Hutt Valley District Health Board

Annual Report 2016

CONTENTS

CHAIR & CHIEF EXECUTIVE'S FOREWORD

We are very pleased to present Hutt Valley District Health Board's (Hutt Valley DHB) Annual Report for the year 1 July 2015 to 30 June 2016. It shows the continued progress being made in a number of key areas of our community and hospital health services and also details where our funding was spent.

Our overall goal for the year was to deliver improved health and equity for our population, provide better patient journeys, live within our means and develop a thriving organisation.

We performed well on a range of measures contributing to these goals, achieving most of our health targets, including 105% of our national elective surgery target. New approaches and strong leadership by a range of staff across the organisation also helped us to achieve and sustain performance on the shorter stays in ED health target. Focusing on shorter stays for patients in all our wards is contributing to improved patient journeys through the hospital and to our overall financial performance.

Our DHB has come through a financially difficult period to finish the year close to budget. A clear savings plan and strong focus on managing our budgets, while continuing to do the right things for our patients, helped us reduce our forecast deficit. Getting back to a break-even position will give us more choices about where we can invest in future to ensure we keep delivering the services our population needs.

The Board was pleased to appoint Dr Ashley Bloomfield as CEO in October 2015. Under his leadership a clear direction has been established for the organisation, with a new structure that will strengthen clinical leadership and management and ensure we continue to deliver on the organisation's goals.

Building a quality and safety culture has been another important area of focus. A key landmark was the appointment of a Clinical Council, with membership from across the Hutt Valley health system. Its role is to advise the Board and Executive on quality and safety matters and provide clinical input into key decisions.

Collaboration continues across the three Wellington region DHBs (Wairarapa, Hutt Valley and Capital & Coast) where it is clinically appropriate and there are clear benefits. For example, where there were previously five laboratories operating across the region, these have been integrated with a brand new state-of-the-art hub laboratory at Wellington Regional Hospital and on-site facilities at the other hospitals. Our strong record of working together was a key driver of the Government's decision to choose Hutt Valley and Wairarapa DHBs to spearhead the national rollout of a new bowel screening programme.

We continue to work closely with primary care and community providers across the Hutt Valley health system. Our main PHO, Te Awakairangi Health Network, is the first in New Zealand to have all its practices meet the Royal New Zealand College of General Practice Foundation Standards or be accredited in the Cornerstone programme. Meeting these standards helps to reassure patients that they are receiving safe and good quality care.

We would like to thank our staff and community providers for their hard work throughout the year. Our patients often tell us it's our people who make the real difference in their journey through the health system. The on-going commitment and professionalism of our staff is key to our success in preventing ill health and delivering high quality care to our patients, their families and our 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

Hutt Valley DHB takes its obligations to be a good employer very seriously and has appropriate plans, policies and processes to meet the seven key elements of 'the Good Employer' as prescribed by the Equal Employment Opportunity (EEO) Commissioner. These 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

Consistent and rigorous recruitment and selection processes are followed to ensure fairness and equal opportunity.

One of the organisation's priorities is to build a thriving organisation for its staff.

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 Hutt Valley DHB values professionalism through leadership. Therefore unacceptable employee behaviour is not tolerated. Last year we updated HR policies and guidelines related to discipline, performance, code of conduct, harassment prevention, and protected disclosures. We are taking other actions to reduce the incidence of bullying and harassment within our organisation for example this year we have established roles as contact people for staff in relation to bullying and harassment prevention and provided external expert training for this. We have other policies including the EEO Policy which will be reviewed this year.

Hutt Valley DHB also has an HR Plan centred on building a positive workplace. The plan includes actions being undertaken in relation to engagement of staff and leadership. It includes building on the leadership development already provided. There will shortly be a pilot for a course for all managers called "What Leaders Need to Know" that is built from the leadership ethos that was agreed by the executive for all 3 DHBs in our sub region. The sub region has also agreed a leadership capability profile and is looking to develop or purchase leadership development that is aligned with that.

Approximately 95.8 % 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 DHB has provided training for all managers and union representatives on the new health and safety legislation.

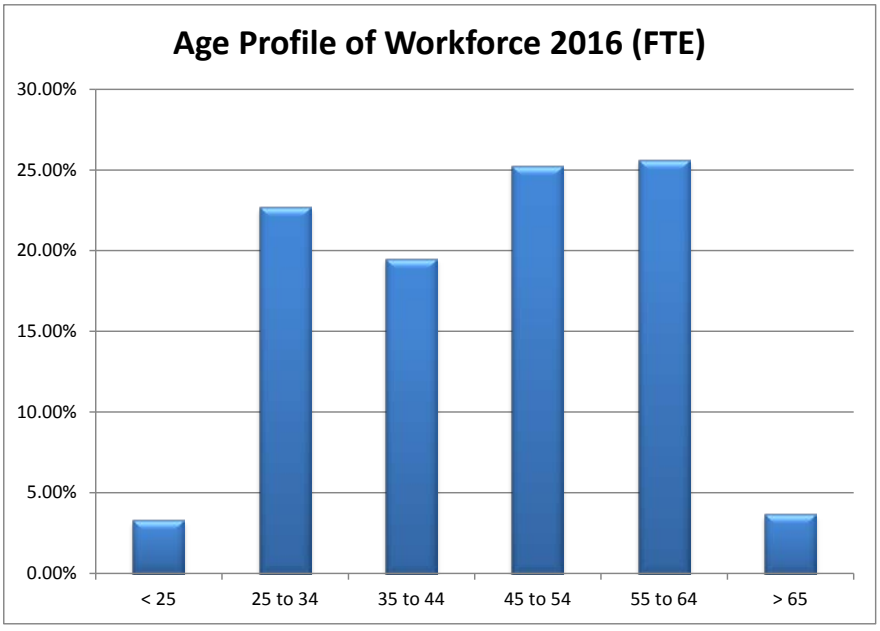
The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation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

WORKFORCE PROFILE

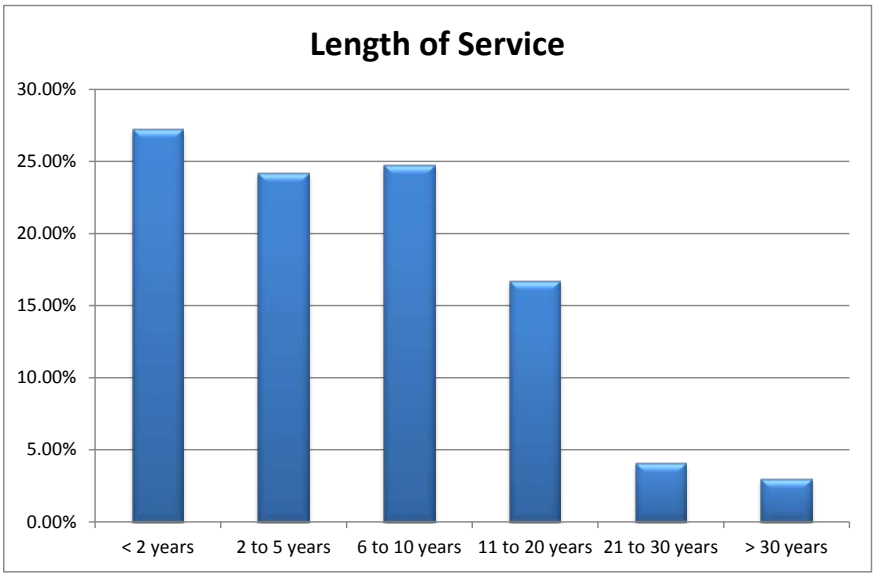
Full Time Equivalent Staff Numbers

	2016	2015	2014	2013	2012	2011	2010
Medical	236	246	232	232	238	233	217
Nursing	696	755	717	708	712	699	685
Allied Health	401	440	428	435	422	396	383
Other	410	442	434	467	480	481	489
Total	1743	1,883	1,811	1,841	1,851	1,809	1,773

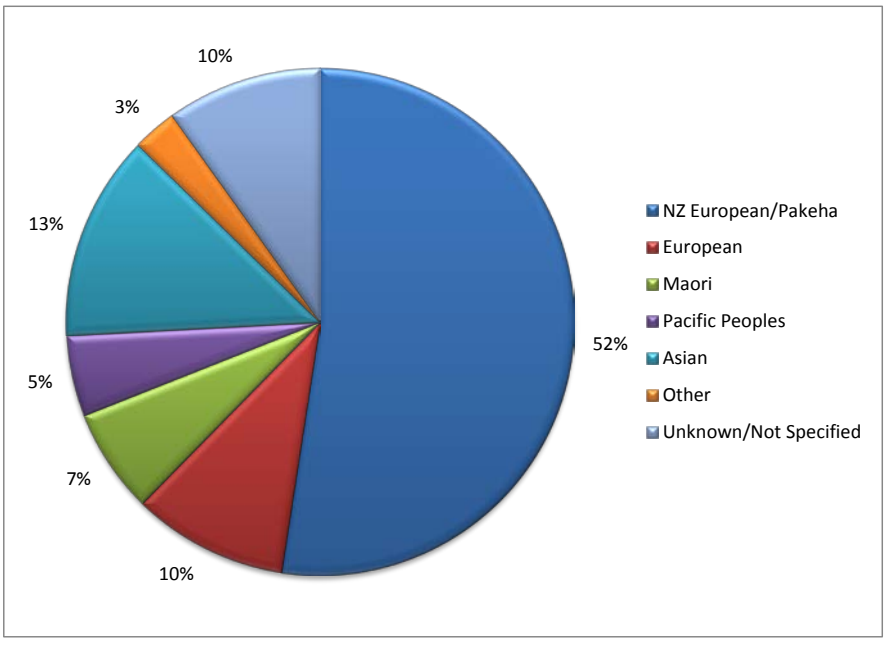
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2016	2015	2014	2013	2012	2011	2010
Female	81.05%	81.65%	81.89%	82.41%	81.95%	81.16%	81.76%
Male	18.95%	18.35%	18.11%	17.59%	18.05%	18.84%	18.24%

REMUNERATION OF EMPLOYEES

Annual remuneration	2016	2015	2014
100,000-109,999	40	37	31
110,000-119,999	29	24	28
120,000-129,999	19	17	12
130,000-139,999	14	8	10
140,000-149,999	15	8	9
150,000-159,999	11	16	9
160,000-169,999	2	9	9
170,000-179,999	8	9	6
180,000-189,999	9	7	9
190,000-199,999	7	12	3
200,000-209,999	5	1	2
210,000-219,999	6	2	9
220,000-229,999	7	5	3
230,000-239,999	3	10	7
240,000-249,999	13	6	11
250,000-259,999	5	6	9
260,000-269,999	7	9	6
270,000-279,999	3	6	
280,000-289,999	6	1	1
290,000-299,999	1	1	2
300,000-309,999	2	2	3
310,000-319,999	3	3	2
320,000-329,999	1		
330,000-339,999			
340,000-349,999	2		
350,000-359,999			
360,000-369,999		1	
370,000-379,999			1
380,000-389,999	1		1
390,000-399,999		1	
400,000-409,999		1	
420,000-429,999			2
440,000-449,999	1		
560,000-569,999	1		
620,000-629,999			
Grand Total	**221**	**202**	**185**

TERMINATION PAYMENTS

During the year ended 30 June 2016, 24 (2015: 4) employees received compensation and other benefits in relation to cessation totalling $498,093 (2015: $138,395). 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 2015/16:

- Hutt Valley DHB continues to exceed the elective surgery health target with 6,101 elective surgeries delivered to the DHB population, 269 more than the target.
- Hutt Valley DHB continues to achieve the better help for smokers to quit (hospital) health target, with 95% of patients who smoke and are seen by a health practitioner offered brief advice and support to quit smoking.
- In Hutt valley DHB, the acute mental health readmission rate continues to decrease.
- Regional Public Health exceeded the target for the percentage of school children receiving Boostrix vaccination and HPV vaccinations in schools.
- 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 children (of both populations) receiving a check.
- Hutt Valley DHB exceeded the target for the percentage of children under 5 years of age enrolled in DHB-funded dental services.
- Hutt Valley DHB met the targets set for hospital quality measures; the number of inpatient falls causing harm, acquired pressure injuries and medication errors continue to decrease. Hutt Valley DHB also exceeded the target for each dimension of the Patient Experience Survey.
- Hutt Valley DHB met targets for percentage of DNA (did not attend) appointments for outpatient first and follow-up specialist appointments.
- Hutt Valley DHB continues to meet the 100% target for 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.
- Hutt Valley DHB met the target for 100% of residential care providers with 3 or more years certification.

MINISTER'S HEALTH TARGETS

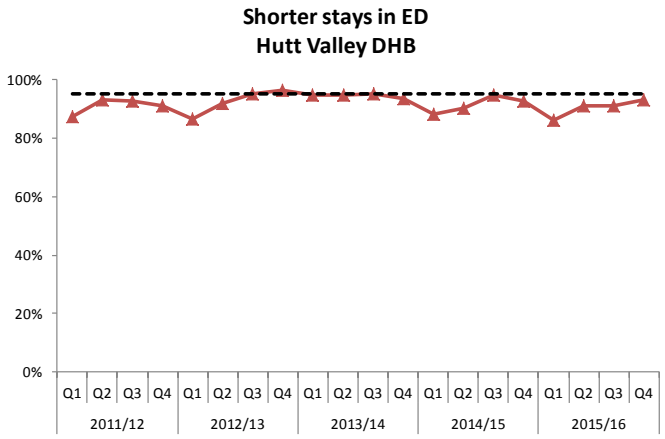
Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. They provide a focus for action.[1] Note the changing vertical (y) axis between graphs and that the 2015/16 performance is the performance for the final quarter.

