Healthy People | *Healthy Families* | *Healthy Communities*

Hutt Valley District Health Board

Annual Report 2018

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004.

HUTT VALLEY DHB

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CHAIR & CHIEF EXECUTIVE'S FOREWORD

Our Priorities

We are very pleased to present Hutt Valley District Health Board's annual report for the year ended June 2018. The Government has directed all DHBs to focus on achieving equity across our populations, the wellbeing of children, mental health and primary health care.

This report indicates our progress on these priority areas. We are strongly committed to building a thriving and sustainable organisation – putting patients at the centre of all that we do, while prudently and strategically managing our resources.

In 2017, we introduced *Our Vision for Change*. This sets the future direction of our DHB, and the following six priority areas indicate the direction we will take towards meeting the Government's over-arching priorities for New Zealanders:

- Supporting people to live well
- Shifting care closer to home
- Delivering shorter, safer smoother care
- Creating an adaptable workforce
- Effective commissioning, and
- Smart infrastructure.

We are making real progress towards many of these areas.

Our Achievements

We have exceeded our targets for reducing amenable mortality rates for Māori and Pacific. This indicates we are on the right track but still have a long way to go to close the equity gaps.

Our targets for getting help to people, through our general practices, to quit smoking have also been exceeded. Getting this support to people in a PHO setting is an effective way of encouraging them to think about quitting. We are on a good trajectory – we have increased the number of all patients who smoke being offered help through PHOs to 94 percent. Importantly, the number of Māori patients who smoke being offered support to quit through their PHO, has gone from 89 percent in 2016/17 to 92 percent in 2017/18. For Pacific people it has increased from 90 percent in 2016/17 to 92 percent in this financial year.

Steady progress has been made towards good oral health. Oral health is an important indicator of general health and our Bee Healthy Regional Dental Service has made very good headway while gaining a high level of awareness in the community. We now reach 26,000 primary and intermediate children in the Hutt Valley and the proportion of Pacific children who are cavity free at five has increased to 52 percent - up from 45 percent in the previous financial year.

There has been significant progress towards Māori mothers recorded as breastfeeding at three months. While this has increased to 46 percent, up from 39 percent the previous financial year, we remain focussed on this key area and will work hard to towards getting better outcomes for Māori breastfeeding mothers.

Significant progress has been made towards improving ambulatory sensitive hospitalisation rates (avoidable hospitalisations). Importantly this is noticeable for Pacific children. Pacific women have featured, in particular, in access to breast screening services – 72 percent of Pacific women in the screening age cohort are now being screened – up from 65 percent in the last financial year.

The big reduction in wait times for access to mental health and addiction services for those 19 and under, is promising. While we have not met this target, we have reduced the wait time so that now, almost 88 percent of those patients are seen within eight weeks – up from 80 percent in the previous year. We will continue to work hard to meet this target.

Being People Focussed

Our Choosing Wisely campaign has been heavily promoted throughout the hospital community. It is a way of thinking – one that empowers our patients to ask the right questions and be informed consumers of our services. We are very proud of the way this has been taken up by our clinicians and staff, because it leads to better outcomes for patients.

We have reshaped our organisational values based on staff and patient feedback. We are now looking to set in place values-based recruitment as a result, and have also developed a welcome programme for new staff to attend.

Planning for the Future

We have spent a good deal of time this year looking ahead. We created our Wellbeing Plan to guide our decision makers, our work and our investment as a DHB. This plan signals to our partners, providers and our community, our intention to champion wellbeing in our community. By working with our partners we want to make a collective impact – and we are committed to playing a key role in driving this way of working to achieve wellbeing in the community. You can read our Wellbeing Plan here http://www.huttvalleydhb.org.nz/about-us/vision-mission-values/wellbeing-plan-2018/

We advanced our Clinical Services Plan in the last financial year. This plan looks at the changes we need in our model of care over the next five to ten years. This plan was developed in this last year through extensive engagement across the health system involving clinicians, managers, community stakeholders, NGOs and consumers. Over 40 workshops and meetings were held to get the document in its current draft. We looking forward to reporting on this in the next annual report.

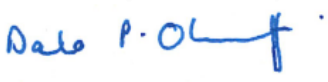
Very good progress was made towards contributing to a health literate and enabled population. Health Care Home is a patient-centred model of care delivered through two key PHOs; Ropata Medical Clinic and Hutt City Health Centre, which reaches around 20 percent of the Hutt Valley population. It is the future model for primary health care and we are very excited at the prospect of other PHOs rolling this model out in the new financial year.

Excellent progress was made towards the Māori Health Strategy to address systemic issues and unconscious bias that can affect decision making and contribute towards the health inequities Māori experience. We will continue with progressing this work in the current financial year.

Our Financial Performance

Our financial performance showed a $3 million deterioration on the previous year, with a $6.9 million deficit affected by the additional costs of delivering care to more people. This was a disappointing result, however we are committed to improving the financial position so we can invest in the services our population will need in future.

Andrew Blair
Chair, Hutt Valley DHB



Dale Oliff
Acting Chief Executive, Hutt Valley DHB

OUR VISION & VALUES

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

Our Vision

Healthy people, healthy families and healthy communities (Whānau Ora ki te Awakairangi).

Our Values

- *Always caring* –We are respectful, kind and helpful.
- *Can do* – We are positive, continually learning and growing, and appreciative.
- *In partnership* – We are welcoming, we listen, we communicate clearly, and we involve others
- *Being our best* – We are innovative, professional, and provide a safe environment for staff and patients.

The Treaty of Waitangi

Māori as the indigenous peoples of Aotearoa have unique rights under Te Tiriti o Waitangi (The Treaty of Waitangi). Hutt Valley DHB values the Treaty and the principles of:

- Partnership – working together with iwi, hapū, whānau and Māori communities to develop strategies and services to improve Māori health and wellbeing
- Participation – involving Māori at all levels of decision-making, planning, development and service delivery
- Protection – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

OUR POPULATION

Hutt Valley DHB covers the Te Awakairangi area – the Hutt Valley – and serves over 146,000 people. Our District Health Board covers both Upper Hutt City and Hutt City. People under 25 years of age account for 32 percent of the Hutt Valley population and those aged 65 years of age account for approximately 15 percent.

The Hutt Valley's population is ethnically diverse; 17 percent of our population identify as Māori, 8 percent as Pacific peoples and 75 percent as New Zealand European, Asian and Other. Overall, the Hutt Valley area has similar proportions of those living in the highest and lowest deprivation areas. However, these overall figures mask the extremes in deprivation seen in the Lower Hutt area, where there is a greater proportion of the population living in the most deprived areas.

AN AVERAGE DAY IN HUTT VALLEY HEALTH

On average five babies are born in the Hutt Valley each day, 18 breast cancer screenings are carried out, 32 children are immunised, 1,870 laboratory tests are done and 284 children visit the school dental service.

In addition to this, 378 people are seen by a primary nurse, 126 by a community nurse. 286 people attend outpatient clinics, 705 hours of home support are carried out, 13 people receive their annual diabetes review and 54 people get the flu vaccination.

At the hospital 131 people visit the Emergency Department and 75 patients are discharged. Each day thirteen new people access mental health support and 775 people reside in aged residential care.

With over 140,000 people living here it all adds up to a phenomenal amount of care and support that is provided to the Hutt Valley community every day.

OUR PERFORMANCE

We exceeded . . .

- Our targets to reduce amenable mortality rates for Māori and Pacific in the Hutt Valley. Amenable mortality rates are the proportion of deaths of people under 75 years old that could be avoided with effective and timely healthcare. While we still have a long way to go to achieving equity, our amenable mortality rates for Māori and Pacific are improving and we are closing the equity gap.

- Our targets to improve our patients' experience of care in Hutt Hospital across: communication, coordination, partnership, and physical and emotional needs.

- The Government targets set for us to improve access to elective services. We increased the target for the number of elective surgical discharges to 6,153 in 2017/18.

- Our target for the percentage of Primary Health Organisation enrolled patients who smoke and have been offered help by a health care practitioner in the last 15 months. Our rates have improved for our total enrolled population, as well as for Māori and Pacific patients. In 2016/17, 91 percent of all patients who smoke were offered help, and 89 percent of Māori and 90 percent of Pacific patients. In 2017/18, this increased to 94 percent of all patients who smoke being offered help, and 92 percent of Māori and 92 percent of Pacific patients who smoke being offered help.

We increased . . .

- Coverage of oral health services to children. Over the last three years the Bee Healthy Regional Dental Service has increased the number of children seen each year by 5,000, and the service now reaches around 73,000 primary and intermediate students every year (including 26,000 children in the Hutt Valley).

- The proportion of Pacific children in the Hutt Valley who were cavity free at age five. In 2015, only 35 percent of Pacific children examined were free of cavities. This increased to 45 percent in 2016, and 52 percent in 2017.

- Breastfeeding rates of Māori women. In 2015/16, only 38 percent of Māori were recorded as breastfeeding at three months. This has increased significantly to 46 percent in 2017/18. While there is still room for improvement, and we remain focussed on improving our rates, our efforts are paying off.

We achieved . . .

- Our target for screening women for breast cancer, with particular improvement in the coverage of Pacific women screened. In 2015/16, 65 percent of Pacific women were screened, and this has increased to 72 percent in 2017/18.

- Our System Level Measure target to reduce total Ambulatory sensitive hospitalisation rates. Ambulatory sensitive hospitalisations (ASH) are mostly unplanned admissions to hospital that could potentially have been avoided through primary care (eg general practice) interventions. As well as achieving our target, we also significantly reduced the ASH rates for Pacific children, from 15,738 admissions in the 12 months to March 2016, to 11,923 admissions in the 12 months to March 2018.

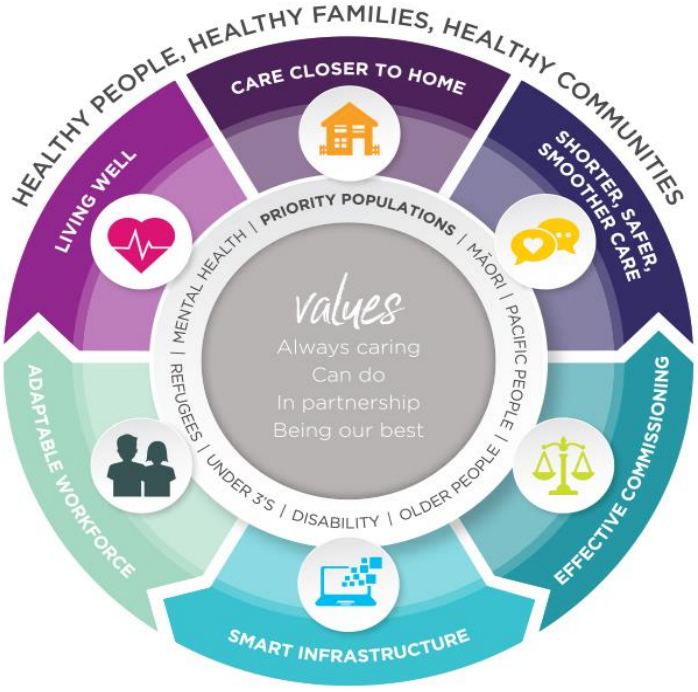
- Reductions in wait times to access hospital mental health services for children and adolescents (0-19 years old). In 2016/17, 80 percent of patients who were referred to our service were seen within eight weeks. We increased this to 91 percent in 2017/18, and we're continuing to reduce our wait times.

ACTIVITIES & OUTCOMES

The Hutt Valley health system performs well, but there are challenges for us now and in the future. We know, for instance, we are not meeting the needs of some people and groups, or supporting everyone to achieve the same standard of good health. We are not achieving equity for Māori or Pacific, or for those on lower incomes. Our population is also aging and there is a growing burden of long-term conditions. Changes are needed for us to appropriately manage and respond to the growing demand on health services.

