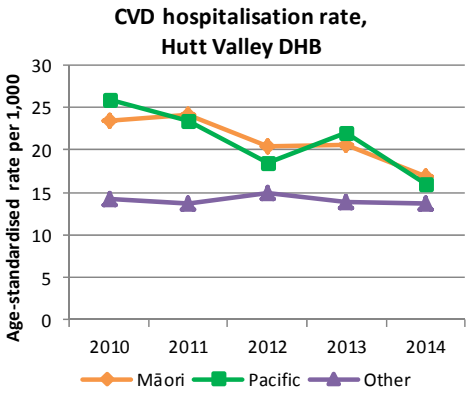
A reduction in the hospitalisation rate for cardiovascular disease (CVD)

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management.

One of the health targets is to provide CVD risk checks for the eligible population (65+ years). By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

In Hutt Valley DHB, Māori and Pacific have a higher rate of CVD hospitalisation than other ethnicities, but this inequity has decreased over the last four years.

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



A reduction in the hospitalisation rate for diabetes

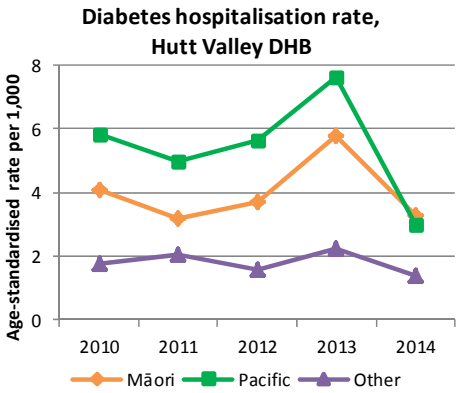
Diabetes is defined by the body's inability to control blood glucose. Diabetes is a chronic condition, which can cause kidney failure, eye disease, foot ulceration and a higher risk of heart disease if not well managed.

The New Zealand Health Survey found that the national prevalence of diagnosed diabetes increased from 5.1% in 2006-07 to 5.6% in 2011-14.

Supporting people to manage their diabetes well reduces acute admissions to hospital.

Diabetes admission rates increased for Māori and Pacific between 2011 and 2013, but have since dropped to below the 2010 rate.

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

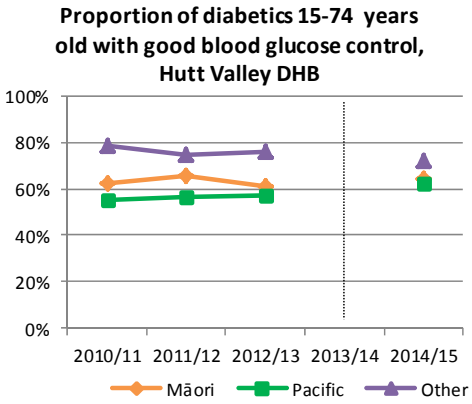


Increased proportion of diabetics checked with satisfactory or better blood glucose control (HbA1c less than or equal to 64 mmol/mol)

Diabetes is a significant cause of ill health and premature death. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as lower limb amputation, kidney failure and blindness, and will improve people's quality of life.

Fewer Māori and Pacific have good blood glucose control when compared to other ethnicities.

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



Results from 2010/11 to 2012/13 are presented as a rate of diabetics who had an HbA1c test. This measure was then revised from 2013/14 to be a rate of all enrolled diabetics, which resulted in a drop in reported performance. There was also a delay in developing reporting with the new methodology, so results for 2013/14 are not available.

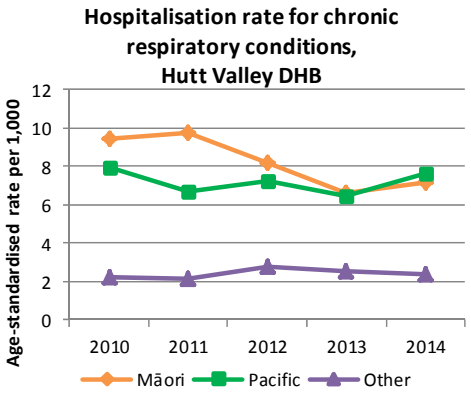
A reduction in the age standardised hospitalisation rate for chronic respiratory conditions

The most common chronic respiratory conditions include asthma and chronic obstructive pulmonary disorder (COPD).

By providing cessation support for people who smoke, improving access to primary care, and helping people to take their medication regularly, we expect that the rate of chronic respiratory hospitalisations for our population will decrease.

In Capital & Coast DHB, the rate of chronic respiratory hospitalisation for Māori has varied over the last five years. Rates for Māori and Pacific are approximately three times higher than the rate for other ethnicities.

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



HEALTH SERVICES OUTCOME: SERVICES CLOSER TO HOME

What difference will we make for our population?

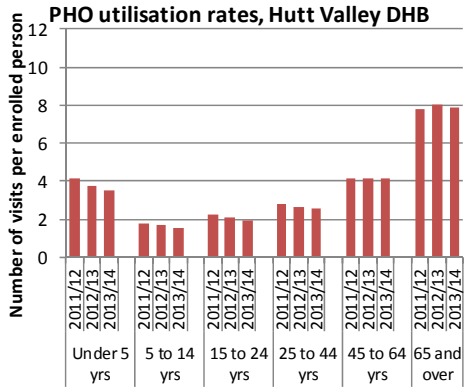
We are working to better integrate health services across the continuum to better provide the services patients require closer to their homes. When services are delivered closer to the patient's home they can better access services and have a relationship of trust with their regular GP, nurse or other clinician. This allows patients to use services when they need them and empowers them to manage their health.

Measures – The DHB measures progress through:

The utilisation rate of primary care by age group

When people are able to access primary care when they need it they can receive treatment earlier, have better continuity of care, and sometimes even prevent a hospital admission. Improved utilisation of primary care appropriate to the needs of the age group reflects patients' ability and willingness to visit their medical home of primary care for their medical treatment.

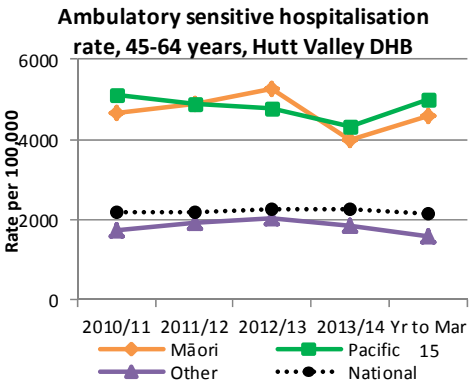
This measure links to the Early Detection & Management output class.



A reduction in ambulatory sensitive hospitalisations of adults (45-64)

Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.

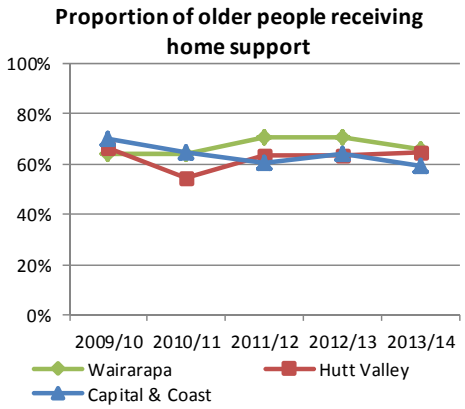
This measure links to the Prevention Services and Early Detection & Management output classes.



Maintain or increase the proportion of patients receiving home based support services of those 65+ who receive DHB funded home based support or aged residential care services

Services that support people to manage their needs and live well, safely and independently in their own homes provide a much higher quality of life, because people stay active and positively connected to their communities. People whose needs are met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions.

This measure links to the Rehabilitation & Support output class.



HEALTH SERVICES OUTCOME: QUALITY HOSPITAL CARE AND COMPLEX CARE FOR THOSE WHO NEED IT

What difference will we make for our population?

Improved patient-focused, clinically driven pathways will provide the flexibility for early intervention and planned readmission where clinically appropriate, and will support improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to establish more stable lives.

Overseas experience shows that systemic changes to the way care is offered to patients can lead to measurable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia and hospital-acquired infections in patients.