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%

2015/16 Performance: 93%

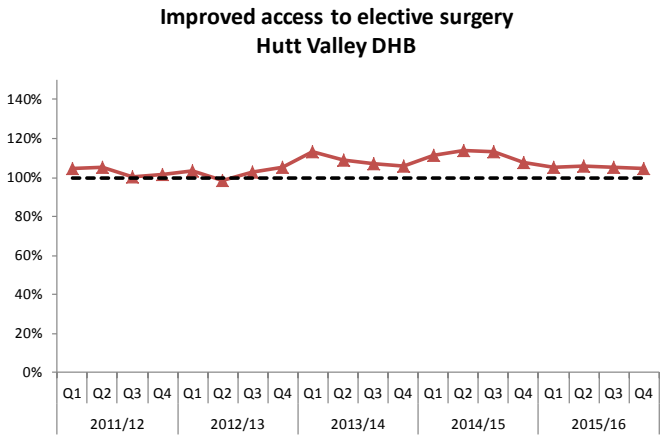


Improved access to elective surgery

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

Target: 5,832 (graph - 100%)

2015/16 Performance: 6,101



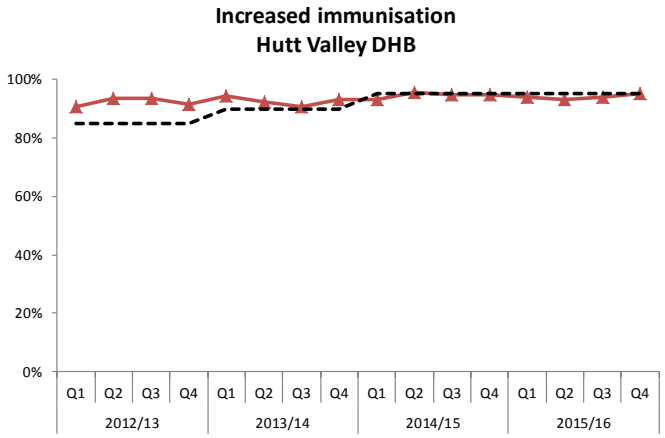
[1] Quoted from the Ministry of Health (http://www.health.govt.nz/new-zealand-health-system/health-targets)

Increased immunisation

85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014.

Target: 95%

2015/16 Performance: 95%

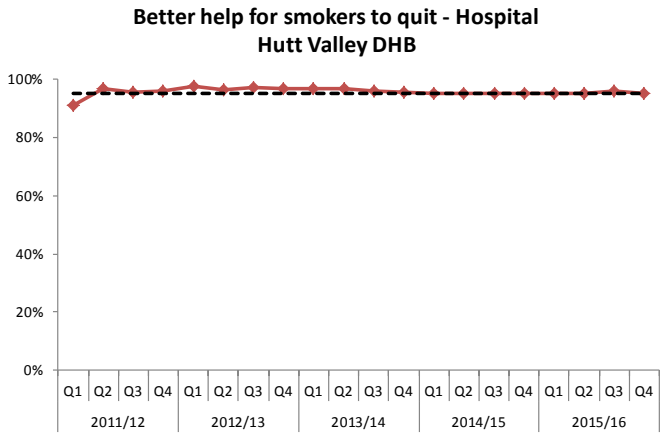


Better help for smokers to quit – Hospital

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%

2015/16 Performance: 95%

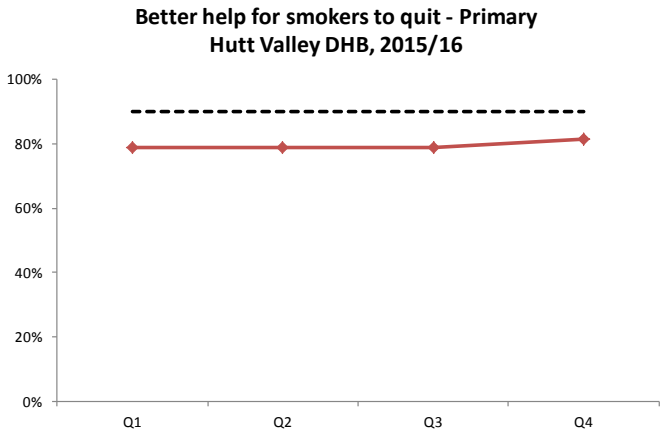


Better help for smokers to quit – Primary care

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.[2]

Target: 90%

2015/16 Performance: 81%



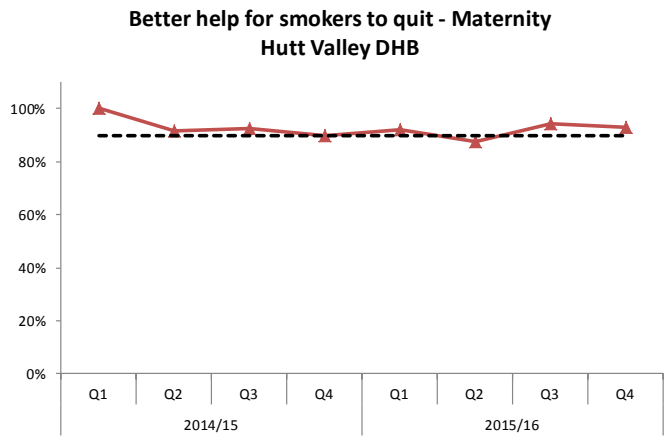
[2] From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking.

Better help for smokers to quit – Maternity

90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Target: 90%

2015/16 Performance: 93%

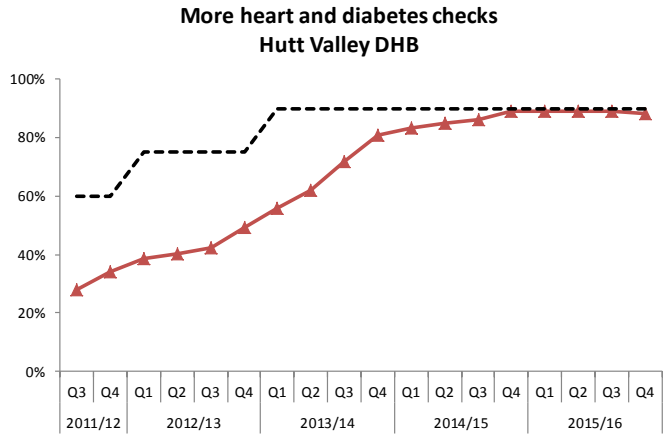


More heart and diabetes checks

90 percent of the eligible population[3] will have had their cardiovascular risk assessed in the last five years.

Target: 90%

2015/16 Performance: 88%

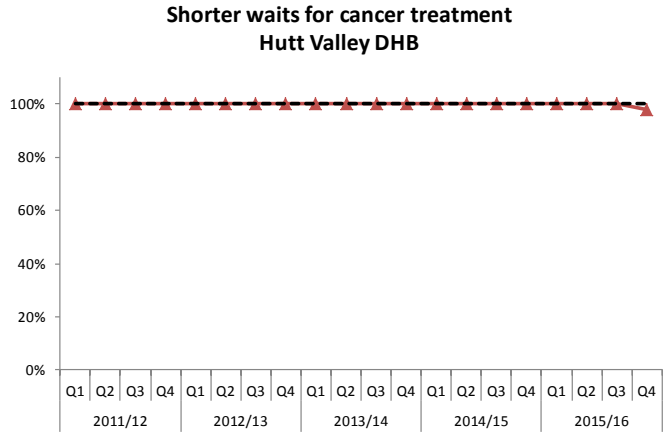


Shorter waits for cancer treatment

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%

2015/16 Performance: 98%



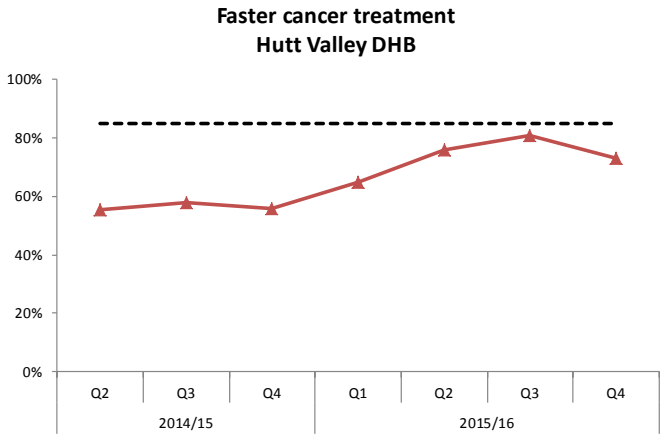
[3] Males of Māori, Pacific or Indian ethnicity aged 35-74 years at the end of the reporting period and enrolled with a PHO; Females of Māori, Pacific or Indian ethnicity aged 45-74 years at the end of the reporting period and enrolled with a PHO; Males of any other ethnicity aged 45-74 years at the end of the reporting period and enrolled with a PHO; Females of any other ethnicity aged 55-74 years at the end of the reporting period and enrolled with a PHO.

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%

2015/16 Performance: 73%



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 nine 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: REDUCED ETHNIC HEALTH DISPARITIES

What difference will we make for our population?

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

Impact measures – The DHB measures progress through:

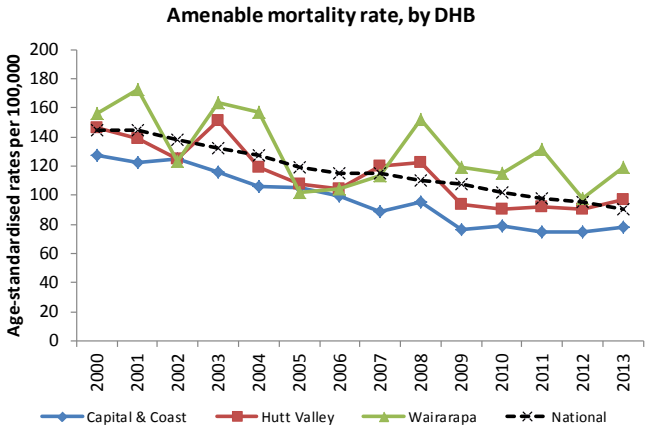
Impact measure: A reduction in amenable mortality rates

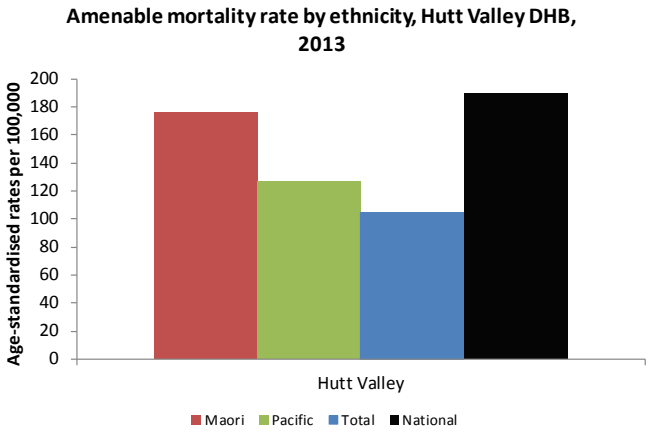
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

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 higher than all ethnicities, indicating that Māori and Pacific are not receiving equitable coverage or quality of healthcare. Māori and Pacific amenable mortality rates in Hutt Valley DHB are lower than the national rate.

The Ministry of Health's Mortality Collection data up to year end 2013 was released in June 2016.





Source: Ministry of Health

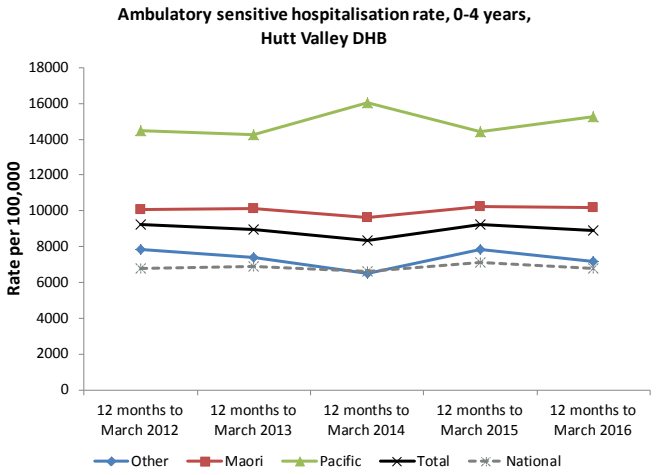
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates[4]

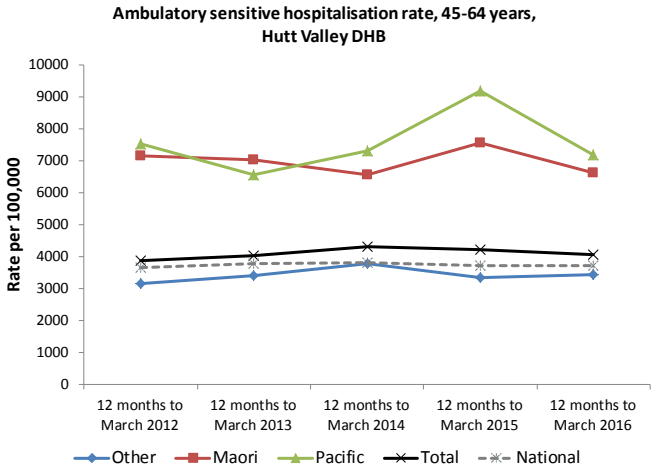
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include, for example, skin infections, dental conditions, asthma, pneumonia, cardiovascular 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, ASH rates amongst Māori and Pacific children (0-4 years) are 1.4 and 2.1 times higher, respectively, compared to Other ethnicities. The ASH rates amongst Māori and Pacific adults (45-64 years) are 1.9 and 2.0 times higher compared to Other adults.