To support these changes and guide our approach over the next five to ten years, we have developed *Our Vision For Change – How We Will Transform The Health System 2017-2027*.[1] This high-level strategy will help us achieve our vision of 'healthy people, healthy families, and healthy communities'. To achieve *Our Vision For Change*, our people, whānau and communities have told us the Hutt Valley health system needs to incorporate the following components.

- Care and services are organised and delivered equitably so everyone has the opportunity to achieve the same level of good health.
- Individuals and whānau are owners of their care and we involve them fully in decision-making about their care.
- Most health services focus on prevention, and health care is provided earlier and closer to people's homes.
- Urgent and complex care is readily available for episodes of ill health but most health care will be planned.
- Individuals and whānau experiences of health care is optimal, throughout their life span.
- Services are planned and delivered in partnership with local government, the wider health, social and education sectors.



- There is a clinically and financially sustainable future for our health system.

Key strategic directions and enablers have been identified to guide and support us towards creating the future health system we want. Our key strategic directions are: support living well, shift care closer to home, and deliver shorter, safer, smoother care. Our key strategic enablers are: adaptable workforce, smart infrastructure and effective commissioning.

The diagram of the following page shows the relationship between:

- the national health vision for all New Zealanders (from the New Zealand Health Strategy)
- the Government's Planning Priorities
- our regional and local visions for healthy people, healthy families, and healthy communities
- what success looks like in terms of outcomes and our ideal future health system for Hutt Valley DHB
- how we will measure our progress and performance
- what we will do to achieve our vision (our key directions and enablers), and
- how we work to achieve our vision (our core values).

[1] http://intranet.huttvalleydhb.org.nz/content/685e5e9b-38ca-4cf5-8e06-eb8bf84b4de7.cmr

Hutt Valley District Health Board – Achieving Our Vision For Change

National Vision	**All New Zealanders live well, stay well, and get well**			
Government Priorities	**Achieving equity**	**Child wellbeing**	**Mental health**	**Primary health care**
Regional Vision	**Central Region DHBs leading together to achieve New Zealand's healthiest communities**			
Our Vision	**Healthy People** (Mauri ora)	**Healthy Families** (Whānau ora)	**Healthy Communities** (Wai ora)	
Our goal for HVDHB	• Services are organised to ensure everyone has the opportunity to achieve the same level of good health • Individuals and whānau are owners of their care and we involve them fully in decision-making about their care • Most health services focus on prevention, and health care is provided earlier and closer to people's homes • Urgent and complex care is readily available for episodes of ill health but most health care will be planned • Individuals and whānau experiences of health care is optimal, throughout their life span • Services are planned and delivered in partnership with local government and the wider social and education sectors • There is a clinically and financially sustainable future for our health system			
Key Progress measures[2]	- **Equity of service access and outcomes for Māori, Pacific, and low income people (across all areas)** - Financial performance - Amenable mortality rates (deaths of people under 75 years old that could be avoided)			
	- Babies breastfed at 3 months - Child fully immunized at 2 years old - Oral health at age five - Screening for breast and cervical cancer (& eventually bowel cancer) - Adults offered help to quit smoking	- Ambulatory Sensitive Hospital (ASH) admissions (0-4 and 75+ yrs) - Diabetes management - ED presentation rates per capita - Acute hospital bed days per capita - Acute readmission to hospital	- Length of inpatient stay in hospital - Time patient is in ED - Waiting time to access mental health and addiction services - Falls in hospital - Access to electives - Patient experience in hospital	
What we're doing to achieve our vision	**Support people living well** We will work collaboratively with partners to create healthy environments, eliminate health inequities, and support people to adopt healthy lifestyles and keep well.	**Shift care closer to home** We will shift services so they are delivered closer to the people using them, so people can receive most of their (non-complex) care within their community or homes.	**Deliver shorter, safer, smoother care** We will coordinate and streamline patient care, so that individuals and whānau experience a shorter, safer and smoother journey through our services.	
	Adaptable Workforce We will create a work environment for staff that values what they do, nurtures skill development and provides the culture for them to be their best and provide quality care. We will have a well-trained and engaged workforce that is adaptable with a diverse skill mix.			
	Effective Commissioning We will ensure our commissioning is informed by evidence to achieve the best health outcomes for individuals and the population, support the elimination of health inequities, and improve people's experience of care.			
	Smart infrastructure We will create a digitally-enabled health system that supports people to stay well, and shares information and care plans for better tracking of care. We will use data to understand people's needs and drive people-focused services. Our hospital facilities will be designed for complex care, and networked with other hospitals.			
How we work	Always Caring	Can Do	**Our Values** In Partnership	Being Our Best

[2] We have chosen some key progress measures to closely monitor the progress we are making towards *Our Vision for Change*. However, it should be noted that we use a number of additional measures to monitor the quality of our service, which cover service access, safety, equity, efficiency, timeliness, outcomes, and patient experience.

OUR PROGRESS

Here we outline our progress in moving the Hutt Valley health system towards our ideal future state, as well as the outcomes we are achieving. It demonstrates Hutt Valley DHB's commitment to meeting Ministerial and public expectations to deliver a high-quality service now, and strategic planning to ensure our system is sustainable and can continue to improve health outcomes in the future.

This section outlines what we've done, how we're tracking, and areas of focus for improvement – under the three key strategic directions in *Our Vision for Change*. It also outlines what we're doing in terms of building our three key strategic enablers.

SUPPORT PEOPLE LIVING WELL

Supporting people living well means:

- We invest in helping people and whanau to help themselves and each other keep well
- We invest in the first three years of life
- We intensify our services for individuals and whānau most at risk of poor life outcomes
- We have shared goals for improving physical and mental health and wellbeing, and eliminating health inequalities across the health and social sector
- We work collaboratively with partners and other sectors to create healthy environments for all.

What We've Done

Wellbeing Plan

We've developed and launched a Wellbeing Plan for the Hutt Valley. This plan focusses on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that affect wellbeing in the Hutt Valley. Key focus areas of the plan are: housing, healthy lifestyles and physical activity, alcohol and other drugs, tobacco, wellbeing at work, and tamariki and whānau with complex social needs. Initiatives will be targeted to Māori and Pacific, as these populations are disproportionately represented in wellness statistics.

Māori Health Strategy

We're developing a Māori Health Strategy to provide detailed guidance on delivering the DHB's strategy, Our Vision For Change, equitably for Māori and transforming the Hutt Valley health system to accelerate and achieve Māori health outcomes. Our Māori Health Strategy is closely aligned to He Korowai Oranga, the national Māori Health Strategy, which aims to achieve Pae Ora (healthy futures for Māori), Wai Ora (healthy environments), Whānau Ora (healthy families), and Mauri Ora (healthy individuals).

Our data tells us we are not performing well for Māori compared to the rest of the population (non-Māori, non-Pacific). The Māori Health Strategy will help us turn this around and close the equity gaps. We will work in partnership with the community, including Iwi, Whānau Ora providers, Māori communities, primary health organisations and NGOs to develop a shared purpose and direction to achieve equity and Māori health outcomes. There is considerable goodwill and knowledge around equity and Māori health across the system. The Māori Health Strategy will help us turn the goodwill into practical changes that make a difference. We know, for instance, there is a need to grow our Māori workforce and continue initiatives to address institutional racism and develop a workforce that is responsive to Māori. We also need better data to underpin our decision making for commissioning services, and monitor the purchase of services so they support equity and contribute to the achievement of better health outcomes for Māori.

Improving sustainability and reducing carbon emissions

We've formed a Sustainability Committee focused on communication, education and achieving positive change across the organization by reducing carbon emissions and improving recycling. The group is working with local councils, Capital & Coast DHB and other interested groups to network and improve sustainability with an aim to become a good corporate citizen within the Hutt Valley region.

Changes already made include purchasing biodegradable paper medication cups and drinking cups, instead of polystyrene cups. We are aiming to reduce plastic water bottles, and medical staff are now provided with re-usable water bottles. A water fountain will be installed in the hospital cafeteria, which complements our healthy food and drink (water only) policy. We're cutting back on the use of disposable coffee cups with donated reusable coffee cups. The meals we provide in the hospital will also be served on crockery plates. We're steam-cleaning all clinical areas of the hospital and eliminating chemical cleaners by 2019. We're replacing thirty hospital fleet petrol vehicles with more environmentally friendly hybrids. Finally, we have applied to become members of CEMARS (Certified Emissions Measurement and Reduction Scheme).

Increased coverage of oral health services to children

We've improved the reach of oral health services to children. We trialled late evening appointments during terms three and four in 2017 at the Naenae Dental Hub. The trial showed promising results and we are looking to other similar initiatives to increase service flexibility. These include oral health checks to pre-aged school children at early childhood centres and Kohanga Reo in high need areas, holiday programmes so high-need children can have dental check ups during school holidays, and working with Māori and Pacific providers and local councils to promote the service and increase its coverage. Over the last three years the Bee Healthy Regional Dental Service increased the number of children seen each year by 5,000, and the service now reaches around 73,000 primary and intermediate school children every year.

Wrap-around care for pregnant women

We've launched a new midwifery drop-in service at Tamariki Ora/Waiwhetu Medical Centre, which provides wrap-around care for pregnant women - many of whom have complex social needs - in partnership with other relevant health and social services to help mother and baby get the best outcomes.

Sudden Unexpected Death in Infancy (SUDI)

We've contracted with local Māori health providers to deliver safe sleep devices to 400 at-risk whānau across the Hutt Valley. Both providers have undertaken to locally weave as many of the wahakura (woven flax bassinets for infants) as possible rather than purchase plastic pods. Kokiri Marae has also been contracted to provide a safe sleep coordination service, working with midwives, general practices and other key stakeholders to support safe sleep education across the Hutt Valley.

Bowel Screening

We've rolled out and embedded the Bowel Screening Programme to detect bowel cancer at an early stage. Eligible residents (aged between 60 and 74) have been screened and when necessary, accessed preventative treatment for bowel cancer. We're continuing to focus the programme on improving participation for priority populations.

Breast Screening

We're focussed on lifting our breast screening rates for Māori and Pacific women. Our rates for Māori and Pacific women are improving. We are data matching with GP practices to identify women who haven't been screened, and we're following-up with them to offer the screen. We're continuing to open weekend clinics to improve accessibility. We also plan to provide after-hours breast screening clinics for women.

Cervical Screening

We're working hard to increase our cervical screening rates, particularly for Māori and Pacific women. Our cervical screening team partners with GP practices to assist with the follow-up of overdue women. This includes booking clinic appointments, arranging transport and support, and referral to support to services. Combined breast and cervical screening days on Saturdays at Hutt Valley DHB has also helped women access 'Free Smear Clinics' out- of-hours, which have been well attended. We're also providing more smear services in the home. After-hours smear clinics have been introduced at Kokiri Marae in Lower Hutt, and Orongomai Marae and Timberlea Community Centre in Upper Hutt. These clinics have been very successful with a good uptake from unscreened and under-screened women.

Supporting people with mental health or addiction issues

We've developed and implemented new services to better support to people with mental health or addiction issues. A new Occupational Service has been established to assist people with mental health or addiction needs to find and keep employment. The road to recovery for a person affected by mental health illness or addictions can be hindered by long-term unemployment. The Occupation Service works with housing and recovery services, and inpatient and rehabilitation care services, to assist mental health service users attain their vocational goals. We've also supported the Hutt Women's Centre to extend its opening hours and provide maternal mental health care to assist support women with mental health needs.

