Healthy People | Healthy Families | Healthy Communities

Hutt Valley District Health Board

Annual Report 2017

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004.

HUTT VALLEY DHB

CONTENTS

CHAIR & CHIEF EXECUTIVE'S FOREWORD

We are pleased to present Hutt Valley District Health Board's Annual Report for the year ended 30 June 2017. It shows that our strategic priorities - improving the health of our population, reducing inequalities, improving the patient journey, offering best value for money and building a thriving organisation - remain at the very heart of what we do.

Health targets

Overall we have continued to perform well for the Hutt Valley community on a range of indicators, including the Minister's Health Targets. Our child immunisation rates are consistently high, including being top in the country in quarter two and we are making very good progress toward the *Raising Healthy Kids* target – referring close to 95% of obese children to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

In the first half of the reporting year, we made significant gains in the *Shorter stays in emergency departments* and *Better Help for Smokers to Quit* targets and these remain a focus. We also delivered even more elective surgery for our population than we had planned, and continue to improve the throughput in our theatres so people can receive timely operations.

We put concrete plans in place to deliver *Faster cancer treatment* for our patients which saw significant improvements in the timeliness of care. Working with Wairarapa and Capital & Coast DHBs, we rolled out a service that provides psychological support to adult cancer patients and their whānau, working flexibly across the region to ensure a consistently high level of care.

Financial performance

The DHB's financial performance showed a $3 million improvement on the previous year, with a smaller deficit at the same time as we delivered care to more people. We are committed to continued improvement so we can invest in the services our population will need in future. In February 2017, Treasury released a report on the financial performance, capital management and productivity of DHBs. Hutt Valley was the only DHB in the country that Treasury identified as having an improved overall performance against key financial indicators.

Patient-focused initiatives

We deliver great care for many people and our aim is to do this for 'every person, every time'. The Hutt Valley DHB's Clinical Council, with members from across the Hutt Valley health system, has now been in place for over a year. The Council has played an important role in strengthening the quality of our care, while also building our capacity and capability for innovation.

The Clinical Council oversaw a new process to allocate a $1M Innovation Fund to support proposals to improve services and develop new models of patient care in 2017/18. There was keen interest across the organisation with 24 proposals put forward and six getting the go ahead. We look forward to reporting on the implementation of the Innovation Fund projects in our next Annual Report.

A new initiative in theatre was introduced to ensure we deliver higher numbers of operations consistently and sustainably. A clinically-led Theatre Leadership Group continues to meet weekly to explore ways to maximise the use of our resources, allowing patients the best possible access to the surgery they need.

The Board supported the rollout of the Health Care Home model in primary care, commencing in 2017/18. This emerging model of care rearranges the way a general practice manages day-to-day operations, strengthens care for people with chronic health conditions, and provides a greater range of options to deal with the acute needs of its patients. It also enables Hutt Valley DHB community and specialist services to better link with primary care. We are excited about its potential to improve outcomes and quality of care.

The Board also approved significant investments in mental health and addictions services and we will continue to improve the access to and responsiveness of these services across the community.

Shaping our values

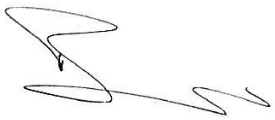
In April 2017, we launched a major project to help transform the way we work and to ensure Hutt Valley DHB is a place where our patients receive consistently outstanding care.

Our current values (outlined on page 4) were developed over 10 years ago and we felt it was timely to refresh these to reflect where the organisation is now and where we want to be in the future.
This project involved engaging with our staff and patients and their families/whānau to find out what matters to them and the responses have informed the development of a refreshed set of values and the behaviours that will support us to deliver great care together for our patients and wider population.

Looking to the future

During the year we also commenced a clinical services planning process, which will help us to identify the services and facilities we will need in future.

It's an exciting time at Hutt Valley DHB and we are confident that the DHB will continue to deliver more and better care for its population in future. This can only be achieved with the hard work of the entire team here at Hutt and we would like to acknowledge and sincerely thank our staff for their continued efforts and commitment.



Andrew Blair
BOARD CHAIR

Dr Ashley Bloomfield
CHIEF EXECUTIVE

VISION, MISSION & VALUES

The following vision, mission and values currently govern the planning and activity of Hutt Valley DHB.

Our Vision

Whānau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities.

Our Mission

Working together for health and wellbeing.

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

Our Values

'Can do' – leading, innovating and acting courageously

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

Working together with passion, energy and commitment

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

Trust through openness, honesty, respect and integrity

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

Striving for excellence

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

OUR PEOPLE

GOOD EMPLOYER OBLIGATIONS REPORT

The 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 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

We are currently in the process of re-shaping our Organisational Values based on staff and patient input. The outcomes of this work will provide the foundation for the DHB's organisational culture change programme over the next 2 to 3 years, contributing to the DHB's priority of building a "Thriving Organisation" for its staff.

Consistent and rigorous recruitment and selection processes are followed to ensure fairness and equal opportunity to all applicants. We are currently upgrading our recruitment management software, which will enable improved information collection and reporting of our key EEO metrics. We will also be including a values based recruitment approach to our Recruitment and Selection processes.

Training and development opportunities are considered for all staff and development plans are included as part of the annual performance review process. We have implemented an online E-Learning tool for staff to access 24/7 to better enable staff to do some of their training around their own timetables. We have also signed up to the SSC Talent Management and Leadership Development framework which will supplement existing leadership development initiatives within the DHB.

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

As a good employer, the DHB values professionalism through leadership. Therefore unacceptable employee behaviour is not tolerated. We have updated HR policies and guidelines related to discipline, performance, and 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 we have established roles as contact people for staff in relation to bullying and harassment prevention and provided external expert training for this. Developing a safe pathway for staff to raise concerns about unacceptable behaviour is also part of a programme of work being developed to embed the new organisational values. We have other policies, including the EEO Policy, which are reviewed.

The DHB also has an HR Plan focused on building a positive workplace. The plan includes actions being undertaken in relation to engagement of staff and leadership - this is reflected in our current review of our DHB Values process with a very staff inclusive process.

We are building on the leadership development we have already provided and have run a number of Clinical Leadership training sessions with one on one follow-up sessions. We also share access to a DHB formatted Front Line Managers training course and hold training sessions throughout the year for all managers called "What Leaders Need to Know".

Approximately 90% of employees are covered by Collective Agreements (CA). All the CAs have remuneration, recognition and conditions clauses. We also take a similar approach for those employees on an individual employment agreement to ensure fairness and equity in remuneration, recognition and conditions across the organisation.

The DHB has provided training for all managers and union representative s on the new health and safety legislation. We have just undergone two audits to our Health and Safety to ensure we stay aligned with new legislation. We have successfully maintained our tertiary status on the ACC Partnership Programme.

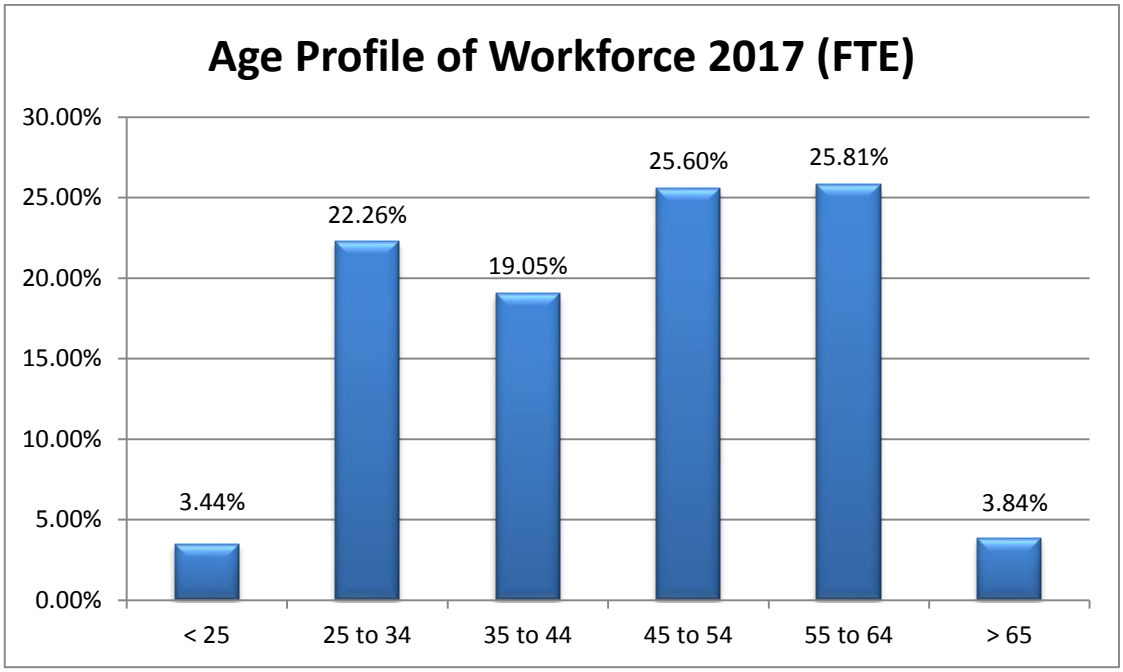
We have just reviewed our Protected Disclosures policy, to ensure it continues to protect the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged, there are established grievance procedures available - including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to a confidential employee assistance programme.

WORKFORCE PROFILE

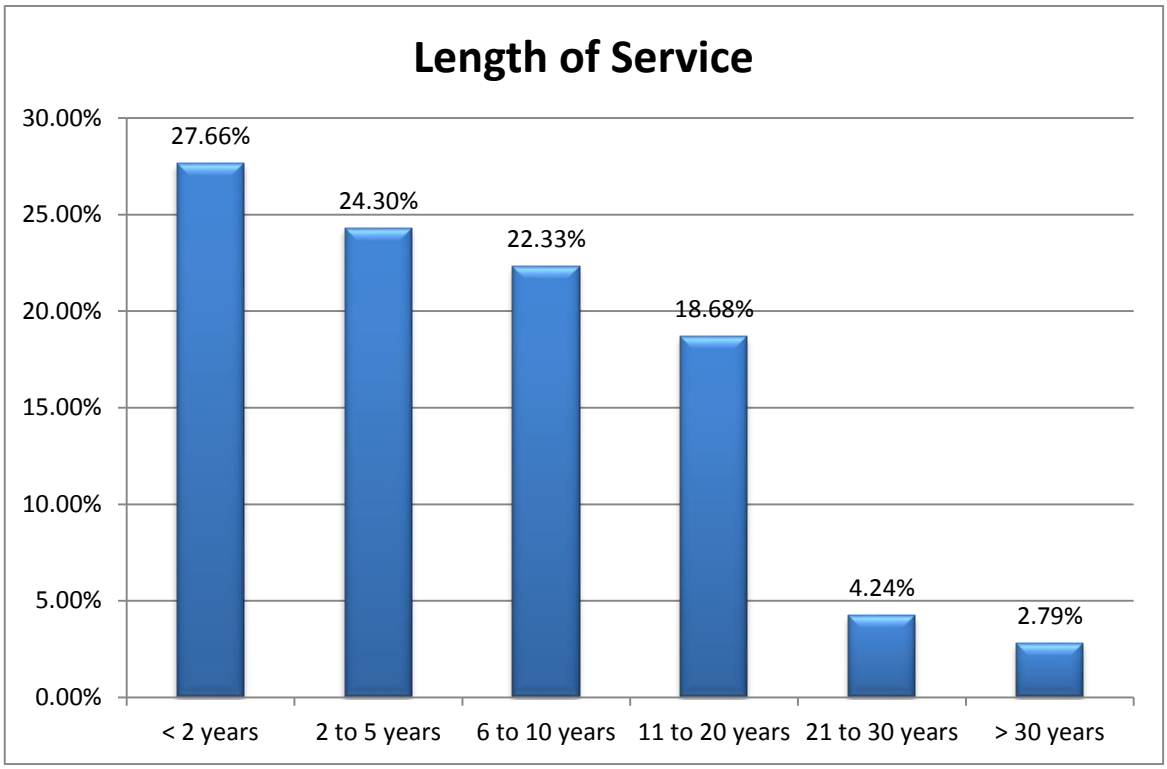
Full Time Equivalent Staff Numbers

	2017	2016	2015	2014	2013	2012	2011
Medical	244	236	246	232	232	238	233
Nursing	696	696	755	717	708	712	699
Allied Health	395	401	440	428	435	422	396
Other	427	410	442	434	467	480	481
Total	1762	1743	1,883	1,811	1,841	1,851	1,809