Note that the methodology for this measure was revised by the Ministry of Health in 2015/16. These figures use the revised methodology.





Source: Ministry of Health

[4] ASH rate for 0-74 years as published in the Annual Plan is no longer available. ASH rates are now calculated for the 0-4 and 45-64 years age groups only.

POPULATION HEALTH OUTCOME: ENVIRONMENTAL AND DISEASE HAZARDS MINIMISED

What difference will we make for our population?

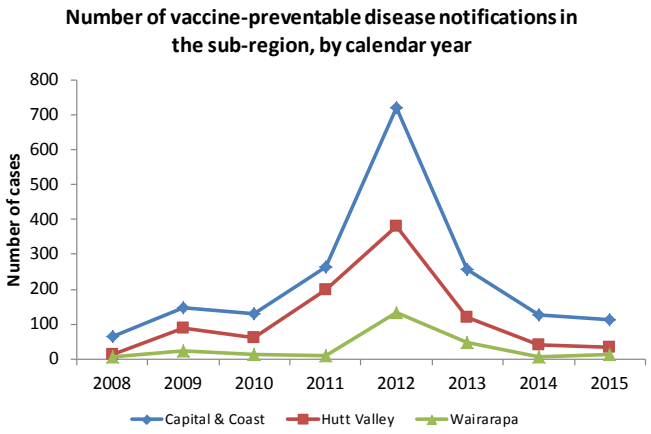
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this Regional Public Health works with Police, councils, and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use.

Measures – The DHB measures progress through:

Impact measure: A decrease in vaccine-preventable disease notifications[5]

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 Hutt Valley DHB, the number of vaccine-preventable disease notifications decreased from 42 cases in 2014 to 34 in 2015. In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will continue to decrease.



Source: Institute of Environmental Science and Research

[5] Includes the following notifiable diseases: Haemophilus influenzae type B, Hepatitis B, Invasive pneumoccocal disease, Measles, Mumps, Pertussis, and Rubella.

Impact measure: An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012, for sales to minors (in the sub-region)

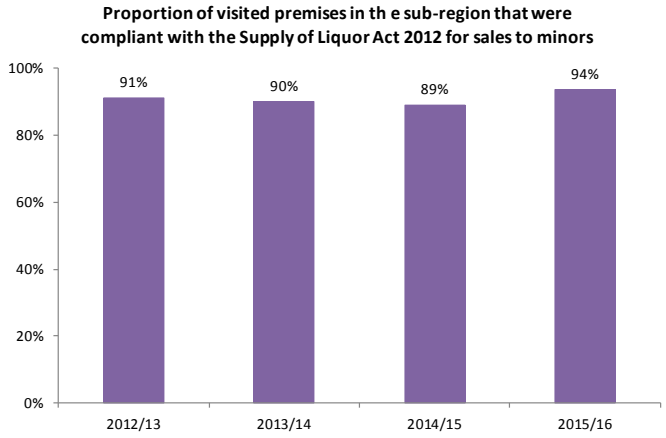
Alcohol is a significant contributor to disease and injury for New Zealanders. Alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime.

In 2007 alcohol consumption was attributed to 5.4% of all deaths for those under 80 years old. In 2004 alcohol accounted for 28,403 years of life lost (disability-adjusted life years – DALYs) representing 6.5% of all DALYs for those under 80 years[6]. Young people, Maori, Pacific peoples and those living in areas of higher socioeconomic deprivation are at greater risk of experiencing harms from alcohol.

Harm reduction strategies include changing both physical and social environments. Effective interventions include regulating the availability of alcohol through minimum legal age of purchase, hours and days of sale restrictions and restriction on the density of outlets.

Controlled purchase operations (CPOs) have been an effective compliance tool over the last ten years, with the national incidence of premises selling to minors declining during this time. Regional Public Health works with Police, volunteers aged 15-17 and the District Licensing Committee to carry out CPOs.

In 2015/16, 94% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors.



Source: Regional Public Health

[6] Ministry of Health (2013). Health loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016. Wellington: Ministry of Health.

POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH: LIFESTYLE FACTORS THAT AFFECT HEALTH ARE WELL MANAGED

What difference will we make for our population?

Lifestyle factors have a significant impact on overall health and well-being and are key contributors to cancer, obesity, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New Zealand using 'disability-adjusted life years' (DALYs) that include both burden from early death and from lives led with disability. There are four key lifestyle factors that drive health loss: smoking (9.1% of health loss), obesity (7.9%), physical inactivity (4.2%) and poor diet (3.3%). Reducing the incidence of these negative lifestyle factors will improve the health of our population.

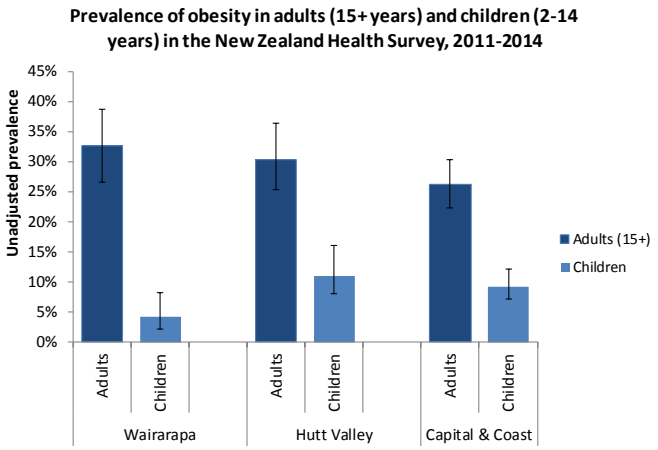
Measures – The DHB measures progress through:

Impact measures: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

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[7].

The most recent NZ Health Survey shows that there is no significant difference in obesity rates across the sub-region. 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.



Source: New Zealand Health Survey, 2011-14. Error bars represent 95% confidence interval.

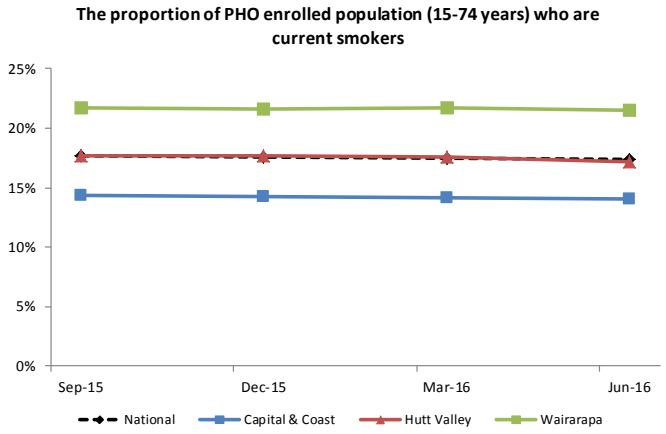
[7] Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health.

Impact measure: A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'

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.

In Hutt Valley DHB, 17% of the PHO enrolled population are recorded as a 'current smoker'.

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



Source: Ministry of Health

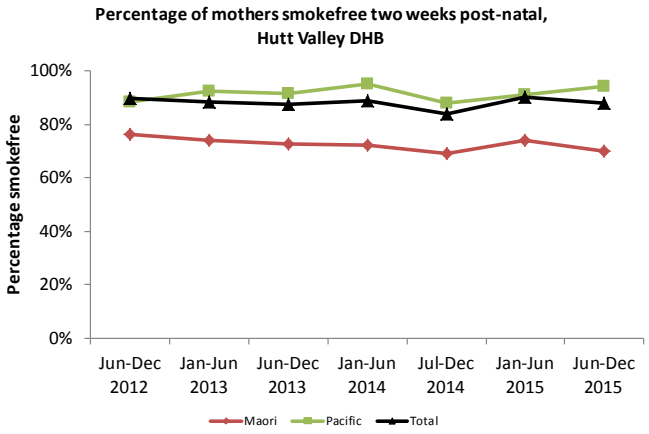
Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions, and tooth decay if they are exposed to cigarette smoke.

Mothers are given smoking cessation advice in hospital, and lead maternity carers provide information about the risks associated with smoking and referrals to smoking cessation providers. By continuing to provide cessation advice and support, we expect that the percentage of mothers who are smokefree two weeks post-natal will increase.

In Hutt Valley DHB, Māori mothers were less likely to be smokefree compared to other ethnicities.

Data for January to June 2016 was not available at time of publication.



Source: WCTO Quality Indicators, Ministry of Health via Trendly

POPULATION HEALTH OUTCOME: CHILDREN HAVE A HEALTHY START IN LIFE

What difference will we make for our population?

A child's circumstances and health can have a lasting effect on their life. Poor health as a child predicts self-rated health and the development of chronic conditions as an adult[8]. For this reason, it important that the DHB provides children and their whānau with high-quality, equitable, and accessible services.

[8] Haas, H. A. (2007). The long-term effects of poor childhood health: An assessment and application of retrospective reports. *Demography, 44*(1), 113-135.

Measures – The DHB measures progress through:

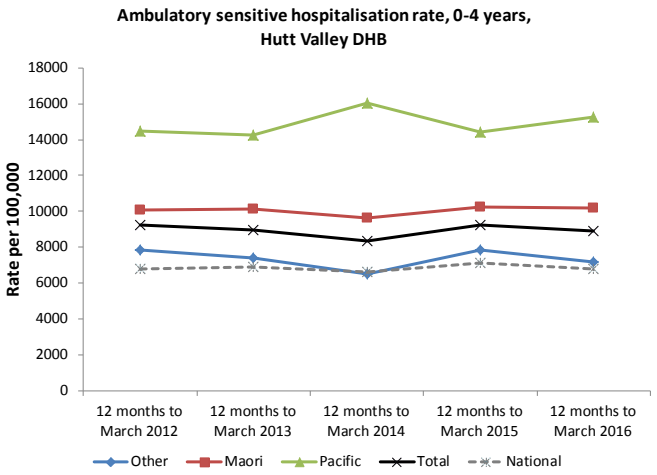
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

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. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, and gastroenteritis.

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, ASH rates amongst Māori and Pacific children are approximately 1.4 and 2.1 times higher, respectively, compared to Other children.

Note that the methodology for this measure was revised by the Ministry of Health in 2015/16. This figure uses the revised methodology.



Source: Ministry of Health

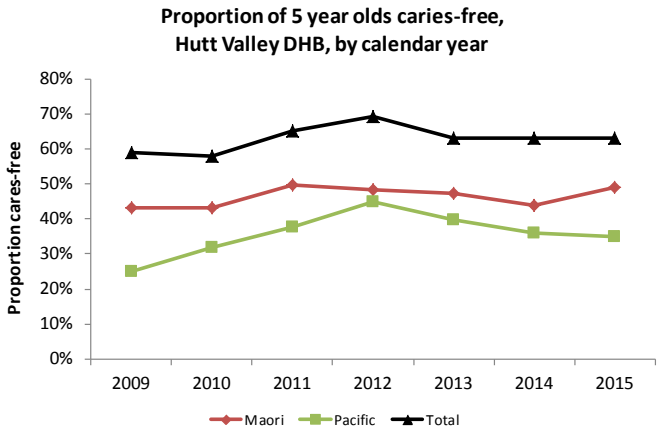
Impact measure: An increase in the proportion of children caries-free at 5 years

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.

In Hutt Valley DHB, the proportion of 5 year olds who are caries-free has been maintained. The proportion of Māori children who are caries-free improved in 2015, although has been declining amongst Pacific children.



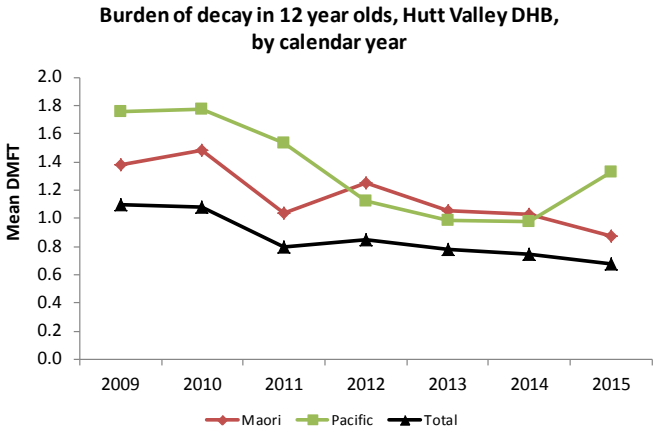
Source: Ministry of Health (Quarterly Reporting Website), Bee Healthy Dental Service

Impact measure: A decrease in the burden of tooth decay 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.

In Hutt Valley DHB, the mean DMFT amongst 12 year olds continues to decrease. Mean DMFT amongst Māori children continues to decline, however in 2015 there was an increase in mean DMFT amongst Pacific children.



Source: Bee Healthy Dental Service

POPULATION HEALTH OUTCOME: LONG-TERM CONDITIONS ARE WELL-MANAGED

What difference will we make for our population?

The New Zealand Burden of Disease Study[9] suggest that over the next decade people will be living longer with more long-term conditions and consequent disability. In response, our health system needs to increasingly focus on the prevention and on-going management of long-term conditions.