Well Homes

We're continuing to support and enhance the Well Homes service, which supports whānau to make their homes warmer, safer and drier. Housing assessors visit a home to conduct healthy housing assessments and provide education. They link whānau to appropriate services such as insulation, heating, curtain banks, beds, bedding, carpets, rugs, financial assistance and social housing providers. We have introduced an automated referral system, so people admitted to hospital with respiratory problems are automatically offered the service. We have also partnered with more agencies to offer further support. For instance, Rimutaka/Arohata Prison, Department of Corrections, provides families in need with bedding, blankets, fire bricks, kindling and draft stoppers to help keep their homes warm and dry. This is a tangible way for offenders to give back to their communities and contributes to the Department of Corrections strategy to reduce re-offending by developing work and living skills.

Building healthy environments and promoting healthy choices

Our Regional Public Health service works with a variety of stakeholders – such as Early Childhood Centres, schools, workplaces, and local councils – to encourage and support the development of health-focused policy and healthy environments. For example, Regional Public Health, along with the Bee Healthy Regional Dental Service and other stakeholders, supported schools such as Randwick School, a decile three primary school in Lower Hutt, to become a 'water only school' and replace sugary drinks with water. Health promotional activities and initiatives are also undertaken by contracted providers (such as primary care and Māori and Pacific providers), collaborative partners (such as Healthy Families Lower Hutt), and Regional Public Health. These activities raise awareness and promote healthy choices across a range of topics.

Nutrition and physical activity programmes

There are a number of nutrition and physical activity programmes in the Hutt Valley targeted to priority populations. We've recently initiated a pilot 'healthy eating and exercise programme' through Sport Wellington that incentivises whānau with obese children identified through the B4 School Check to enrol in and complete the programme. Sport Wellington also delivers a free Active Families programme to help children and their whānau create a healthier lifestyle by becoming more active and learning about healthy eating. Te Awakairangi Health provides a Healthy Families Coach Service, where a team of dietitians and exercise specialists provide advice, ongoing support, and encouragement around nutrition, physical activity, and other healthy lifestyle changes. General practices can prescribe Green Prescriptions, where a referral is made for free physical activity and nutrition support. There are also Maternal Green Prescriptions

specifically designed for pregnant women. Wesley Community Action, community groups and organisations work with Regional Public Health to enable locally run fruit and vegetable cooperatives to provide fresh fruit and vegetables at affordable prices. Bags of fresh fruit and vegetables are delivered each week through 14 distribution centres across Hutt Valley. From 30 January to 30 June 2018, there were 14,310 orders for bags of fruit and vegetables.

How We're Tracking

Progress Measure	Baseline	Target 2017/18	Actual 2017/18	Trends – including equity gap [3]
Amenable mortality rates (rate per 100,000)	Deaths in 2009-2013: Total: 93 Māori: 180 Pacific: 157	Māori: 175 Pacific: 152	Deaths in 2011-2015:[4] Total: 94 Māori: 167 Pacific: 136	Achieved targets and ethnicity equity gap is reducing. However, significant ethnicity equity gap remains.
Babies breastfed at 3 months	2015/16: Total: 53% Maori: 38% Pacific: 52%	≥60%	Total : 55% Maori: 46% Pacific: 49%	Total performance is static, but good improvement for Māori.
Children fully immunized at 2 years	2015/16: Total: 95% Māori: 95% Pacific: 97%	≥95%	Total: 91% Māori: 90% Pacific: 94%	Our rates are consistent with a national trend of reducing rates, which is in part due to immunisation receiving negative publicity.
Children with no cavities at five years of age	2015: Total: 63% Māori: 49% Pacific: 35%	68%	2017: Total: 66% Māori: 50% Pacific: 52%	Overall increasing slowly and good improvement for Pacific.
Women screened for cervical cancer	2015/16: Total: 76% Māori: 69% Pacific: 71%	≥80%	Total : 67% Māori: 70% Pacific: 75%	Total rates reduced but Māori remaining static and Pacific improved.
Women screened for breast cancer	2015/16: Total: 73% Māori: 67% Pacific: 65%	≥70%	Total : 72% Maori: 69% Pacific: 68%	Total static with some improvement for Pacific.
PHO enrolled patients who smoke and are offered help to quit	2016/17: Total: 91% Māori: 89% Pacific: 90%	≥90%	Total: 94% Māori: 92% Pacific: 92%	Total rates improving and above target.
Hospital patients who smoke and are offered help to quit	2015/16: Total: 94% Māori: 93% Pacific: 95%	≥95%	2017/18: Total: 83% Māori: 81% Pacific: 91%	Technical data issues affecting our rates are being addressed.

[3] This is an assessment on whether the overall trend is improving, declining, or static, and whether the gap between Māori, Pacific, and other ethnicities is reducing, growing, or static. Red background represents a concerning trend, orange a trend we need to monitor closely, and a green represents a positive trend.

[4] Note: baseline rate is calculated from data available for 2013 (deaths in 5 year period 2009-2013), and actual 2017/18 rate is from the most recent report of 2015 data (deaths in 5 year period 2011-2015). There is currently a time lag for reporting of mortality data so the mortality rate for deaths in 2017-2021 will not be reported until financial year 2023/24.

Our Focus on Improvement

Smoking cessation

Smoking is a major risk factor for many cancers and for respiratory and cardiovascular disease. It's one of the leading modifiable risks to health accounting for about 9 percent of all illness, disability and premature mortality.[5] While overall rates of smoking have decreased within Hutt Valley, our rates of smoking amongst Māori, in particular, are high. It is estimated that 32 percent of Māori smoke in the Hutt Valley, compared to 17 percent across the total Hutt Valley population. Nationally, it is estimated that 37 percent of Māori smoke and 16 percent of the total New Zealand population smoke.[6] We're working to decrease smoking rates in the Hutt Valley through youth appropriate communication strategies and health promoting activities, smoking cessation training to midwives and pharmacists, and implementing the Hapu Mama programme at Kokiri Marae. The Hapu Mama programme is a new incentivised programme that encourages pregnant women and their partners to give up smoking. We've also started work on the development of a Hutt Valley Health System Tobacco Control Plan, in collaboration with key partners across council, primary care, community providers and Regional Public Health. Our rates of offering PHO enrolled patients who smoke help to quit are on target and improving, and we're working to improve the accuracy of our hospital data (discussed below).

Hospital patients who smoke and are offered help to quit

Hospital patients are asked about smoking and we are working to improve our screening rates. Patients identified as smokers are advised to quit, and offered a referral to the Regional Stop Smoking Service, Takiri Mai Te Ata (TMTA) for support to quit. Some system changes have affected the target 'hospital patients who smoke are offered advice to quit'.

From March 2017, we began piloting an electronic system to refer patients to TMTA. This included changes to the electronic discharge summary. However, we found smoking status, and the offering of quitting advice, became less accurately recorded. During the year, we also introduced an electronic nursing assessment recording tool (Trendcare). This may have had an impact on our processes for obtaining the correct data for the target. To improve this we have:

- continued revising and improving the electronic discharge summary, each iteration aiming to address issues and simplify the processes for recording data that informs the target;
- worked with specific departments to raise awareness of the target and identify the improvement actions; and
- continued to provide smoking cessation training.

We are planning to have TMTA staff at the hospital working face-to-face with patients who smoke, to assist them to quit. There has been an increase in the number of smokers referred to a quit service, as a result of the discharge summary changes, and we will continue refining our referral systems.

Breastfeeding Support

We're working hard to improve our breastfeeding rates in the Hutt Valley. Breastfeeding is important for the physical health and wellbeing of mothers and babies. Hutt Valley DHB's hospital Lactation Service offers breastfeeding support to mothers and babies in the hospital and runs outpatient appointments. On discharge from the antenatal ward, over 95 percent of mums have established breastfeeding. However, our breastfeeding rates drop at around six weeks postnatal, due in part to other broader wellbeing issues. Our breastfeeding rates are particularly low for Māori and we're focused on addressing this.

A Māori health provider, Te Rūnanganui, has been contracted to provide community breastfeeding support targeted to Māori women. This service is provided by an experienced lactation consultant, supported by

[5] Institute for Health Metrics and Evaluation (IHME). 2016. *GBD Compare.* Seattle, WA: IHME, University of Washington.

[6] New Zealand Health Survey: https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update/_w_b4015220/_w_befe7127/#!/home

Tamariki Ora staff and the Iwi Health Coordinator. Hutt Valley DHB also has a Breastfeeding Support Service that provides free drop-in clinics in the community as well as home visits. We also fund community antenatal classes with two hours of breastfeeding education. This includes specific antenatal classes for women under 24 and their support persons, and Kaupapa Māori Antenatal and Kaiāwhina Education classes held on Te Kakano o Te Aroha Marae.

Screening for family violence

We're working to improve our screening rates for family violence, so that issues are identified and help can be offered. We are aiming for 80 percent of eligible women 16 years old or over to be screened. Currently our rates of screening range from under 10 percent to around 50 percent, depending on the hospital service. To address this, we have adopted new Child Abuse and Neglect and the Intimate Partner Violence Policies and have implemented the national Family Violence Assessment and Intervention Guideline. Good progress has been made implementing the Violence Intervention Programme (including training) in the maternity and paediatric wards, and we're working to fully implement it in our Emergency Department. We're also focussed on developing clinical champion roles in each of key designated services.

SHIFT CARE CLOSER TO HOME

Shifting care closer to home means:

- Care is community-based 'by default' - services are delivered closer to people and their whānau
- Enhanced primary care functions as the 'health care home' of people and their whānau
- Health professionals and community providers collaborate, and work as one team to support people in their communities
- A hospital facility footprint focused on complex care and designed for contemporary models of care.

What We've Done

Health Care Homes

We've enhanced primary care by progressing the Health Care Home (HCH) patient-centred model of care across the Hutt Valley. The HCH is a team-based health care delivery model, led by primary health clinicians, providing comprehensive and continuing health care to help reduce disparities, improve access to timely care, and support people and their whānau to get the best possible health outcomes.

Ropata Medical Centre and Hutt City Health Centre have adopted the HCH model, representing approximately 20 percent of Hutt Valley DHB's 'enrolled population' (those enrolled with a general practice). Both practices have a new triage service, where patients calling the practices first thing in the morning may talk directly to a general practitioner or nurse. Talking to a health professional means some issues may be resolved over the phone, saving people the time and hassle of going to the practice. Both Hutt City Health Centre and Ropata Medical Centre offer extended opening hours, increasing the opportunity for patients to see their doctor outside normal working hours. They also use patient portals, so patients can go online to order repeat prescriptions, book appointments, check results and message their GP or nurse directly.

Implementation planning is progressing with other practices expected to adopt the HCH model in 2018/19 and 2019/20.

Primary Options for Acute Care

Primary Options for Acute Care (POACs) are funded packages of care or interventions that enable acute conditions to be managed in the community rather than the hospital. We've expanded POACs to support more acute conditions to be managed in the community through clinical pathways. POACs are used for deep vein thrombosis, cellulitis, acute urinary retention, acute asthma, renal colic, headache/migraine and dehydration. Further planning is underway to increase the uptake of POACs and to expand cover to a broader range of conditions in 2018/19.

Specialist support for general practice

We've improved patient care in the community by setting up a standardised process where general practice staff can phone a senior medical specialist for urgent (same day) advice. This is now available for geriatrics, paediatrics, cardiology and mental health. Work is progressing to expand this service to other fields such as palliative care, general medicine, and respiratory conditions. We've also developed and implemented a standardised process for general practice staff to access non-urgent advice from a medical specialist (within 1-3 days). This process has been established for diabetes and child and adolescent mental health. Work is underway to expand the model to cardiology, respiratory, adult mental health, and geriatric conditions. Timely access to specialist advice assists with hospital avoidance, greater coordination of care for the patient (especially if a referral for an acute specialist assessment is required) and improved support and up-skilling for general practice staff.

Better management of acute respiratory events in the community

A new model of care has been developed to better manage acute respiratory events in the community. Under the new model, patients with respiratory problems have a plan for accessing urgent (acute) medical services in the community when needed (via an ambulance and primary care pathway). A number of emergency department presentations have been avoided because patients are able to manage their condition in partnership with their general practice, using back-pocket prescriptions and access to immediate advice and support. The model is being expanded to more patients, targeted to practices with the greatest need, and planning is underway to manage more acute triage in the home setting by the Ambulance Service.