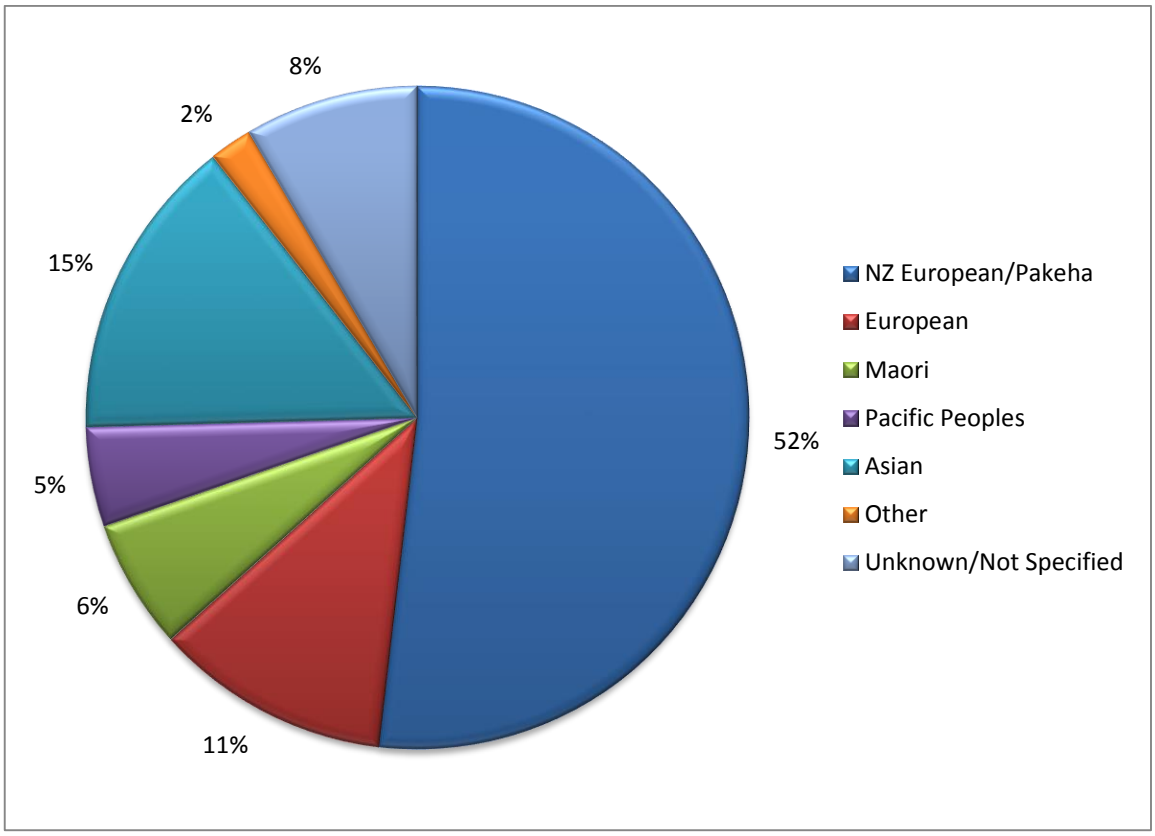
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2017	2016	2015	2014	2013	2012	2011
Female	80.56%	81.05%	81.65%	81.89%	82.41%	81.95%	81.16%
Male	19.44%	18.95%	18.35%	18.11%	17.59%	18.05%	18.84%

REMUNERATION OF EMPLOYEES

Annual remuneration	2017	2016	2015
100,000-109,999	40	40	37
110,000-119,999	26	29	24
120,000-129,999	17	19	17
130,000-139,999	15	14	8
140,000-149,999	10	15	8
150,000-159,999	16	11	16
160,000-169,999	11	2	9
170,000-179,999	12	8	9
180,000-189,999	7	9	7
190,000-199,999	6	7	12
200,000-209,999	6	5	1
210,000-219,999	4	6	2
220,000-229,999	9	7	5
230,000-239,999	6	3	10
240,000-249,999	9	13	6
250,000-259,999	4	5	6
260,000-269,999	8	7	9
270,000-279,999	6	3	6
280,000-289,999	4	6	1
290,000-299,999	3	1	1
300,000-309,999		2	2
310,000-319,999		3	3
320,000-329,999		1	
330,000-339,999	3		
340,000-349,999	2	2	
350,000-359,999	1		
360,000-369,999			1
370,000-379,999			
380,000-389,999	1	1	
390,000-399,999			1
400,000-409,999			1
420,000-429,999	1		
430,000-439,999	1		
440,000-449,999		1	
560,000-569,999		1	
Grand Total	**223**	**221**	**202**

TERMINATION PAYMENTS

During the year ended 30 June 2017, 23 (2016: 24) employees received compensation and other benefits in relation to cessation totalling $401,089 (2016: $498,093). The payments were in the nature of redundancy or retirement gratuities.

PERFORMANCE HIGHLIGHTS

- Hutt Valley DHB exceeded the Minister's Health Target of providing advice and support to 90% of pregnant women to quit smoking, through their DHB-employed midwife or Lead Maternity Carer.

- Hutt Valley DHB met the target for reducing the number of avoidable hospitalisations for 0-4 year olds. Our focus on high needs populations saw a reduction in avoidable hospitalisations for Pacific children with dental, respiratory and asthma conditions.

- Hutt Valley DHB achieved the oral health target for the percentage of children under the age of five enrolled in DHB-funded dental services, with 97% of children enrolled.

- Hutt Valley DHB met the target to increase the number of caries-free children at 5 years of age for Māori and Pacific populations.

- We achieved the target for the percentage of eligible children receiving a B4 School Check.

- The rate of acute readmissions was reduced and the average length of stay in Hutt Valley Hospital decreased for both acute and elective patients.

- We exceeded the target of over 90 percent of PHO enrolled patients who smoke being offered help to quit smoking by a health care practitioner in the last 15 months.

- Hutt Valley DHB continued to meet the target for maintaining or increasing the number of people 65+ who have received DHB-funded home based support services.

- We achieved our performance targets in the annual Patient Experience Survey, which focused on communication, co-ordination, partnership and physical and emotional needs.

MINISTER'S HEALTH TARGETS

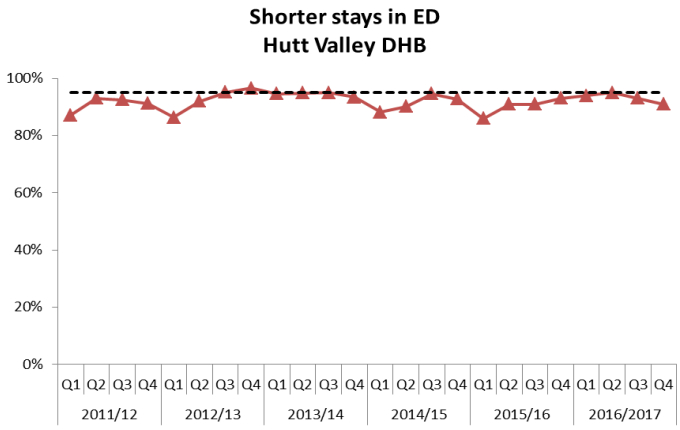
Health targets are a set of national performance measures specifically designed to focus work on improving the performance of health services in areas that reflect significant public and government priorities[1].

Shorter stays in Emergency Departments

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

Target: 95%

2016/17 Performance: 91%

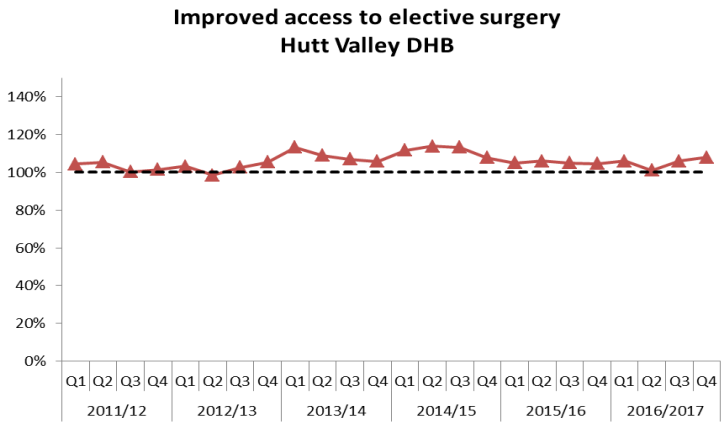


Improved access to elective surgery

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

Target: 100%

2016/17 Performance: 6,543 (108%)



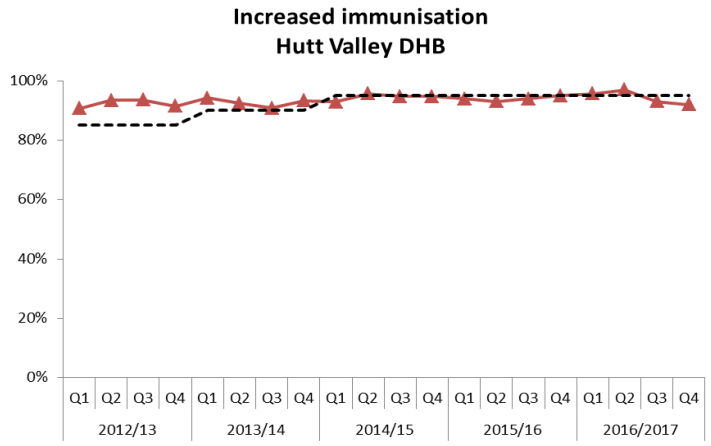
[1] Note the changing vertical (y) axis between graphs and that the 2016/17 performance is the performance for the final quarter.

Increased immunisation

95 percent of eight month olds will have their primary course of immunisation on time.[2] (Primary course immunisation events occur at six weeks, three months and five months.)

Target: 95%

2016/17 Performance: 94%

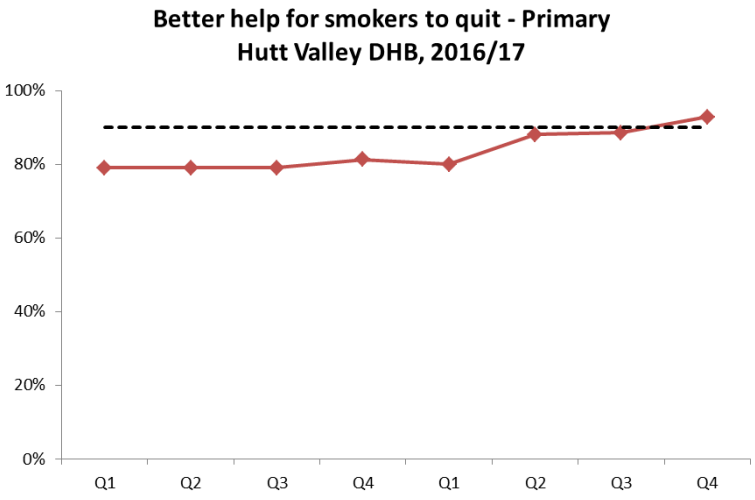


Better help for smokers to quit – Primary care

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.[3]

Target: 90%

2016/17 Performance: 92.8%

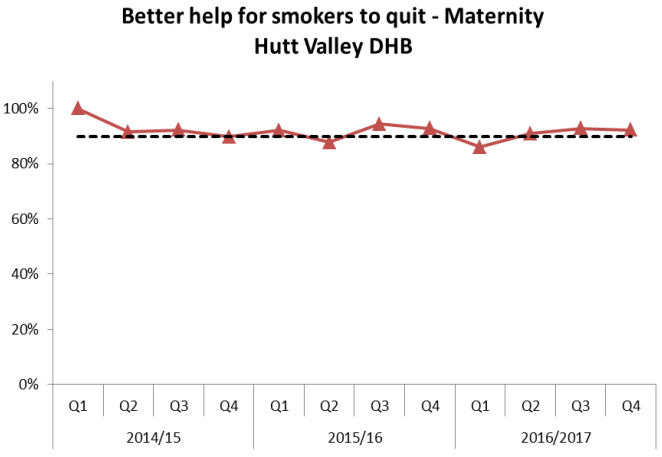


Better help for smokers to quit – Maternity

90 percent 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%

2016/17 Performance: 92%



[2] Target for on-time immunisation set at 95% from December 2014.

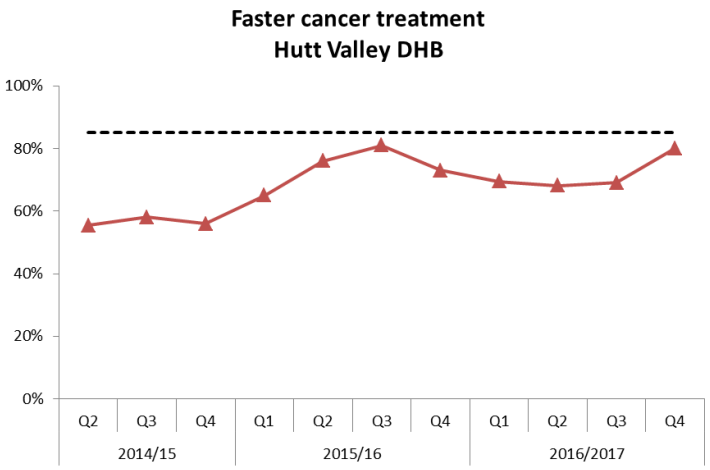
[3] From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required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

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[4].

Target: 85%

2016/17 Performance: 80%

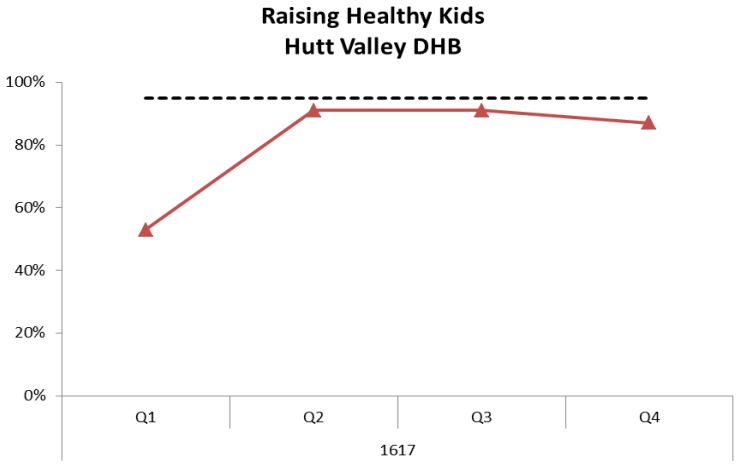


Raising Healthy Kids

By December 2017, 95 per cent of obese children (BMI>98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Target: 95%

2016/17 Performance: 87%



This Health Target was introduced in 2016/17; there is no data for prior years.

[4] Target increased from 85% in July 2016 to 90% June 2017.

IMPACTS & OUTCOMES

In our role as the major funder and provider of health, wellbeing and disability services in the Hutt Valley district, the HVDHB is expected to deliver against the national health system outcomes, to meet our objectives under the NZ Public Health and Disability Act, and in so doing to make and maintain positive changes in the health of our population. Decisions that we make about which services to fund and deliver have a significant impact on the health of people in our district, and contribute to the effectiveness of the entire health system.

As part of our accountability we need to demonstrate whether we are meeting the expectations of government and to show how we are making a positive difference in health and wellbeing for the people, whānau and communities in our district.

In this section we report on the nine intended DHB outcomes and their associated impact measures described in our Annual Plan 2016/17 to provide an insight into how our DHB is making a difference, and where there are areas in which we are working to improve.