[9] Ministry of Health

Measures – The DHB measures progress through:

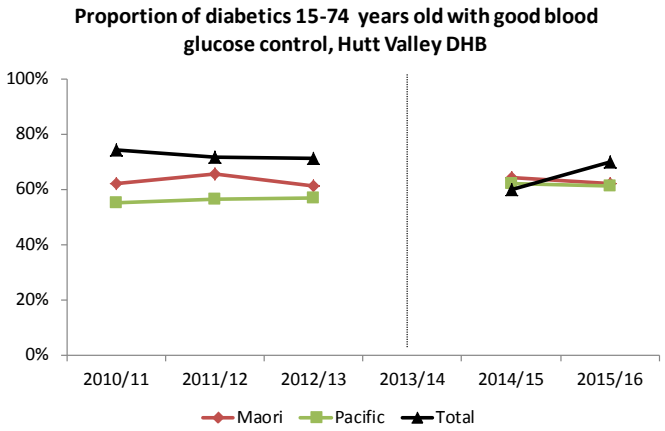
Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

Diabetes is a long-term condition that is caused by the body not being able to control its blood sugar levels properly. Diabetes is associated with kidney failure, eyesight problems, foot ulcers, and cardiovascular disease. However, with good diet and exercise, diabetes can be controlled and the risks associated with diabetes minimised. A lower level of HbA1c in the blood indicates that a person's diabetes is being well-managed.

General Practices in our sub-region are required to have a 'Practice Population Plan' that outlines the services and support that they will provide to diabetics. By improving the quality of care and empowering people with diabetes to look after their health, we expect to see an increase in the proportion of diabetics with good blood glucose control.

In Hutt Valley DHB, the proportion of peoples with diabetes with satisfactory blood glucose control increased. Although, decreased amongst Māori and Pacific diabetics.

Results from 2010/11 through to 2012/13 are as a proportion of diabetics who had an HbA1c tests. The methodology was revised in 2013/14 to be a proportion if all enrolled diabetics. Due to a delay in developing the new methodology, 2013/14 results are unavailable.

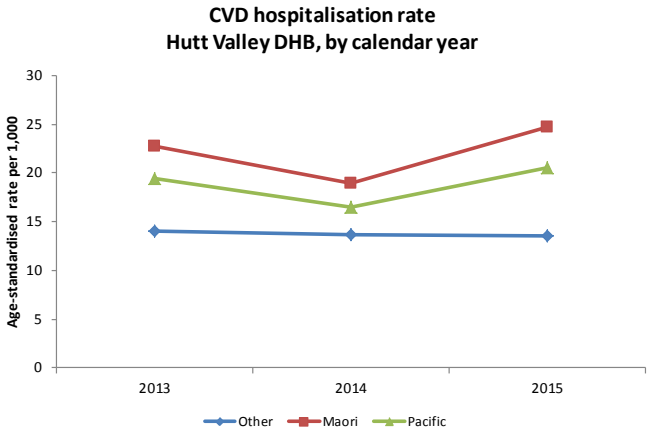


Impact measure: A decrease in the hospitalisation rate for cardiovascular disease

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. 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, the CVD hospitalisation rate increased amongst Māori and Pacific and has been maintained amongst Other ethnicities.



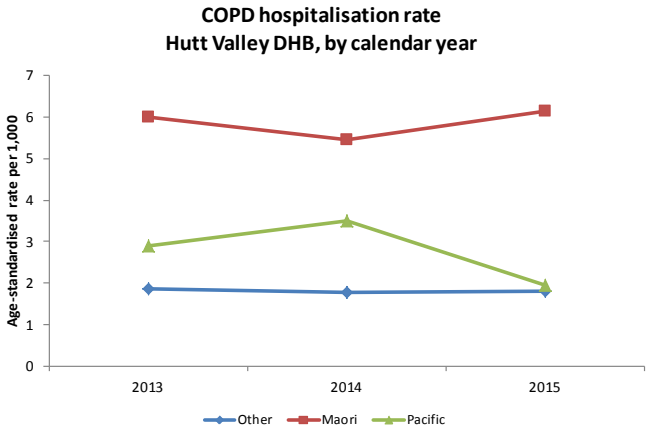
Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the result of damage to the lungs. COPD is most commonly associated with smoking, and although lung damage is permanent, quitting smoking can help to improve COPD symptoms and prevent further damage.

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 COPD hospitalisations for our population will decrease.

In Hutt Valley DHB, the COPD hospitalisation rate for Pacific is on par with Other ethnicities. However, the Māori COPD hospitalisation rate increased in 2015 and is approximately 3.4 times higher than the hospitalisation rate of other ethnicities.



Source: National Minimum Dataset, ICD codes J40-J44, 15+ year olds

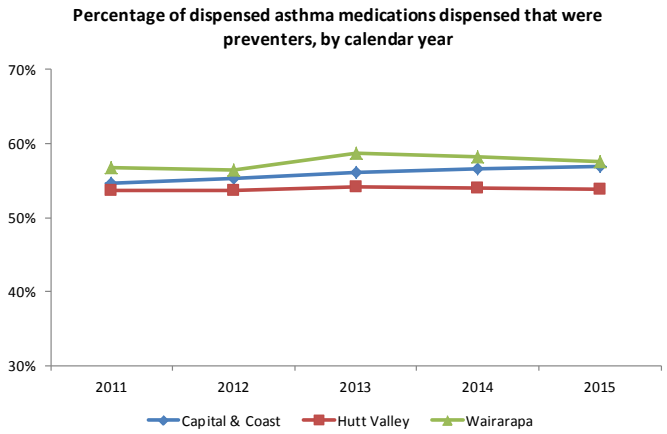
Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers

Asthma occurs when a person's airways tighten and produce more mucous, making it difficult to breathe. It is often caused by pollen, cold air, or respiratory infections. People with on-going asthma generally use a preventer, which reduces the chance that their asthma will be triggered. They can also use a reliever, which they take to reduce their symptoms if they have trouble breathing.

If a person's asthma is well-managed, they should be using their preventer more frequently than their reliever.

A higher percentage of preventers dispensed indicates that asthma is being well-managed. By improving access to primary care, and supporting people to take their long term medications, we expect that people will use more preventers and less relievers.

In Hutt Valley DHB, the proportion of asthma medication dispensed which were preventers has remained at 54% overtime.[10]



Source: Pharmaceutical Claims Data Mart

[10] Earlier figures published in the Annual Plan were based on an incorrect methodology supplied by HQSC. This figure presents revised calculations of the above impact measure.

HEALTH SERVICES OUTCOME: PEOPLE RECEIVE HIGH QUALITY HOSPITAL AND SPECIALIST HEALTH SERVICES WHEN THEY NEED THEM

What difference will we make for our population?

Equitable and timely access to intensive assessment and treatment can significantly improve people'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). 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.

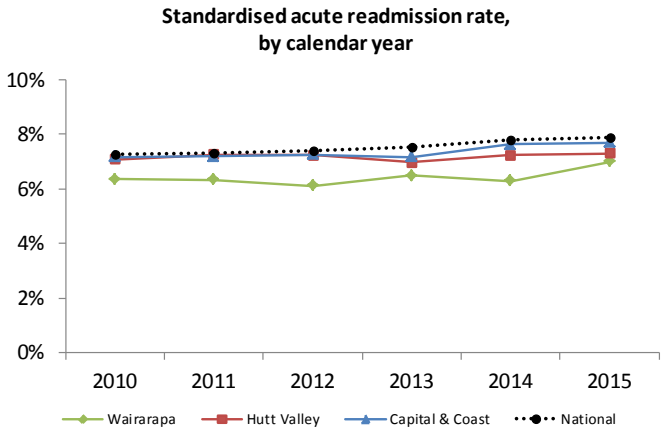
Measures – The DHB measures progress through:

Impact measure: A reduction in the standardised[11] rate of acute readmissions to hospital within 28 days

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

The standardised acute readmission rate has remained at about 7% for Hutt Valley DHB 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 Section 3.3.3), which shows that the effectiveness and efficiency of treatment in hospital has improved.

Note that the methodology for this measure is being revised by Ministry of Health in 2015/16.



Source: Ministry of Health

[11] The standardised acute readmission rate accounts for casemix and population differences between DHBs, in order to improve the comparability of the measure across the sector. Refer to the Ministry of Health website (www.moh.govt.nz) for more information on how this measure is calculated.

Impact measure: Maintain or reduce the age-standardised[12] cancer mortality rate

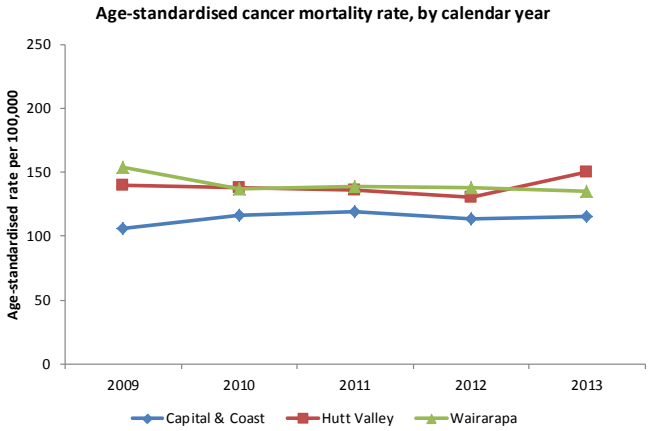
More people are developing cancer, mainly because the population is growing and getting older.

Many cancers can be cured if they're found and treated in time. It is estimated that in New Zealand, about one person in every three who gets cancer is cured.

By screening women for breast and cervical cancer, and providing timely cancer treatment, we expect that the cancer mortality rate will decrease.

In Hutt Valley DHB, the age-standardised cancer mortality rate increased during 2013.

The Ministry of Health's Mortality Collection data up to year end 2013 was released in June 2016.



Source: Ministry of Health Mortality dataset

[12] Age-standardisation accounts for differences in the age structure between populations and changes in the age structure over time. The age-standardised rate estimates what the rate would be if the age structures were the same. See also Section 3.2.2.

HEALTH SERVICES OUTCOME: PEOPLE RECEIVE HIGH QUALITY MENTAL HEALTH SERVICES WHEN THEY NEED THEM

What difference will we make for our population?

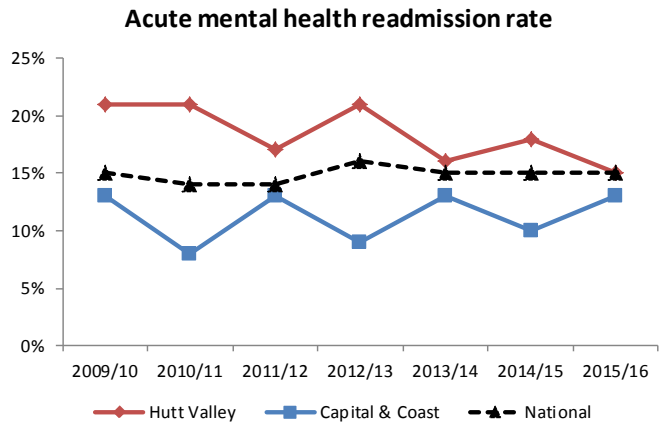
Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act.

Measures – The DHB measures progress through:

Impact measure: A reduction in the rate of acute readmissions to inpatient mental health services within 28 days

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

In Hutt Valley DHB, the acute mental health readmission rate has decreased from 2012/13 and was on par with the national readmission rate.



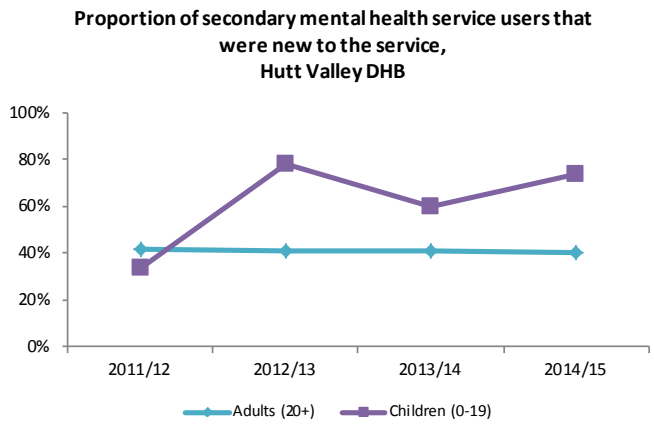
Source: Ministry of Health

Impact measure: An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years)

This measure indicates the responsiveness of secondary mental health services to people who require secondary mental health care for the first time.

By ensuring that existing users of secondary mental health services only receive these services for as long as they need them, we can increase our capacity and remove access barriers for new service users. As a result, we expect that the proportion of service users that are new will increase.

In Hutt Valley DHB, the proportion of children who are new users of secondary mental health has increased while the proportion of adults has remained comparatively stable.



Source: Ministry of Health

HEALTH SERVICES OUTCOME: RESPONSIVE HEALTH SERVICES FOR PEOPLE WITH DISABILITIES

What difference will we make for our population?

Disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities. In 2013, an estimated 24% of people living in New Zealand were identified as disabled. National estimates by age and gender applied to the sub-region indicate a disabled population of approximately 109,000 people: 11,000 in Wairarapa (27%), 33,000 in Hutt Valley (24%) and 65,000 in CCDHB (23%). The DHB has a responsibility to provide responsive and appropriate health services to people with disabilities.

Measures – The DHB measures progress through:

Impact measure: An increase in the proportion of patients and clinicians that found the Health Passport useful (as a percentage of patients and clinicians that responded to an evaluation survey and reported using the Health Passport) The Health Passport is a document that a person takes with them when they use medical services. The Health Passport contains information about the person that they would like hospital staff to know. For example, a Health Passport includes how a person would like to be communicated with, their medical conditions, what medications they are allergic to, and their religious/spiritual preferences. An increase in the proportion of people that find the Health Passport useful will indicate that the Health Passport is achieving its aims and improving the quality of care of patients when they are in hospital.	Measure to be developed

HEALTH SERVICES OUTCOME: IMPROVE THE HEALTH, WELL-BEING AND INDEPENDENCE OF OUR REGION'S OLDER PEOPLE

What difference will we make for our population?