Falls prevention and management

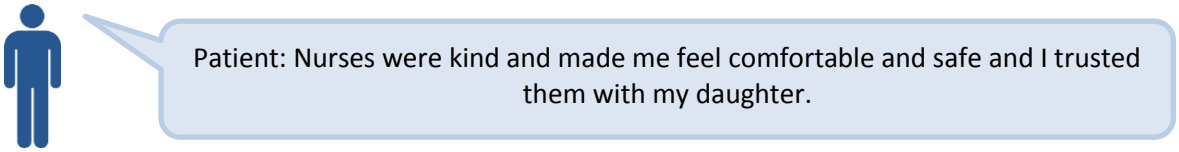
We've partnered with ACC to establish a falls prevention and management programme across Hutt Valley, Capital & Coast, and Wairarapa DHBs. The programme is delivered in the community and aims to reduce the incidence and impact of falls and fractures in older people. The programme includes falls risk screening, assessment, triage and management of frail elderly delivered in primary care; in-home strength and balance programmes delivered by our community physiotherapy teams, and group based community and balance programme delivered by local providers and coordinated by Sports Wellington.

Rheumatic Fever Prevention Programme

We're continuing to implement the Rheumatic Fever Prevention Programme to reduce cases of rheumatic fever in the Hutt Valley. Rheumatic fever can develop after a 'strep throat' – a throat infection caused by a Group A Streptococcus bacteria. Most strep throats get better and do not lead to rheumatic fever. However, in a small group of people an untreated strep throat leads to rheumatic fever one to five weeks after a sore throat. This can cause the heart, joints, brain and skin to become inflamed and swollen.

Hutt Valley is one of ten regions in New Zealand with a high incidence of rheumatic fever, and Māori and Pacific children and young adults have the highest rates. It is highly likely that a combination of crowded housing conditions and socio-economic deprivation, barriers to primary healthcare access, and the subsequent higher burden of untreated strep sore throat infections, are important factors leading to higher rates of rheumatic fever among Māori and Pacific people.

Under the Rheumatic Fever Prevention Programme, children with sore throats are assessed and treated, as appropriate, on the day they present. There are eight general practices and 16 pharmacies actively engaged in the programme. Targeted resource material has been developed and distributed, with support from community providers, to promote sore throat and rheumatic fever awareness – causes and prevention. There are strong links between the Rheumatic Fever Prevention Programme and the Well Homes programme. A combined Well Homes and Rheumatic Fever Governance Group meets quarterly to oversee implementation of the programme.



Better support in the community for people with mental health or addiction needs

We've launched a new community-based Youth Mental Health Respite Service with a focus on meeting the needs of young people in distress, including young Māori Tangata whai ora and Pacific people. We're working with local council to implement training for key stakeholders around suicide prevention and supporting first symptoms of mental health. This training will help better equip a diverse range of people in the community to engage with people experiencing mental health difficulties.

Community-Based Maternal Mental Health Services

Hutt Valley DHB funds several community-based maternal mental health services. Nāku Ēnei Tamariki provides an intensive community-based maternal mental health and social support service targeting Māori, Pacific, and low-income pregnant women, new mothers, and their whānau. Lower Hutt Women's Centre provides community-based primary mental health services, targeted to Māori, Pacific, and low income women. General practice provides primary mental health services for low income Māori or Pacific people over the age of 12. We're also scoping options to improve screening of maternal mental health in primary care and increase access to maternal mental health interventions, particularly for Māori, Pacific, and low-income women.

Cochlear implantation surgery

We've started providing cochlear implantation assessment and surgery at Hutt Hospital. A cochlear implant is an electronic medical device that does the work of damaged parts of the inner ear (cochlea) to provide sound signals to the brain. Until 2016 all patients had to travel to Christchurch for their assessment and surgery. In 2016 we started assessments and then in 2017/18 we started performing surgery. During 2017/18, we undertook 40 first specialist assessments, 16 surgeries, and 18 follow up appointments. The new closer-to-home service at Hutt removes the physical barrier that has existed for some people needing this life-changing surgery.

Community Pharmacist Strategy

We're developing a Community Pharmacist Strategy for the Hutt Valley to improve management of medications and the advice given to patients to improve health and wellbeing outcomes. We are supporting pharmacists to spend more time with patients and deliver expert advice about medications. The strategy aims to release pharmacists from supply activities and provide more patient and prescriber advice. We are also allocating more resources towards complex patients and our higher need communities to support equity of access and outcomes. We want to enable pharmacists to work with a wider team of health practitioners and providers – including general practice, community health, mental health, and aged residential care providers – for shared care of complex patients.

Building community resilience

We're increasing our community focus on emergency planning. We are working with community pharmacies to make sure they have plans in place and know what to do in an emergency. We are also working with Aged Residential Care facilities in the Hutt Valley so they are prepared and able to continue operating in a major event. Business continuity plans for our primary health organisations and general practices are up-to-date. Pandemic planning has been initiated through the Regional Public Health and Hutt Valley DHB, which will lead the way to integrating plans with community and health service providers. We are encouraging health and community services to participate in national and local exercises to test our emergency response planning.

Hutt Valley DHB has responsibility for the psychosocial response to emergencies affecting our population. Psychosocial leads and emergency planners from three DHBs have collaborated on how best to coordinate services in the Wellington region. This work has been based on an initial reconciliation of collective resources and the development of a comprehensive plan to increase psychosocial support capability and capacity in the short, medium and long term. Lessons have been learned from recent flooding events in Edgecumbe (Eastern Bay of Plenty) and Rotorua. Hutt Valley DHB has coordinated community training in Psychological First Aid to a diverse group, which is an important component in preparation to increase community psychosocial resilience to adverse events.

How We're Tracking

Progress Measure	Baseline	Target 2017/18	Actual 2017/18	Trend – including equity gap
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	12 Months to March 2016: Total: 8,749 Māori: 10,176 Pacific: 15,738	Total: ≤9,258 Māori: ≤ 9,739 Pacific: ≤13,910	12 Months to March 2018: Total: 8,794 Māori: 10,314 Pacific: 11,923	Target achieved for total, but significant equity gap remains. Māori rate has increased. Significant reduction in Pacific rate.
ASH Rates (avoidable hospitalisations) for 45-64 years	12 Months to March 2016: Total: 4,091 Māori: 6,842 Pacific: 7,335	Total: ≤3,948 Maori: ≤6,080 Pacific: ≤7,104	12 Months to March 2018: Total: 4,759 Māori: 8,478 Pacific: 7,706	Total rate increasing and increases across all ethnicities.
Well managed diabetes in primary care	2015/16: Total: 61% Māori: 50% Pacific: 50%	≥70%	Total: 55% Māori: 50% Pacific: 48%	Total rates have dropped. Māori has remained static and Pacific has dropped.
ED presentation rates per capita	2015/16: Total: 33% Māori: 41% Pacific: 45%	Not applicable	Total: 32% Māori: 40% Pacific: 44%	ED presentation rates per capita are relatively static.
Acute hospital bed days per capita	2016/17: Total: 350 Māori: 450 Pacific: 546	Total: 378 Māori: 432 Pacific: 496	Total: 347 Maori: 566 Pacific: 566	Total acute hospital bed days per capita have decreased, but Māori and Pacific have increased.
Acute readmission to hospital	Year to March 2016 Total: 12% Māori: 14% Pacific: 13%	Not applicable	Year to March 2018 Total: 12% Māori: 13% Pacific: 13%	Acute readmissions to hospital have been relatively static over last year three years. The national average standardised rate is 12%.

Our Focus on Improvement

Reducing avoidable hospitalisations for Māori and Pacific (ASH rates)

We remain focussed on reducing our rates of Ambulatory Sensitive Hospitalisations (ASH), particularly for Māori and Pacific. ASH hospitalisations are mostly acute (unplanned) admissions that are considered potentially avoidable through interventions delivered in primary care. In New Zealand children, ASH accounts for around 30 percent of all acute and arranged medical and surgical discharges in that age group each year.[7] Reducing ASH rates, and disparities for Pacific and Māori, is a top priority for Hutt Valley DHB and our System Level Measures Improvement Plan for 2018/19 includes a ranged of initiatives to improve rates.

Managing diabetes closer to home

Diabetes is a major cause of disability and premature death in New Zealand.[8] About 10,000 people in the Hutt Valley have diabetes, with a disproportionate number of Pacific people affected. Diabetes management is a good indicator of the responsiveness of a health service to people most in need. Our rates of well-managed diabetes in primary care show there is room for improvement. We're focussed on improving the management of diabetes in primary care and in the home. We're piloting and evaluating a digital health self-management programme for diabetes management in the Hutt Valley. The programme is targeted to Māori and Pacific people and encourages participants to undertake sufficient and sustained lifestyle changes to improve their ability to self-manage their condition. We're also working closely with our local primary health organisations to improve diabetes management of diabetes, particularly amongst Māori and Pacific people.

DELIVER SHORTER, SAFER AND SMOOTHER CARE

Shorter, safer and smoother care means:

- People and whanau can communicate with a wider range of health providers electronically
- Patients, their whanau and health professionals engage in informed conversations about treatments and interventions that add value to care
- Individualised shared care plans are built around what's important to people and whanau
- Primary and community services coordinate care across a wide range of health and social services based on a shared care plan
- All health professionals within the system engage and collaborate in training, leadership and quality improvement activities and opportunities.

What We've Done

Choosing Wisely

We've embraced the Choosing Wisely campaign, which promotes a culture where patients and health professionals have well-informed conversations around their treatment options. This leads to improved health literacy and a better understanding of what really matters to patients, as well as better decisions and improved outcomes (and where low-value and inappropriate clinical interventions are avoided).

[7] https://www.hqmnz.org.nz/library/Ambulatory_sensitive_hospitalisation_rate_per_100,000_population_for_0_to_4_year_olds.

[8] Ministry of Health. 2018. *Health and Independence Report 2017. The Director-General of Health's Annual Report on the State of Public Health*. Wellington: Ministry of Health.

Red2Green Initiative (improving patient flow)

We've adopted the 'Red2Green Initiative' in Hutt Valley Hospital to improve efficiency and avoid wasting the patient's time. Under this initiative, delays in patient care are monitored using a simple measure, where a 'red' bed day is a wasted day for hospital patients and a 'green' bed day is a productive one. Red days are when a patient does not receive all their planned value-adding care. Green days are when everything that had been planned for the patient occurs without delays. Red2Green helps find the reasons why there are delays in care so they can be addressed, through applying quality improvement methods or changing systems. Getting accurate data on the number of red days, and why they occurred, helps clinicians and managers clear the blockages and improve care. For example, getting elderly patients out of their hospital bed and moving again without unnecessary delays will improve their mobility (just one day of bed rest in a person over 80 years of age results in a 2 to 5 percent decrease in muscle strength). Red2Green avoids unnecessary delays for in-patients, and improves patient flow and the patient's experience of care.

Patient: *The staff all knew each other well and the care was seamless. I didn't have to follow up on anything. Excellent coordination and care.*

Elective surgical services

We've continued to improve access to elective surgery services. Every year for the last ten years, we've exceeded the Government targets set for us to improve access to elective services. A number of initiatives allow us to continue offering the right level of elective surgery to our patients. We have adopted the Elective Surgical Forecast Tool from Waitemata DHB. It helps us map what we can deliver through our theatre, what capacity we have, and how well we're using this capacity. This tool also helps us monitor and measure peaks and troughs, and help support the areas of population with greatest need. We've also improved our communication with patients about their appointments. We consulted with consumers to refine the letters we sent to patients about their surgical appointments. These letters are now shorter, clearer and easier to read.