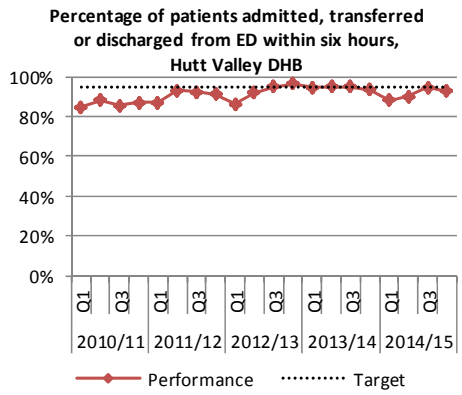
Measures – The DHB measures progress through:

The percentage of patients admitted, transferred or discharged from the Emergency Department within six hours

Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through DHB services. It also demonstrates a commitment to addressing the needs of patients and valuing their time.

Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through management of acute demand in the community, improved capacity in ED and supported discharge into services in the community.

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

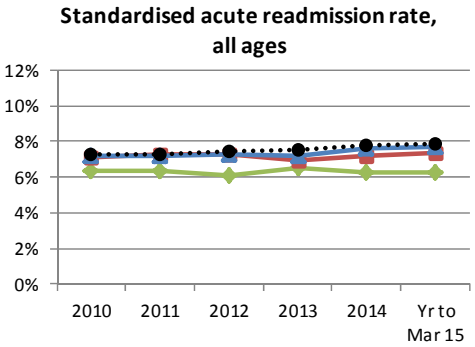


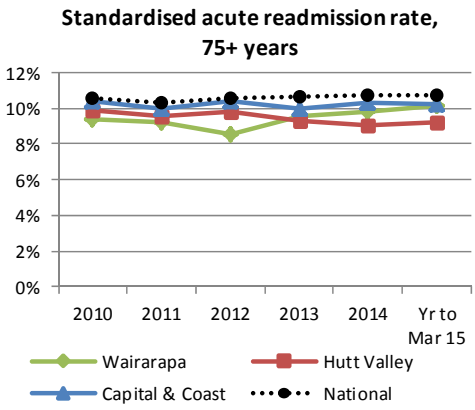
A reduction in the standardised rate of acute readmissions within 28 days, Total & 75+

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (ie 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.

The standardised acute readmission rate has remained at about 6.5% for Wairarapa and 7% for Hutt Valley and Capital & Coast over the last five years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased (see Statement of Performance), which shows that the effectiveness and efficiency of treatment in hospital has improved.

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



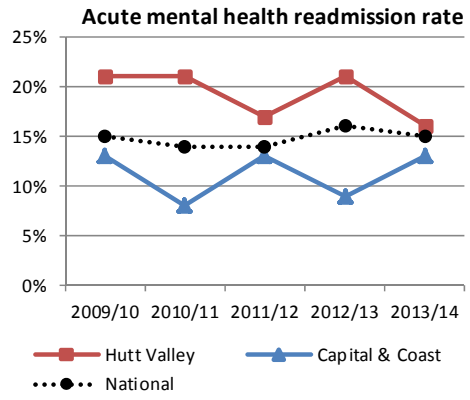


A reduction in the rate of acute readmissions within 28 days to Mental Health Services

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 maintain the person out of hospital.

This indicator helps identify if investigation into the functioning of the system is needed to determine any areas in which it might be breaking down. Improved performance on this measure demonstrates better whole of system performance.

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

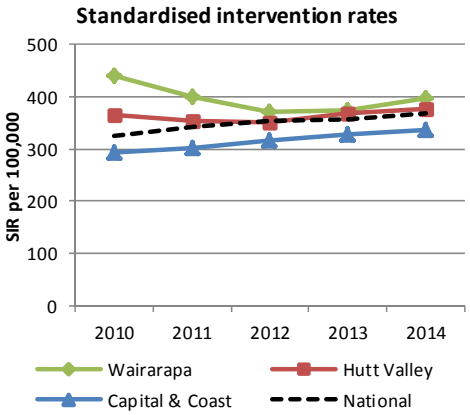


Maintain or increase standardised intervention rates (SIR) for elective services

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

The SIR in Hutt Valley DHB is similar to the national rate, which indicates that our residents have a similar level of access to elective services compared to patients nationally.

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



STATEMENT OF PERFORMANCE

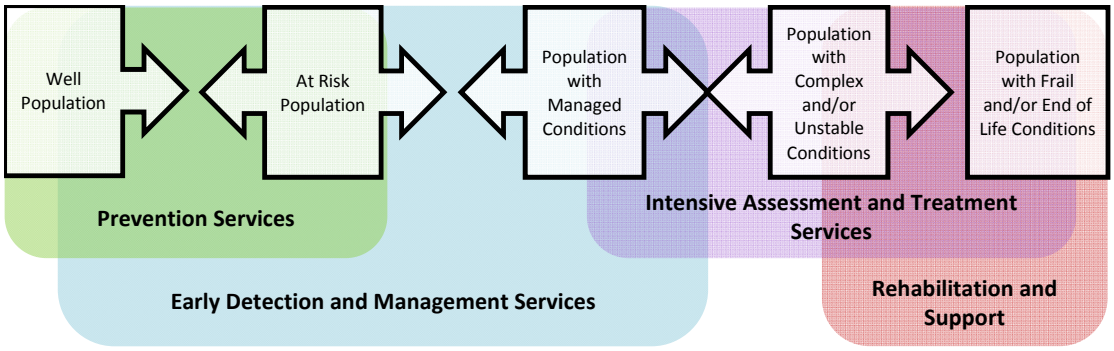
OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

In the Statement of Performance, we evaluate our performance (outputs) against the targets that we set in the Statement of Performance Expectations in our 2014/15 Annual Plan. We choose outputs that will make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes 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. The outputs here provide a picture of the health service activity across the whole of the Hutt Valley health system.

Our four Output Classes and their related services are:

1. Prevention Services
    - Health promotion and public health services
    - Immunisation services
    - Smoking cessation services
    - Screening services
2. Early Detection and Management Services
    - Primary care (GP) services
    - Oral health services
3. Intensive Treatment and Assessment Services
    - Medical and surgical services
    - Cancer services
    - Mental health and addictions services
4. Rehabilitation and Support Services
    - Disability services
    - Health of older people services

Scope of DHB Operations – Output Classes in the Continuum of Care



VOTE HEALTH ESTIMATES OF APPROPRIATIONS

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

INTERPRETING OUR PERFORMANCE

Types of measures

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 report on 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. When possible and relevant, we have also broken our performance down by ethnicity.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T

We have identified new measures in 2014/15 with a † symbol. These measures were introduced in the 2014/15 Annual Plan and did not appear in the 2013/14 Annual Report. Our 2013/14 performance has therefore not been audited by Audit New Zealand.

Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly. But, by standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been

standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

OUTPUT CLASSES: FINANCIAL PERFORMANCE ($000s)

Revenue	2013/14 Actual	2014/15 Budget	2014/15 Actual
Prevention	22,096	21,623	22,004
Early Detection and Management	114,578	128,291	117,908
Intensive Assessment and Treatment	257,424	249,936	260,649
Rehabilitation and Support	59,550	61,704	61,787
Total	**453,648**	**461,554**	**462,348**

Expenditure	2013/14 Actual	2014/15 Budget	2014/15 Actual
Prevention	21,539	22,015	22,061
Early Detection and Management	106,488	119,991	108,343
Intensive Assessment and Treatment	267,386	258,203	280,924
Rehabilitation and Support	60,059	61,345	58,560
Total	**455,472**	**461,554**	**469,888**

OUTPUT CLASS 1: PREVENTION SERVICES

Description

'Preventative' health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

Context

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. It has been estimated that 70% of health funding is spent on long-term conditions. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The majority of chronic conditions are preventable or could be better managed. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. These prevention services also support people to address any risk factors that contribute to both acute events (e.g., alcohol-related injury) and the development of long-term conditions (e.g., obesity or diabetes). High health need and at-risk population groups (low socio-economic, Māori, and Pacific) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Health promotion and public health services: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices. Health promotion and public health services enable people to increase control over their health and its determinants, and thereby improve their health. A range of strategies are used, such as those as described by the Ottawa Charter: public policy, reorienting the health system, developing supportive environments, community action, and supporting individual personal skills. While health has a significant role here, some outcomes such as obesity require a joined-up approach to address the determinants of health, such as income, housing, food security, employment, and quality working conditions; our DHB and RPH work with other sectors (e.g. housing, justice, education) to enable this.

Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care, allied health and public health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process[a]: Ask all patients whether they smoke and document their response; if the patient smokes, provide brief advice to quit smoking; and if patient agrees, provide Cessation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

Screening services: encourage uptake of services predominately funded and provided through the National Screening Unit that help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

How we measure the performance of our Prevention Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Immunisation services	**Health Target:** The percentage of eight month olds fully vaccinated	C	93%	**95%**	95%	Achieved
	The percentage of Yr 7 children provided Boostrix vaccination in schools [b]	C	2013: 70%	**2014: 70%**	2014: 79%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose)	C	2013: 69%	**2014: ≥60%**[c]	2014: 68%	Achieved
	The percentage of enrolled people over 65 years vaccinated against flu	C	68%	**70%**	65%	Not Achieved
	High Needs		67%		63%	Not Achieved
Smoking cessation services	**Health Target:** The percentage of hospitalised smokers receiving advice and help to quit	C	96%	**95%**	95%	Achieved
	Health Target: The	C	71%	**90%**	86%	Not Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
	percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking					
Screening services	The percentage of eligible children receiving a Before School Check	C	90%	**90%**	90%	Achieved
	High Need		90%		90%	Achieved
	The percentage of eligible women (25-69) having cervical screening in the last 3 years	C	79%	**≥80%**	77%[d]	Not Achieved
	Māori		64%		68%	Not Achieved
	Pacific		64%		70%	Not Achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	73%	**70%**	72%	Achieved
	Māori		64%		66%	Not Achieved
	Pacific		64%		66%	Not Achieved
Health promotion and public health services	The percentage of infants breastfed at 6 months [be]	C	60%[†]	**59%**[f]	63%	Achieved
	Number of new referrals to Public Health Nurses in primary/intermediate schools [g] – Hutt Valley DHB only	V	2013: 948	**2014: 786**	2014: 934	Achieved
	The number of disease notifications investigated in the sub-region[h]	V	1,797	**2,500**	1,955	**Refer Comment**
	The number of environmental health investigations in the sub-region	V	587	**680**	562	**Refer Comment**
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	277[†]	**280**	354	Achieved
	Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	V	25[†]	**28**	29	Achieved

Comments on Performance

Immunisation services

Hutt Valley DHB achieved the eight month old immunisation Health Target. Primary Health Organisations (PHOs) are being supported and encouraged to implement initiatives to increase immunisation coverage. Immunisation education is provided for primary health care nurses and hospital staff that have immunisation responsibilities. Primary healthcare providers also receive a list of children who are overdue for immunisation so that they can follow up to ensure that the children receive their immunisations.

The Regional Public Health Immunisation team work in schools to ensure that HPV and Boostrix vaccinations are completed in a timely manner and according to all national protocols. The team met the targets for both vaccination programmes in the 2014 calendar year.

The influenza vaccination period was extended by the Ministry of Health in 2014/15 due to a prolonged flu season. As a result, we expect the percentage of enrolled people over 65 years vaccinated against flu to increase over the next quarter (September 2015). Te Awakairangi PHO continues to support practices to provide influenza vaccination for at-risk patients.

Smoking cessation services

Hutt Valley DHB achieved the Health Target for smoking cessation advice in hospital. The DHB did not achieve the Health Target for smoking cessation advice in primary care. However, PHOs have made significant progress on this target, with performance increasing by 15% between 2013/14 and 2014/15.

Screening services

Hutt Valley DHB achieved the target for cervical screening for the total population, but Māori and Pacific and breast screening rates did not meet the target. To improve our screening rates, the screening service has implemented data matching with primary care and 'priority' women days for Māori, Pacific, and women living in the most deprived areas. Independent service providers, such as Mana Wahine based at Kokiri Marae and Te Runanga o Taranaki Whanui based at Waiwhetu Marae, work to locate and assist priority women to engage with screening services.

Health promotion and public health services

Public health nurses continue to respond to the community's needs in primary and intermediate schools. Referrals to public health nurses are made by teachers, health professionals, social workers, and caregivers. The public health nurses make weekly visits to Decile 1-3 (students with lowest family income) schools and fortnightly visits to Decile 4-6 schools. The public health nurses also respond to email and phone requests from Decile 7-10 (highest income) schools.

The disease notifications investigated target is an estimate as it was based on disease notification and investigation data from the two previous years. The number of disease notifications increased by 158 between 2013/14 and 2014/15. The primary purpose of notification is to trigger an appropriate public health response to prevent further illness. The secondary purpose is for disease surveillance, which allows us to predict, observe, and minimise the harm caused by an outbreak or epidemic/pandemic situation.

The environmental health investigations target is an estimate as it was based on the number of investigations in previous years. There has been a decrease in the amount of reactionary regulatory work since January 2015, which has resulted in a lower number of environmental health investigations. This decrease has occurred occasionally in the past, but such reductions in workload have been temporary. Positively, this temporary reduction in workload has freed up time to review and update Standard Operating Procedures.

The alcohol controlled purchase operations target is an estimate as it was based on the number of alcohol controlled purchase operations completed in previous years. This performance measure was not included in the 2013/14 DHB Annual Plan. The number of controlled purchase operations has increased in 2014/15 due to a better partnership with Police and an increased volume of controlled purchase operations in the Wellington City area.

Regional Public Health made 29 submissions in 2014/15. Of these submissions, 31% were to local councils for their long term ten year plans. A written and oral submission was presented to the parliamentary health select committee on the Health Protection Bill.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT

Description

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations.

Context

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For our DHB, diabetes, COPD, asthma, and chronic respiratory conditions are significant long-term conditions that are prevalent in our population. Early detection and management services based in the community deliver earlier identification of risk, provide opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health checks); providing education

and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.

Oral health services: are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.

How we measure the performance of our Early Detection & Management Services:

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Primary care services	The number of DHB domiciled population enrolled in a PHO	V	140,369	**140,367**	140,552	Achieved
	Māori		21,872	**22,045**	21,982	Not Achieved
	Pacific		11,229[†]	**11,394**	11,045	Not Achieved
	The percentage of the PHO enrolled population enrolled in Care Plus	C	5%	**5%**	6%	Achieved
	The ratio of nurse and GP visits by high need patients versus non high need patients [i]	V	1.12	**≥1.05**	1.09	Achieved
	Health Target: The percentage of eligible people assessed for CVD risk within the last five years	C	81%	**90%**	89%	Not Achieved
Oral health services	The percentage of children under 5 years enrolled in DHB funded dental services[j]	C	2013: 47%	**2014: 85% 2015: 85%**	2014: 55%	Not Achieved
	The percentage of adolescents accessing DHB funded dental services	C	2013: 69%	**2014: 85% 2015: 85%**	2014: 73%	Not Achieved

Comments on Performance

Primary care services

Hutt Valley DHB did not meet the target for the number of DHB-domiciled population enrolled in a PHO. These targets were set with population projections based on the 2006 Census, which overestimated the 2014/15 population by approximately 2,000 people in Hutt Valley DHB compared to the latest projections from the 2013 Census. Enrolment rates are 98% for the total population, 91% for Māori, and 99% for Pacific.

The target ratio of nurse and GP visits by high need patients versus non high need patients was achieved. The ratio indicates that 'high need' patients (Māori, Pacific, and those living in the most deprived areas) are visiting primary care services more than non-high need patients, which is good. During 2014/2015, 'very low

cost access' funding was provided to practices for which at least half of the enrolled population was identified as 'high need'. This funding allowed practices to have low consultation fees, which reduced the financial barriers to accessing primary health care for the 'high need' population.

Oral health services

The preschool oral health enrolment target in 2014/15 was not achieved. However, the Oral Health Service has made significant progress on this target, with performance increasing by 8% between 2013/14 and 2014/15. Initiatives to increase pre-school enrolments include data-matching with primary care, enrolling newborns, working with Well Child Tamariki Ora providers, working with early childhood centres, and developing internal IT and administration systems.

The adolescent utilisation target was not achieved. However, the Oral Health Service has made progress on this target, with performance increasing by 4% between 2013/14 and 2014/15. The Oral Health Service is working with the Hutt Valley Governance Group to raise awareness of 'FREE dental care for under 18 year olds'. The service is also working with contracting dentists to identify areas with low access rates and ways to improve utilisation.

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT

Description

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals in a hospital setting. Hospitals often provide these services because clinical expertise (across a range of areas) and specialist equipment need to be located in the same place. These services include inpatient, outpatient, emergency, and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population. Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals, and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Context

Equitable and timely access to intensive assessment and treatment can significantly improve a person's quality of life, either through early intervention (i.e., removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e., major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing

opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

Medical and surgical services: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service; addressing increasing needs and matching commitments to capacity.