Our ageing population will increase pressure on the health system. National estimates suggest that the increase in health expectancy over the period 2006–2016 will be less than the corresponding increase in life expectancy. In other words, people will live longer, and they will live longer in good health, but they will also live longer in poor health, with multiple comorbidities, functional impairments and frailty. The DHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population.

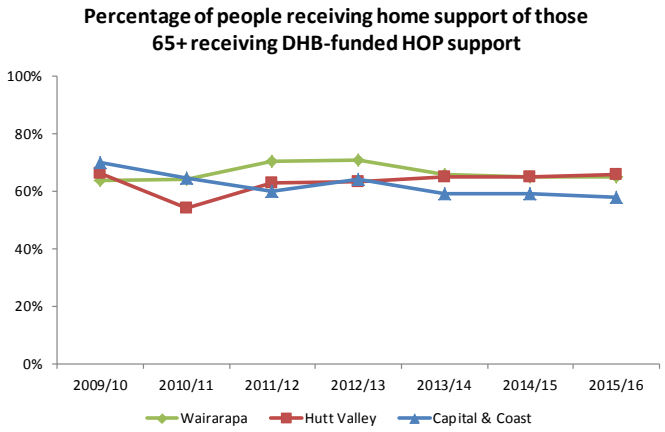
Measures – The DHB measures progress through:

Impact measure: 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)

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[13] found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy." This shows the importance of helping older people to maintain their independence.

By providing comprehensive and high-quality home-support services, we expect there will be an increase in the proportion of people receiving home support rather than in residential care.

In Hutt Valley DHB, the proportion of patients receiving home based support services has been maintained.



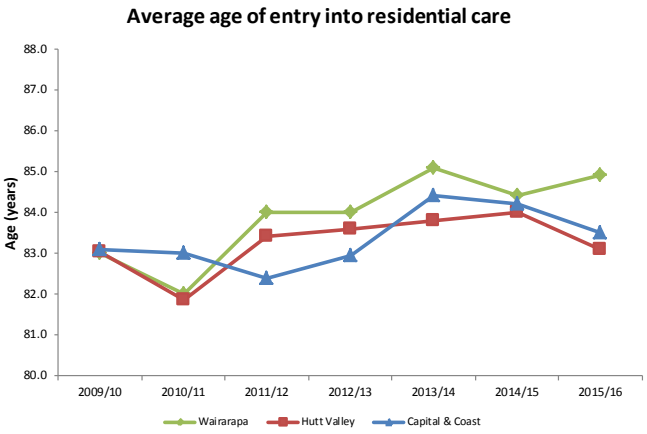
Source: Health of Older People regional benchmarking

[13] Hambleton, P., Keeling, S., & McKenzie, M. (2008). Quality of life is ... : The views of older recipients of low-level home support. *Social Policy Journal of New Zealand, 33*, 146-162.

Impact measure: Maintain or increase the average age of entry into residential care

An increase in the average age of entry into residential care would indicate that older people are remaining independent and staying at home for longer. By providing quality home support services to those who need them and high-quality and timely health services for older people to help them maintain their health, we expect that the average age of entry into residential care will increase.

In Hutt Valley DHB, the average age of entry into residential care is 83 years.



Source: Health of Older People regional benchmarking

STATEMENT OF PERFORMANCE

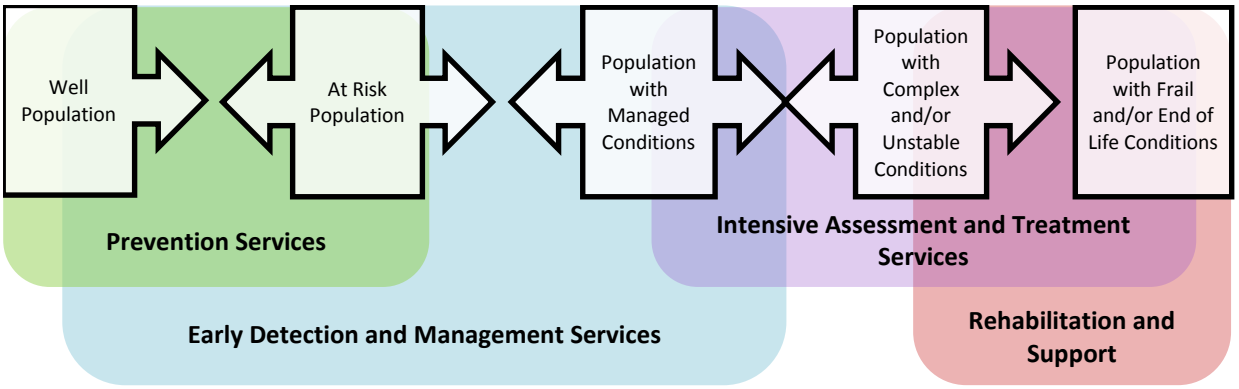
OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

One of the functions of this Annual Report is to evaluate the effectiveness of the decisions we make on behalf of our population, we do this by evaluating the services ('outputs') funded and provided in 2015/16.[14]

Our four Output Classes and their related services are:

1. Prevention Services
   - Health protection and monitoring services
   - Health promotion services
   - Immunisation services
   - Smoking cessation services
   - Screening services
2. Early Detection and Management Services
   - Primary care (GP) services
   - Oral health services
   - Pharmacy 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



[14] DHB performance is also measured by the Ministry of Health through quarterly reporting against the Performance Monitoring Framework. A copy of previous years' Annual Reports on Output Class delivery and achievement can be found on our DHB website

The outputs reflect a picture of health service activity across the whole of the Hutt Valley health system. We choose outputs that make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes that we are seeking to achieve over the longer term. These outputs also cover areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. To give a representative picture of our performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care and are applicable to all DHBs.

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
DHB of Domicile	DoD
DHB of Service	DoS

Ethnicity	Abbreviation
Māori	M
Pacific	P
Total (all ethnicities)	T

We have identified new measures in 2015/16 with a † symbol. These measures were introduced in the 2015/16 Annual Plan and did not appear in the 2014/15 Annual Report. Our 2014/15 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.

Targets and Estimates

Some of our performance measures are demand-based, and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our expected 2015/16 performance (indicated with 'Est.') based on historical trends.

Appropriation Reporting

	2014/15 Actual $000	2015/16 Budget $000	2015/16 Actual $000
Appropriation revenue	357,834	365,331	365,331

The Appropriation revenue received by Hutt Valley DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

OUTPUT CLASSES: FINANCIAL PERFORMANCE ($000s)

Revenue	2014/15 Actual	2015/16 Budget	2015/16 Actual
Prevention	22,004	21,267	21,918
Early Detection and Management	117,908	138,601	152,304
Intensive Assessment and Treatment	260,649	258,327	269,424
Rehabilitation and Support	61,787	55,412	55,489
Total	**462,348**	**473,607**	**499,495**

Expenditure	2014/15 Actual	2015/16 Budget	2015/16 Actual
Prevention	22,061	22,088	22,154
Early Detection and Management	108,343	126,210	141,202
Intensive Assessment and Treatment	280,924	277,564	288,314
Rehabilitation and Support	58,560	54,466	54,786
Total	**469,888**	**480,330**	**506,458**

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[15]: Ask all patients whether they smoke and document their response; if the patient smokes,

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

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	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Public health protection and regulatory services	The number of disease notifications investigated in the sub-region[16]	V	1,955	Est. 1,797	1,692	Not achieved
	The number of environmental health investigations in the sub-region	V	562	Est. 684	988	Achieved
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	354	Est. 277	142	Not achieved
Health promotion and preventive intervention services	Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	V	29	Est. 25	30	Achieved
	The percentage of infants fully or exclusively breastfed at 3 months[†17]	C		≥60%	50.4%	Not achieved
	Number of new referrals to Public Health Nurses in primary/intermediate schools[18]	V, DoS	2014: 934	Est. Total: 898	932	Achieved

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

[17] This measure is based on all WCTO providers (not just Plunket).

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

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The number of adult referrals to the Green Prescription programme in the sub-region†	V, DoS		Est. 3,904	3,734	Not achieved
Immunisation Services	**Integrated Performance & Incentive Framework (IPIF) Health Start:** The percentage of two year olds fully immunised	C	95%	≥95%	95%	Achieved
	Health Target: The percentage of eight month olds fully vaccinated	C	93%	≥95%	95%	Achieved
	The percentage of Yr 7 children provided Boosterix vaccination in the schools in the DHB[19]	C, DoS	79%	2015: ≥70% 2016: ≥70%	81%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	68%	≥65%[20]	74%	Achieved
Smoking cessation services	**Health Target:** The percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	C	New methodology	≥90%	81%	Not achieved
	Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	95%	≥95%	95%	Achieved

[19] Targets and performance are for the calendar year to align with school year.
[20] Target aligned to national target.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	Health Target: The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking†	C, DoS	90%	≥90%	93%	Achieved
Screening services	The percentage of eligible children receiving a B4 School Check	C	High dep[21]: 90%	≥90%	High dep: 90%	Achieved
			T:90%		T: 90%	Achieved
	IPIF Health Adult: The percentage of eligible women (25-69 yrs) having cervical screening in the last 3 years	C	M: 68%	≥80%	M: 69%[22]	Not achieved
			P: 70%		P: 71%	Not achieved
			T: 77%		T: 76%	Not achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 66%	≥70%	M: 67%	Not achieved
			P: 66%		P: 65%	Not achieved
			T: 72%		T: 73%	Achieved

Comments on Performance

Immunisation services

To continue the achievement of our immunisation Health Targets, effective communications with OutReach is paramount. OutReach continues to vaccinate an average of five children a week. The numbers of referrals are between 10 and 20 weekly. The coordinator continues to prompt practices about the timeliness of vaccinations, the need to recall within tight timeframes, as well as early referral to OIS to achieve the eight month olds fully vaccinated target.

[21] 'High dep' refers to children living in high deprivation areas: See Atkinson, J., Salmond, S., & Crampton, P. (2014). *NZDep2013 Index of Deprivation*, Wellington: Department of Public Health, University of Otago.

[22] 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.

Smoking cessation services

From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking. This requires more pro-active follow-up and advice for all people, rather than opportunistic interventions when patients are attending an appointment. Te Awakairangi Health Network has improved performance by 2.5% from Quarter 3 to Quarter 4 over the 2015-2016 year, ending the year on 81.4% of enrolled smokers offered brief advice and support to quit smoking. Cosine Ropata results have been inconsistent and finished on 85% in Q4.

A workshop led by Dr John McMenamin, MOH Clinical Health target champion, was well attended by Hutt Valley and other PHOs. The new Regional Stop Smoking Service is based at Kokiri Marae in Petone and will be working with practices to promote quit attempts.

Screening services

The Hutt team have met both the B4 School Check targets for this financial year. Staff continue to home visit/door knock to locate high needs families with success. With the reduction in state housing in some areas, families have moved away meaning finding children and meeting the target has been more of a challenge this year.

Health promotion and public health services

The target for the number of disease notifications investigated in the sub-region is an estimate based on the two previous year's disease notification/investigation data. For the 2015/2016 year, there was a decrease in the number of notified communicable diseases (1,692) based on the number of investigations in the previous year. The primary purpose of notification is to trigger an appropriate public health response to prevent further illness. The secondary purpose is for disease surveillance, to predict, observe and minimise the harm caused by an outbreak or epidemic/pandemic situation.

This year, fewer control purchase operations were conducted. This is principally to reduce the financial cost of conducting control purchase operations outside of normal business hours.

In the sub-region, the Public Health Nurse (PHN) new referrals target does not include the throat swabbing work undertaken by PHNs in Porirua in Capital & Coast DHB. Some of the throat swabbing work had been moved to community health workers (CHWs) and this reverted back to PHNs when the CHWs resigned. The PHNs in Porirua have also carried out the supply of antibiotics for GAS+ patients; this does not occur in Hutt Valley and Wairarapa DHBs.

In 2015/2016, the Ministry of Health funded the development of a holistic model of care to reduce Sudden Unexpected Death in Infancy (SUDI) and address SUDI risk factors in the Hutt Valley. The objective is to support the Hutt Valley DHB to develop a holistic approach to SUDI prevention and meet the requirements of the 2015/16 Māori Health Plan. The plan covered a wide range of providers and service delivery methods, including a Targeted community breastfeeding support service.

The Lactation Consultant saw 158 clients with 93% still breastfeeding at discharge. The Breastfeeding Support Service aims to target Maori, Pacific and teen mothers.

- 39.24% were Maori;
- 17.88% were Pacific Island;
- 14.55% were teenagers.

The Green Prescription referral target was increased by approximately 25% from the 2014/15 year and the new referral target was achieved. Increased promotion of the GRx programme is indicated. Within this result 91% (453/500) of the GRxPlus referral target for the year was achieved.

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	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Primary care services	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	140,552	≥98%	98%	Achieved
	The rate ratio of nurse and GP visits by high need patients versus non high need patients[23][24]	C, DoS	1.09	≥1.12	1.10	Not achieved
	The percentage of practices with a current Diabetes Practice Population Plan†	Q, DoS		50%	32%	Not achieved
	Health Target: The percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	89%	≥90%	88%	Not achieved
	The number of new and localised Health Pathways in the sub-region†	Q		≥150	172	Achieved
	The average number of users (per month) of the Health Pathways website†	V	536	≥1,000	1,375	Achieved
Oral health services	The percentage of children under 5 years enrolled in DHB-funded dental services[25]	C, DoD	2014: 55%	2015: ≥85% 2016: ≥85%	2015: 96%	Achieved
	The percentage of adolescents accessing DHB-funded dental	C, DoD	2014: 73%	2015: ≥85%	2015: 73%	Not achieved

[23] 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.

[24] This figure is for Te Awakairangi Health Network only and is methodologically consistent the Annual Plan and previous publications.