Care Capacity Demand Management

We have advanced the Care Capacity Demand Management (CCDM) programme in partnership with the New Zealand Nurses Organisation, the Public Service Association and the Safe Staffing Healthy Workplaces Unit.[9] The CCDM programme helps the DHB match the capacity to care with patient demand, and supports staff to provide high-quality and safe care to our patients, while improving the work environment and organisational efficiency. CCDM enables the DHB to invest effectively by getting an accurate forecast of patient demand, removing as much variability as possible from the system, and matching the required resources as closely as possible (in staff numbers and skill mix). This helps the hospital run more effectively, improves our patients' experience and outcomes and makes working at Hutt Valley DHB more satisfying for our staff. Ultimately it means having the right staff, with the right skill mix, in the right place, to deliver the right care, to the right patients.

[9] The Safe Staffing and Healthy Workplaces Unit sits within District Health Boards New Zealand and is part of a collaborative agreement between the New Zealand Nurses' Organisation and the DHBs.

Winter Surge Planning

We've developed a winter plan for the DHB to ensure we proactively manage demand over the busy winter flu season. The plan includes a range of actions across the system to address, plan for, and manage the increased demand experienced over the winter period. An operational committee from across primary, community, and hospital care meets to oversee the plan and monitor surges in demand. We've also developed a system-wide surge monitoring framework to closely monitor demand and capacity throughout winter periods.

Health Pathways

We've improved consistency of best practice care, and seamless referral between services, by making it easier for primary care clinicians to access best practice online advice, based on local clinical and service pathways. Health Pathways are localised to each DHB and provide an electronic best practice clinical pathway for primary care. Pathways for over 390 conditions are now live. Recent pathways have been developed for pregnancy (antenatal care), anxiety, depression and suicide prevention in adults, asthma in adults, and elder abuse and neglect. Multiple pathways are also under development.

Improved care for frail and elderly patients

We've introduced developments to improve care for frail and elderly patients in our hospital. We've introduced initiatives such as communal table to help patients socialise, with a focus on getting them up and dressed in their own clothes to help boost their recovery. Another new initiative is the introduction of memory boxes, which contain nostalgic items that job patients' memories.

Our Older Persons and Rehabilitation Service (OPRS) has also embraced the 'Live Stronger for Longer' campaign, which offers practical advice, information and resources for over 65s, and those who care for them. OPRS has introduced a 'Close Care' initiative for older patients with mental health or neurological conditions, such delirium or dementia, encouraging engagement and activities. OPRS is also piloting animal assisted therapy pilot with a Labrador to support stroke rehabilitation. A new programme called 'Whānau as Partners' is also being developed to encourage family/whanau to help with care for their loved one while they are in hospital. A familiar face can help them feel safe and experience less anxiety.

A frailty screening tool and approach has been rolled out for use in the Emergency Department, to identify frail patients earlier and provide the appropriate care and support, including activities to reduce deconditioning (loss in muscle strength). The tool also identifies patients at risk of frequent attendances and admissions, and puts supports in place to keep them well for longer in their place of residence. This is only the first phase of this work. We are also planning to extend use of the tool across the hospital and improve our approach to understanding the best management of frailty for our population.

Early recognition and response to patient deterioration

We've rolled out the National Early Warning Score (EWS) to all adult inpatient areas in Hutt Hospital. EWS is being introduced as part of a Health Quality and Safety Commission initiative and will ultimately be used throughout New Zealand hospitals to standardise how we detect, manage and communicate about patient deterioration.

We've launched a new Patients at Risk service to support hospital staff in providing the best care to patients and, when necessary, quickly identify and respond to patient deterioration. The service comprises four experienced nurse specialists who walk the wards, check in with the nurses on duty, and offer support, education and coaching for health care professionals who are delivering patient care or planning care needs. The ethos of the service is always to be proactive, and help staff recognise a patient at risk before they deteriorate. The service operates 365 days a year.

Shorter, safer and smoother care for people with mental health or addiction needs

We've made several changes to the Infant, Child, Adolescent and Family Service (ICAFS) to improve service access and responsiveness. There are two teams under the new structure: the Tautāwhi team provides brief interventions and responds to acute youth presentations, and the Kaiārahi team provides more in-depth interventions and ensures clients referred from the front door team are seen within 12 weeks. Since the changes, wait times for ICAFS have significantly reduced.

We've opened a new Youth Respite Service in Lower Hutt for the Wellington region. Respite and recovery services offer a welcoming place for people experiencing mental health difficulties to rest and recover in a home-like environment. Well trained staff are available 24 hours a day. Respite and recovery may be a planned break away from home, a transition from hospital, or a way of preventing further distress and avoiding admission to hospital. The service is the result of work with Capital & Coast DHB and was a co-designed with the provider and in consultation with local Iwi. The service comprises a six-bed facility and staff will work collaboratively alongside Child & Adolescent Mental Health Services to deliver a responsive, youth-friendly, family-whānau supportive, and clinically safe environment where young people are supported towards wellness.

We're working with our sub-regional DHB partners (Capital & Coast and Wairarapa DHBs) to modernise Te Whare Ahuru Acute, an acute mental health inpatient service, located on the Hutt Hospital campus, which services the Wellington region and the Wairarapa.[10] Te Whare Ahuru was opened in 1997 and requires reconfiguration and upgrading to ensure we deliver culturally safe and best practice clinical care in the future. As part of the first phase of this project, we've undertaken a co-design process that has included input from mental health clinicians, other health service providers, iwi and Māori health providers, consumers, their families and whānau. We then worked with stakeholders to refine the proposal and the key design features for the refurbished facility. This is a significant sub-regional project and we aim to starting the building and refurbishment process in 2020.

How We're Tracking

Progress Measure	Baseline	Target 2017/18	Actual 2017/18	Trend – including equity gap
Length of inpatient stay in hospital (average days)	2016/17: Acute: 2.3 Elective: 1.6	Acute: 2.4 Elective: 1.6	Acute: 2.3 Elective: 1.5	Target achieved.
Time patient is in ED (discharged or transferred with 6 hours)	2015/16: 93%	95%	92%	Performance is relatively static and target was not achieved.
The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services[11]	2016/17: 44% < 3 wks 80% < 8 wks	Targets: 80% < 3 wks 95% < 8 wks	58% < 3 wks 91% < 8 wks	Targets were not achieved but waiting times are reducing and have improved significantly.
Falls in hospital (Rate of falls causing harm per 1,000 bed days)	2016/17: 1.4	≤ 2	1.4	Target achieved.

[10] Te Whare Ahuru Acute Inpatient Unit services three DHBs: Capital and Coast, Hutt Valley, and Wairarapa.

[11] We have used local wait time data as this is more accurate than the national (PP8) data.

Progress Measure	Baseline	Target 2017/18	Actual 2017/18	Trend – including equity gap
Access to electives	2016/17: 106%	100%	105%	We consistently exceed the Government targets set for us to improve access to elective services.
Patient experience in hospital (Average patient score out of 10 across four domains)	2016/17: Communication: 8.5 Coordination: 8.3 Partnership: 8.3 Physical and emotional needs: 8.8 Average of 8.5 across the four domains	Average of 8.5 across the four domains	Communication: 8.8 Coordination: 8.8 Partnership: 8.9 Physical and emotional needs: 8.9 Average of 8.8 across the four domains	We have exceeded our target and our patient experience of care is improving across all four domains.

Our Focus on Improvement

Shorter stays in the Emergency Department

We're working to make our Emergency Department more efficient. We've initiated a 'Shorter Stays' project that aims to give patients a better experience in the Emergency Department and reduce the time they spend there before being discharged to specialist wards or sent home. The project's approach has been to focus on the patient's journey from triage to treatment and discharge. We've been examining the processes that make this journey as efficient and focussed on the best experience possible for patients. The project is focussed on valuing patients' time.

This work has resulted in better use of the eWhiteboards, which now provide clinicians with faster and easier access to a range of patient data, making them more visible and speeding up assessment and discharge. We've also begun streamlining processes and the pathways for patients with abdominal pain and falls (which make up for a large proportion of Emergency Department attendances).

Services to whānau with complex health and social needs

Our services looking after people with high complexities are stretched, and while there are examples of good community / cross-sector liaison, there remains a need to improve integration and cohesion across agencies and providers. We have reviewed and changed our service specifications for Whānau Ora contracts to include more focus on whānau with high complex health and social needs, enabling a holistic approach for an individual to include wider household/whānau as appropriate. The changes include the use of allied health staff, marae-based staff, and qualified kaiarahi (navigators). Both of our Whānau Ora providers will be using cloud-based technology to capture client information and track their progress, as well as populate anonymised reports for the DHB.

Enhancing Whānau Ora services is a start and part of a bigger systems response. Improving our response to whānau with complex health and social needs requires a whole-of-system response, with integrated working across health, social and justice sector agencies. Both primary and secondary (specialist) services have an important role to play, as well as community and social sector agencies. Future work is planned to improve our service response to high need communities, including the development of local integrated approaches to family/whānau health and social issues.

ADAPTABLE WORKFORCE

An adaptive workforce means:

- A health system culture that nurtures professional competence and staff wellbeing
- A well-trained workforce able to motivate and support people to stay well
- A flexible and adaptable workforce with greater diversity in skill mix
- A workforce that is technologically capable
- Different workforces take on new roles and responsibilities
- Health professionals, leaders and managers engage and collaborate in training, leadership and quality improvement activities and opportunities.

What We've Done

Building our workforce

We're building a workforce that is responsive and reflects our population. We value cultural intelligence and are working to strengthen and grow the cultural competence of our workforce. This work includes the development of a sustainable Māori workforce plan and further staff development of cultural competencies, in particular Tikanga (Māori customs and traditional values) and Te Ao Māori (the Māori world). Our Pacific Health Unit delivers cultural support through training for health practitioners within the hospital and out in primary care. These activities support our collaboration with primary care partners to improve and achieve health equity and outcomes for Māori and Pacific people.

WorkWell

We're dedicated to improving the wellbeing of our employees and we've signed up to the WorkWell programme. This provides a framework supporting workplaces to develop and implement a wellbeing programme that creates a happier, healthier and more productive workplace for employees and it follows a step-by-step process for continually improving employee wellbeing. The WorkWell approach is evidence-based and strongly modelled on the World Health Organisation's Healthy Workplaces model, where workers and managers collaborate using a continual improvement process to protect and promote health, safety and wellbeing of all workers. The programme includes initiatives to promote physical activity, mental wellbeing and healthy eating.

'Nursing at its Best' Project

We've implemented a 'Nursing at Its Best' project across the hospital to support nurses to be their best. The achievements include:

- a Patient Observation Policy, flowchart and request form to support and guide nursing staff with the level of observation required for patients who need close observation
- a pamphlet for patients and their families to describe patient observation within a hospital environment
- standard job descriptions and interview templates in line with values-based recruitment and processes to support filling nursing vacancies with the right skill mix
- an annual leave tool kit to support Clinical Nurse Managers with annual leave planning.

Nursing staff have embraced the 'Nursing at its Best' agreed to continue developing it as the name of the Hutt Valley DHB Nursing Strategy and Action Plan, which is currently being developed.

Allied Health Career Framework

We've collaborated with Wairarapa and Capital & Coast DHBs to develop and roll out a new Allied Health Career Framework. The framework supports the growth and development of the Allied Health workforce through developing advanced clinical and/or leadership roles with consistency across DHBs. The framework also supports services to have the optimal allied health skill mix to meet current and future patient and community health needs. The framework is being used across all services within Hutt Valley, Wairarapa, and Capital & Coast DHBs, and is currently applied to the following professions: alcohol and other drug clinicians, dietitians, podiatrists, social workers, audiologists, occupational therapists, psychotherapists, counsellors, physiotherapists, and speech-language therapists. We're continuing to work with our sub-regional DHB partners and other stakeholders to add more professional groups to the framework.