Cancer services: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

Mental health and addictions services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we measure the performance of our Intensive Assessment & Treatment Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T	94%	**95%**	91%	Not Achieved
	Health Target: The number of surgical elective discharges delivered by any DHB for the Hutt Valley domiciled population	V	5,226	**5,014**	5,405	Achieved
	The standardised average length of stay for inpatients (days) [k] – Acute	T	4.06	**3.88**	4.04	Not Achieved
	Elective		3.15	**3.15**	3.17	Not Achieved
Quality measures	The percentage of "DNA" (did not attend) appointments for outpatient first specialist assessments	Q	8%[†]	**6%**[l]	7%	Not Achieved
	Māori		16%[†]		14%	Not Achieved
	Pacific		19%[†]		13%	Not Achieved
	The number of hospital acquired pressure sores	Q	18[†]	**0**	30	Not Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
	The number of central line acquired bacteraemia infections in ICU	Q	0	**0**	0	Achieved
	The rate of falls per 1,000 bed days	Q	2.16	**<3.93**	2.11	Achieved
	The rate of medication errors per 1,000 bed days	Q	3.34	**<1.90**	3.37	Not Achieved
Cancer services	Shorter Waits for Cancer Treatment - The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	100%	Achieved
	Health Target: Faster Cancer Treatment – The percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks[m]	T	New measure	**85% by June 2016**	56%	Not Achieved
Mental health and addictions services	The number of people accessing secondary mental health services	V	6,044[†]	**6,300**	6,166	Not Achieved
	Māori		1,623[†]	**1,747**	1,661	Not Achieved
	Pacific		353[†]	**360**	384	Not Achieved
	Percentage of people admitted to an acute mental health inpatient service who were seen by mental health community team in the 7 days prior to the day of admission	Q	46%[†]	**75%**	41%	Not Achieved
	Percentage of people discharged from an acute mental health inpatient service who were seen by mental health community team in the 7 days following the day of discharge	Q	49%[†]	**90%**	39%	Not Achieved
	The percentage of patients 0-19 referred to non-urgent mental health services who are seen within eight weeks[n]	T	91%[†]	**95%**	87%	Not Achieved
	The percentage of patients 0-19 referred to non-urgent addictions services who are seen within eight weeks	T	97%[†]	**95%**	97%	Achieved

Comments on Performance

Medical and surgical services

Hutt Valley DHB did not achieve the Shorter Stays in ED Health Target in 2014/15. To improve performance, the DHB has implemented a 'Dial a Doctor' campaign that encourages patients to visit their GP rather than

presenting at ED. Most Hutt Valley General Practices have allocated an appointment in their schedule for these patients. Senior staff are present in ED during busy periods. In addition, the DHB is reviewing staffing, processes, and sustainability in ED to identify areas in which to improve.

The medical ward is working to improve acute average length of stay. A project to improve the length of stay for stroke and pneumonia patients is starting in September. There is also work to: improve systems and processes for multi-disciplinary teams, which are groups of clinicians from different areas who work together to manage a patients' care; align teams and team nursing; and to implement criteria-led discharge, helps ensure that patients are discharged as soon as is it is safe and appropriate for them to return home.

Hutt Valley was 0.02 short of achieving the elective average length of stay target. This slightly higher length of stay was driven by the type and acuity of surgery that Hutt performs. There has been an increase in plastics and orthopaedic surgery which affected the length of stay. Length of stay will be a key focus as we continue to look for efficiencies.

Quality measures

Hutt Valley DHB continues to work to reduce 'Did Not Attends' at outpatient appointments. Audiology, Ear Nose and Throat, Paediatrics, and Diabetes outpatient clinics have been targeted this year, with the aim of reducing inequalities for tamariki Māori and those with long term conditions. A whānau ora approach is used and sometimes multiple phone calls or innovative approaches are needed. Good results have been seen in these specialities. Although Hutt Valley DHB did not meet the target in 2014/15, 'Did Not Attend' rates for Māori and Pacific have decreased since 2013/14.

To reduce the number of hospital-acquired pressure injuries, Hutt Valley DHB has established a Guideline Implementation Pressure Injury Group, which is developing a number of initiatives including: education for clinicians about pressure injury prevention; an Adult Decision Tree for Pressure Relieving devices; a patient information leaflet; a Pressure Injury Policy across both Wairarapa and Hutt Valley DHBs; and a rollout of the 'SKINN care bundle', which provides guidelines for best practice to reduce pressure injuries.

To decrease the rate of falls in hospital, Hutt Valley DHB uses a Mobility Alert system which identifies patients at risk of a fall. We are working with other DHBs in the Central Region to place mobility assessments on the patient management system.

Hutt Valley DHB actively encourages reporting of medication errors as an active way of identifying focus for improvement. The Medicines Committee also reviews medication errors on a monthly basis and follows up any identified trends or 'one offs'. A new Wairarapa & Hutt Valley DHB Medication Management Policy is in draft form and due for release by the end of 2015.

Cancer services

Hutt Valley DHB is working to meet the 85% target for Faster Cancer Treatment by June 2016. Initiatives include: improving diagnostic timeliness, reducing variation in triaging of referrals, focussing on one tumour stream (e.g. lung), developing an electronic dashboard of the patient's journey so as to provide visibility to the staff, raising the profile of Faster Cancer Treatment amongst the clinicians, and a clearer governance and escalation process.

Mental health and addictions services

Although Hutt Valley DHB did not meet the target for the number people accessing secondary mental health services, there has been an increase in the number of people accessing the service from 2013/14 to 2014/15. These targets were set with population projections based on the 2006 Census, which overestimated the 2014/15 population by approximately 2,000 people in Hutt Valley DHB compared to the latest projections from the 2013 Census. Access rates have increased between 2013/14 and 2014/15.

Hutt Valley DHB has implemented two service improvement processes in the last 18 months: a 'Functional Assertive Community Treatment' (FACT) meeting model, which provides multi-disciplinary care for long-term mental health clients in the community; and a Post-Acute Care project, which follows-up mental health clients after they have been discharged from a mental health inpatient service. These processes should increase the percentage of people who are seen pre- and post- mental health inpatient admission.

OUTPUT CLASS 4: REHABILITATION AND SUPPORT

Description

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services may be provided at home, as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Context

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions. As a result, effective support services will help to reduce demand for acute services and improve access to other services and interventions. Support services will have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. It will also free up resources for investment into early intervention, health promotion, and prevention services that will help people stay healthier for longer. Our DHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that our DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Outputs

Health of older people services: These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports.

How we measure the performance of our Rehabilitation & Support Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Health of older people services	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	Q	100%	**≥95%**	100%	Achieved
	The number of InterRAI assessments	V	3,405	**≥2,709**[o]	1,481[p]	Not Achieved
	The number of people receiving home and community support services	V	1,987	**1,936**[o]	2,035	Achieved
	The number of days of Short-term Care (respite bed days, day respite, and community day activity support)[q]	V	9,503[†]	**9,852**[o]	12,517	Achieved
	The number of subsidised aged residential care bed days	V	309,233	**309,225**[o]	296,913	Achieved
	The percentage of residential care providers meeting three year certification standards[r]	Q	87%	**≥93%**	94%	Achieved
Disability services	The number of Disability Forum meetings (sub-regional and local)	V	2	**2**	4	Achieved

Comments on Performance

Health of Older People Services

Hutt Valley DHB continues to exceed the target for the percentage of older people with long-term support needs who have had an interRAI assessment. The actual number of assessments is dependent on the needs of the older population so this measure is descriptive rather than aspirational.

The increase in the use of short term care to support carers is encouraging. Hutt Valley DHB has worked to improve the service to carers as interRAI data had shown that Hutt Valley DHB carers were experiencing more stress than carers in other DHBs. The increase in people receiving home and community support

services and the decrease in residential care bed days is positive, as it indicates that the strategy to enable people to stay in their homes is working.

There is one facility in Hutt Valley DHB that has two year certification. Three facilities (20%) have four year certification and the remaining have three year certification.

Disability services

Our priority in 2014/15 has been engagement with the local community. Hutt Valley DHB was part of four sub-regional and local Disability Forum meetings in 2014/15. This engagement has helped us to improve the partnership between staff and communities in service development and planning.