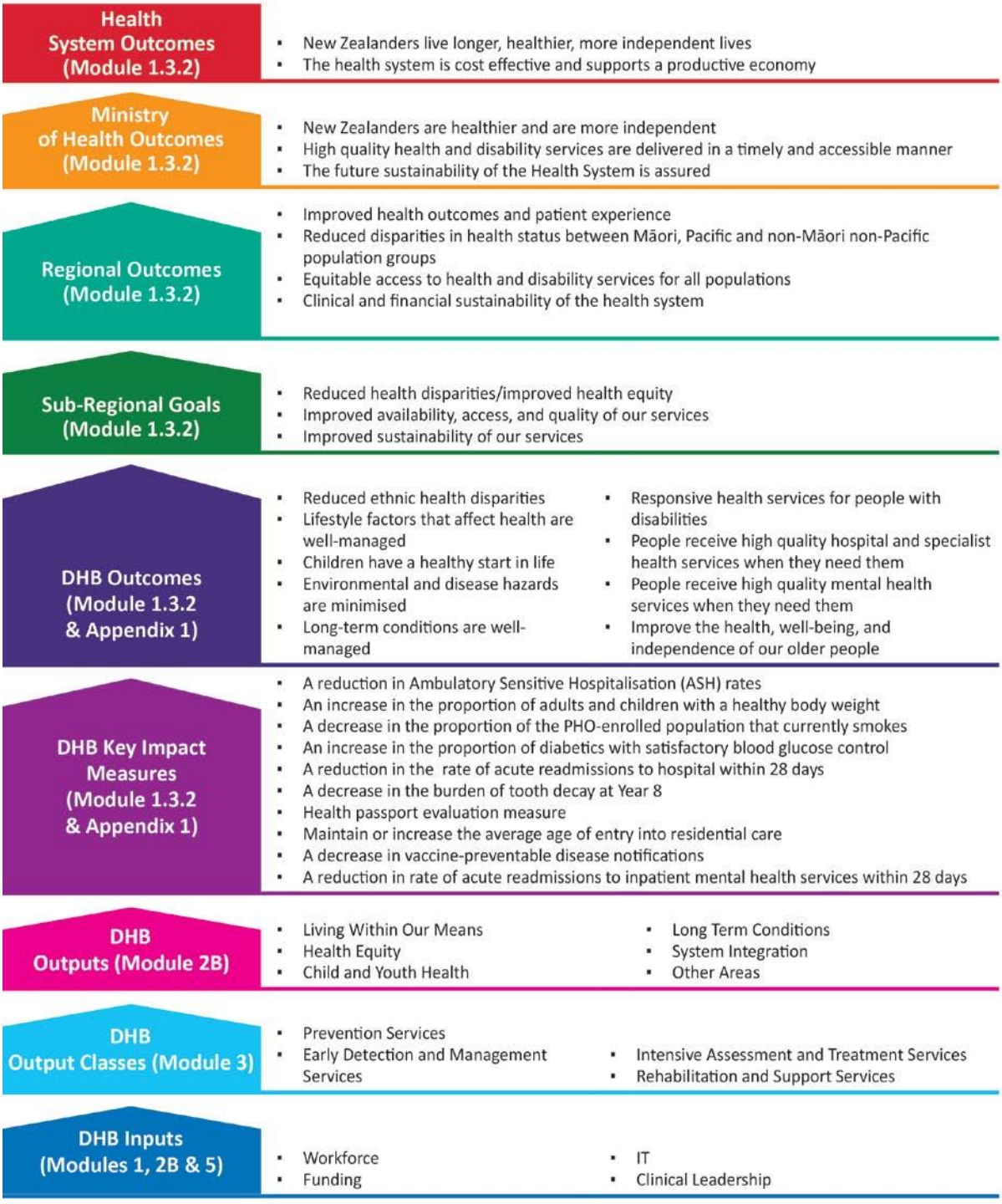
In this impact and outcomes analysis there are both outcome measures – where success will be evident over the longer term – and impact measures that reflect changes over a shorter period of time. By tracking the change in contributory impact measures and looking at trends in the outcome measures we can assess our performance and ensure that we are progressing in the right direction. These measures are selected from the national reporting framework and data sources to allow us to consistently monitor our performance over time and to compare with other DHBs so that we may learn from, and share strategies that make a positive difference.

In the following section – the Statement of Service Performance - we cover measures across four output classes that provide an indication of the volume and coverage of services funded and delivered, alongside service quality indicators.

Taken together, these different measures allow us to evaluate the quality and effectiveness of our service delivery and determine whether our DHB is making a positive difference to the health and wellbeing of our community.

The hierarchy of outcomes, impact measures and output class measures is presented in the Intervention Logic Diagram here. This depicts how the services that we provide or fund – *the outputs* – will impact on the health of our population and, over the longer term, will result in the positive health outcomes that we want for our populations and that are expected by Government.

Intervention Logic Diagram



POPULATION HEALTH OUTCOME: REDUCED ETHNIC HEALTH DISPARITIES

What difference will we make for our population?

There are clear health disparities for several population groups in our district (and across New Zealand) that result from a complex interplay of factors including cultural responsiveness, design of models of care, accessibility of services and the wider social determinants of health. It is our responsibility to commission and deliver services that are of value to, and meet the needs of all our populations.

As we pursue our goal to reduce ethnic disparities in health outcomes for our population, the system outcomes we monitor include amenable mortality rates and ambulatory sensitive hospitalisation rates across ethnicities.

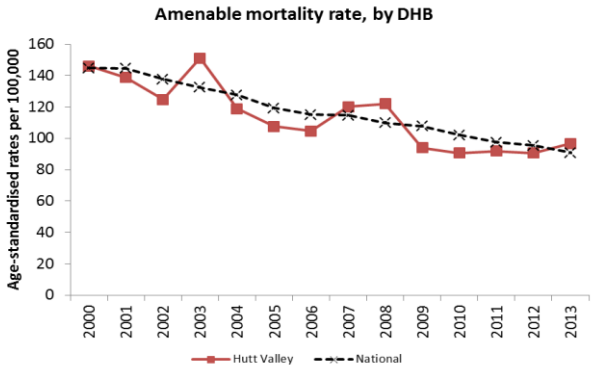
Impact measure: A reduction in amenable mortality rates

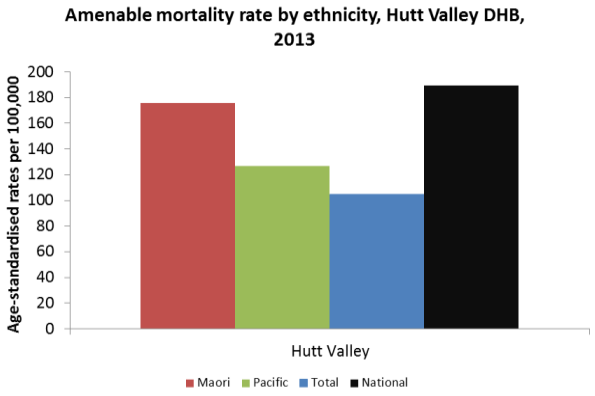
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

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

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

Several medical conditions that contribute to amenable mortality rates are influenced by lifestyle choices such as smoking, nutrition and activity levels. Our key interventions include a focus on wellness initiatives as well as focussing on the wider social determinants of health. The Hutt Valley DHB is developing a system wide Wellness plan to ensure optimal connection and coordination of activities for tackling preventable diseases.





Source: Ministry of Health June 2016[5].The graphs show the most recent data available from the Ministry of Health.

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

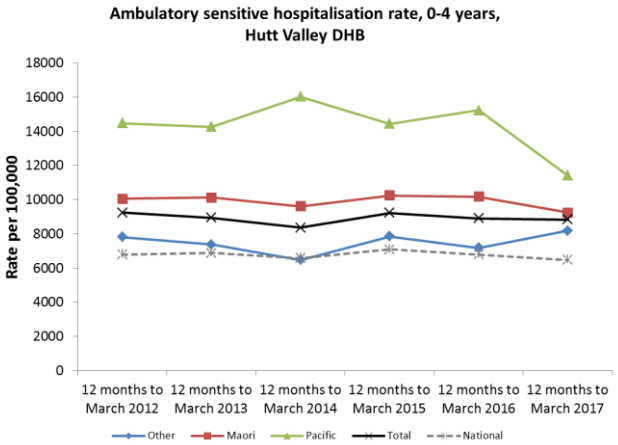
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates[6]

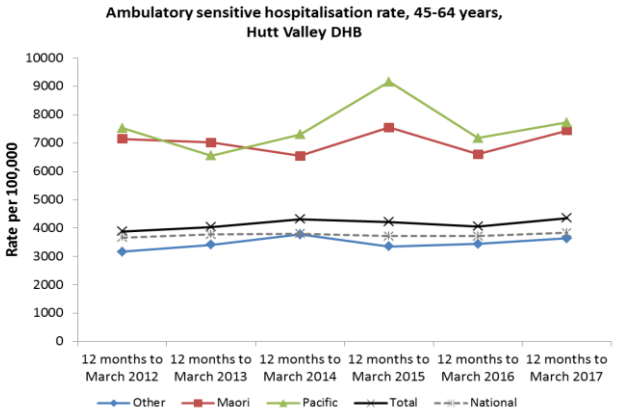
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include, for example, skin infections, dental conditions, asthma, pneumonia, cardiovascular 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 13% and 39% higher, respectively, compared to other ethnicities. The ASH rates amongst Māori and Pacific adults (45-64 years) are twice as high as the rate for other adults.

In 2016/17 we have seen a reduction in avoidable hospitalisations for Pacific children with dental conditions, respiratory and asthma conditions. (See the commentary on child ASH rates, page 25.)





Source: Ministry of Health

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

POPULATION HEALTH OUTCOME: ENVIRONMENTAL AND DISEASE HAZARDS MINIMISED

What difference will we make for our population?

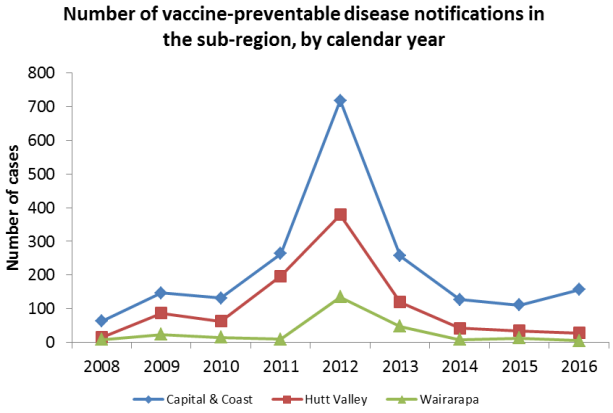
To prevent ill-health and maintain wellbeing for everyone we work to minimize harmful environment factors and disease hazards. The Regional Public Health service provides effective public health disease surveillance, investigation and control programs to minimize the impact of communicable water and food borne diseases, and works in partnership with Police, local councils and community agencies on public health programmes to reduce the level of harm from alcohol and drug use in our region.

We monitor our performance and progress in minimizing environmental and disease hazards by measuring our impact on vaccine preventable disease notifications and alcohol control operations.

Impact measure: A decrease in vaccine-preventable disease notifications

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

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications returned to previous levels in 2014 and has been maintained at this low level in the Hutt Valley. The number of vaccine-preventable disease notifications should remain low where population vaccination coverage is maintained at high levels.



Source: Institute of Environmental Science and Research

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)

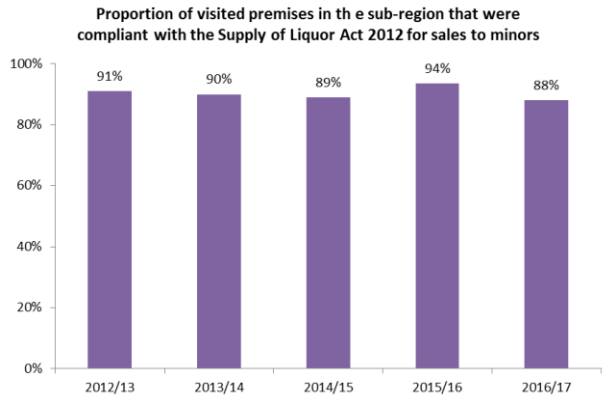
Alcohol is a significant contributor to disease and injury for New Zealanders. Alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime.

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[7]. Young people, Māori, 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 2016/17, 88% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors.



Source: Regional Public Health

[7] 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 the overall health and wellbeing of our people/whānau and are important contributors to illnesses that are major causes of death and poor health: cancer, obesity, cardiovascular disease and diabetes. There are four key lifestyle factors that drive health loss: smoking (9.1% of health loss), obesity (7.9% of health loss), physical inactivity (4.2%) and poor diet (3.3%). By working to reduce the incidence of these negative lifestyle factors we will improve the health of our people/whānau.

We monitor our performance and progress on preventing ill-health by measuring our impact on obesity prevalence rates and smoking cessation rates.

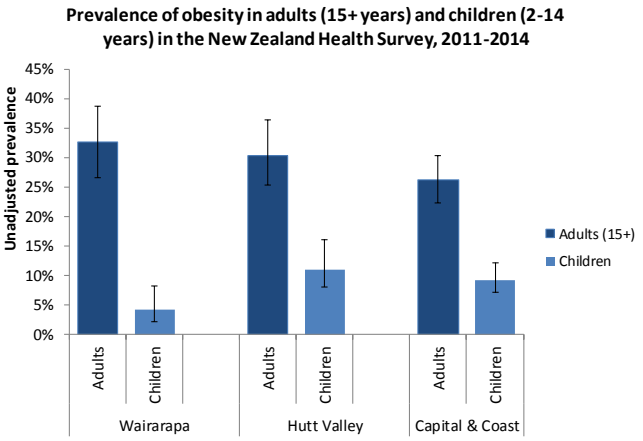
Impact measures: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

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.

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.