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

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	services			2016: ≥85%		
Pharmacy services	The number of initial prescription items dispensed†	V, DoS		Est. 1,566,000	1,569,032	Achieved
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item†	C, DoD		Est. 80%	81%	Achieved
	The number of people registered with a Long Term Conditions programme in a pharmacy†	V, DoS		Est. 6,000	5,828	Not achieved
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy†	V, DoS		Est. 200	200	Achieved

Comments on Performance

Primary care services

The DHB has maintained the percentage of DHB domiciled population that is enrolled in practices within the Hutt Valley DHB area. During 2015/2016, the DHB funded the Practice Sustainability Programme through Te Awakairangi Health Network. The aim of this programme was to support practices seeking to transition to new and more sustainable arrangements. The project focuses on facilitating and supporting practice-led change, reviewing and changing models of care. The focus will improve both acute care and long term conditions care, facilitating changes that assist the practice to liberate capacity and as a result ensure better access to nurse and GP visits for high needs patients.

The DHB continually monitors the health care provided to the populations that are known to have poorer outcomes, in particular Māori, Pacific and lower socio-economic groups through the Equity Monitoring Indicators.

The Diabetes Practice Population Plan target was not achieved, partly due to a protracted negotiation period. The PHOs have agreed to a target of 100% by 30 September 2017.

Hutt Valley DHB achieved slightly under the target for the CVD Health Target. The PHOs have continued to support general practices to achieve the target by providing feedback on performance and IT support to ensure that all eligible individuals are encouraged to get a check when due.

To achieve the Health Pathways targets there have been more established pathway localisation and development processes, as well as a continually expanding network of engaged collaborators across primary and secondary care has contributed to exceeding the target.

Based on achieving the average number of users (per month) of the Health Pathways website, and although not formally assessed, the assumption is that the information offered by Health Pathways meets the needs of primary care practitioners and that their use help clinicians be more effective during consultations and when making referrals.

Oral health services

The target for the percentage of children under 5 years enrolled in DHB-funded dental services was achieved. Achieving the target is the outcome of working in collaboration with PHOs to identify children not enrolled in the dental service and automatically enrolling preschool children in this service. However, families are given the option to 'opt out' of enrolment in the service.

Over 97% of year 8 students were transferred by the DHB to dentists who hold the combined adolescent contract. There is no audit process in place to measure if individual dentists are doing all they can to examine the children referred to them. In Hutt Valley DHB, there is multi-agency engagement to promote the uptake of the free dental service for 0-18 year olds across the community.

Pharmacy services

The number of people registered with a Long Term Conditions programme in a pharmacy is reflective of the national trend. Improved access to primary and secondary care information about patient conditions will enable pharmacies to more easily assess risk and select patient needing the higher level of care that this service would provide.

There has been steady uptake in the number of people participating in the Community Pharmacy Anticoagulant Management (CPAM) service and some pharmacies are now at their maximum contracted volume. The DHB continues to encourage pharmacies to work with GPs to carefully select the patients who will benefit most from this higher cost service. Some pharmacies are at their maximum contracted volume. The DHB continues to encourage pharmacies to work with GPs to carefully select the patients who will benefit most from this higher cost service.

The total number of initial prescriptions and percentage of DHB domiciled population who were dispensed at least one prescription item are descriptive measures of volumes only. These measures are not the focus for service improvement or improving health status.

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	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T, DoS	91%	≥95%	93%	Not achieved
	Health Target: The number of surgical elective discharges	V, DoD	5,405	≥5,832	6,101	Achieved
	The standardised[26] inpatient average length of stay (ALOS) in days, Acute[27]	T, DoST,	4.04	≤2.47	2.48	Not Achieved
	The standardised inpatient average length of stay (ALOS) in days, Elective	DoS	3.17	≤1.59	1.62	Not Achieved
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	2.11	≤2.2	2.0	Achieved
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	0.4[28]	<0.5	0.3	Achieved
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	3.37	<3.3	3.1	Achieved
	The weighted average score in the Patient Experience Survey[29†]	Q, DoS		>8.0	Communication: 8.2 Coordination: 8.4 Partnership: 8.3 Physical and Emotional Needs: 8.5	Achieved

[26] Standardised to diagnosis-related group (DRG) and co-morbidity/complication codes. See the Ministry of Health website (www.moh.govt.nz) for more information about how this is calculated.

[27] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2015 (2014/15 baseline) and 12 months ending March 2016 (2015/16 performance).

[28] This measure was not reported as a rate per 1,000 in the previous annual report.

[29] In this measure, patients rate aspects of their hospital visit, with 10 being the best possible score. A person's age and gender affects how they respond in the Patient Experience Survey. The weighted score accounts for differences in the age and gender structure between DHBs to allow comparison.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	7.2%	≤7.2%	7.0%	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments†	Q, DoS	7.9%	≤8.5%	8.1%	Achieved
Cancer services	The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	T, DoD	100%	100%	99.8%	Not achieved
	Health Target: The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred[30]	T, DoD	56%	≥85%	73%	Not achieved
Mental health and addictions services	The number of people accessing secondary mental health services	V	T: 6,166	Est. 6,070	T: 6,297	Achieved
	The percentage of people accessing secondary mental health services†	C		≥4.2%	4.4%	Achieved

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

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks[31]	T, DoS	87%	≥95%	41%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	97%	≥95%	76%	Not achieved
	The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission	Q, DoS	41%	≥46%	36%	Not achieved
	The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge	Q, DoS	39%	≥49%	38%	Not achieved

Comments on Performance

Medical and surgical services

In 2015/16, the shorter waits in emergency departments Health Target was not achieved. However, there is steady growth in the right direction and improvements have been seen with active work streams, an increase in workforce and service improvement.

Hutt Valley DHB is increasing year on year on the number of patients who are able to be provided elective surgery through the efficient use of our resources.

[31] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2015 (2014/15 baseline) and 12 months ending March 2016 (2015/16 performance).

Despite not achieving the acute average length of stay for 2015/16, there has been significant improvement from the previous year (3.17) as a result of a concerted project on average length of stay in our Medical Ward. This has meant improvement in processes, communication with all workforces and a focus on 'valuing patient's time'. There has been a specific project focusing on stroke and improving models of care with consistent clinician and early transfer to rehab. This has shown a reduction in length of stay for stroke patients and improved outcomes.

U-book is the electronic portal whereby patients are able to book their own first specialist outpatient appointments online. Whilst this was introduced some time ago, there has been a noticeable increase in the number of patients using this system to choose the appointments that fit with their schedule. The Pacific team continues to target the under 15s, while the Maori Health team targets specific services such as paediatric, gynaecology, audiology and ENT. U-Book has now started to be used for follow-up appointments and this will enable the DHB to further reduce DNAs.

The DHB achieved all quality targets for the 2015/16 financial year. The falls prevention working group continues to actively introduce and monitor falls prevention improvements to reduce patient harm from falls in the hospital. The Guideline Implementation Pressure Injury Group continues to develop and monitor pressure injury prevention initiatives in order to prevent pressure injuries developing for patients whilst in hospital care. The Medication Safety working group continues to work on initiatives that reduce medication errors within the hospital.

Understanding and enhancing the experience of patients in our hospital is a priority, the National Patient Experience survey is one way that helps us review our performance in this area.

Cancer services

The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy, is continually being monitored by Capital & Coast DHB as the service provider. Palliative patients are having less priority than curable patients and this appears to be related to volume.

In relation to the faster cancer treatment Health Target, there has been a greater focus on the triaging clinician noting a high suspicion of cancer and to be seen within two weeks. We expect to achieve the 85% target in the next financial year.

Mental health and addictions services

Hutt Valley DHB met the target number of people accessing secondary mental health services. Increased access occurred for the 20-64 years and 65+ year population groups

The target for the percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks is not achieved due to current staff capacity not meeting the demand to treat individuals. The Infant, Child, Adolescent and Family mental health service (ICAFS) reports that 3 FTE clinical positions are required but there is no funding available. However, in early 2016 the 3DHB Mental Health, Additions and Intellectual Disability (MHAID) service have made an agreement for the local PHO Primary Mental Health to assist them with managing the demand.

Agreement has been confirmed to engage Te Awakairangi Health Network to provide treatment to 25 cases that were waiting for treatment in the Hutt Child and Adolescent Mental Health Service (CAMHS &ICAFS). This has now commenced. Further work on the Choice appointment process and acute flow is underway. Improved integration with primary care providers is also underway.

The target for the percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks is not achieved due to two sub regional/regional youth NGO AOD services inaccurate reporting in early 2015 but has improved with closer monitoring by SIDU.

The percentage of people admitted to an acute mental health inpatient service that were seen by the mental health community team in the 7 days prior to the day of admission is an area that has been identified as a KPI focus area for the service for this year.

The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge has been identified as a KPI focus area for the coming year. There is a local goal of 95% set for post discharge contact. We are currently developing service wide protocols to ensure clients are seen within 7 day timeframes. These will include:

- A whiteboard (daily meeting) process
- Developing daily/weekly team level reports that show where the teams are tracking
- Reviewing the service operations manuals and clarifying rules of engagement.
- Reviewing the data quality
- Incorporating a DNA process

This Project commenced during 2015/16.

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	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 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	C, DoS	100%	100%	100%	Achieved
	The total number of InterRAI assessments	V, DoS	1,481	Est. 3,460[32]	3,362[33]	Not achieved
	The number of people 65+ who are being supported to live at home[†]	V, DoS		Est. 1,538[34]	1,552	Achieved

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

[33] 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.

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

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home†	C, DoS		≥ 65%	66%	Achieved
	The number of subsidised aged residential care bed days[35]	V, DoS	296,913	Est. 314,029[36]	295,905	Not achieved
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	94%	≥ 95%	100%	Achieved
Disability services	The number of Disability Forums	V	4	HVDHB: 1 3DHB: 1	HVDHB: 1 3DHB: 1	Achieved
	The number of sub-regional Disability Newsletters†	V		6	8[37]	Achieved
	The total number of hospital staff that have completed the Disability Responsiveness eLearning Module†	Q		300	77	Not achieved
	The total number of Disability Alert registrations[38†]	Q		3,400	2,042	Not achieved

Comments on Performance

Health of Older People Services

The 100% target for 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 continues to be achieved.

The total number of InterRAI assessments is a descriptive measure of volumes only and is not the focus for service improvement or improving health status. The DHB is satisfied that all people being referred for an interRAI assessments are receiving them and that these assessments are informing their care plans. The 2015/16 result shows the total number of InterRAI assessments completed in the national interRAI data

[35] Subsidised bed days are any DHB-funded bed days including top-up clients and people paying less than the maximum client contribution.

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

[37] The form of communication of the sub-regional disability newsletters has changed and is an equivalent to a newsletter.

[38] It is estimated that 23% of the DHB's population has a disability. Disability Alerts help clinicians to identify and respond to the needs of the patients with disabilities. By increasing the number of Disability Alerts, we can improve the quality of care for our patients with disabilities. In addition, Disability Alerts allow us to track outcomes (e.g., length of stay) for patients with disabilities so that we can identify areas in which we need to focus or improve.

warehouse. These include RAI-HC & Contact assessments, created in each DHB's office including assessments transferred out of office. The result for 2015/16 is lower than the target because the method of measuring the number of assessments also included reviews and reassessments which are not recorded in the national data warehouse.

There are increased numbers of older people who are being supported to live at home. This is in line with our strategy and investment made in enabling people to stay at home. In keeping with the strategy of enabling people to stay at home the result of the number of subsidised aged residential care bed days is positive especially combined with the increase of those supported at home.

Having 100% facilities with 3 or more years certification is a first for the Hutt Valley. We are working with facilities to increase the number of facilities with a 4 year accreditation.

Disability services

In Hutt Valley DHB, eLearning was pulled for one week due to a transition to a new eLearning model. The Disability Responsiveness eLearning Module eLearning is not mandatory.

Some patients with Disability Alerts have passed away. Taking their alerts out of the system has reduced the total number of alerts.