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[a] ABC for Smoking Cessation Quick Reference Card, PHARMAC

[b] Targets and performance are for the calendar year to align with school year.

[c] Target aligned to national target.

[d] Data from National Screening Unit. Note that coverage rates in 2013/14 are based on population projections derived from Census 2006, whilst rates in 2014/15 are based on population projections derived from Census 2013.

[e] Plunket data only, for exclusive, full and partial breastfeeding.

[f] National target.

[g] This target is an estimated volume, rather than an aspirational target.

[h] This measure and the following 'Health promotion and public health services' measures are part of RPH's statutory activity and cover the sub-region (Wairarapa, Hutt Valley, and Capital & Coast DHBs).

[i] The ratio (high need: non high need) of standardised GP and nurse utilisation rate. This measures equity of access, as those with high needs are likely to require more visits.

[j] As oral health measures are reported on a calendar year the Ministry of Health requests targets be specified for each year.

[k] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2015 (2014/15 performance).

[l] This is a long-term target.

[m] This is a new measure that replaced the 'Shorter Waits for Cancer Treatment' Health Target from 1 October 2014.

[n] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2015 (2014/15 performance).

[o] This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.

[p] Note that there have been changes in the recording and reporting of the number of InterRAI assessments. The methodology for 2014/15 gives an underestimate of performance compared to the methodology for the target.

[q] Only includes volume paid as fee for service and excludes bulk-funded dedicated respite beds (3 Beds in Hutt Valley)

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

[†] These measures were introduced in 2014/15 and did not appear in the 2013/14 Annual Report. Our 2013/14 performance has therefore not been audited by Audit New Zealand.

FINANCIAL STATEMENTS

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STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Revenue				
Operating Revenue	2	461,120	460,454	452,509
Interest		1,228	1,100	1,138
Total Income		**462,348**	**461,554**	**453,647**
Expenditure				
Personnel Costs	3	164,759	159,404	156,571
Depreciation, Amortisation & Impairment expense	10-11	12,334	11,109	10,985
Outsourced Services		14,597	10,843	13,031
Clinical Supplies		25,642	25,608	23,886
Infrastructure and Non-Clinical expenses		13,701	13,800	14,175
Other District Health Boards		83,454	80,988	81,506
Non-Health Board Providers		140,314	143,867	139,976
Capital Charge	4	7,289	8,240	7,410
Finance costs	5	3,970	3,490	3,969
Other expenses	6	3,828	4,205	3,962
Total Expenditure		**469,888**	**461,554**	**455,471**
Net surplus / (deficit)		**(7,540)**	-	**(1,824)**
Other comprehensive revenue and expense				
Gain on property revaluations		11,534	-	-
Total comprehensive revenue and expense for the Year		**3,994**	**-**	**(1,824)**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Audited $000
Equity as at 1 July		93,614	93,038	94,579
Capital Contributions from the Crown		-	2,067	1,066
Repayment of equity to the Crown		(207)	-	(207)
Total Comprehensive revenue and expense for the Year		3,994	-	(1,824)
Equity as at 30 June	16	**97,401**	**95,105**	**93,614**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	13,400	22,576	23,623
Debtors and other receivables	8	15,126	13,408	15,641
Inventories	9	1,391	1,492	1,466
Total Current Assets		**29,917**	**37,476**	**40,730**
Non-Current Assets				
Property, Plant and Equipment	10	201,626	199,115	197,639
Intangible Assets	11	14,228	12,666	11,567
Trust and bequest funds	12	1,288	1,187	1,288
Total Non-Current Assets		**217,142**	**212,968**	**210,494**
Total Assets		**247,059**	**250,444**	**251,224**
Liabilities				
Current Liabilities				
Creditors and other payables	13	31,698	38,616	40,970
Employee entitlements and provisions	14	29,167	28,281	26,996
Borrowings	15	15,402	15,328	8,991
Total Current Liabilities		**76,267**	**82,225**	**76,957**
Non-Current Liabilities				
Employee entitlements and provisions	14	6,515	6,978	6,440
Borrowings	15	65,588	64,949	72,925
Trust and bequest funds	12	1,288	1,187	1,288
Total Non-Current Liabilities		**73,391**	**73,114**	**80,653**
Total Liabilities		**149,658**	**155,339**	**157,610**
Net Assets		**97,401**	**95,105**	**93,614**
Equity				
Crown equity	16	44,730	46,530	44,937
Revaluation reserves	16	91,341	79,805	79,807
Accumulated deficit	16	(38,670)	(31,230)	(31,130)
Total Equity	16	**97,401**	**95,105**	**93,614**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Cashflows from Operating Activities				
Cash receipts		478,209	459,635	463,954
Payments to providers		(240,396)	(224,854)	(234,992)
Payments to suppliers & employees		(228,908)	(212,634)	(209,752)
Goods and Services Tax (net)		(423)	(5)	(168)
Capital charge paid		(7,289)	(8,240)	(7,410)
Net cash flows from Operating Activities	17	**1,193**	**13,902**	**11,632**
Cashflows from Investing Activities				
Interest Received		1,228	1,100	1,137
Proceeds from sale of property, plant and equipment		-	(7)	-
Purchase of property, plant and equipment		(6,109)	(11,979)	(9,650)
Investments		(1,538)	(1,337)	(1,464)
Net cash flows from Investing Activities		**(6,419)**	**(12,223)**	**(9,975)**
Cashflows from Financing Activities				
Equity Contribution		-	1,000	1,066
Loans and finance lease raised/(paid)		1,312	(696)	1,312
Interest paid		(3,864)	(3,490)	(3,960)
Payment of Finance Leases		(2,238)	-	(895)
Repayment of Equity		(207)	-	(207)
Net cash flows from Financing Activities		**(4,997)**	**(3,186)**	**(2,684)**
Net Increase / (Decrease) in Cash and Cash Equivalents		**(10,223)**	**(1,508)**	**(1,027)**
Cash and cash equivalents at beginning of year	7	23,623	24,084	24,650
Cash and Cash Equivalents at end of year		**13,400**	**22,576**	**23,623**

The accompanying notes form part of these financial statements. Explanations of major changes from last year are provided in note 26.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

1 STATEMENT OF ACCOUNTING POLICIES

Reporting entity

Hutt Valley District Health Board (Hutt Valley DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing Hutt Valley DHB includes the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. 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. Hutt Valley DHB does not operate to make a financial return.

Hutt Valley DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for Hutt Valley DHB are for the year ended 30 June 2015, and were approved by the Board on 30 October 2015.

Basis of Preparation

Going Concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that Hutt Valley DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect Hutt Valley DHB during the period of one year from the date of signing the 2014/15 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of Comfort

The Board has received a letter of comfort dated 22 October 2015 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability

Operating and cash flow forecasts

The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities to meet the investing and financing cash flow requirements of Hutt Valley DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements

The forecasts for the next three year prepared by Hutt Valley DHB show that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants of other borrowing restrictions.

While the Board is confident in the ability of Hutt Valley DHB to continue as a going concern, if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether Hutt Valley DHB would be able to continue as a going concern based on current trading terms and legislative requirements.

If Hutt Valley DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

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 have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards.

Presentation Currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

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 Hutt Valley DHB's financial statements.

Standards issued and not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. Hutt Valley DHB has applied these standards in preparing 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Hutt Valley DHB will apply these updated standards in preparing its 30

June 2016 financial statements. Hutt Valley DHB expects there will be minimal or no change in applying these updated accounting standards.

Significant Accounting Policies

Revenue

The specific accounting policies for significant revenue items are explained below:

Ministry of Health (MoH) revenue

Hutt Valley DHB is primarily funded through revenue received from the MoH. This funding is restricted in its use for the purpose of Hutt Valley DHB meeting its objectives specified in its founding legislation and the scope of the relevant appropriations from the Funder.

Hutt Valley DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the MoH has been determined to be equivalent to the amounts due in the funding arrangements.

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.

Expenses

Capital Charge

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

Borrowing costs

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 and other short-term highly liquid investments with original maturities of three months or less

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.

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.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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. 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 revenue and expense 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 revenue and expense 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 revenue and expense.