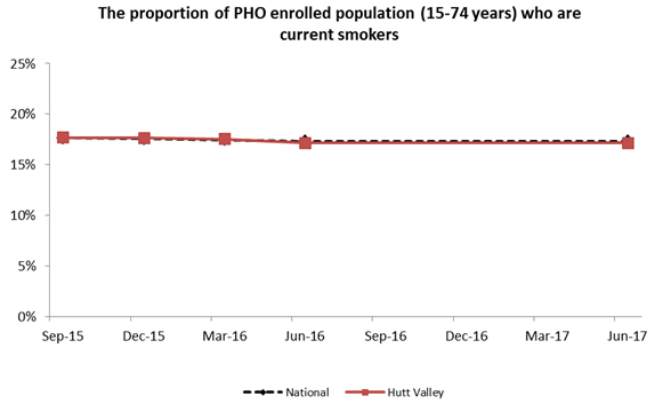
By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

Local initiatives that encourage healthier diets and more physical activity such as the sub-regional Green Prescription programme for adults and families are important components of the inter-sectorial approach to tackling obesity.



Source: New Zealand Health Survey, 2011-14. Error bars represent 95% confidence interval. The graphs show the most recent data available from the Ministry of Health.

Obesity is not solely a health issue. There are many social determinants which require collective and coordinated action. HVDHB is developing a broad Wellness Strategy to better connect and coordinate the activities for tackling these modifiable lifestyle diseases.	

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 the Hutt Valley, 19% of the total PHO enrolled population are recorded as a 'current smoker', with higher rates for Māori (38%) and Pacific people (25%). Health target monitoring[8] shows that increasing numbers of enrolled smokers have been offered help to quit smoking by their health care practitioner in the last 15 months. By focusing provision of smoking cessation advice and support on populations with higher numbers of current smokers, we aim to reduce the overall percentage of people who smoke and improve health outcomes.	 Source: Ministry of Health

[8] Health Target 5 – refer page 12 of this report

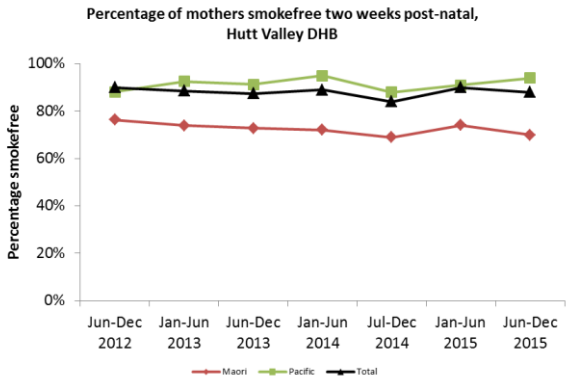
Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

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 focusing provision of smoking cessation advice and support on those populations where smoking is more prevalent, we aim to increase the overall percentage of mothers who are smokefree two weeks post-natal.

In Hutt Valley DHB, Māori mothers were less likely to be smokefree compared to other ethnicities. New initiatives continue to be developed to engage hapu women.

Data from January 2016 onwards was not available at time of publication.



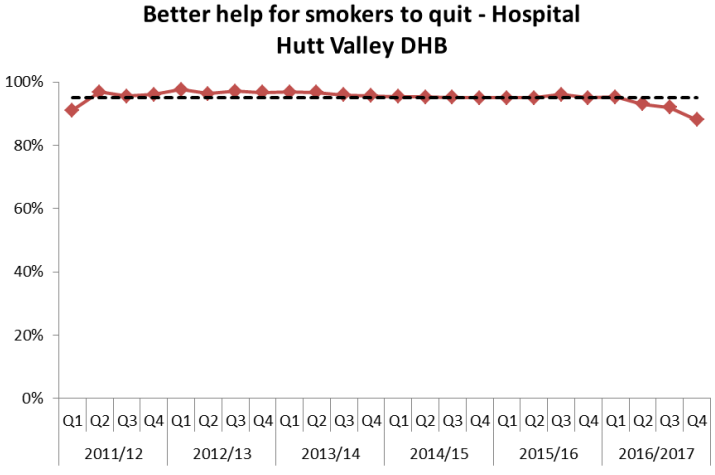
Source: WCTO Quality Indicators, Ministry of Health via TrendlyNZ. The graphs show the most recent data available from the Ministry of Health

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%

2016/17 Performance: 88%



POPULATION HEALTH OUTCOME: CHILDREN HAVE A HEALTHY START IN LIFE

A child's circumstances and health can have a lasting effect on the rest of their life. Poor health as a child predicts self-rated health and the development of chronic conditions as an adult. It is vitally important that children and their whānau across all population groups have equitable access to high quality services that meet their needs and are of value.

As we pursue our goal to reduce ethnic disparities in health outcomes for children up to four years of age the system outcome we monitor is ambulatory sensitive hospitalisation rates for 0-4 age group across ethnicities.

We monitor our performance and progress on establishing a healthy start for all children by tracking trends in the Ambulatory Sensitive Hospitalisation (ASH) rate health outcome measure for children aged 0-4 years. We track short term progress by monitoring our impact on the numbers of children free of dental caries at five years of age and the burden of tooth decay in Year 8 children.

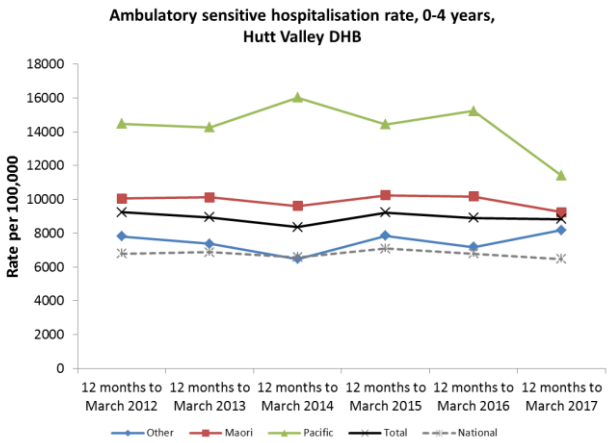
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

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 now approximately 13% and 39% higher, respectively, compared to other children, and the total rate remains above the national average.

In 2016/17 we have seen a reduction in avoidable hospitalisations for Pacific children, with fewer admissions for dental conditions, respiratory and asthma illnesses. The reduction in admissions reflects our focus on tackling these prevalent illnesses through the whole of system integration work program. These conditions remain the most prevalent reasons for hospitalisations and we continue to focus on high needs populations to improve child health outcomes; and in particular to reduce the disparities for Māori and Pacific children.[9]



Source: Ministry of Health

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

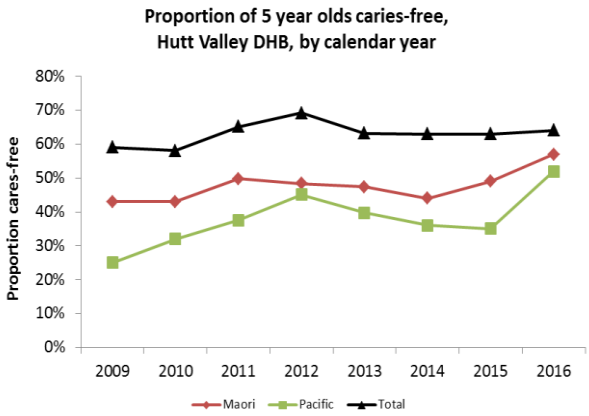
Impact measure: An increase in the proportion of children caries-free at 5 years

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 sub-regional enrolment system is in place with the aim to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination to identify children with poor oral health and refer them 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 five year-olds who are caries-free has been maintained overall and we have seen an improvement in the proportion of Māori and Pacific children who are caries-free at five years of age.



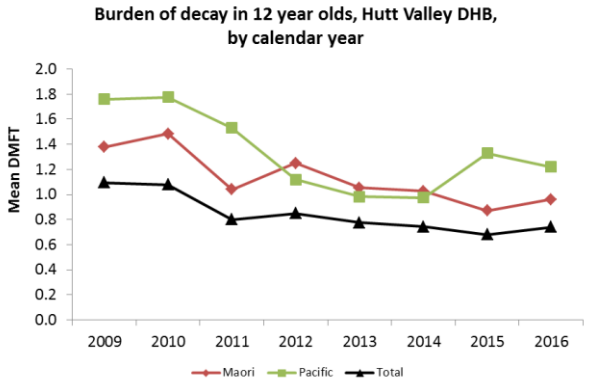
Source: Ministry of Health (Quarterly Reporting Website), Bee Healthy Dental Service

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 12 year-olds will decrease.

In Hutt Valley DHB, the mean DMFT amongst 12 year olds has increased slightly for the total population reflecting improved dental care overage.



Source: Bee Healthy Dental Service

In the short term this results in more diagnoses and treatment. It is expected that in the long term, enhanced early dental care will help to reduce the burden of decay in this age group.	

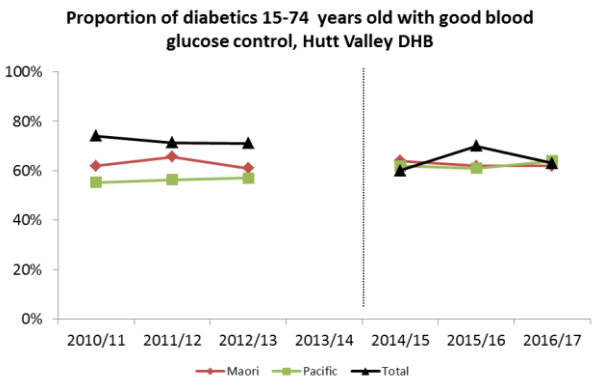
POPULATION HEALTH OUTCOME: LONG-TERM CONDITIONS ARE WELL-MANAGED

What difference will we make for our population?

The New Zealand Burden of Disease Study predicts that over the next decade people will be living longer, but with more long-term conditions such as cardiovascular disease, respiratory illnesses, cancer, diabetes and depression. These conditions are also more prevalent amongst Māori and Pacific people and are associated with significant disparities in health outcomes across populations groups.

To keep people well, our health system need to focus more on prevention and ongoing good management of long term conditions.

We monitor our performance and progress in managing long term conditions well by measuring our impact on the proportion of people/whānau with diabetes who satisfactorily manage their blood glucose as measured by HbA1c levels.

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 'Long Term Condition Practice 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	 Results from 2010/11 through to 2012/13 measure the proportion of diabetics who had an HbA1c test. The methodology was revised in 2013/14 to measure the proportion of all enrolled diabetics. Data for the new measure only available from 2014/15 onwards.

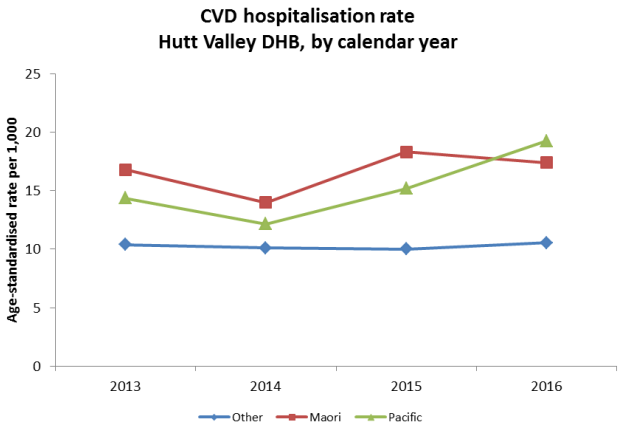
glucose control.

In Hutt Valley DHB, the proportion of people/whānau with diabetes with satisfactory blood glucose control is similar across all ethnicities including for Māori and Pacific people. This reflects good progress by primary care teams focussing on these populations with high prevalence of diabetes and in achieving a reduction in the number of patients with higher HbA1c levels.

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 has slightly decreased amongst Māori but increased for the Pacific population and has been maintained amongst other ethnicities.



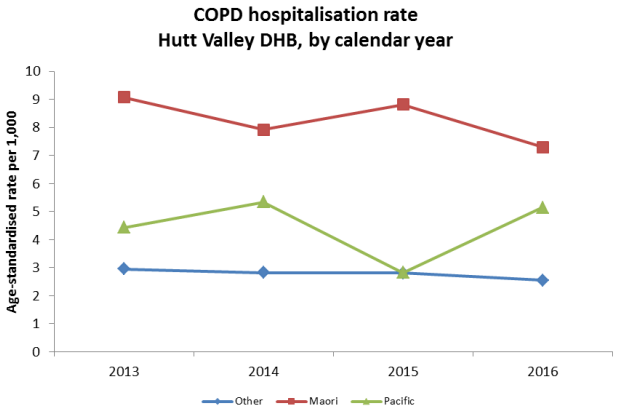
Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

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 has increased in 2016 when compared to previous years. Māori rate has decreased in 2016 and Other has had no significant change.



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

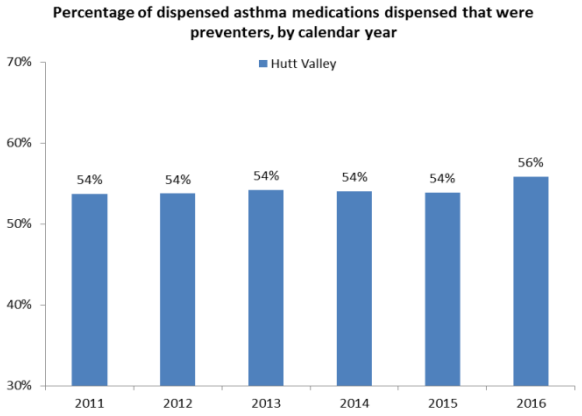
Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers

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 indicate 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



Source: Pharmaceutical Claims Data Mart

medication dispensed which was preventers has increased to 56% from 54% over the last few years.	

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

What difference will we make for our population?

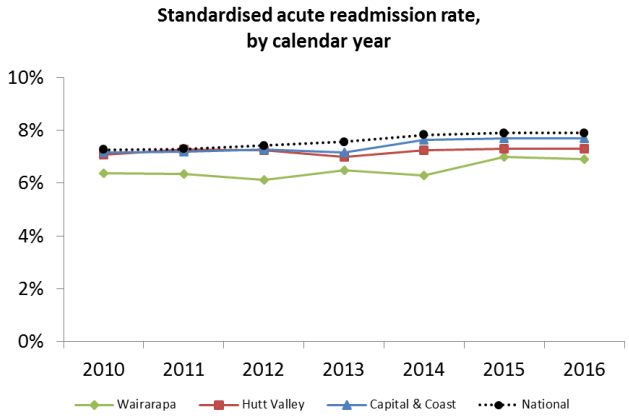
Equitable and timely access to high quality specialist assessment, care and treatment can significantly improve people's quality of life, either through early intervention (such as removal of an obstructed gall bladder to prevent repeat attacks of abdominal pain, and to reduce the risk of cancer and infection) or through corrective action (such as major joint replacements to relieve pain and improve mobility). Improving our service delivery, our systems and processes will improve patient safety, reduce the number of adverse hospital events causing harm and improve outcomes for people/whānau using our services.