FINANCIAL STATEMENTS

CONTENTS

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Revenue				
Operating Revenue	2	498,797	472,507	461,120
Interest		698	1,100	1,228
Total Income		**499,495**	**473,607**	**462,348**
Expenditure				
Personnel Costs	3	165,779	166,270	164,759
Depreciation, Amortisation & Impairment expense	10-11	13,158	13,258	12,334
Outsourced Services		19,333	17,874	14,597
Clinical Supplies		23,799	24,548	25,642
Infrastructure and Non-Clinical expenses		14,444	11,937	13,701
Other District Health Boards		89,149	86,056	83,454
Non-Health Board Providers		165,547	143,232	140,314
Capital Charge	4	7,622	7,792	7,289
Finance costs	5	3,826	3,851	3,970
Other expenses	6	3,801	5,512	3,828
Total Expenditure		**506,458**	**480,332**	**469,888**
Net (deficit) / surplus		**(6,963)**	**(6,725)**	**(7,540)**
Other comprehensive revenue and expense				
Gain on property revaluations		-	-	11,534
Total comprehensive revenue and expense for the Year		**(6,963)**	**(6,725)**	**3,994**

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 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Equity as at 1 July		97,401	97,610	93,614
Capital Contributions from the Crown		1,223	1,068	-
Repayment of equity to the Crown		(207)	-	(207)
Total Comprehensive revenue and expense for the Year		(6,963)	(6,725)	3,994
Equity as at 30 June	17	**91,454**	**91,953**	**97,401**

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 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	10,544	13,184	13,400
Debtors and other receivables	8	15,527	16,461	15,126
Inventories	9	1,481	1,391	1,391
Total Current Assets		**27,552**	**31,036**	**29,917**
Non-Current Assets				
Property, Plant and Equipment	10	195,324	199,117	201,626
Intangible Assets	11	17,780	10,257	14,228
Investments in Joint Ventures	12	400	-	-
Trust and bequest funds	13	1,419	1,288	1,288
Total Non-Current Assets		**214,923**	**210,662**	**217,142**
Total Assets		**242,475**	**241,698**	**247,059**
Liabilities				
Current Liabilities				
Creditors and other payables	14	34,696	26,392	31,698
Employee entitlements and provisions	15	28,066	30,783	29,167
Borrowings	16	9,622	19,256	15,402
Total Current Liabilities		**72,384**	**76,431**	**76,267**
Non-Current Liabilities				
Employee entitlements and provisions	15	6,816	6,516	6,515
Borrowings	16	70,415	61,038	65,588
Trust and bequest funds	13	1,406	5,760	1,288
Total Non-Current Liabilities		**78,637**	**73,314**	**73,391**
Total Liabilities		**151,021**	**149,745**	**149,658**
Net Assets		**91,454**	**91,953**	**97,401**
Equity				
Crown equity	17	45,746	45,797	44,730
Revaluation reserves	17	91,341	91,341	91,341
Accumulated deficit	17	(45,633)	(45,185)	(38,670)
Total Equity	17	**91,454**	**91,953**	**97,401**

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 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Cashflows from Operating Activities				
Cash receipts		504,293	471,173	478,209
Payments to providers		(260,226)	(229,288)	(240,396)
Payments to suppliers & employees		(225,648)	(225,143)	(228,908)
Goods and Services Tax (net)		341	-	(423)
Capital charge paid		(7,622)	(7,792)	(7,289)
Net cash flows from Operating Activities	18	**11,138**	**8,950**	**1,193**
Cashflows from Investing Activities				
Interest Received		698	1,100	1,228
Proceeds from sale of property, plant and equipment		(44)	(7)	-
Purchase of property, plant and equipment		(10,513)	(6,778)	(6,109)
Investments		(400)	(1,000)	(1,538)
Net cash flows from Investing Activities		**(10,259)**	**(6,685)**	**(6,419)**
Cashflows from Financing Activities				
Equity Contribution		1,000	1,068	-
Loans and finance lease raised/(paid)		-	(696)	1,312
Interest paid		(3,781)	(3,851)	(3,864)
Payment of Finance Leases		(954)	-	(2,238)
Repayment of Equity		-	-	(207)
Net cash flows from Financing Activities		**(3,735)**	**(3,479)**	**(4,997)**
Net (Decrease) / Increase in Cash and Cash Equivalents		**(2,856)**	**(1,214)**	**(10,223)**
Cash and cash equivalents at beginning of year	7	13,400	14,400	23,623
Cash and Cash Equivalents at end of year		**10,544**	**13,186**	**13,400**

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 2016

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 2016, and were approved by the Board on 31 October 2016.

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 2015/16 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.

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 2015, the External Reporting Board issued *Disclosure Initiative (Amendments to PBE IPSAS 1), 2015 Omnibus Amendments to PBE Standards*, and A*mendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments*. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. Hutt Valley DHB will apply these amendments in preparing its 30 June 2017 financial statements. Hutt Valley DHB expects there will be no effect in applying these amendments.

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	10 to 100 years	1.% to 10.0%
Building Structure, Services and Fit out	6 to 53 years	1.9% to 18.0%
Plant and equipment	2 to 29 years	3.5% to 74.7%
Computer equipment	3 to 22 years	4.5% to 33.3%
Leased assets	7 to 15 years	6.5% to 14.3%
Motor vehicles	6 to 10 years	10.0% to 18.0%

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 National Oracle Solution (NOS) rights (formally 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 (NOS) 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 NOS Programme, a national initiative, facilitated by NZ Health Partnerships Limited (NZHPL), 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 NZHPL through the on-charging of depreciation on the NOSassets to the DHBs will be used to, and is sufficient to, maintain the NOS assets standard of performance or service potential indefinitely.

As the NOS 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

	2016 Actual $000	2015 Actual $000
Ministry of Health contract funding	404,661	395,848
ACC Contract revenue	5,435	4,702
Other Government	817	1,742
Revenue from other District Health Boards	82,888	54,114
Other patient care related revenue	4,516	4,435
Other Income:		
Donations and bequests received	203	204
Gain on sale of fixed assets	44	-
Rental income and services	233	75
Total Operating Income	**498,797**	**461,120**

3 PERSONNEL COSTS

	2016 Actual $000	2015 Actual $000
Salaries and wages	163,030	157,985
Defined contribution plan employer contributions	3,549	4,528
Increase/(decrease) in liability for employee entitlements	(800)	2,246
Total Personnel Costs	**165,779**	**164,759**

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 2016 was 8% (2015: 8%).

5 FINANCE COSTS

	2016 Actual $000	2015 Actual $000
Interest on Crown Loans	3,754	3,869
Interest on finance leases	72	101
Total Finance Costs	**3,826**	**3,970**

6 OTHER EXPENSES

	2016 Actual $000	2015 Actual $000
Audit Fees for financial statement audit	151	121
Audit-related fees for internal audit services	92	105
Operating lease expense	3,128	3,067
Impairment of debtors	40	78
Board member fees	284	258
Loss on disposal of property, plant and equipment	106	199
Total Other expenses	**3,801**	**3,828**

7 CASH AND CASH EQUIVALENTS

	2016 Actual $000	2015 Actual $000
Call Deposits with NZ Health Partnerships Ltd	4,233	9,912
Cash at bank and on hand	6,311	588
Other Call deposits		2,900
Total Cash and cash equivalents	**10,544**	**13,400**

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 NZ Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL 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 $19.6 million (2015: $15.8m).

8 DEBTORS AND OTHER RECEIVABLES

	2016 Actual $000	2015 Actual $000
Ministry of Health	5,585	6,531
Other DHBs	3,068	3,058
PHARMAC	4,031	3,385
Trade debtors - other	2,253	1,880
Provision for doubtful debts	(226)	(255)
	14,711	**14,599**
Prepayments	816	527
Total Debtors and other receivables	**15,527**	**15,126**
Total Debtors and other receivables comprises:		
Revenue from the sale of goods and services (exchange transactions)	1,092	1,573
Revenue from grants (non-exchange transactions)	14,435	13,553
Total Debtors and other receivables	**15,527**	**15,126**

The carrying value of receivables approximates their fair value.

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

	2016			2015		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	12,956	(1)	12,955	12,344	(1)	12,343
Past due 1-30 days	641	(2)	639	972	(3)	969
Past due 31-60 days	49	(1)	48	178	(3)	175
Past due >60days	1,291	(222)	1,069	1,360	(248)	1,112
Total	**14,937**	**(226)**	**14,711**	**14,854**	**(255)**	**14,599**

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:

	2016 Actual $000	2015 Actual $000
Balance at 1 July	(255)	(231)
Provisions write back/(made)	(39)	(48)
Receivables written off during the year	68	24
Closing Balance	**(226)**	**(255)**

9 INVENTORIES

	2016 Actual $000	2015 Actual $000
Pharmaceuticals	152	191
Surgical and medical supplies	1,339	1,210
	1,491	**1,476**
Provision for obsolescence	(10)	(10)
Total Inventories	**1,481**	**1,391**

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 (2015: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2015: 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 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
Balance 30 June 2015	16,030	2,312	166,814	39,250	2,062	2,341	228,809
Additions	-	-	1,765	3,079	-	-	4,844
Disposals	-	-	-	(671)	-	(50)	(721)
Work in progress (Reverse 2015)			(1,989)	(2,973)	-	-	(4,962)
Work In progress	-	-	3,729	1,936	-	-	5,665
Balance at 30 June 2016	16,030	2,312	170,319	40,621	2,062	2,291	233,635

Accumulated depreciation and impairment losses							
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
Balance at 1 July 2015		-	212	25,123	748	1,100	27,183
Depreciation expense	-	133	8,118	2,975	178	275	11,679
Depreciation on disposals	-	-	-	(501)	-	(50)	(551)
Balance 30 June 2016	-	133	8,330	27,597	926	1,325	38,311
Carrying Amounts							
At 1 July 2014	13,625	2,049	164,092	13,393	3,002	1,478	197,639
At 30 June 2015 and 1 July 2015	16,030	2,312	166,602	14,127	1,314	1,241	201,626
At 30 June 2016	16,030	2,179	161,989	13,024	1,136	966	195,324

The net carrying amount of assets held under finance leases is $1.14m (2015: $1.31m) 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.

Capitalised interest of $5.96m was included in the 2015 land and building revaluation..

Valuation

Land and building valuations are done on a five year cycle. A full valuation was done in 2015 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	NOS Shared Services Rights	Investment In RHIP	Total
	$000	$000	$000	$000
Cost or valuation				
Balance 1 July 2014	15,991	1,546	2,744	20,281
Additions	2,719	364	1,537	4,620
Adjustments	(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
Balance 1 July 2015	15,489	1,910	4,281	21,680
Additions	4,341	-	1,306	5,647
Work in progress (reverse 2015)	(2,236)	-	-	(2,236)
Work In progress	1,619	-	-	1,619
Balance 30 June 2016	19,213	1,910	5,587	26,710
Accumulated amortisation and impairment losses				
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
Balance at 1 July 2015	7,452	-	-	7,452
Amortisation expense	1,478	-	-	1,478
Balance 30 June 2016	8,930	-	-	8,930
Carrying Amounts				
At 1 July 2014	7,277	1,546	2,744	11,567
At 30 June 2015 and 1 July 2015	8,037	1,910	4,281	14,228
At 30 June 2016	10,283	1,910	5,587	17,780

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 2016, the DHB had made payments totalling $1.91m (2015: $1.91m) to NZHPL in relation to the National Oracle Solution(“NOS”) programme, (formally Finance, Procurement and Supply Chain (“FPSC”)) which was in progress at year end. This is a national initiative facilitated by NZHPL. In return for these payments, the DHB gains NOS rights. In the event of liquidation or dissolution of NZHPL, 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 NOS rights that have been issued.

These NOS 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 NOS assets.

It is expected that the final costs of the NOS programme will exceed the original budget. NZHPL 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 NOS programme will proceed as originally planned. In this scenario, the DRC of the NOS rights is considered to equate, in all material respects, to the costs capitalised to date such that the NOS rights are not impaired. However, the future of the NOS programme is uncertain and any future decision to re-scope or discontinue the NOS programme will require a reassessment of the recoverable amount (i.e. DRC) of the NOS rights.

During 2015 Hutt Valley DHB and the other DHBs involved in the RHIP project (formally CRISP project) signed a variation to the original agreement regarding investment in RHIP. It was agreed that investments in CRTAS would no longer be for the acquisition of Class B redeemable Preference Shares. The capital payments to CRTAS for the RHIP project have been reclassified as Work in Progress as at 30 June 2016 as all partners in the RHIP project are to share ownership of the intangible assets resulting from RHIP. 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 INVESTMENTS IN COMPANIES & JOINT VENTURES

	2016 Actual $000	2015 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares – Allied Laundry Limited	400	-
Closing Balance	**400**	**-**

13 TRUST AND BEQUEST FUNDS

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

	2016 Actual $000	2015 Actual $000
Opening balance	1,288	1,288
Funds received	180	139
Interest received	53	66
Funds disbursed	(102)	(205)
Closing Balance	**1,419**	**1,288**

14 CREDITORS AND OTHER PAYABLES

	2016 Actual $000	2015 Actual $000
Payables under exchange transactions		
Creditors	2,157	696
Accrued expenses	22,437	19,960
Interest	402	429
Income in advance	16	41
Total payables under exchange transactions	25,012	21,126
Payables under non-exchange transactions		
Taxes	2,392	1,857
Inter-district flows	791	4,172
Trusts	6,501	4,473
Other	-	70
Total payables under non-exchange transactions	9,684	10,572
Total Creditors and other payables	**34,696**	**31,698**

See note 25 for liquidity risk

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

15 EMPLOYEE ENTITLEMENTS AND PROVISIONS

	2016 Actual $000	2015 Actual $000
Current portion		
Salary and Wages Accrued	4,518	5,988
Annual leave	16,467	16,761
Long Service Leave	818	803
Retirement Gratuities	601	690
Continuing Medical Education Leave and Expenses	1,007	971
Other Entitlements	4,655	3,954
Total Current portion	**28,066**	**29,167**
Non-current portion		
Long Service leave	1,868	1,668
Retirement Gratuities	703	921
Continuing Medical Education Leave and Expenses	2,717	2,528
Other Entitlements	1,528	1,398
Total Non-current portion	**6,816**	**6,515**
Total Employee Entitlements and Provisions	**34,882**	**35,682**

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 4.75% (2015: 4.68%) and an inflation factor of 2.0% (2015: 2.5%) has been used.

16 BORROWINGS

	2016 Actual $000	2015 Actual $000
Current portion		
Finance Leases	622	952
Crown Loans - fixed interest	9,000	14,450
	9,622	**15,402**
Non-current portion		
Finance Leases	415	1,038
Crown Loans - fixed interest	70,000	64,550
	70,415	**65,588**
Total borrowings	**80,037**	**80,990**
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 $83.4m (2015: $82.9m). 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 $1.037m (2015: $1.990m). Fair value is estimated at the present value of future cash flows.

Analysis of Finance Lease

	2016 Actual $000	2015 Actual $000
Minimum lease payments payable:		
Not later than one year	724	1,139
Later than one year and not later than five years	511	1,256
Later than five years	-	-
Total minimum lease payments	1,235	2,395
Future finance charges	(198)	(405)
Present value of minimum lease payments	1,037	1,990
Present value of minimum lease payable:		
Not later than one year	622	952
Later than one year and not later than five years	415	1,038
Later than five years	-	-
Total present value of minimum lease payments	1,037	1,990

Description of finance leasing arrangements

Hutt Valley DHB has entered into no new finance leases during the year (2015: Nil). In total Hutt Valley DHB holds 3 finance leases. The finance leases are for medical equipment. There are no restrictions placed on Hutt Valley DHB by any of the finance leasing arrangements.