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 and associated depreciation of major classes of property, plant and Equipment were reviewed during the year and have been estimated as follows:

Site Improvements	6 to 33 years	3.0% to 16.7%
Building Structure, Services and Fit out	2 to 55 years	1.8% to 50.0%
Plant and equipment	2 to 25 years	4.0% to 50.0%
Computer equipment	3 to 10 years	10.0% to 33.3%
Leased assets	3 to 15 years	6.7% to 33.3%
Motor vehicles	8 to 10 years	10.0% to 12.5%

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 Finance Procurement and Supply Chain (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	10.0% to 33.3%

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 and a reliable estimate of the obligation can be made.

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 surplus or deficit of the Scheme.

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.

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

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 performance expectations 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:

Estimating the fair value of land and buildings

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

	2015 Actual $000	2014 Actual $000
Ministry of Health contract funding	395,848	387,968
ACC Contract revenue	4,702	4,279
Other Government	1,742	1,595
Revenue from other District Health Boards	54,114	53,409
Other patient care related revenue	4,435	4,953
Other Income:		
Donations and bequests received	204	235
Rental income and services	75	71
Total Operating Income	**461,120**	**452,509**

3 PERSONNEL COSTS

	2015 Actual $000	2014 Actual $000
Salaries and wages	157,985	151,440
Defined contribution plan employer contributions	4,528	4,126
Increase/(decrease) in liability for employee entitlements	2,246	1,005
Total Personnel Costs	**164,759**	**156,571**

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 2015 was 8% (2014: 8%).

5 FINANCE COSTS

	2015 Actual $000	2014 Actual $000
Interest on Crown Loans	3,869	3,904
Interest on finance leases	101	65
Total Finance Costs	**3,970**	**3,969**

6 OTHER EXPENSES

	2015 Actual $000	2014 Actual $000
Audit Fees for financial statement audit	121	122
Audit-related fees for internal audit services	105	50
Operating lease expense	3,067	3,460
Impairment of debtors	78	(11)
Board member fees	258	304
Loss on disposal of property, plant and equipment	199	37
Total Other expenses	**3,828**	**3,962**

7 CASH AND CASH EQUIVALENTS

	2015 Actual $000	2014 Actual $000
Call Deposits with Health Benefits Ltd	9,912	17,624
Cash at bank and on hand	588	99
Other Call deposits	2,900	5,900
Total Cash and cash equivalents	**13,400**	**23,623**

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

The Hutt Valley DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue used in determining working capital limits, and is defined as one-twelve of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For the Hutt Valley DHB that equates to $15.8 million (2014: $18m).

8 DEBTORS AND OTHER RECEIVABLES

	2015 Actual $000	2014 Actual $000
Ministry of Health	6,531	5,879
Other DHBs	3,058	2,002
PHARMAC	3,385	2,975
Trade debtors - other	1,880	4,458
Provision for doubtful debts	(255)	(230)
	14,599	**15,084**
Prepayments	527	557
Total Debtors and other receivables	**15,126**	**15,641**
Total Debtors and other receivables comprises:		
Revenue from the sale of goods and services (exchange transactions)	1,573	4,785
Revenue from grants (non-exchange transactions)	13,553	10,856
Total Debtors and other receivables	**15,126**	**15,641**

The carrying value of receivables approximates their fair value.

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

	2015			2014		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	12,344	(1)	12,343	15,789	(2)	15,788
Past due 1-30 days	972	(3)	969	394	(10)	384
Past due 31-60 days	178	(3)	175	(1,835)	-	(1,834)
Past due >60days	1,360	(248)	1,112	964	(218)	746
Total	**14,854**	**(255)**	**14,599**	**15,314**	**(230)**	**15,084**

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.

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

	2015 Actual $000	2014 Actual $000
Balance at 1 July	(231)	(342)
Provisions write back/(made)	(48)	11
Receivables written off during the year	24	100
Closing Balance	**(255)**	**(230)**

9 INVENTORIES

	2015 Actual $000	2014 Actual $000
Pharmaceuticals	191	168
Surgical and medical supplies	1,210	1,308
	1,401	**1,476**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,391**	**1,466**

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 (2014: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2014: 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 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
Disposals	-	-	(5)	(719)	7	(186)	(903)
Work in Progress	-	-	409	(1,177)	-	-	(768)
Balance at 30 June 2014	13,625	2,173	171,046	42,187	3,794	2,451	235,276
Balance 30 June 2014	13,625	2,173	171,046	42,187	3,794	2,451	235,276
Additions	-	28	966	714	(8)	32	1,732
Disposals	-	-	(15)	(469)	-	-	(484)
Adjustments	-	634	(866)	(856)	4	2	(1,082)
Revaluation increase/(decrease)	2,405	(523)	(6,306)	(5,299)	(1,728)	(144)	(11,595)
Work In Progress	-	-	1,989	2,973	-	-	4,962
Balance at 30 June 2015	16,030	2,312	166,814	39,250	2,062	2,341	228,809

Accumulated depreciation and impairment losses							
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
Balance at 1 July 2014	-	124	6,954	28,794	792	973	37,637
Depreciation expense	-	120	8,312	2,696	206	271	11,605
Depreciation on disposals	-	-	(15)	(272)	-	-	(287)
Adjustment	-	634	(223)	389	4	-	804
Elimination on revaluation	-	(878)	(14,816)	(6,484)	(254)	(144)	(22,576)
Balance 30 June 2015	-	-	212	25,123	748	1,100	27,183
Carrying Amounts							
At 1 July 2013	13,625	2,167	169,519	14,895	2,091	1,740	204,037
At 30 June 2014 and 1 July 2014	13,625	2,049	164,092	13,393	3,002	1,478	197,639
At 30 June 2015	16,030	2,312	166,602	14,127	1,314	1,241	201,626

The net carrying amount of assets held under finance leases is $1.3m (2014: $3.00m) 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 to reclassify fixed asset costs and accumulated depreciation balances to align the General Ledger balances with the Fixed Assets register. No such adjustments were made in the prior 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. 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.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Hutt Valley DHBs earthquake prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement costs in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

	Acquired Software	FPSC Shared Services Rights	Investment In CRTAS	Total
	$000	$000	$000	$000
Cost or valuation				
Balance 1 July 2013	11,763	810	1,280	13,853
Additions	1,187	736	1,464	3,387
WIP	3,041	-	-	3,041
Balance 30 June 2014	15,991	1,546	2,744	20,281
Balance 1 July 2014	15,991	1,546	2,744	20,281
Additions	2,719	364	1,537	4,620
Adjustment	(3,978)	-	-	(3,978)
Revaluation	(1,479)	-	-	(1,479)
Work In Progress	2,236	-	-	2,236
Balance 30 June 2015	15,489	1,910	4,281	21,680
Accumulated amortisation and impairment losses				
Balance at 1 July 2013	8,292	-	-	8,292
Amortisation expense	422	-	-	422
Balance 30 June 2014	8,714	-	-	8,714
Balance at 1 July 2014	8,714	-	-	8,714
Amortisation expense	729	-	-	729
Adjustment	41	-	-	41
Revaluation	(2,032)	-	-	(2,032)
Balance 30 June 2015	7,452	-	-	7,452
Carrying Amounts				
At 1 July 2013	3,471	810	1,280	5,561
At 30 June 2014 and 1 July 2014	7,277	1,546	2,744	11,567
At 30 June 2015	8,037	1,910	4,281	14,228

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 2015, the DHB had made payments totalling $1.91m (2014: $1.54m) 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.

During 2015 Hutt Valley DHB and the other DHBs involved in the CRISP project signed a variation to the original agreement regarding investment in CRISP. It was agreed that investments in CRTAS would no longer be for the acquisition of Class B redeemable Preference Shares. The capital payments to TAS for the CRISP project have been reclassified as Work in Progress as at 30 June 2015 as all partners in the CRISP project are to share ownership of the intangible assets resulting from CRISP. Hutt Valley DHB had treated the initial contributions as Investment in Associates in the financial statements to 30 June 2014. These have now been reclassified as Work in Progress.

12 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.

	2015 Actual $000	2014 Actual $000
Opening balance	1,288	1,099
Funds received	139	402
Interest received	66	28
Funds disbursed	(205)	(241)
Closing Balance	**1,288**	**1,288**

13 CREDITORS AND OTHER PAYABLES

	2015 Actual $000	2014 Actual $000
Payables under exchange transactions		
Creditors	696	1,315
Accrued expenses	19,960	21,746
Interest	429	423
Income in advance	41	1,792
Total payables under exchange transactions	21,126	25,276

Payables under non-exchange transactions		
Taxes	1,857	1,984
Inter-district flows	4,172	5,611
Trusts	4,473	8,099
Other	70	-
Total payables under non-exchange transactions	10,572	15,694
Total Creditors and other payables	**31,698**	**40,970**

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.