We monitor our performance and progress in delivery of timely and high quality hospital and specialist health services by measuring our impact on the rate of acute readmissions to hospital.

Impact measure: A reduction in the standardised[10] rate of acute readmissions to hospital within 28 days

A decrease in the rate of acute readmissions indicates 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 for Hutt Valley DHB has remained steady, reducing slightly to 7.1% for all ages over the last year. At the same time the average length of stay in our hospital facilities has decreased for acute admissions (to 2.24 days) and for elective admissions to 1.56 days, which shows that the effectiveness and efficiency of treatment in hospital has continued to improve.



Source: Ministry of Health[11]. The graphs show the most recent data available from the Ministry of Health.

[10] 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.

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

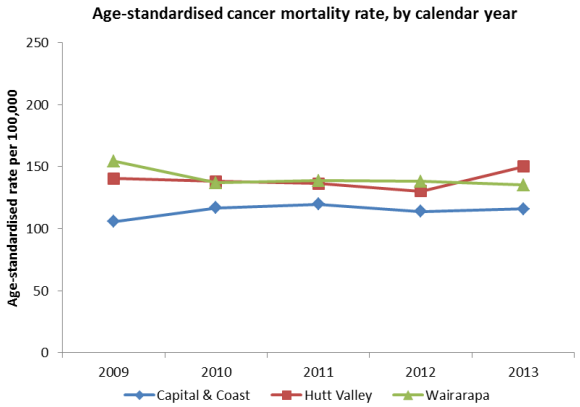
Impact measure: Maintain or reduce the age-standardised cancer mortality rate

Because more people are living longer into old age, more of us are developing cancer.

Many cancers can be cured if they are found and treated early. 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.

The most recent Ministry of Health's Mortality Collection data was up to year end 2013.



Source: Ministry of Health Mortality dataset. The graphs show the most recent data available from the Ministry of Health.

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 for people/whānau who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response for acute need and as required under the Mental Health Act.

Equitable and timely access to high quality specialist assessment, care and treatment across the region and across ethnicities and age groups is necessary to improve the mental health and wellbeing of our people/whānau.

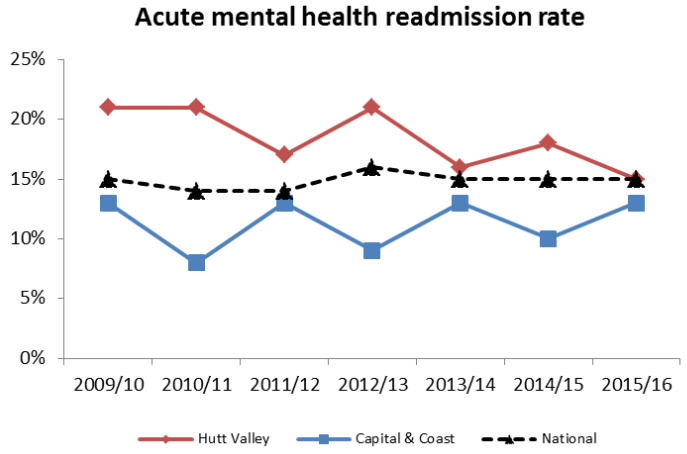
We monitor our performance and progress in delivery of timely and high quality specialist mental health services by measuring our impact on the reducing the number of acute readmissions to inpatient mental health units, and the number of new users accessing secondary mental health services.

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 mental health 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.



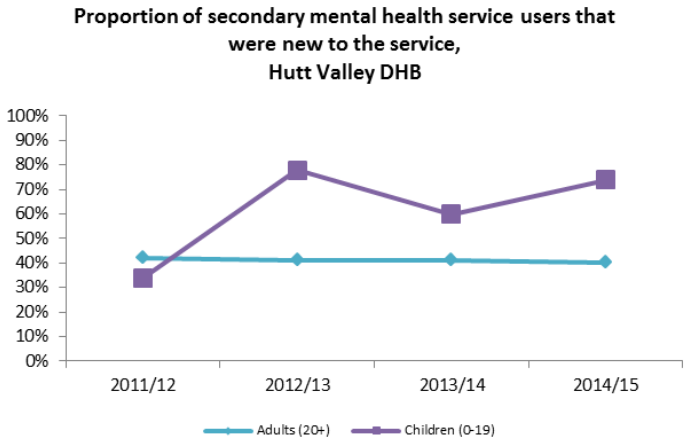
Source: Ministry of Health

Due to the provider of the national KPI data migrating to an online dashboard, 2016/17 data is not yet available.

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

Due to the provider of the national KPI data migrating to an online dashboard, 2016/17 data is not yet available.

HEALTH SERVICES OUTCOME: RESPONSIVE HEALTH SERVICES FOR PEOPLE WITH DISABILITIES

What difference will we make for our population?

Disability is defined as a 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 our sub region indicate that approximately 109,000 people live with a disability – 11,000 in Wairarapa (27%), 33,000 in Hutt Valley (24%) and 65,000 in Capital and Coast DHB (23%).

We work to provide responsive services to people/whānau living with a disability.

We monitor our performance and progress in provision of responsive health services for people with a disability by surveying the usefulness of the Health Passport.

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.	Note this measure is under development with a review of the Health Passport.

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

What difference will we make for our population?

It is expected that in the coming decades people will live longer; they will live longer in good health but also they will live longer in poor health often with multiple co-morbidities, mobility impairments and frailty. Our ageing population will increase pressure on the health system. By providing access to patient-centered, coordinated services for older people/whānau we can improve the health, wellbeing and independence of our older population.

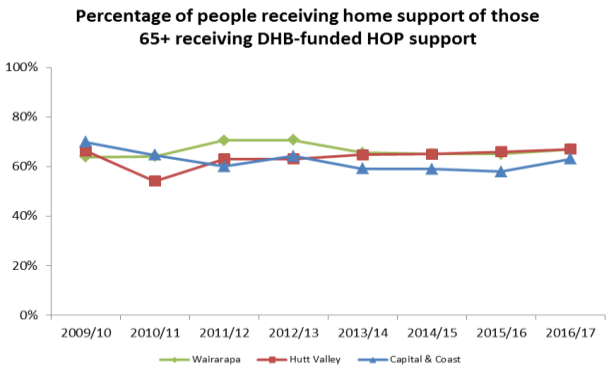
We monitor our performance and progress on improving the health wellbeing and independence of older people by measuring our impact on the proportion of people continuing to live in their homes supported with home based services, and by tracking the age of entry into Aged Residential Care facilities.

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[12] 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 that 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.



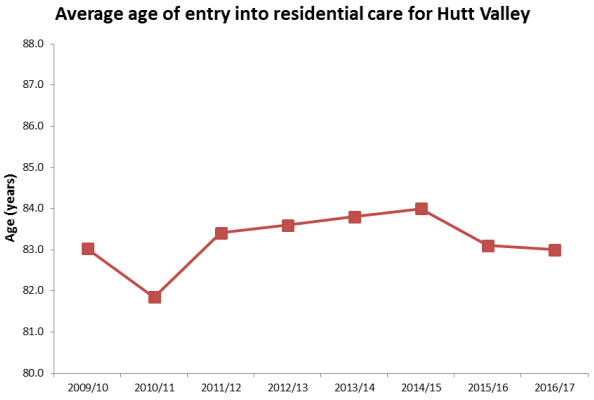
Source: Health of Older People regional benchmarking.

[12] Hambleton, P., 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 steady at 83 years.



Source: Health of Older People regional benchmarking

STATEMENT OF PERFORMANCE

OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

In this section we evaluate measures across four output classes that provide an indication of the volume and coverage of services funded and delivered by the HVDHB, alongside service quality indicators. These Output Classes follow the classification established by the Ministry of Health for use by all DHBs as a logical fit with stages spanning the continuum of care.

The four Output Classes and their related services are:

Prevention Services

- Health protection and monitoring services
- Health promotion services
- Immunisation services
- Smoking cessation services
- Screening services

Early Detection and Management services

- Primary care (GP) services
- Oral health services
- Pharmacy services

Intensive Treatment and Assessment Services

- Medical and surgical services
- Cancer services
- Mental Health and Addiction services

Rehabilitation and Support services

- Disability services
- Health of older people services

Within these Output Classes, the measures we have chosen reflect activity across the whole of the Hutt Valley health system and help us to monitor that we are on track to achieve positive long term outcomes. Some of the measures that we have chosen to reflect outputs of services we fund or deliver are also Performance Measures used by the Ministry to monitor DHB performance through the quarterly reporting system.

INTERPRETING OUR PERFORMANCE

Types of measures

Evaluating performance is more than measuring the volume of services delivered or the number of patients cared for. In monitoring our progress we want to be sure that the people who most need services are getting those services in a timely way, and that these services are delivered to the right quality standard. In the tables below we note the types of output measure, and where appropriate the results are detailed for different ethnicities.

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

Standardisation, Targets and Estimates

In some cases the results are standardized for population characteristics, such as age, to allow meaningful comparison between different populations, for example, to compare between two or more districts that may have different age group profiles.

Some measures reflect our pursuit of a target, such as aiming to screen 70% or more eligible women for breast cancer in the last two years. Other measures are more simply an estimate of the volume of a service rather than a target and are included to provide an indication of the extent of services funded or undertaken by the DHB, such as the number of prescription items filled in one year. We report on these measures by commenting if the volume is in line with our estimate, lower or higher than estimated.

Appropriation Reporting

	2015/16 Actual $000	2016/17 Budget $000	2016/17 Actual $000
Appropriation revenue	365,331	372,955	372,955

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	2015/16 Actual	2016/17 Budget	2016/17 Actual
Prevention	21,918	21,219	22,065
Early Detection and Management	152,304	164,636	164,765
Intensive Assessment and Treatment	269,424	270,845	268,643
Rehabilitation and Support	55,489	71,367	71,074
Total	**499,495**	**528,068**	**526,547**

Expenditure	2015/16 Actual	2016/17 Budget	2016/17 Actual
Prevention	22,154	21,578	22,358
Early Detection and Management	141,202	163,827	164,165
Intensive Assessment and Treatment	288,314	273,845	274,968
Rehabilitation and Support	54,786	71,360	68,857
Total	**506,458**	**530,610**	**530,346**

OUTPUT CLASS 1: PREVENTION SERVICES

- Health protection and monitoring services
- Health promotion services
- Immunisation services
- Smoking cessation services
- Screening 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.

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). Our main focus is on 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. 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. The range of strategies used, includes those 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 wider determinants of health, such as income, housing, food security, employment, and quality working conditions; our DHB and Regional Public Health 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 by ensuring high rates of immunisation in our populations. 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 to smokers to help smokers quit. Clinicians follow the ABC process:[13] Ask all patients whether they smoke and document their response; if the patient smokes, provide brief advice to quit smoking; and if patient agrees, provide Cessation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

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

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

How we measure the performance of our Prevention Services

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Public health protection and regulatory services	The number of disease notifications investigated in the sub-region[14]	V	HVDHB 395 Māori 44 Pacific 21	HVDHB 505 Māori 52 Pacific 31	HVDHB 425 Māori 49 Pacific 25	Lower than estimated
	The number of environmental health investigations in the sub-region	V	322	206	316	Higher than estimated
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	37	78	3	Less than estimated
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	30	29	17	Lower than estimated
	The percentage of infants fully or exclusively breastfed at 3 months[15]	C	50.4%	≥60%	50%	Not achieved
	Number of new referrals to Public Health Nurses in primary and intermediate schools	V, DoS	HVDHB 932 Māori 468 Pacific 211	HVDHB 898 Māori 466 Pacific 40	898	In line with estimate
	The number of adult referrals to the Green Prescription programme in the sub-region.[16]	V, DoS	3,734	1,218	1,393	Not achieved

[14] 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).

[15] This measure is based on all WCTO providers (not just Plunket), data based on trendly.co.nz

[16] This measure reflects referrals across the sub-region for Wairarapa, Hutt Valley and Capital & Coast DHBs.

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Immunisation Services	**Integrated Performance & Incentive Framework (IPIF) Health Start:** The percentage of two year olds fully immunised	C	95%	95%	94%	Not achieved
	Health Target: The percentage of eight month olds fully vaccinated	C	95%	95%	93%	Not achieved
	The percentage of Year 7 children provided Boostrix vaccination in the schools in the DHB[17]	C, DoS	81%	75%	78%	Achieved
	The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	74%	70%	64.7%	Not Achieved[18]
Smoking cessation services	**Health Target:** The percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in the last 15 months	C	81%	≥90%	92.80%	Achieved
	The percentage of hospitalised smokers receiving advice and help to quit.	C	95%	95%	88%	Not achieved

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

[18] Final dose is Dose 3 and target is 70% for year 2016/17.

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 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	93%	≥90%	92.3%	Achieved
Screening services	The percentage of eligible children receiving a B4 School Check	C	90%	≥ 95%	91.50%	Not Achieved
	IPIF Health Adult: The percentage of eligible women (25-69 yrs) having cervical screening in the last 3 years	C	M: 69%[19]	≥80%	M: 66.8%	Not achieved
			P: 71%		P: 71.2%	Not achieved
			T: 76%		T: 75.6%	Not achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 67%	≥70%	M: 67%	Not achieved
			P: 65%		P: 68%	Not achieved
			T: 73%		T: 75%	Achieved

Comments on Performance

Immunisation services

Immunisation services continue to be a significant focus in primary care and community health providers with final immunisation rates very close to target. Contributing to this has been an increase in the rate of Māori children fully immunised at two years, and achievement of a high rate of immunisation against HPV for Pacific girls. We continue to monitor and adapt services to ensure that children with delayed immunisations are reached.