Quality and Safety Walk-Rounds

We've continued with Quality and Safety Walk-Rounds, where members of the Executive Leadership Team visit an area in the DHB to meet with patients and staff. This helps increase staff engagement and demonstrate the DHB's commitment to quality and safety for patients, staff and the public. Through structured and informal discussions, issues can be raised, good practices identified, and actions agreed to improve quality and safety. The walk-rounds have been held on a monthly basis since June 2016.

Calderdale skills sharing framework

The Calderdale Framework provides a clear and systematic method of reviewing skill mix and roles within a service to ensure quality and safety for patients.[12] Hutt Valley DHB has two Calderdale facilitators who have begun delivering training sessions to DHB staff. The first training session focussed on supporting skill sharing between physiotherapists and assistants working in orthopaedics. The Central Region is committed to supporting the implementation of the Calderdale Framework and will be training two practitioner-level Calderdale experts who will be able to support our facilitators.

Emergency management training

We continue to focus on learning lessons from incidents, training and emergency exercises. This has provided invaluable preparation for senior managers who have led or been part of the organisational response to incidents. Lessons from the Kaikoura-Hurunui earthquake have been identified and acted on. Regular training and exercising has provided an opportunity to test new response documentation tools, and enhanced organisational response capacity and capabilities. Exercises themes have included, earthquake, tsunami, severe weather, hazardous substances and fire. We've also activated our Emergency Operations Centre in response to significant events, like the NZNO Nurses Strike. This has helped us identify what we do well in incidents, and where we need to improve.

Staff member: I want to keep upskilling and learning. I feel supported here. It is like a family and I would be happy to have a family member looked after here. I love my job.

[12] https://www.calderdaleframework.com/

EFFECTIVE COMMISSIONING

Effective commissioning means:

- Decisions by all those working in the system demonstrate responsible stewardship of resources
- Commissioning for outcomes – measuring against what matters to patients and whanau
- Whānau, communities and health professionals are central to allocation decisions
- Available resources achieve equitable and sustainable outcomes
- Resources are considered across the whole of system, including across the broader social sector
- 'Smart investments' are based on sharing of data and pooling of resources.

What We've Done

Partnership with Iwi

We've established an Iwi Relationship Board to formalise the relationship between local Iwi and Hutt Valley DHB. Both Iwi and the DHB want to build on existing relationships, share aspirations and strategic directions, and develop a robust engagement partnership so Māori and Iwi have opportunities to engage across the DHB system.

Clinical Services Plan

Our Clinical Services Plan for the Hutt Valley provides a high-level understanding of our clinical needs and demands across the system over time. The plan provides options on how we can best plan and address the challenges we will face with increasing demand for health services in the future. The plan considers changes to service configurations and models of care, additional investment in strategic enablers such as IT and workforce, and moving services into the community and closer to home. The plan provides practical options to increase our focus on prevention and early intervention, and will guide our commissioning of services for the years to come.

Planning our future infrastructure needs

Hutt Valley DHB is responsible for the stewardship of the health resources and infrastructure in the district. The service changes signalled in the Clinical Services Plan require us to assess the current state of the hospital campus as well as the changes to our facilities needed in the years to come. We've started this process with a comprehensive condition assessment of our current infrastructure and facilities. We're also working closely with Capital & Coast DHB to better understand the service options across our network of hospitals in Lower Hutt, Kenepuru, and Wellington. We are working in partnership with Capital & Coast DHB to plan how we can best coordinate and configure our services in the future.

Resilient facilities

Ensuring our facilities are safe and resilient is an important part of our stewardship. Hutt Valley DHB has upgraded its facilities for earthquake resilience. While we have no earthquake prone buildings, we have strengthened our resilience through practical upgrades. For example, we have improved bracing and restraints to ensure 'non-structural' items are all well restrained in the event of an earthquake. We've also installed a generator for Pilmuir House (so our management and administration teams can still operate in a power failure) and installed a treatment plant for our existing on-campus water-bore so we can provide water to the hospital, and the wider community, in an emergency.

Consumer Involvement

Hutt Valley DHB receives consumer feedback through its complaints and compliments processes, patient experience surveys and consumer group forums. This information is analysed and directly informs continuous quality improvements and effective commissioning. A training programme on consumer co-design has been developed to support the use of co-design methodology in service improvement projects, and service development and commissioning. We want the consumer perspective to become part of the way we do things. We're also establishing a Consumer Council with members from diverse backgrounds, experiences and knowledge. The Consumer Council will give our patients, whānau and communities, a strong voice in planning, designing and delivering great services across the Hutt Valley.

Clinical involvement

Our Clinical Council comprises hospital and primary care clinicians from different disciplines. It facilitates clinical engagement in organisational decisions and informs effective commissioning based on clinical evidence and expertise. The Council's principal focus is on quality and safety, but it also provides advice on key proposed organisational service changes and measures to use organisational resources effectively and equitably.

We've also established clinical networks (or steering groups) to guide planning and provide oversight to our integration work programme. This work is focussed on improving how primary and secondary health services work together so people in the Hutt Valley have well-coordinated and seamless healthcare. We have a Child Health Network, an Acute Demand and Community Care Network, a Long Term Conditions Network, and a recently-established Mental Health Network. We're also developing a Clinical Ethics Network to help practitioners deal with ethical issues they come across in their clinical practice, as well as provide advice on allocating health care resources. The networks meet regularly to drive and oversee relevant areas of work under the integration work programme. The clinical networks report to our Alliance Leadership Team (called Hutt Inc.), which is made up of senior DHB managers, clinical leaders, and other experts, including representation from Pacific and Māori Health Services. The clinical networks make recommendations to Hutt Inc. on the best use of resources to achieve the optimal outcomes.

Children's Outpatient Services Review

We've started a review of the Children's Health Outpatient Service at Hutt Valley Hospital. This service provides family-centred support, education, and treatment services to children from 0-15 years with acute and chronic conditions. The service comprises specialists and community nurses with advanced skills in caring for children with complex health needs.

This review is comprehensive and includes examination of the end-to-end process flow through the service, analysis of service data trends and financial information, research and comparison with other DHBs and similar projects, and consultation with clinical, management and administration staff.

The review confirms the Children's Health Outpatient Service is high quality and, that despite increases in demand, has managed to decrease its waitlist for new patients, with 95 percent of children seen within two months of referral. The review will make a number of recommendations to enable the service to work in closer partnership with primary and community care providers, and better meet the needs of complex patients in the community. Alongside finalising the review, a work programme will also be developed.

Mental Health and Addiction Commissioning Plan

We're developing a Mental Health and Addiction Commissioning Plan to help identify where we invest or reallocate resources to address equity issues. The plan is informed by data and feedback from meetings held with mental health providers and consumers. The work has a strong focus on equity, and understanding the range of services need to improve outcomes for Māori.

Targeted access to publicly funded community radiology

We've collaborated with Capital & Coast and Wairarapa DHBs to use consistent criteria to refer patients to community radiology services. The agreed criteria are put in an electronic referral form, which is pre-populated with the patient details. The criteria (and useful tips) become available to GPs through drop down boxes. The referrals are monitored for consistency with the criteria through audits of selected procedures. That process not only identifies referral practice at variance to the criteria, but also areas where the criteria need strengthening. A GP leader visits practices to discuss referral variation and promote the criteria.

As a result we've been able to better target resources to those who need it most. Publicly funded community radiology services in Hutt Valley DHB are free to quintile 4 and 5 users, Community Service Card holders, and High User Health Card holders. Breast screening for high risk women is also fully funded. Now the most deprived 40 percent of the Hutt Valley population have access to fully funded radiology referred by GPs in the Hutt Valley.

New model of care for community podiatry services

We've reviewed our community podiatry services so our patients receive the right level of care and our health resources are appropriately managed. We completed an audit and review of the service in 2017 following a period of high service demand on Hutt Valley's Community Podiatry Programme. This found most patients had moderate to high podiatry problems that were appropriately treated through the programme. However, it also found a significant proportion of low-risk patients would be more appropriately managed by general practice, and a small number with active foot disease would be more appropriately managed by hospital specialist services. We've corrected this situation by putting a more sustainable model of care for podiatry services in place.

SMART INFRASTRUCTURE

Smart Infrastructure means:

- A digitally-enabled health system that finds technological solutions to improved care and experience for people and whānau; support people and whānau to stay well with more individualised care; allow the patient, and those involved in the care of that patient, to share information/care plans; and improve quality of care through better tracking of care, reduced variation in care, and reduced errors
- Use of data to understand people's needs and drive people focused services
- A hospital facility footprint designed for complex care, and networked with other hospital services.

What We've Done

Patient portal

Patient portals are secure online sites, provided by general practices, where patients can access their health information and interact with their general practice. Patient portals give people convenient and secure electronic access to their health information, increasing their ability to manage their own health care. Hutt Valley DHB is continuing to support roll out of patient portals. At June 2018, Hutt Valley DHB's largest Primary Health Organisation, Te Awakairangi Health Network (TeAHN), had 16 practices using a patient portal with over 21,500 people activated in the Hutt Valley. TeAHN staff are working on activating the last four practices, as well as increasing the portal functionality offered by existing practices.

Electronic referrals

We've implemented secure electronic 'e-referrals' between Hutt Hospital, general practice, and Pacific radiology. E-referrals has also been implemented for bowel screening. This speeds up the referral process and also helps ensure that referral criteria are applied consistently. Planning is underway to develop a generic e-referral form to use across Hutt Valley DHB. Longer term solutions that have additional functionality (including full integration with health pathways and the ability to provide a solution for e-referrals for advice and secure messaging options) are also being investigated.

Quality & Patient Safety Dashboard

We're continuing to enhance our Hutt Valley DHB Quality and Patient Safety 'dashboard'. This reports on quality and patient safety indicators that are internationally recognised in a range of aspects of quality. The data in the dashboard presents trends over time and helps staff identify and understand why there are variations in the data. For instance, variation may be normal and due to seasonal variability of health service demand, or it could be caused by other circumstances. Understanding the type of variation enables staff to determine the improvement approach required to address it. The dashboard enhancements will be able to pull 'live' data from our Safety, Quality and Reportable Events (SQuARE) database. This means managers closer to care will be able to see what is happening in their areas of accountability and, if necessary, quickly make changes to improve patient safety and care.

Patient (Nursing) Care Plan Project

We've worked with nurses and other staff to develop and roll out a standardised patient care plan for use across inpatient areas of Hutt Hospital. Work is now underway to support the care plan project with electronic assessment tools and mobile devices, such as computers on wheels and iPads. A pilot of the electronic Adult Assessment Tool and a selection of electronic mobile devices began in December 2017 in the Medical Assessment Planning Unit (MAPU) and Orthopaedics. The electronic assessment tool incorporates a range of key assessments and patient screens into the one tool, and provides patient information in one place. This makes it easier for staff to undertake a comprehensive patient assessment and frees up their time for patient care. Further roll of the electronic assessment tools and mobile devices will be considered once the pilot is completed.

'Ubook' – our online booking system

We've upgraded and re-launched Ubook - our online booking system so patients can book outpatient hospital services online. Ubook gives patients the flexibility to choose appointments that work for them. It means our patients are more in control of and avoids unnecessary letters and paperwork. Ubook is a good example of 'smart infrastructure' with the inclusion of its multiple booking function. Patients who require multiple tests will have these booked as close together as possible – and will only get one notification. Patients are also be able to update their contact details online so our database will be more up-to-date and our administration staff will be freed up for other work. Putting the control into the hands of patients has also dramatically reduced the number of missed appointments, saving us time and resources.

Use of Artificial Intelligence

Artificial intelligence (AI) can improve the efficient use of healthcare resources in a variety of ways, leading to better patient care and outcomes. AI systems can be used to analyse medical data and help provide genomics based healthcare and personalised treatment plans, support the delivery of virtual and online health services, help design new drugs and medical therapies. AI can also improve health system processes and assist in repetitive jobs such as reviewing scans or laboratory results.