14 EMPLOYEE ENTITLEMENTS AND PROVISIONS

	2015 Actual $000	2014 Actual $000
Current portion		
Salary and Wages Accrued	5,988	4,872
Annual leave	16,761	15,650
Long Service Leave	803	1,290
Retirement Gratuities	690	797
Continuing Medical Education Leave and Expenses	971	991
Other Entitlements	3,954	3,397
Total Current portion	**29,167**	**26,996**
Non-current portion		
Long Service leave	1,668	1,698
Retirement Gratuities	921	908
Continuing Medical Education Leave and Expenses	2,528	2,560
Other Entitlements	1,398	1,274
Total Non-current portion	**6,515**	**6,440**
Total Employee Entitlements and Provisions	**35,682**	**33,436**

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% (2014:4.68%) and an inflation factor of 2.5% (2014:2.5%) has been used.

15 BORROWINGS

	2015 Actual $000	2014 Actual $000
Current portion		
Finance Leases	952	991
Crown Loans - fixed interest	14,450	8,000
	15,402	**8,991**
Non-current portion		
Finance Leases	1,038	1,925
Crown Loans - fixed interest	64,550	71,000
	65,588	**72,925**
Total borrowings	**80,990**	**81,916**
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 $82.9m (2014: $81.2m). 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 $1.990m (2014: $2.916m). Fair value is estimated at the present value of future cash flows.

Analysis of Finance Lease

	2015 Actual $000	2014 Actual $000
Minimum lease payments payable:		
Not later than one year	1,139	1,026
Later than one year and not later than five years	1,256	2,218
Later than five years	-	-
Total minimum lease payments	2,395	3,244
Future finance charges	(405)	(328)
Present value of minimum lease payments	1,990	2,916
Present value of minimum lease payable:		
Not later than one year	952	991
Later than one year and not later than five years	1,038	1,925
Later than five years	-	-
Total present value of minimum lease payments	1,990	2,916

Description of finance leasing arrangements

Hutt Valley DHB has entered into no new finance leases during the year (2014: three). In total Hutt Valley DHB holds 3 finance leases totalling $4.83 million (2014: $4.83m) for periods ranging from 3 to 5 years. The finance leases are for medical equipments. There are no restrictions placed on Hutt Valley DHB by any of the finance leasing arrangements.

16 EQUITY

	Crown Equity $000	Land* $000	Buildings* $000	Accumulated Deficit $000	Total Equity $000
Balance at 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)
Revaluation surplus					
Surplus/(deficit) for the year	-	-	-	(1,824)	(1,824)
Balance at 30 June 2014	**44,937**	**9,264**	**70,543**	**(31,130)**	**93,614**
Balance at 1 July 2014	44,937	9,264	70,543	(31,130)	93,614
Contribution from the Crown	-	-	-	-	-
Repayment of Equity	(207)	-	-	-	(207)
Revaluation surplus		2,405	9,129	-	11,534
Surplus/(deficit) for the year	-	-	-	(7,540)	(7,540)
Balance at 30 June 2015	**44,730**	**11,669**	**79,672**	**(38,670)**	**97,401**

***Revaluation Reserves**

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

	2015 Actual $000	2014 Actual $000
Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities		
Net surplus/(deficit)	(7,540)	(1,824)
Add/(less) non-cash items:		
Depreciation and amortisation expense	12,334	10,985
Increase/(decrease) in Provisions	2,271	894
Total non-cash items	**14,605**	**11,880**
Add/(less) items classified as investing or financing activity:		
(Gains)/losses on sale of property, plant and equipment	199	37
Net interest paid	2,642	2,830
Total items classified as investing or financing activity	**2,841**	**2,867**
Add/(less) movements in statement of financial position items:		
(Increase)/decrease in debtors and other receivables	489	(3,668)
(Increase)/decrease in inventories	74	(30)
Increase/(decrease) in creditors and other payables	(9,276)	2,408
Net movements in Working Capital items	**(8,713)**	**(1,290)**
Net cash flow from Operating Activities	**1,193**	**11,632**

18 CAPITAL COMMITMENTS AND OPERATING LEASES

	2015 Actual $000	2014 Actual $000
Capital commitments - Buildings	1,256	1,203
Operating Leases as lessee		
Not later than one year	1,416	1,438
Later than one year and not later than five years	1,933	2,043
Later than five years	40	71
Total Non-cancellable Operating Lease Commitments	**3,389**	**3,552**

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.

19 CONTINGENCIES

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2015 (2014: Nil).

20 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.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect Hutt Valley DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other Government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel

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

	2015 Actual $000	2014 Actual $000
Salaries and other short-term employee benefits	2,019	1,947
Full time equivalent	8.06	9.03
Total key management personnel compensation	**2,019**	**1,947**

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 $46.0m (2014: $47.5m), with total expenditure of $71.90m (2014: $75.78m). The amount owing to Hutt Valley DHB by Capital & Coast DHB at the end of the financial year was $2.11m (2014: $1.46m), and the amount Hutt Valley DHB owed to Capital & Coast DHB was $3.74m (2014: $4.62m).

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 $5.40m (2014: $5.90m), with total expenditure of $1.17m (2014: $1.12m). The amount owing to Hutt Valley DHB by Wairarapa DHB at the end of the financial year was $879k (2014: $466k), and the amount owing to Wairarapa DHB was $24k (2014: $65k).

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 (2014: nil).

21 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	2015 Actual $000	2014 Actual $000
Dr Virginia Hope	Chair	46	47
Wayne Guppy	Deputy Chair	29	29
David Bassett	Current Member	22	23
David Ogden	Current Member	23	23
John Terris	Current Member	23	22
Kathryn Austin	Current Member	22	23
Ken Laban	Current Member	21	22
Peter Douglas	Current Member	22	22
Sandra Greig	Current Member	22	13
Jaimes Wood	Current Member	23	13
Ron Mark	Member to October 2014	3	12
Prior year members:			
Peter Glensor	HAC Chair to December 2013		12
Keith Hindle	FRAC Chair to December 2013		11
Iris Pahau	Member to December 2013		9
Total Board member remuneration		**256**	**281**
Total Headcount		**11**	**14**

Board and committee meeting attendances in the year to 30 June 2015:

Board Member	Position	Meetings Attended		Meetings held during tenure	
		Board	Committee	Board	Committee
Virginia Hope	Board Chair	8	24	9	25
Wayne Guppy	Deputy Board Chair	9	12	9	18
David Bassett	Current Member	9	9	9	11
David Ogden	Current Member	7	10	9	11
John Terris	Current Member	9	14	9	14
Kathryn Austin	Current Member	9	8	9	10
Ken Laban	Current Member	5	2	9	8
Peter Douglas	Current Member	8	5	9	15
Sandra Greig	Current Member	7	6	9	6
Jaimes Wood	Current Member	8	7	9	11
Ron Mark	Member to October 2014	1	0	2	0

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.

22 EMPLOYEE REMUNERATION

Details of employee remuneration can be found in the 'Our People' section – please refer to page 7 of this report.

23 EVENTS AFTER THE BALANCE DATE

There are no significant events subsequent to balance date.

24 FINANCIAL INSTRUMENTS

Fair Values

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

	2015		2014	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	$000	$000	$000	$000
Cash and cash equivalents	13,400	13,400	23,623	23,623
Debtors and other receivables	15,126	15,126	15,640	15,640
Creditors and other payables	31,698	31,698	40,971	40,971
Crown loans-fixed interest	79,000	82,930	79,000	81,200
Finance leases	1,990	1,990	2,916	2,916
	141,214	**145,144**	**162,151**	**164,351**

Financial Instrument 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.