Smoking cessation services

There has been continued progress in primary care settings to achieve the target levels for delivery of ABC advice for smoking cessation. The population of hospital patients for this measure includes those presenting

[19] 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.

to the Emergency Department, where in the last 12 months fewer people were given ABC advice. This is due largely to the pressure of high workload. As better workload and resourcing balance is restored the DHB will re-establish consistent provision of ABC advice to smokers.

Screening services

Considering total numbers of women screened the overall rate of breast screening is satisfactory. Our focus remains on reaching Māori and Pacific women to further increase coverage for both breast screening and cervical screening in these populations groups.

Health promotion and public health services

The measures used to evaluate health promotions and public health services demonstrate that the Regional Public Health service is both responsive and proactive. The service has undertaken significant numbers of disease investigations and environmental health investigations in response to notifications and has continued to be proactive in promoting good health through provision of expert advice to inform public health policy.

Controlled Purchase Operations (CPO) visits are led by the New Zealand Police service, with Regional Public Health (RPH) working in collaboration with policing units. Decisions on which premises to visit for CPO work are determined by police, targeting high risk premises rather than evenly distributed geographical location across the DHB sub-region. RPH has input into these targeting decisions. Accordingly the number of premises visited within the Hutt Valley district will fluctuate from year to year. In 2016/17 there were significantly fewer visits to premises selling alcohol which is in part due to normal fluctuation, and also impacted by the suspension of normal CPO scheduling while health and safety matters were addressed and new operating procedures developed for this work. With this work complete and police staff resourcing issues resolved it is expected that from 2017 the expected volume of CPO visits will be undertaken, contributing to the maintenance of a healthy physical and social environment across our district.

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, with some population groups suffering 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 ensure 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	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Primary care services	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	98%	≥98%	98%	Achieved
	The percentage of practices with a current Long Term Condition plan	Q, DoS	32%	90%	78%	Achieved
	The percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	88%	90%	87.10%	Not achieved
	The number of new and localised Health Pathways in the sub-region	Q	172	250	320	Achieved
	The average number of users (per month) of the Health Pathways website[20]	V	4,500	Est.5,750	7,913	In line with estimate

[20] This measure reflects referrals across the sub-region for Wairarapa, Hutt Valley and Capital & Coast DHBs. Number of sessions equals number of average users.

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Oral health services	The percentage of children under 5 years enrolled in DHB-funded dental services[21]	C, DoD	96%	95%	97%	Achieved
	The percentage of adolescents accessing DHB-funded dental services	C, DoD	2015: 73%	2015: ≥85% 2016: ≥85%	67.9%	Not achieved
Pharmacy services	The number of initial prescription items dispensed	V, DoS	1,569,032	Est. 1,543,994	1,550,429	In line with estimate
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item	C, DoD	81%	Est. 80%	83%	In line with estimate
	The number of people registered with a Long Term Conditions programme in a pharmacy	V, DoS	5,828	Est. 6,000	2,485	In line with estimate
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	V, DoS	205	220	210	In line with estimate

Comments on Performance

Primary care services

The DHB has maintained the high percentage of DHB domiciled population that is enrolled in practices within the Hutt Valley DHB area. 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.

In 2016/17 the number of Hutt Valley primary care practices with Long Term Condition Plans in place increased to 78% to achieve the target, while practices achieved slightly under the target for assessment of Cardiovascular Disease risk in their eligible population. The PHOs have continued to support general

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

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.

Significant work has focused on future sustainability of primary care with planning for the launch of Health Care Home practice development programme from 2017/18. This work will strengthen the delivery and future sustainability of primary care services in the Hutt Valley.

Work has continued on localising and launching more Health Pathways resulting in the target being well exceeded with 320 pathways now live on-line. The number of users to the website has grown substantially, indicating the value of the site to primary care practitioners.

Oral health services

The oral health target for percentage of children under five years are enrolled in DHB-funded dental services was achieved with 97% of children enrolled. Achieving the target is the outcome of working in collaboration with PHOs to identify children not enrolled in the dental services and automatically enrolling preschool children in this service. However, families are given the option to 'opt out' of enrolment in the service.

Pharmacy services

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 and indicate the significant number of interactions between people/whānau and community pharmacists and potential for enhanced pharmacist input to the health system.

The number of people registered with a Long Term Conditions programme in a pharmacy is 2,485. Improved access to primary and secondary care information about patient conditions will enable pharmacies to more easily assess risk and identify those patients needing the higher level of care that this service would provide.

The number of people participating in the Community Pharmacy Anticoagulant Management (CPAM) service is steady as 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.

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 mostly in a hospital setting where clinical expertise (across a range of areas) and specialist equipment are 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 for 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 are 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	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T, DoS	93%	95%	90.8%	Not achieved
	Health Target: The number of surgical elective discharges	V, DoD	6,101 100%	6,007	6,543 108%	Achieved
	The standardised[22] inpatient average length of stay (ALOS) in days, Acute[23]	T, DoST,	2.48	<2.35	2.24	Achieved
	The standardised inpatient average length of stay (ALOS) in days, Elective	DoS	1.62	≤1.55	1.58	Not Achieved
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	2.1	≤2.0	1.4	Achieved
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	0.3	≤0.5	0.5	Achieved
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	3.1	≤3.1	4.5	Not Achieved

[22] 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.

[23] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2017.

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
	The weighted average score in the Patient Experience Survey[24]	Q, DoS	Communication: 8.2 Coordination: 8.4 Partnership: 8.3 Physical and Emotional Needs: 8.5	8.5	Communication: 8.5 Coordination: 8.7 Partnership: 8.6 Physical and Emotional Needs: 8.8	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	7.0%	≤7%	6.0%	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments	Q, DoS	8.1%	≤8%	9.0%	Not Achieved
Cancer services	The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	T, DoD	99.8%	100%	90%	Not achieved

[24] 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	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
	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[25]	T, DoD	73%	≥85%	80%	Not achieved
Mental health and addictions services	The number of people accessing secondary mental health services	V	Total 6,297	Est. 6,033	Total 6,317	In line with estimate
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks	T, DoS	41%	≥95%	71%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	76%	≥95%	95%	Achieved
	The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the seven days prior to the day of admission.	Q, DoS	36%	≥46%	N/A	Not achieved[26]

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

[26] This is the most recent data available from the Ministry of Health. Due to the provider of the national KPI data migrating to an online dashboard, 2016/17 data is not yet available.

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
	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	38%	≥49%	N/A	Not achieved[27]

Comments on Performance

Medical and surgical services

In 2016/17, the Health Target focused on shorter waiting times in the Emergency Department was not achieved. Maintaining gains made in this performance measure has proven difficult. The DHB remains committed to sustaining an improved level of performance workforce and service improvement.

The improvements in hospital processes that resulted in reduction of the average length of stay (ALOS) in 2015/16 for both acute and elective hospital patients have been sustained, with further reductions in the duration of stays in 2016/17. The high quality of processes and care provided to sustain this performance is also demonstrated by the maintenance of low readmission rates and the strong performance by the HVDHB in the Patient Experience Survey results. A number of projects focusing on quality of care for patients are ongoing through the hospital service to ensure that we continue to make gains in delivering shorter, safer and smoother care in our hospital.

Cancer services

Ensuring that cancer patients receive prompt high quality care is a high priority for our DHB. There has been a significant effort made to improve the care for cancer patients and to sustain the improvements made. This effort has resulted in an increase in the proportion of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. While the DHB has not yet achieved the target for this measure our performance on this measure has improved and we are focused on continuing to improve and sustaining the gains made.

Mental health and addictions services

The demand for Mental Health Services in our district is growing in line with expectations. The capacity of the MHAIDs service to see people in line with the targets has not been met across all services due in most part to insufficient capacity in the relevant services. Building the capacity and capability in the MHAIDS services in our district is a key focus for the HVDHB. We continue to work on improving the integration of

[27] This is the most recent data available from the Ministry of Health. Due to the provider of the national KPI data migrating to an online dashboard, 2016/17 data is not yet available.

services with primary care in partnership with the PHOs and with community providers. This work will be further strengthened in 2017/18.

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, working 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	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 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%	99.8%	Achieved
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	C, DoS	66%	≥ 65%	67%	Achieved
	Percentage of the population aged 75+ years who are in Aged Residential Care (including private payers).	C, DoS	11%	≥11%	12%	In line with estimate
	The number of subsidised aged residential care bed days[28]	V, DoS	295,905	Est. 314,029[29]	286,254	In line with estimate
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	100%	≥ 95%	100%	Achieved
Disability services	The number of Disability Forums	V	HVDHB: 1 3DHB: 1	HVDHB: 1 3DHB: 1	HVDHB: 3 3DHB: 1	Achieved
	The number of sub-regional Disability Newsletters	V	8	≥2	12	Achieved
	The total number of hospital staff that have completed the Disability Responsiveness eLearning Module	Q	77	≥80	423	Achieved

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

[29] 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	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
	The total number of Disability Alert registrations[30]	Q	2,042	≥6,220	4,162 [31]	Fewer than estimated

Comments on Performance

Health of Older People Services

The percentage of people aged 65 years and over who have received long term home support services in the last three months and who have had an InterRAI assessment has been sustained. This means that people have been assessed using a comprehensive clinical tool (the InterRAI) and the information used to complete a care plan. The number of people continuing to live at home with support is in line with expectations for our district. Our aim is to enable people to remain living well in their own home with DHB investment in appropriate support services. It is positive to see the achievement against our target of more than 65 percent of people aged 65+ receiving DHB-funded HOP support being supported to live at home.

We are again pleased to report that 100% of the aged residential care facilities in our district meet the three-yearly certification standard requirements.

Disability services

We are pleased to report the gains made in increasing the awareness and responsiveness of Disability services in our district. More staff have completed the e-learning modules around disability responsiveness and we have met the targets we set for issuing newsletters and holding Disability forums. This is a solid foundation from which to continue to improve the delivery of high quality patient centred services for those living with disability.

[30] 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.

[31] This figure represents cumulative total of alerts, where people may register more than one alert. Alerts excluded from cumulative count in event of a patient death.

FINANCIAL STATEMENTS

CONTENTS

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Revenue				
Operating Revenue	2	525,996	527,368	498,797
Interest		551	700	698
Total Income		**526,547**	**528,068**	**499,495**
Expenditure				
Personnel Costs	3	168,950	168,950	165,779
Depreciation, Amortisation & Impairment expense	10-11	13,306	13,550	13,158
Outsourced Services		15,740	13,052	19,333
Clinical Supplies		24,588	25,730	23,799
Infrastructure and Non-Clinical expenses		14,735	12,270	14,444
Other District Health Boards		89,238	84,307	89,149
Non-Health Board Providers		191,450	196,270	165,547
Capital Charge	4	5,864	7,327	7,622
Finance costs	5	2,277	3,642	3,826
Other expenses	6	4,198	5,512	3,801
Total Expenditure		**530,346**	**530,610**	**506,458**
Net (deficit) / surplus		**(3,799)**	**(2,541)**	**(6,963)**
Other comprehensive revenue and expense				
Gain on property revaluations		4,010	-	-
Total comprehensive revenue and expense for the Year		**211**	**(2,541)**	**(6,963)**

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

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Equity as at 1 July		91,454	91,454	97,401
Capital Contributions from the Crown		79,000	-	1,223
Repayment of equity to the Crown		(207)	(207)	(207)
Revaluation Surplus		4,010	-	-
Net (deficit) / surplus		(3,799)	(2,542)	(6,963)
Equity as at 30 June	17	**170,458**	**88,705**	**91,454**

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	13,237	8,499	10,544
Debtors and other receivables	8	19,499	12,785	15,527
Inventories	9	1,443	1,481	1,481
Total Current Assets		**34,179**	**22,765**	**27,552**
Non-Current Assets				
Property, Plant and Equipment	10	191,759	195,961	195,324
Intangible Assets	11	19,475	17,306	17,780
Investments in Joint Ventures	12	550	-	400
Trust and bequest funds	13	1,369	1,419	1,419
Total Non-Current Assets		**213,153**	**214,686**	**214,923**
Total Assets		**247,332**	**237,451**	**242,475**
Liabilities				
Current Liabilities				
Creditors and other payables	14	36,913	29,661	34,696
Employee entitlements and provisions	15	30,278	27,466	28,066
Borrowings	16	471	9,223	9,622
Total Current Liabilities		**67,662**	**66,350**	**72,384**
Non-Current Liabilities				
Employee entitlements and provisions	15	7,181	6,816	6,816
Borrowings	16	663	70,173	70,415
Trust and bequest funds	13	1,368	5,407	1,406
Total Non-Current Liabilities		**9,212**	**82,396**	**78,637**
Total Liabilities		**76,874**	**148,746**	**151,021**
Net Assets		**170,458**	**88,705**	**91,454**
Equity				
Crown equity	17	124,538	45,538	45,746
Revaluation reserves	17	95,352	91,341	91,341
Accumulated deficit	17	(49,432)	(48,174)	(45,633)
Total Equity	17	**170,458**	**88,705**	**91,454**

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Cashflows from Operating Activities				
Cash receipts		523,654	529,819	504,293
Payments to providers		(280,688)	(280,577)	(260,226)
Payments to suppliers & employees		(225,379)	(224,350)	(225,648)
Goods and Services Tax (net)		744	-	341
Capital charge paid		(5,864)	(7,326)	(7,622)
Net cash flows from Operating Activities	18	**12,467**	**17,566**	**11,138**
Cashflows from Investing Activities				
Interest Received		551	700	698
Proceeds from sale of property, plant and equipment		-	(7)	(44)
Purchase of property, plant and equipment and Intangible assets		(7,436)	(13,064)	(10,513)
Investments		(150)	(2,750)	(400)
Net cash flows from Investing Activities		**(7,035)**	**(15,121)**	**(10,259)**
Cashflows from Financing Activities				
Equity Contribution		-	-	1,000
Loans and finance lease raised/(paid)		-	(641)	-
Interest paid		(2,630)	(3,642)	(3,781)
Payment of Finance Leases		98	-	(954)
Repayment of Equity		(207)	(207)	-
Net cash flows from Financing Activities		**(2,739)**	**(4,490)**	**(3,735)**
Net (Decrease) / Increase in Cash and Cash Equivalents		**2,693**	**(2,045)**	**(2,856)**
Cash and cash equivalents at beginning of year	7	10,544	10,544	13,400
Cash and Cash Equivalents at end of year		**13,237**	**8,499**	**10,544**

The accompanying notes form part of these financial statements. Explanations of major changes from last year are provided in note 25.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

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 2017, and were approved by the Board on 31 October 2017.