Hutt Valley DHB is exploring AI opportunities. We are exploring the addition of AI to the referral process being managed by software robots. AI also has potential to interpret the data in a referral and direct it to the correct service/department.

Progress on other 'smart infrastructure'' projects

- *A 3DHB ICT Strategy*: Hutt Valley DHB is working with our sub-regional DHB partners on a new Information Technology and Communications (ICT) strategy for Capital & Coast, Hutt Valley and Wairarapa DHBs. The strategy will guide the development of a digitally enabled health and disability system to support the quality, efficiency and sustainability of our health and disability system.
- *National Maternity System*: Hutt Valley DHB is planning to adopt the National Maternity System, which enables a new way of collecting, sharing and viewing maternity and neonatal data to support women to be involved in their own care and, in time, enable them to have electronic access to their maternity information.
- *eVitals*: Hutt Valley DHB is piloting eVitals, a new system for digitally collecting nursing observations and assessments, alerting clinicians to deterioration in a patient's health. The real-time system eliminates the need to search for records to identify patterns, ultimately resulting in more clinical time to focus on the patient.
- *Health services via digital technology*: Hutt Valley DHB is deploying a modern and integrated digital solution that enables regional sharing of information, optimal use of clinical resources, and new models and processes of care. Work is progressing on a common regional Shared Care Record for use by community, primary, and hospital health services across the Central Region. The Shared Care Record allows authorised health practitioners involved in a patient's care to access up-to-date health information from the patient's medical centre. It also enables the patient to view and participate in their care plans with online, self-service options.
- *NZ ePrescription Service*: Hutt Valley DHB is progressing implementation of the NZ ePrescription Service (NZePS). This provides a secure messaging channel for prescribing and dispensing systems to exchange prescription information electronically. It helps a health practitioner review the medicines the patient is actually taking and check them against what they should be taking (medicines reconciliation).

HEALTH TARGETS

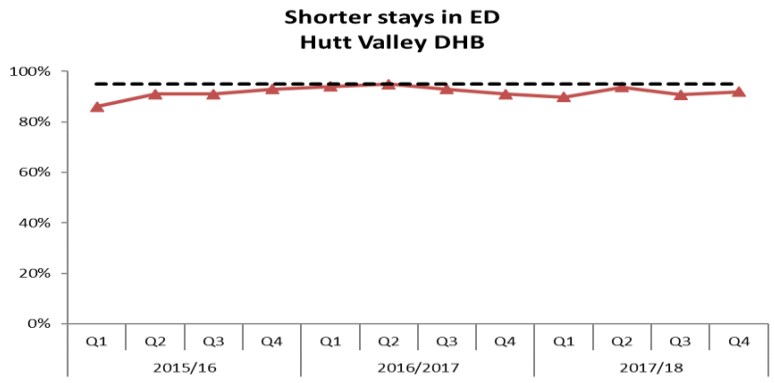
Health targets are a set of national performance measures specifically designed to focus work on improving the performance of health services in areas that reflect significant public and government priorities.[13]

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%

2017/18 Performance: 92%

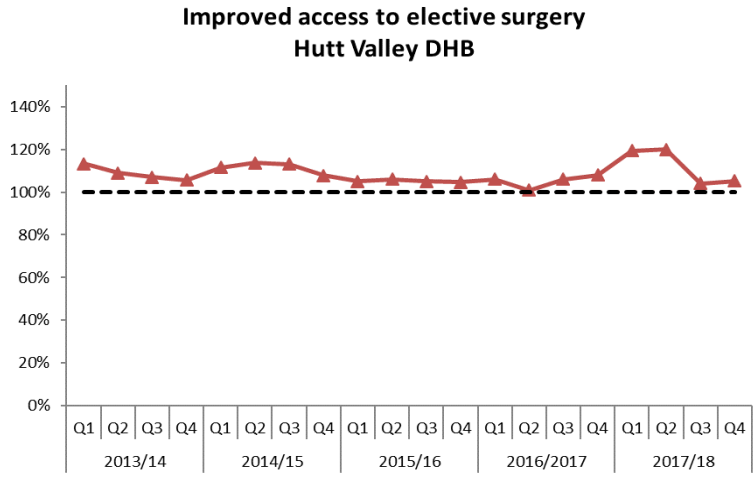


Improved access to elective surgery

More people have access to elective surgical services

Target: 100%, 6,153 discharges

2017/18 Performance: 105.2%, 6,472 discharges



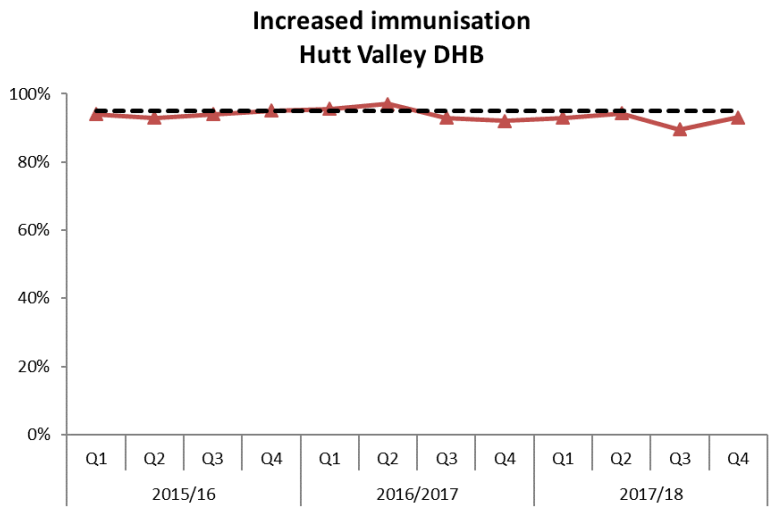
[13] Note the changing vertical (y) axis between graphs and that the 2017/18 performance is the performance for the final quarter.

Increased immunisation

95 percent of eight month olds will have their primary course of immunisation on time.[14] (Primary course immunisation events occur at six weeks, three months and five months.)[15]

Target: 95%

2017/18 Performance: 93.1%

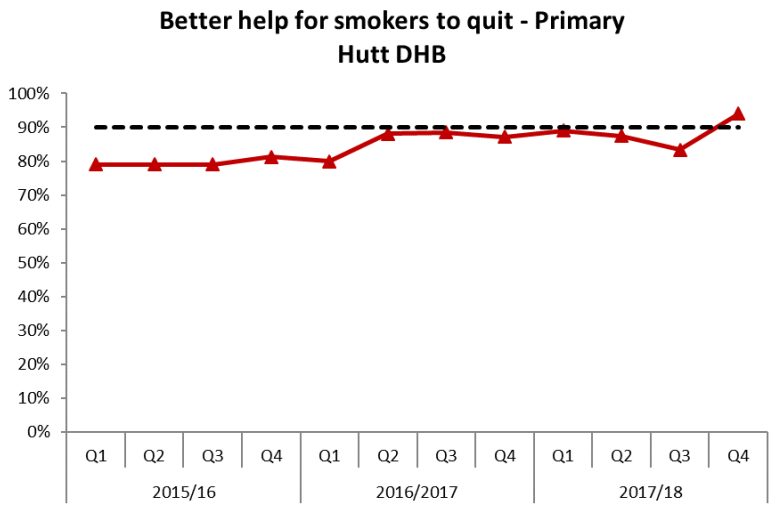


Better help for smokers to quit – Primary care

90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.[16] [17]

Target: 90%

2017/18 Performance: 94%



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

[15] Performance 2017/18 is for the final quarter.

[16] 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.

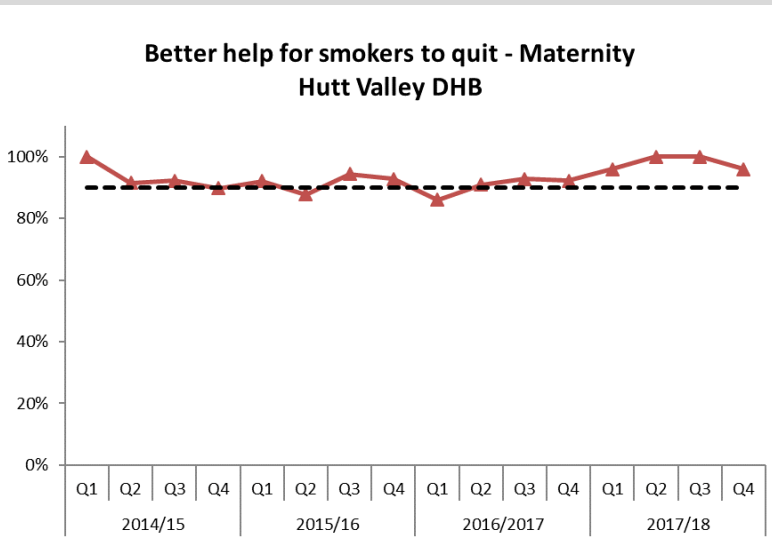
[17] Performance 2017/18 is for the final quarter.

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%

2017/18 Performance: 96%

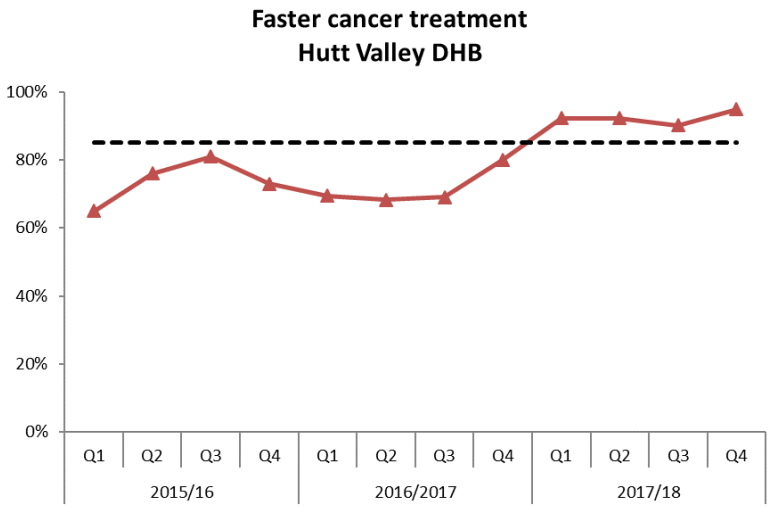


Faster cancer treatment

90 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.

Target: 90%

2017/18 Performance: 94.8%

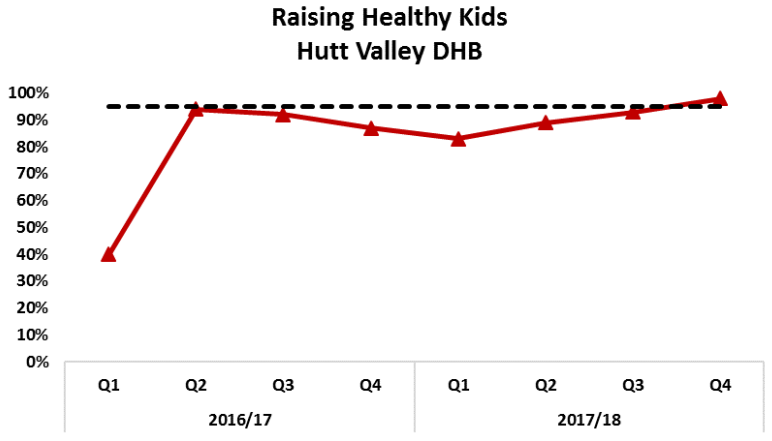


Raising Healthy Kids

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.[18]

Target: 95%

2017/18 Performance: 98%



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

[18] Performance 2017/18 is for the final quarter.