Market Risk

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 2015, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2014/15, 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:

	2015 Actual $000	2014 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
A-1+	4,776	7,288
AA-	-	-
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	9,912	17,624
Total	**14,688**	**24,912**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	13,400	23,623
Trust and bequest funds	1,288	1,289
Debtors and other receivables	15,126	15,640

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

Management of 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 6 months $000	6-12 months $000	Later than 1 year $000
2014					
Creditors and other payables	40,971	40,971	40,971	-	-
Finance leases	2,916	3,095	436	436	2,223
Crown Loans-fixed interest	79,000	93,113	1,899	9,929	81,285
Total	**122,887**	**137,178**	**43,306**	**10,365**	**83,508**

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2015					
Creditors and other payables	31,698	31,698	31,698	-	-
Finance leases	1,990	2,395	1,139	745	511
Crown Loans-fixed interest	79,000	93,808	18,023	3,633	72,152
Total	**112,688**	**127,901**	**50,860**	**4,378**	**72,663**

25 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.

26 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 2015 are provided below.

Statement of Comprehensive revenue and expense

The Hutt Valley DHB recorded a gain after revaluation of $3.944m (deficit of $7.540 excluding revaluation gain) 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,
- Higher costs relating to staff, in particular in nursing due to additional staff above budget approved for safe staffing and acute demand,
- Hospital activity is above budget in acute areas due to a delay in implementation of acute model of care changes,
- 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.

The above higher than budgeted costs were partly offset by higher devolved funding from the Ministry of Health.

Statement of Financial Position

Cash and cash equivalents were lower than budget due to increased spending mainly in relation to employee, Inter district flows and outsourced costs.

Property plant and equipment and revaluation reserves are higher than budget due to the asset revaluation completed as at 30 June 2015.

Statement of Cash Flows

The net cash flow decreased due to the deficit position of the DHB as expenses continue to increase above the funding increase received.

27 COST OF SERVICE STATEMENTS FOR OUTPUT CLASSES

For the year ended 30 June 2015

	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
$000s	2014\15 Actual	2014\15 Budget	2013\14 Audited	2014\15 Actual	2014\15 Budget	2013\14 Audited	2014\15 Actual	2014\15 Budget	2013\14 Audited	2014\15 Actual	2014\15 Budget	2013\14 Audited	2014\15 Actual	2014\15 Budget	2013\14 Audited
Income															
Operating Income	21,942	21,568	22,039	117,868	128,255	114,541	259,525	248,929	256,382	61,785	61,702	59,548	461,120	460,454	452,509
Interest Income	62	55	57	40	36	37	1,124	1,007	1,042	2	2	2	1,228	1,100	1,138
Total Income	**22,004**	**21,623**	**22,096**	**117,908**	**128,291**	**114,579**	**260,649**	**249,936**	**257,424**	**61,787**	**61,704**	**59,550**	**462,348**	**461,554**	**453,648**
Expenditure															
Personnel Costs	13,026	13,259	12,773	4,673	10,363	4,267	143,548	132,293	136,154	3,512	3,489	3,378	164,759	159,404	156,572
Depreciation	262	145	254	712	828	704	11,344	10,123	10,014	16	13	14	12,334	11,109	10,985
Outsourced Services	1,351	1,389	1,133	1,081	1,093	1,083	11,737	7,932	10,393	428	429	423	14,597	10,843	13,031
Clinical Supplies	669	755	1,035	498	499	407	23,196	21,191	21,308	1,279	1,166	1,135	25,642	23,611	23,886
Infrastructure and Non Clinical Expenses	816	627	577	579	831	590	12,239	14,284	12,938	67	54	70	13,701	15,796	14,175
Other District Health Boards	62	59	62	11,894	15,157	14,666	67,879	62,188	63,117	3,619	3,583	3,661	83,454	80,987	81,506
Non Health Board Providers	1,226	1,317	1,281	86,234	87,009	82,059	3,878	3,705	5,993	48,976	51,835	50,644	140,314	143,866	139,978
Capital Charge	328	371	334	962	1,083	976	5,988	6,773	6,088	11	13	12	7,289	8,240	7,410
Interest Expense	62	62	62	41	41	41	3,865	3,385	3,863	2	2	2	3,970	3,490	3,969
Other	1,051	990	955	102	438	122	2,639	2,725	2,832	36	55	53	3,828	4,208	3,962
Internal Allocations	3,208	3,041	3,072	1,567	2,649	1,574	(5,389)	(6,396)	(5,314)	614	706	667	-	-	0
Total Expenditure	**22,061**	**22,015**	**21,539**	**108,343**	**119,991**	**106,488**	**280,924**	**258,203**	**267,386**	**58,560**	**61,345**	**60,059**	**469,888**	**461,554**	**455,472**
Net Surplus / (Deficit)	**(57)**	**(392)**	**557**	**9,565**	**8,300**	**8,090**	**(20,275)**	**(8,267)**	**(9,962)**	**3,227**	**359**	**(510)**	**(7,540)**	**0**	**(1,824)**

STATEMENT OF RESPONSIBILITY

We are responsible for the preparation of Hutt Valley District Health Board's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Hutt Valley District Health Board under section 19A of the Public Finance Act 1989.

We have the 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 our opinion, these financial statements and the statement of performance fairly reflect the financial position and operations of Hutt Valley District Health Board for the year ended 30 June 2015.

Signed on behalf of the Board:

Dr Virginia Hope
Board Chair
30 October 2015

Wayne Guppy
Deputy Board Chair
30 October 2015

Independent Auditor's Report

To the readers of the Hutt Valley District Health Board's financial statements and performance information for the year ended 30 June 2015

The Auditor-General is the auditor of the 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 the performance information, including the performance information for an appropriation, of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 44 to 79, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, 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 on pages 9 to 42.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2015; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers

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 included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 9 to 42:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2015. 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 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 the 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 the performance information. We were unable to determine if there were 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the 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 in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

Board is responsible for preparing financial statements and performance information that:

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

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

The Board is 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 the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

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:	**Head Office Physical Address:**
Hutt Valley District Health Board	Executive Reception
Private Bag 31-907	Pilmuir House, Pilmuir Street
Lower Hutt 5040	Hutt Hospital Campus
Website: www.huttvalleydhb.org.nz	Lower Hutt 5010
Phone: (04) 566 6999	
Bankers	**Auditor**
Westpac	Audit New Zealand Wellington, on behalf of the Controller and Auditor-General

Board Members

The Board has ten members. Seven are elected. Three are appointed by the Minister of Health (including the Chair and Deputy Chair).

Dr Virginia Hope, Chair	**Ken Laban**
Wayne Guppy, Deputy Chair	**David Ogden**
Katy Austin	**John Terris**
David Bassett	**Jaimes Wood**
Peter Douglas	**Sandra Greig**

Executive Leadership Team for Wairarapa and Hutt Valley DHBs *as at 30 June 2015*

Warrick Frater	Interim Chief Executive Officer	**Judith Parkinson**	Chief Financial Officer
Carolyn Cooper	Interim Chief Operating Officer	**Jill Stringer**	Communications Manager
Helen Pocknall	Executive Director of Nursing & Midwifery	**Kuini Puketapu**	Executive Director Māori Health Development Unit, Hutt Valley DHB
Sisira Jayathissa	Acting Chief Medical Officer	**Tofa Suafole Gush**	Executive Director of Pacific Peoples Health
Russell Simpson	Executive Director Allied Health, Scientific & Technical	**Ashley Bloomfield (3DHB)**	Executive Director Service Integration & Development Unit (SIDU)
Donna Hickey	Acting Executive Director People & Culture 3DHB	**Glen Willoughby**	Acting Chief Information Officer
Bridget Allen	Chief Executive, Te Awakairangi Health Network (PHO)	**Eng Chew**	3DHB Corporate Services Manager
Amber O'Callaghan	Executive Director Quality & Risk		

Ashley Bloomfield Chief Executive Officer as of 12 October 2015

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 / Capital & Coast	**Katy Austin**	Hutt Valley
Dr Virginia Hope (Deputy)	Hutt Valley / Capital & Coast	**Sandra Greig**	Hutt Valley
Helen Kjestrup	Wairarapa	**Fa'amatuainu Tino Pererira**	Hutt Valley
Janine Vollebregt	Wairarapa	**David Choat**	Capital & Coast
Leanne Southey	Wairarapa	**Chris Laidlaw**	Capital & Coast
Liz Falkner	Wairarapa	**Helene Ritchie**	Capital & Coast

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 / Capital & Coast	**Ken Laban**	Hutt Valley
Alan Shirley	Wairarapa	**Sue Kedgley**	Capital & Coast
Fiona Samuel	Wairarapa	**Nick Leggett**	Capital & Coast
Rob Irwin	Wairarapa	**John Terris**	Hutt Valley