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 2016/17 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.

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 2017, the External Reporting Board issued PBE IFRS 9 *Financial Instruments*. In April 2017 the XRB issued *Impairment of Revalued Assets*. The timing of Hutt Valley DHB adopting these standards will be guided by when Treasury and the Ministry of Health adopt these standards. Hutt Valley DHB has not yet assessed the impact of these new standards.

Significant Accounting Policies

Revenue

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

Ministry of Health (MoH) revenue

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

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

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

ACC contracted revenue

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Rental income

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

Provision of services

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

Donations and bequests

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

Expenses

Capital Charge

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

Borrowing costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred except to the extent they are directly attributable to the acquisition or construction of a qualifying asset.

Leases

Finance Leases

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

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

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

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

Operating Leases

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

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

Foreign currency transactions

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

Cash and Cash equivalents

Cash and cash equivalents includes cash on hand, deposits held on call with NZ Health Partnerships Limited (NZHPL) 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 consist 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 NOS assets 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

Employers 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 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

	2017 Actual $000	2016 Actual $000
Ministry of Health contract funding	412,240	404,661
ACC Contract revenue	5,542	5,435
Other Government	727	817
Revenue from other District Health Boards	100,762	82,888
Other patient care related revenue	5,967	4,516
Other Income:		
Donations and bequests received	446	203
Gain on sale of fixed assets	-	44
Rental income and services	312	233
Total Operating Income	**525,996**	**498,797**

3 PERSONNEL COSTS

	2017 Actual $000	2016 Actual $000
Salaries and wages	162,539	163,030
Defined contribution plan employer contributions	3,834	3,549
Increase/(decrease) in liability for employee entitlements	2,577	(800)
Total Personnel Costs	**168,950**	**165,779**

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 changed during the year. The rate for the first six months from 1 July 2016 to 31 December 2016 was 7% and the rate for the second 6 months from 1 January 2017 to 30 June 2017 was 6% (2016: 8%).

5 FINANCE COSTS

	2017 Actual $000	2016 Actual $000
Interest on Crown Loans	2,228	3,754
Interest on finance leases	49	72
Total Finance Costs	**2,277**	**3,826**

6 OTHER EXPENSES

	2017 Actual $000	2016 Actual $000
Audit Fees for financial statement audit	142	151
Audit-related fees for internal audit services	109	92
Operating lease expense	3,526	3,128
Impairment of debtors	126	40
Board member fees	286	284
Loss on disposal of property, plant and equipment	9	106
Total Other expenses	**4,198**	**3,801**

7 CASH AND CASH EQUIVALENTS

	2017 Actual $000	2016 Actual $000
Call Deposits with NZ Health Partnerships Ltd	7,134	4,233
Cash at bank and on hand	6,103	6,311
Total Cash and cash equivalents	**13,237**	**10,544**

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 $20.1m (2016: 19.6m).

8 DEBTORS AND OTHER RECEIVABLES

	2017 Actual $000	2016 Actual $000
Ministry of Health	8,217	5,379
Other DHBs	3,078	3,068
PHARMAC	4,191	4,031
Trade debtors - other	1,652	2,253
Other Departments	191	206
Provision for doubtful debts	(311)	(226)
	17,018	**14,711**
Prepayments	2,481	816
Total Debtors and other receivables	**19,499**	**15,527**
Total Debtors and other receivables comprises:		
Revenue from the sale of goods and services (exchange transactions)	4,949	1,092
Revenue from grants (non-exchange transactions)	14,550	14,435
Total Debtors and other receivables	**19,499**	**15,527**

The carrying value of receivables approximates their fair value.

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

	2017			2016		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	14,366	-	14,366	12,956	(1)	12,955
Past due 1-30 days	168	(8)	160	641	(2)	639
Past due 31-60 days	694	(16)	678	49	(1)	48
Past due >60days	2,101	(287)	1,814	1,291	(222)	1,069
Total	**17,329**	**(311)**	**17,018**	**14,937**	**(226)**	**14,711**

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:

	2017 Actual $000	2016 Actual $000
Balance at 1 July	(226)	(255)
Provisions write back/(made)	(126)	(39)
Receivables written off during the year	41	68
Closing Balance	**(311)**	**(226)**

9 INVENTORIES

	2017 Actual $000	2016 Actual $000
Pharmaceuticals	119	152
Surgical and medical supplies	1,324	1,339
	1,443	**1,491**
Provision for obsolescence	-	(10)
Total Inventories	**1,443**	**1,481**

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 (2016: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2016: 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 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)
Adjustments	-	-	(1,989)	(2,973)	-	-	(4,962)
Revaluation increase/(decrease)	-	-	-	-	-	-	-
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
Balance 30 June 2016	16,030	2,312	170,319	40,621	2,062	2,291	233,635
Additions	-	322	158	1,365	-	-	1,845
Disposals	-	-	-	(473)	-	-	(473)
Adjustments	-	-	(3,729)	(1,936)			(5,665)
Revaluation increase/(decrease)	4,010	-	-	-	-	-	4,010
Work In progress	-	-	4,595	3,169	-	-	7,764
Balance at 30 June 2017	20,040	2,634	171,343	42,746	2,062	2,291	241,116

Accumulated depreciation and impairment losses							
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
Balance at 1 July 2016	-	133	8,330	27,597	926	1,325	38,311
Depreciation expense	-	135	8,156	2,762	178	275	11,506
Depreciation on disposals	-	-	-	(459)	-	(1)	(460)
Balance 30 June 2017	-	268	16,486	29,900	1,104	1,599	49,357
Carrying Amounts							
At 1 July 2015	16,030	2,312	166,602	14,127	1,314	1,241	201,626
At 30 June 2016 and 1 July 2016	16,030	2,179	161,989	13,024	1,136	966	195,324
At 30 June 2017	20,040	2,366	154,857	12,846	958	692	191,759

The net carrying amount of assets held under finance leases is $1.0m (2016: 1.14m) for plant and equipment.

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

Capitalised interest of $5.96m was included in the 2017 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.

11 INTANGIBLE ASSETS

	Acquired Software	NOS Shared Services Rights	Investment In RHIP	Total
	$000	$000	$000	$000
Cost or valuation				
Balance 1 July 2015	15,489	1,910	4,281	21,680
Additions	4,341	-	1,306	5,647
Adjustments	(2,236)	-	-	(2,236)
Work in progress	1,619	-	-	1,619
Balance 30 June 2016	19,213	1,910	5,587	26,710
Balance 1 July 2016	19,213	1,910	5,587	26,710
Additions	2,164	-	-	2,164
Adjustments	(1,619)			(1,619)
Work In progress	1,986	-	964	2,950
Balance 30 June 2017	21,744	1,910	6,551	30,205
Accumulated amortisation and impairment losses				
Balance at 1 July 2015	7,452	-	-	7,452
Amortisation expense	1,478	-	-	1,478
Adjustment	-	-	-	-
Revaluation	-	-	-	-
Balance 30 June 2016	8,930	-	-	8,930
Balance at 1 July 2016	8,930	-	-	8,930
Amortisation expense	1,800	-	-	1,800
Balance 30 June 2017	10,730	-	-	10,730
Carrying Amounts				
At 1 July 2015	8,037	1,910	4,281	14,228
At 30 June 2016 and 1 July 2016	10,283	1,910	5,587	17,780
At 30 June 2017	11,014	1,910	6,551	19,475

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

During the year no further capital payments were made 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. Therefore as at 30 June 2017, capital payments remain at a total of $1.91m (2016: $1.91m). 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

	2017 Actual $000	2016 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares – Allied Laundry Limited	550	400
Closing Balance	**550**	**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.

	2017 Actual $000	2016 Actual $000
Opening balance	1,419	1,288
Funds received	272	180
Interest received	27	53
Funds disbursed	(349)	(102)
Closing Balance	**1,369**	**1,419**

14 CREDITORS AND OTHER PAYABLES

	2017 Actual $000	2016 Actual $000
Payables under exchange transactions		
Creditors	2,526	2,157
Accrued expenses	21,798	22,437
Inter-district flows	2,324	791
Interest	-	402
Income in advance	2,400	16
Total payables under exchange transactions	29,048	25,803
Payables under non-exchange transactions		
Taxes	1,737	2,392
Trusts	6,128	6,501
Total payables under non-exchange transactions	7,865	8,892
Total Creditors and other payables	**36,913**	**34,696**

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

	2017 Actual $000	2016 Actual $000
Current provision		
Salary and Wages Accrued	6,287	4,518
Annual leave	17,077	16,467
Long Service Leave	2,090	818
Retirement Gratuities	487	601
Continuing Medical Education Leave and Expenses	1,057	1,007
Other Entitlements	3,280	4,655
Total Current provision	**30,278**	**28,066**
Non-current provision		
Long Service leave	1,757	1,868
Retirement Gratuities	670	703
Continuing Medical Education Leave and Expenses	2,826	2,717
Other Entitlements	1,928	1,528
Total Non-current provision	**7,181**	**6,816**
Total Employee Entitlements and Provisions	**37,459**	**34,882**

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% (2016: 4.75%) and an inflation factor of 2.0% (2016: 2.0%) has been used.

16 BORROWINGS

	2017 Actual $000	2016 Actual $000
Current portion		
Finance Leases	471	622
Crown Loans - fixed interest	-	9,000
	471	**9,622**
Non-current portion		
Finance Leases	663	415
Crown Loans - fixed interest	-	70,000
	663	**70,415**
Total borrowings	**1,134**	**80,037**
Total borrowing facility limits		
Crown Loans - fixed interest	-	79,000
	-	**79,000**

Crown Loans

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity.

On 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onwards all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of the existing Crown loans to equity was completed by a non-cash transaction, other than interest due at the conversion date.

As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 financial year and increasing DHB appropriations for the increase capital charge cost to the DHB thereafter.

The value of the Hutt Valley DHB loans converted to equity on 15 February 2017 was $79m.

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 $1.134m (2016: $1.037m). Fair value is estimated at the present value of future cash flows.

Analysis of Finance Lease

	2017 Actual $000	2016 Actual $000
Minimum lease payments payable:		
Not later than one year	492	724
Later than one year and not later than five years	736	511
Later than five years	-	-
Total minimum lease payments	1,228	1,235
Future finance charges	(94)	(198)
Present value of minimum lease payments	1,134	1,037
Present value of minimum lease payable:		
Not later than one year	471	622
Later than one year and not later than five years	663	415
Later than five years	-	-
Total present value of minimum lease payments	1,134	1,037

Description of finance leasing arrangements

Hutt Valley DHB has entered into new finance leases during the year 2017: $2.7m (2016: 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

	$000	Land Revaluation Reserve $000	Buildings Revaluation Reserve $000	$000	$000
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)
Revaluation surplus	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	(6,963)	(6,963)
Balance at 30 June 2016	**45,746**	**11,669**	**79,672**	**(45,633)**	**91,454**
Balance at 1 July 2016	45,746	11,669	79,672	(45,633)	91,454
Crown Loan converted into Equity	79,000	-	-	-	79,000
Repayment of Equity	(207)	-	-	-	(207)
Revaluation Reserve	-	4,010	-	-	4,010
Surplus/(deficit) for the year	-	-	-	(3,799)	(3,799)
Balance at 30 June 2017	**124,539**	**15,679**	**79,672**	**(49,432)**	**170,458**

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

	2017 Actual $000	2016 Actual $000
Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities		
Net surplus/(deficit)	(3,799)	(6,963)
Add/(less) non-cash items:		
Depreciation and amortisation expense	13,306	13,158
Increase/(decrease) in Provisions	2,662	(830)
Total non-cash items	**15,968**	**12,328**
Add/(less) items classified as investing or financing activity:		
(Gains)/losses on sale of property, plant and equipment	9	150
Net interest paid	1,677	3,056
Total items classified as investing or financing activity	**1,686**	**3,206**
Add/(less) movements in statement of financial position items:		
(Increase)/decrease in debtors and other receivables	(4,058)	(371)
(Increase)/decrease in inventories	37	(90)
Trust Movement	(360)	-
Increase/(decrease) in creditors and other payables	2,993	3,028
Net movements in Working Capital items	**(1,388)**	**2,567**
Net cash flow from Operating Activities	**12,467**	**11,138**

19 CAPITAL COMMITMENTS AND OPERATING LEASES

	2017 Actual $000	2016 Actual $000
Capital commitments	4,002	1,954
Operating Leases as lessee		
Not later than one year	1,784	1,677
Later than one year and not later than five years	2,028	1,075
Later than five years	6	-
Total Non-cancellable Commitments	**7,820**	**4,706**

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.
- Theatre related equipment and CT scanner are leased for periods ranging from 3 to 5 years, with expiry dates from April 2020 to June 2022.

20 CONTINGENCIES

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2017 (2016: 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.

	2017 Actual $000	2016 Actual $000
Salaries and other short-term employee benefits	1,871	2,413
Full time equivalent	10.30	9.75
Total key management personnel compensation	**1,871**	**2,413**

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 $72.3m (2016: $60.3m), with total expenditure of $83.7m (2016: $82.3m). The amount owing to Hutt Valley DHB by Capital & Coast DHB at the end of the financial year was $2.17m (2016: $2.06m), and the amount Hutt Valley DHB owed to Capital & Coast DHB was $5.27m (2016: $2.30m).

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 $11.9m (2016: $10.6m), with total expenditure of $0.8m (2016: $1.12m). The amount owing to Hutt Valley DHB by Wairarapa DHB at the end of the financial year was $0.60m (2016: $1.19m), and the amount owing to Wairarapa DHB was $0.005m (2016: $0.065m).