17 EQUITY

	Crown Equity $000	Land* $000	Buildings* $000	Accumulated Deficit $000	Total Equity $000
Balance 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**
Balance at 1 July 2015	44,730	11,669	79,672	(38,670)	97,401
Contribution from the Crown	1,223	-	-	-	1,223
Repayment of Equity	(207)	-	-	-	(207)
Surplus/(deficit) for the year	-	-	-	(6,963)	(6,963)
Balance at 30 June 2016	**45,746**	**11,669**	**79,672**	**(45,633)**	**91,454**

***Revaluation Reserves**

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

	2016 Actual $000	2015 Actual $000
Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities		
Net surplus/(deficit)	(6,963)	(7,540)
Add/(less) non-cash items:		
Depreciation and amortisation expense	13,158	12,334
Increase/(decrease) in Provisions	(830)	2,271
Total non-cash items	**12,328**	**14,605**
Add/(less) items classified as investing or financing activity:		
(Gains)/losses on sale of property, plant and equipment	150	199
Net interest paid	3,056	2,642
Total items classified as investing or financing activity	**3,206**	**2,841**
Add/(less) movements in statement of financial position items:		
(Increase)/decrease in debtors and other receivables	(371)	489
(Increase)/decrease in inventories	(90)	74
Increase/(decrease) in creditors and other payables	3,028	(9,276)
Net movements in Working Capital items	**2,567**	**(8,713)**
Net cash flow from Operating Activities	**11,138**	**1,193**

19 CAPITAL COMMITMENTS AND OPERATING LEASES

	2016 Actual $000	2015 Actual $000
Capital commitments	1,954	1,256
Operating Leases as lessee		
Not later than one year	1,677	1,416
Later than one year and not later than five years	1,075	1,933
Later than five years	-	40
Total Non-cancellable Operating Lease Commitments	**4,706**	**3,389**

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 sixteen years with an expiry date of September 2017

- 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 one to three years, with expiry dates from September 2016 to September 2019.

20 CONTINGENCIES

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2016 (2015: Nil).

21 RELATED PARTY TRANSACTIONS

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

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.

	2016 Actual $000	2015 Actual $000
Salaries and other short-term employee benefits	2,413	2,019
Full time equivalent	9.75	8.06
Total key management personnel compensation	**2,413**	**2,019**

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 $60.3m (2015: $46.0m), with total expenditure of $82.3m (2015: $71.90m). The amount owing to Hutt Valley DHB by Capital & Coast DHB at the end of the financial year was $2.06m (2015: $2.11m), and the amount Hutt Valley DHB owed to Capital & Coast DHB was $2.30m (2015: $3.74m).

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 $10.6m (2015: $5.50m), with total expenditure of $1.12m (2015: $1.17m). The amount owing to Hutt Valley DHB by Wairarapa DHB at the end of the financial year was $1.19m (2015: $0.879m), and the amount owing to Wairarapa DHB was $0.065m (2015: $0.024m).

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 (2015: nil).

22 BOARD MEMBER REMUNERATION AND MEETINGS ATTENDED

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

Board Member	Position	2016 Actual $000	2015 Actual $000
Dr Virginia Hope	Chair	46	47
Wayne Guppy	Deputy Chair	28	29
David Bassett	Current Member	23	22
David Ogden	Current Member	23	23
John Terris	Current Member	23	23
Kathryn Austin	Current Member	23	22
Ken Laban	Current Member	22	21
Peter Douglas	Current Member	22	22
Sandra Greig	Current Member	22	22
Yvette Grace	Current Member	17	
Jaimes Wood	Member to March 2016	17	23
Prior year members			
Ron Mark	Member to October 2014		3
Total Board member remuneration		265	256
Total full time equivalent		**0.87**	**0.99**

Board and committee meeting attendances in the year to 30 June 2016:

Board Member	Position	Meetings Attended			Meetings held		
		Board	FRAC	Committee	Board	FRAC	Committee
Virginia Hope	Board Chair	7	10	10	7	10	10
Wayne Guppy	Deputy Board Chair	6	6	4	7	10	4
David Bassett	Current Member	6	8	-	7	10	-
David Ogden	Current Member	7	10	3	7	10	3
John Terris	Current Member	6	8	5	7	10	6
Kathryn Austin	Current Member	6	-	9	7	-	10
Ken Laban	Current Member	7	2	6	7	2	6
Peter Douglas	Current Member	5	8	-	7	10	-
Sandra Greig	Current Member	7	-	3	7	-	4
Yvette Grace	Current Member	3		1	5	-	3
Jaimes Wood	Member to March 2016	4	5	-	5	7	-

Roger Jarrold is the external chair of the Finance Risk & Audit Committee (FRAC) for HVDHB, CCBHD and 3DHB. During the year he attended 9 of the 10 FRAC meetings held.

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.

23 EMPLOYEE REMUNERATION

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

24 EVENTS AFTER THE BALANCE DATE

There are no significant events subsequent to balance date.

25 FINANCIAL INSTRUMENTS

Fair Values

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

	2016		2015	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	$000	$000	$000	$000
Cash and cash equivalents	10,544	10,544	13,400	13,400
Debtors and other receivables	15,527	15,527	15,126	15,126
Creditors and other payables	32,288	32,288	29,800	29,800
Crown loans-fixed interest	79,000	83,416	79,000	82,930
Finance leases	1,037	1,037	1,990	1,990
	138,396	**142,812**	**139,226**	**143,246**

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.

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 2016, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2016/17, 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:

	2016 Actual $000	2015 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
AA+	7,730	4,776
AA-	-	-
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	4,233	9,912
Total	**11,963**	**14,688**

Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	10,544	13,400
Trust and bequest funds	1,419	1,288
Debtors and other receivables	15,527	15,126

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 New Zealand Health Partnerships 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
2015					
Creditors and other payables	29,800	29,800	29,800	-	-
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	**110,790**	**126,003**	**48,962**	**4,378**	**72,663**

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2016					
Creditors and other payables	32,288	32,288	32,288	-	-
Finance leases	1,037	1,235	724	267	245
Crown Loans-fixed interest	79,000	87,124	12,406	21,587	53,131
Total	**112,325**	**120,647**	**45,418**	**21,854**	**53,375**

26 CAPITAL MANAGEMENT

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

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

27 EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2016 are provided below.

Statement of Comprehensive revenue and expense

The Hutt Valley DHB recorded a deficit of $6.963m compared with a budget deficit of $6.725m. The major variances were:

- Higher outsourced costs primarily due to covering medical vacancies and interim executive leadership team while the new structure was developed.
- Higher costs relating to staff, in particular in nursing due to additional staff above budget to ensure safe staffing and acute demand. New rosters in orderlies resulted in reduced costs
- Clinical suppliers in respect of pharmaceuticals for immune disorders and blood products
- Implant and Prosthesis costs in surgical due to increased volumes of work
- 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
- New Laboratories contract resulted in variances to budget in revenue and expenditure with no overall net impact.

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. Intangible assets were higher than budget due to higher than expected capitalisation of work in progress during the year.

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.

28 COST OF SERVICE STATEMENTS FOR OUTPUT CLASSES

For the year ended 30 June 2016

$000s	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
	2015\16 Actual	2015\16 Budget	2014\15 Audited	2015\16 Actual	2015\16 Budget	2014\15 Audited	2015\16 Actual	2015\16 Budget	2014\15 Audited	2015\16 Actual	2015\16 Budget	2014\15 Audited	2015\16 Actual	2015\16 Budget	2014\15 Audited
Income															
Operating Income	21,883	21,212	21,942	152,281	138,565	117,868	268,786	257,320	259,525	55,848	55,410	61,785	498,797	472,507	461,120
Interest Income	35	55	62	23	36	40	638	1,007	1,124	1	2	2	698	1,100	1,228
Total Income	21,918	21,267	22,004	152,304	138,601	117,908	269,424	258,327	260,649	55,849	55,412	61,787	499,495	473,607	462,348
Expenditure															
Personnel Costs	12,812	12,762	13,026	4,748	10,592	4,673	144,608	139,424	143,548	3,611	3,492	3,512	165,779	166,270	164,759
Depreciation	298	395	262	760	794	712	12,082	12,052	11,344	19	16	16	13,158	13,258	12,334
Outsourced Services	1,380	1,174	1,351	1,091	1,279	1,081	16,435	14,992	11,737	427	429	428	19,333	17,874	14,597
Clinical Supplies	586	738	669	481	481	498	21,497	22,163	23,196	1,235	1,166	1,279	23,799	24,548	25,642
Infrastructure and Non Clinical Expenses	658	605	816	610	899	579	13,111	10,358	12,239	65	74	67	14,444	11,937	13,701
Other District Health Boards	56	56	62	15,424	14,499	11,894	70,182	67,955	67,879	3,487	3,546	3,619	89,149	86,056	83,454
Non Health Board Providers	1,242	1,157	1,226	115,108	93,219	86,234	3,980	4,016	3,878	45,216	44,840	48,976	165,547	143,232	140,314
Capital Charge	341	349	328	1,050	1,068	962	6,220	6,363	5,988	12	12	11	7,622	7,792	7,289
Interest Expense	62	62	62	41	41	41	3,719	3,746	3,865	2	2	2	3,825	3,851	3,970
Other	1,076	1,028	1,051	122	503	102	2,559	3,932	2,639	43	49	36	3,802	5,512	3,828
Internal Allocations	3,643	3,762	3,208	1,767	2,835	1,567	(6,079)	(7,437)	(5,389)	669	840	614	0	0	0
Total Expenditure	22,154	22,088	22,061	141,202	126,210	108,343	288,314	277,564	280,924	54,786	54,466	58,560	506,458	480,330	469,888
Net Surplus / (Deficit)	(236)	(821)	(57)	11,102	12,391	9,565	(18,890)	(19,237)	(20,275)	1,063	946	3,227	(6,963)	(6,723)	(7,540)

STATEMENT OF RESPONSIBILITY

We are responsible for the preparation of Hutt Valley DHBs 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 DHB under section 19A of the Public Finance Act 1989.

We have 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 statement of performance fairly reflect the financial position and operations of Hutt Valley DHB for the year ended 30 June 2016.

Signed on behalf of the Board:

Dr Virginia Hope
Board Chair
31 October 2016

Wayne Guppy
Deputy Board Chair
31 October 2016

Independent Auditor's Report

To the readers of Hutt Valley District Health Board's financial statements and performance information for the year ended 30 June 2016

The Auditor-General is the auditor of Hutt Valley District Health Board (the Health Board). The Auditor-General has appointed me, Kelly Rushton, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and 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 59 to 95, that comprise the statement of financial position as at 30 June 2016, 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 10 to 57.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 59 to 95:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended.

- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

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

In respect of the 30 June 2015 comparative information only, some significant performance measures of the Health Board, (including some of the national health targets), relied on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2015 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2016 year, however, the limitation cannot be resolved for the 30 June 2015 year, which means that the Health Board's performance information reported in the statement of performance for the 30 June 2016 year, may not be directly comparable to the 30 June 2015 performance information.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 10 to 57:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, 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; and

- 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 31 October 2016. 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 whether there are material misstatements in the statement of performance 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

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

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Standards;
- 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: Hutt Valley District Health Board Private Bag 31-907 Lower Hutt 5040 Website: www.huttvalleydhb.org.nz Phone: (04) 566 6999	**Head Office Physical Address:** Executive Reception Pilmuir House, Pilmuir Street Hutt Hospital Campus Lower Hutt 5010
Bankers Westpac New Zealand Limited	**Auditor** 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	**Yvette Grace**
Peter Douglas	**Sandra Greig**

Executive Leadership Team for Wairarapa and Hutt Valley DHBs *as at 30 June 2016*

Ashley Bloomfield	Chief Executive Officer	**Judith Parkinson**	Chief Financial Officer
Warrick Frater	Interim Chief Operating Officer	**Anna Mahoney**	Interim 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
Steve Whittaker	Acting Executive Director Allied Health, Scientific & Technical	**Sandra Williams (3DHB)**	Acting Executive Director Service Integration & Development Unit (SIDU)
Donna Hickey	Acting Executive Director People & Culture 3DHB	**Shayne Hunter**	Chief Information Officer
Bridget Allen	Chief Executive, Te Awakairangi Health Network (PHO)	**Nigel Fairley**	General Manager, MHAIDs
Amber O'Callaghan	Executive Director Quality & Risk		

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.			
Nick Leggett (Chair)	Capital & Coast	**Katy Austin**	Hutt Valley
Dr Virginia Hope (Deputy)	Hutt Valley / Capital & Coast	**Sandra Greig**	Hutt Valley
Derek Milne	Wairarapa	**Fa'amatuainu Tino Pererira**	Hutt Valley
Alan Shirley	Wairarapa	**Wayne Guppy**	Hutt Valley
Leanne Southey	Wairarapa	**Helene Ritchie**	Capital & Coast
Jane Hopkirk		**Kim Smith**	Wairarapa
Tristram Ingham		**Margaret Faulkner**	

Hospital Advisory Committee			
The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Hutt Hospital and its services.			
Dr Virginia Hope (Chair)	Hutt Valley	**Yvette Grace**	Hutt Valley
Katy Austin	Hutt Valley	**Ken Laban**	Hutt Valley
John Terris	Hutt Valley	**David Ogden**	Hutt Valley