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 (2016: 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**	**2016/17 actual ($000)**	**2015/16 actual ($000)**
Andrew Blair	Chair (since December 2016)	26	0
Wayne Guppy	Deputy Chair	29	28
David Ogden	Current Member	23	23
John Terris	Current Member	23	23
Ken Laban	Current Member	23	22
Peter Douglas	Current Member	22	22
Yvette Grace	Current Member	21	17
Tim Ngan-Kee	Current Member (since December 2016)	13	0
Kim von Lanthen	Current Member (since 9 May 2017)	3	0
Prue Lamason	Current Member (since December 2016)	12	0
Lisa Bridson	Current Member (since December 2016)	12	0
Previous Board Members (until new Board elected December 2016)			
Dr Virginia Hope	Chair until 4 December 2016	20	46
David Bassett	Member until 4 December 2016	10	23
Kathryn Austin	Member until 4 December 2016	10	23
Sandra Greig	Member until 4 December 2016	9	22
Jaimes Wood	Member until March 2016		17
Total Board member remuneration		256	265
Total full time equivalent		**0.97**	**0.87**

Board and committee meeting attendances in the year to 30 June 2017:

Board Member	Position	Meetings Attended				Meetings held			
		Board	FRAC	HAC	CPHAC-DSAC	Board	FRAC	HAC	CPHAC-DSAC
Andrew Blair	Board Chair (from 5 December 2016)	7	6	0	0	9	11	2	4
Wayne Guppy	Deputy Board Chair	8	8	2	3	9	11	2	4
David Ogden	Current Member	9	9	2	0	9	11	2	4
John Terris	Current Member	9	5	2	1	9	11	2	4
Ken Laban	Current Member	7	8	2	0	9	11	2	4
Peter Douglas	Current Member	7	9	0	0	9	11	2	4
Yvette Grace	Current Member	7	0	2	0	9	11	2	4
Tim Ngan Kee	Current Member since 5 December 2016	7	6	0	0	9	11	2	4
Kim von Lanthen	Current Member since 9 May 2017	2	1	0	0	9	11	2	4
Prue Lamason	Current Member since 5 December 2016	6	0	0	0	9	11	2	4
Lisa Bridson	Current Member since 5 December 2016	6	0	0	1	9	11	2	4
Previous board and committee members									
Virginia Hope	Board Chair until 4 December 2016	1	5	1	3	9	11	2	4
David Bassett	Member until 4 December 2016	2	4	0	0	9	11	2	4
Kathryn Austin	Member until 4 December 2016	1	0	2	3	9	11	2	4
Sandra Greig	Member until 4 December 2016	2	0	0	2	9	11	2	4

Roger Jarrold is the external chair of the Finance Risk & Audit Committee (FRAC) for HVDHB. During the year he attended 8 of the 11 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 5 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:

	2017		2016	
	Carrying Amount $000	Fair Value $000	Carrying Amount $000	Fair Value $000
Cash and cash equivalents	13,237	13,237	10,544	10,544
Debtors and other receivables	19,499	19,499	15,527	15,527
Creditors and other payables	36,913	36,913	32,288	32,288
Crown loans-fixed interest	-	-	79,000	83,416
Finance leases	1,134	1,134	1,037	1,037
	70,783	**70,783**	**138,396**	**142,812**

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:

	2017 Actual $000	2016 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
AA+	7,472	7,730
AA-	-	-
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	7,134	4,233
Total	**14,606**	**11,963**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	13,237	10,544
Trust and bequest funds	1,369	1,419
Debtors and other receivables	19,499	15,527

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
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**

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2017					
Creditors and other payables	32,776	32,776	32,776	-	-
Finance leases	1,134	1,485	591	569	325
Crown Loans-fixed interest	-	-	-	-	-
Total	**33,910**	**34,261**	**33,367**	**569**	**325**

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 2017 are provided below.

Statement of Comprehensive revenue and expense

The Hutt Valley DHB recorded a deficit of $3.799m compared with a budget deficit of $2.541m. The major variances were:

- Reduction in funding due to reduced capital charge rate and debt to equity conversion. This is offset by reduced expense
- Higher costs in outsourced medical is due to 3DHB services in mental health and radiology along with locum cover in Children's and Women's Health.
- Higher other District Health Board costs primarily due to PCT wash-ups budgeted in Pharmaceutical line and increased acute activity in neonatal, cardiothoracic and neurosurgery.

Statement of Financial Position

Cash and cash equivalents were higher than budget due to recovery of the deficit position which has a positive impact on cash as spending slows down. Increase in total assets is largely due to increase in land revaluation. Increase in creditors and other payables are due to increase in Income in advance for pay equity. Increase in Employee Entitlements is mainly due to increase in actuarial valuations.

During the year, Hutt Valley DHBs existing crown loans of $79m were converted into Crown equity via a non-cash transaction.

Statement of Cash Flows

The net cash flow increased due to the improved financial position.

28 COST OF SERVICE STATEMENTS FOR OUTPUT CLASSES

For the year ended 30 June 2017

$000s	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
	2016\17 Actual	2016\17 Budget	2015\16 Audited	2016\17 Actual	2016\17 Budget	2015\16 Audited	2016\17 Actual	2016\17 Budget	2015\16 Audited	2016\17 Actual	2016\17 Budget	2015\16 Audited	2016\17 Actual	2016\17 Budget	2015\16 Audited
Income															
Operating Income	22,037	21,179	21,883	164,747	164,610	152,281	268,139	270,213	268,786	71,073	71,366	55,848	525,996	527,368	498,797
Interest Income	28	40	35	18	26	23	504	632	639	1	1	1	551	700	698
Total Income	22,065	21,219	21,918	164,765	164,636	152,304	268,643	270,845	269,425	71,074	71,367	55,849	526,547	528,068	499,495
Expenditure															
Personnel Costs	12,780	12,156	12,812	9,698	10,420	4,748	142,379	142,807	144,608	4,094	3,567	3,611	168,950	168,950	165,779
Depreciation	273	364	298	776	790	760	12,237	12,380	12,082	21	16	19	13,306	13,550	13,158
Outsourced Services	1,347	1,049	1,380	1,459	1,273	1,091	12,620	10,302	16,435	313	429	427	15,740	13,053	19,333
Clinical Supplies	501	545	586	497	511	481	22,174	23,507	21,497	1,416	1,166	1,235	24,588	25,730	23,799
Infrastructure and Non Clinical Expenses	395	519	659	733	914	610	13,532	10,495	13,111	76	70	65	14,735	11,998	14,444
Other District Health Boards	59	416	56	18,765	15,836	15,424	67,036	64,076	70,182	3,378	3,979	3,487	89,238	84,307	89,149
Non Health Board Providers	2,006	1,507	1,242	127,627	129,370	115,108	4,339	5,329	3,980	57,478	60,064	45,216	191,450	196,270	165,547
Capital Charge	253	326	341	992	1,040	1,050	4,610	5,949	6,220	9	11	12	5,864	7,327	7,622
Interest Expense	39	62	62	26	41	41	2,211	3,536	3,719	1	2	2	2,277	3,642	3,825
Other	1,073	1,075	1,076	530	530	122	2,484	4,131	2,559	111	49	43	4,198	5,783	3,802
Internal Allocations	3,632	3,559	3,643	3,062	3,102	1,767	(8,654)	(8,667)	(6,079)	1,960	2,007	669	0	0	0
Total Expenditure	22,358	21,578	22,155	164,165	163,827	141,202	274,968	273,845	288,314	68,857	71,360	54,786	530,346	530,610	506,458
Net Surplus / (Deficit)	(293)	(359)	(237)	600	809	11,102	(6,325)	(3,000)	(18,889)	2,217	7	1,063	(3,799)	(2,542)	(6,963)

STATEMENT OF RESPONSIBILITY

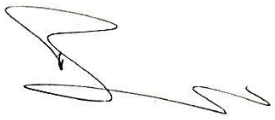
We are responsible for the preparation of Hutt Valley DHBs financial statements and statement of performance, and for the judgements made in them.

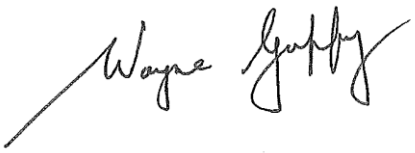
We are responsible for any end of year performance information provided by Hutt Valley DHB under section 19A of the Public Finance Act 1989.

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 2017.

Signed on behalf of the Board:





Andrew Blair
Board Chair
31 October 2017

Wayne Guppy
Deputy Board Chair
31 October 2017

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 2017

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 his behalf.

Opinion

We have audited:

- the financial statements of the Health Board on pages 58 to 94, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 10 to 15 and 17 to 56.

In our opinion:

- the financial statements of the Health Board on pages 58 to 94:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with the Public Benefit Entity Reporting Standards.
- the performance information of the Health Board on pages 10 to 15 and 17 to 56:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery 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; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information and we explain our independence.

Basis for opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit 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.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards 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

MINISTERIAL DIRECTIONS

Hutt Valley DHB complies with the following Ministerial Directions:

- The 2011 Eligibility Direction issues under s.32 of the NZ Public Health and Disability Act 2000
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of Government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. Procurement and ICT apply to Hutt Valley DHB
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizable ICT business transactions and investment specifically listed within the 2014 direction.

DIRECTORY

Head Office Postal Address: Hutt Valley District Health Board Private Bag 31-907 Lower Hutt 5040 Website: www.huttvalleydhb.org.nz Facebook: www.facebook.com/HuttValleyDHB 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 eleven members. Six are elected. Four are appointed by the Minister of Health (including the Chair and Deputy Chair). *In May 2017, an additional appointment was made by the Ministry after a Board Member passed away.*

Dr Virginia Hope, Chair (until 4 December 2016)	**Sandra Greig** (until 4 December 2016)
Katy Austin (until 4 December 2016)	**David Bassett** (until 4 December 2016)
Andrew Blair (from 5 December 2016)	**Wayne Guppy, Deputy Chair**
Ken Laban	**Peter Douglas**
Yvette Grace	**John Terris**
David Ogden	**Tim Ngan Kee** (from 5 December 2016)
Lisa Bridson (from 5 December 2016)	**Prue Lamason** (from 5 December 2016)
Kim von Lanthen (from 9 May 2017)	

Executive Leadership Team for Hutt Valley DHB *as at 30 June 2017*

Ashley Bloomfield	Chief Executive Officer	**Judith Parkinson**	General Manager – Finance and Corporate Services
Dale Oliff	Chief Operating Officer	**Amber O'Callaghan**	General Manager – Quality, Service Improvement and Innovation
Chris Kerr	Director of Nursing	**Kerry Dougall**	Director of Māori Health
Sisira Jayathissa	Chief Medical Officer	**Tofa Suafole Gush**	Director of Pacific Peoples Health

Claire Tahu	Director of Allied Health, Scientific & Technical	**Helene Carbonatto**	General Manager – Strategy, Planning and Outcomes
Fiona Allen	General Manager – Human Resources and Organisational Development	**Shayne Hunter**	Chief Information Officer, 3DHB IT Services
Bridget Allen	Chief Executive, Te Awakairangi Health Network (PHO)	**Nigel Fairley**	General Manager, MHAIDs

Community & Public Health Advisory Committee

The Community & Public Health Advisory Committee advises the Boards on the health needs and status of our population. This is a joint committee with Wairarapa, Hutt Valley, and Capital & Coast District Health Boards.

Dame Fran Wilde (Chair) (from 5 December 2016)	Capital & Coast	**Yvette Grace (Deputy)** (from 5 December 2016)	Hutt Valley
Sue Kedgley (from 5 December 2016)	Capital & Coast	**Andrew Blair** (from 5 December 2016)	Capital & Coast / Hutt Valley
Sue Driver (from 5 December 2016)	Capital & Coast	**Eileen Brown** (from 5 December 2016)	Capital & Coast
Lisa Bridson (from 5 December 2016)	Hutt Valley	**Prue Lamason** (from 5 December 2016)	Hutt Valley
John Terris (from 5 December 2016)	Hutt Valley	**'Ana Coffey** (from 5 December 2016)	Capital & Coast
Derek Milne	Wairarapa	**Fa'amatuainu Tino Pererira**	Hutt Valley
Alan Shirley	Wairarapa	**Jane Hopkirk**	Wairarapa
Kim Smith	Wairarapa	**Dr Tristram Ingham**	Capital & Coast
Nick Leggett (Chair) (until 4 December 2016)	Capital & Coast	**Katy Austin** (until 4 December 2016)	Hutt Valley
Dr Virginia Hope (Deputy) (until 4 December 2016)	Hutt Valley / Capital & Coast	**Sandra Greig** (until 4 December 2016)	Hutt Valley
Leanne Southey (until 4 December 2016)	Wairarapa	**Wayne Guppy** (until 4 December 2016)	Hutt Valley
Margaret Faulkner (until 4 December 2016)	Capital & Coast	**Helene Ritchie** (until 4 December 2016)	Capital & Coast

Finance Risk and Audit Committee

Roger Jarrold (Chair)	**Wayne Guppy (Deputy)**
Andrew Blair (from 5 December 2016)	**David Ogden**
Tim Ngan Kee (from 5 December 2016)	**Kim von Lanthen** (from 9 May 2017)

Peter Douglas (until 31 August 2017)	**Ken Laban**
David Bassett (until 4 December 2016)	
Hospital Advisory Committee	
The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Hutt Hospital and its services. From 5 December 2016, HAC business has been carried out at board meetings by the full Board, rather than through separate HAC meetings. Separate HAC meetings will be held if needed.	
Dr Virginia Hope (Chair) (until 4 December 2016)	**Katy Austin** (until 4 December 2016)
Andrew Blair (Chair) (from 5 December 2016)	**Wayne Guppy (Deputy)** (from 5 December 2016)
Prue Lamason (from 5 December 2016)	**Lisa Bridson** **(**from 5 December 2016)
Tim Ngan Kee (from 5 December 2016)	**Kim von Lanthen** (from 9 May 2017)
Peter Douglas (until 31 August 2017)	**Yvette Grace**
David Ogden	**Ken Laban**
John Terris	