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 Hutt Valley DHB, 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 standardised 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

	2016/17 Actual $000	2017/18 Budget $000	2017/18 Actual $000
Appropriation revenue	372,955	384,880	384,878

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	2016/17 Actual	2017/18 Budget	2017/18 Actual
Prevention	22,065	19,788	20,337
Early Detection and Management	164,765	253,178	252,308
Intensive Assessment and Treatment	268,643	203,965	205,331
Rehabilitation and Support	71,074	64,014	72,469
Total	**526,547**	**540,945**	**550,445**

Expenditure	2016/17 Actual	2017/18 Budget	2017/18 Actual
Prevention	22,358	20,714	21,492
Early Detection and Management	164,165	254,179	251,407
Intensive Assessment and Treatment	274,967	204,414	213,646
Rehabilitation and Support	68,857	63,741	70,791
Total	**530,347**	**543,048**	**557,336**

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:[19] 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.

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

How we measure the performance of our Prevention Services

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Health protection and statutory regulation	The number of disease notifications investigated	V	HVDHB 425 Māori 49 Pacific 25	HVDHB 395 Maori 44 Pacific 21	HVDHB 543 Maori 76 Pacific 52	Higher than estimated
	The number of tobacco retailers visited during controlled purchase operations	V	56	56	0 volunteers withdrew[20]	Lower than estimated
	The number of environmental health investigations sub-region[21]	V	316	322	214	Lower than estimated
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	37	37	26	Lower than estimated
Health promotion and education	Number of new referrals to Public Health Nurses in primary and intermediate schools	V, P	HVDHB 932 Māori 468 Pacific 211	HVDHB 898 Māori 466 Pacific 40	HVDHB 818 Māori 380 Pacific 172	Lower than estimated
	The number of adult referrals to the Green Prescription programme in the sub-region.[22]	V, P	1,393	900[23]	1,203	Achieved
Breastfeeding	Percentage of infants fully or exclusively breastfed at 3-months	Q	HVDHB 57% Maori 39% Pacific 46%	≥60%	HVDHB 55% Maori 46% Pacific 49%	Not achieved
Immunisation	Percentage of 2-year olds fully immunised	C	HVDHB 95% Maori 91% Pacific 95%	≥95%	HVHDB 91.2% Maori 90.4% Pacific 93.8%	Not achieved

[20] Tobacco control purchase operations are reliant on volunteer school pupils , unfortunately the volunteers for this year withdrew and were unable to be replaced.

[21] Result for this measure is a total figure for the sub-regional DHBs: Wairarapa,Hutt Valley and Capital & Coast DHBs.

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

[23] New service & target in place from Jan 2017 (Hutt only target however reporting is only available at 3DHB level).

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
	Health Target: The percentage of eight month olds fully vaccinated	C	HVDHB: 95% Maori 94% Pacific 98%	≥95%	HVDHB 93.1% Maori 86.9% Pacific 92.3%	Not achieved
	The percentage of Year 7 children provided Boostrix vaccination in the schools in the DHB region[24]	C, DoS	HVDHB 81% Maori 87% Pacific 87%	≥70%	HVHDB 78% Maori 85% Pacific 87%	Achieved
	The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB region	C, DoS	HVDHB 72% Maori 79% Pacific 89%	≥75%	HVDHB 66% Maori 57% Pacific 57%	Not Achieved[25]
Smoking cessation services	**Health Target:** Percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in last 15 months.	C	88%	≥90%	94%	Achieved
	The percentage of hospitalised smokers receiving advice and help to quit.	C	93%	95%	83.4%	Not achieved
	Health Target: Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC being offered brief advice and support to quit smoking.	C, DoS	50%	≥90%	96%	Achieved
B4SC	The percentage of eligible children receiving a B4 School Check	C	HVDHB 90% High Dep 90%	≥90%	HVDHB 101.5% High Dep 100%	Achieved

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

[25] Final dose coverage is based on HPV-2 Quadrivalent coverage as per Ministry of Health.

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Screening	**IPIF Health Adult:** The percentage of eligible women (25-69 yrs) having cervical screening in the last 3 years	C	HVDHB 77% Maori 68% Pacific 73%	≥80%	HVDHB 67% Maori 70% Pacific 75%	Not achieved
	The percentage of eligible women (45-69 yrs) having breast screening in the last 2 years	C	HVDHB 74% Maori 66% Pacific 66%	≥70%	HVDHB 68.9% Maori 68.3% Pacific 71.8%	Not 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 high rate of Maori and Pacific children receiving Boostrix vaccinations. 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 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.

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	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Primary Care services / Long term conditions management	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	T : 98% M: 90% P: 99%	≥98%	T : 90% M: 86% P: 87%	Not Achieved
	Percentage of practices with a current Diabetes Practice Population plan (or LTC plan that includes diabetes)	Q, DoS	78%	≥90%	100%	Not 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	320	375	390	Achieved
	The average number of users (per month) of the Health Pathways website[26]	V	1,703	2,000	2,103	Achieved
Oral health	The percentage of children under 5 years enrolled in DHB-funded dental services[27]	C, DoD	T : 97% M: 81% P: 83%	≥95%	T : 93.7% M: 77.7% P: 80.5%	Not Achieved
	The percentage of adolescents accessing DHB-funded dental services	C, DoD	67.9%	≥85%	69.3%	Not achieved
Pharmacy services	The number of initial prescription items dispensed	V, DoS	1,637,708	1,637,708	1,507,080	In line with estimate

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

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

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item	C, DoD	83%	≥ 80%	81%	Achieved
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	V, DoS	213	220	206	Not achieved

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 2017/18 the number of Hutt Valley primary care practices with Long Term Condition Plans in place increased to 100% 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 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 93.7% of children enrolled. Although we did not achieve the target, we continue to work 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	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Elective and Acute (ED) inpatient/ outpatient	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T, DoS	94%	95%	91.90%	Not achieved
	Health Target: The number of surgical elective discharges	V, DoD	106%	100%	105.2%	Achieved
	The standardised[28] inpatient average length of stay (ALOS) in days, Acute[29]	T, DoST,	2.24	2.4	2.31	Achieved
	The standardised inpatient average length of stay (ALOS) in days, Elective	DoS	1.58	1.6	1.47	Achieved
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	1.4	≤2.0	1.42	Achieved
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	0.5	≤0.5	0.89	Not Achieved

[28] 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.

[29] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2018.

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	4.5	≤3.1	4.6[30]	Not Achieved
	The weighted average score in the Patient Experience Survey[31]	Q, DoS	Communication: 8.5 Coordination: 8.7 Partnership: 8.6 Physical and Emotional Needs: 8.8	8.5	Communication: 8.8 Coordination: 8.8 Partnership: 8.9 Physical and emotional needs: 8.9	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	7%	≤7%	7%	In line with target
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments	Q, DoS	8%	≤8%	8%	In line with target
Cancer services	Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat	T, DoD	86%	≥85%	94.9%	Achieved

[30] This measure counts errors that had the potential to cause harm such as incorrect dose because some errors were not directly related to patient care (e.g. count of stored controlled drugs). Reliable records of actual patient harm is not readily available in the reportable events data. The result for 17/18 is higher partly due to the change in method for counting the number of medication errors causing harm than used for 16/17 performance and for setting the target.

[31] 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	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 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	T, DoD	68%	≥90%	87.1%	Not achieved
Mental health and addictions services	The number of people accessing secondary mental health services	V	Total: 6297 Maori: 1698 Pacific: 385	Total: 6050 Maori: 1690 Pacific: 380	Total: 6583 Maori: 1784 Pacific: 376	In line with target
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks	T, DoS	80%	≥95%	88%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	94.5%	≥95%	97.1%	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%	38.6%	Not achieved

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 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%	65%	Achieved

Comments on Performance

Medical and surgical services

In 2017/18, 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 across the last two years, with further reductions in the duration of stays in 2017/18. 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 services with primary care in partnership with the PHOs and with community providers. This work will be continued in 2018/19.

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	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 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[32]	C, DoS	100%	100%	99.70%	Not Achieved
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	C, DoS	67%	≥ 65%	66%	Achieved
	Percentage of the population aged 75+ years who are in Aged Residential Care (including private payers).	C, DoS	12%	≥11%	12%	Achieved
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	100%	100%	100%	Achieved
Disability services	The number of Disability Forums	V	HVDHB: 1 3DHB: 1	HVDHB: 1 3DHB: 1	0 (A forum is planned for 2018/19)	Not Achieved
	The number of sub-regional Disability Newsletters	V	8	≥3	2	Not Achieved
	The total number of hospital staff that have completed the Disability Responsiveness eLearning Module	Q	77	≥840	734	Not Achieved

[32] The measure is based on the number of clients who have ever had an interRAI assessment as per the Ministry definition. The measure is not based on a count of "completed care plans" as these plans are not recorded in a way that is easy to count.

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
	The total number of Disability Alert registrations[33]	Q	2,042	4,000	4,817[34]	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 all of the aged residential care facilities in our district meet the three-yearly certification standard requirements consistently since last two years.

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 although we did not meet the target for issuing newsletters; staff awareness has been gained through the e learning. This is a solid foundation from which to continue to improve the delivery of high quality patient centred services for those living with disability.

LEGISLATIVE BREACH

Hutt Valley DHB is required to complete its Statement of Performance Expectations (SPE) by the start of the financial year under Section 149C of the Crown Entities Act 2004. This requirement has not been met for the SPE for the 2018/19 year, which was due to be completed by 30 June 2018.

The 2018/19 SPE is yet to be signed by the Board at the time of issuing the 30 June 2018 financial statements.

[33] 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.

[34] 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.

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

During 2017 we commenced a programme to re-shape our Organisational Values based on staff and patient input. The outcomes of this work has provided the basis for the introduction of a values based recruitment model and the development of a "Welcoming" programme for the DHB. During 2018 our focus has been on developing the tools and processes to recognise and encourage the behaviours defined by our values. At the same time we have commenced a co-design programme with staff to develop our own organisational pathways for dealing with inappropriate and unacceptable (including bullying) behaviours. This includes the development of eLearning modules and training workshops.

Consistent and rigorous recruitment and selection processes are followed to ensure fairness and equal opportunity to all applicants. Our recruitment management software has been upgraded and we are developing improved information collection processes and reporting of our key EEO metrics. We are also reviewing recruitment strategies and implementing new approaches to attracting and recruiting a more diverse workforce reflective of our communities.

Training and development opportunities are considered for all staff and development plans are included as part of the annual performance review process. We continue to develop and enhance our online E-Learning for staff, enabling 24/7 access giving staff the ability to complete some of their training around their own timetables. Several forums are in place to consider workplace practices. Topics include health and safety, and professional practices for relevant staff.

We are building on the leadership development we have already provided and have continued to offer a Clinical Leadership programme and coaching to senior clinical and managerial staff. The Executive Leadership Team have commenced a leadership programme and implementation of the SSC talent management framework is progressing We also share access to a DHB formatted Front Line Managers training course and hold briefing sessions throughout the year for all managers. This year we have also piloted new management programmes for middle managers and have commenced development of a manager and staff induction programme.

Approximately 90% of HVDHB 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 a range of policies in place to support staff and provides flexible work practices that enable staff to balance work with home and personal requirements. Over the next 12 – 18 months a key focus for the DHB will be increasing the diversity of its workforce, in particular Māori and Pacific staff and introducing processes and to support staff experiencing domestic violence.

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.

We are about to commence implementation of a new Health, Safety and Wellbeing Strategy. This new strategy builds on the current health and safety function, enhancing existing practices, systems and processes, taking the DHB to the next level where health, safety and wellbeing is integral to business, with participation and engagement from all levels. Committing to this new strategy will enable a healthy and well workforce, and safe workplace and environment for staff, patients and whanau.

The DHB has committed to the Workwell programme and will be working toward achieving its bronze accreditation. The key focus of the wellbeing programme for the next 12-18 months include mental and physical wellbeing.

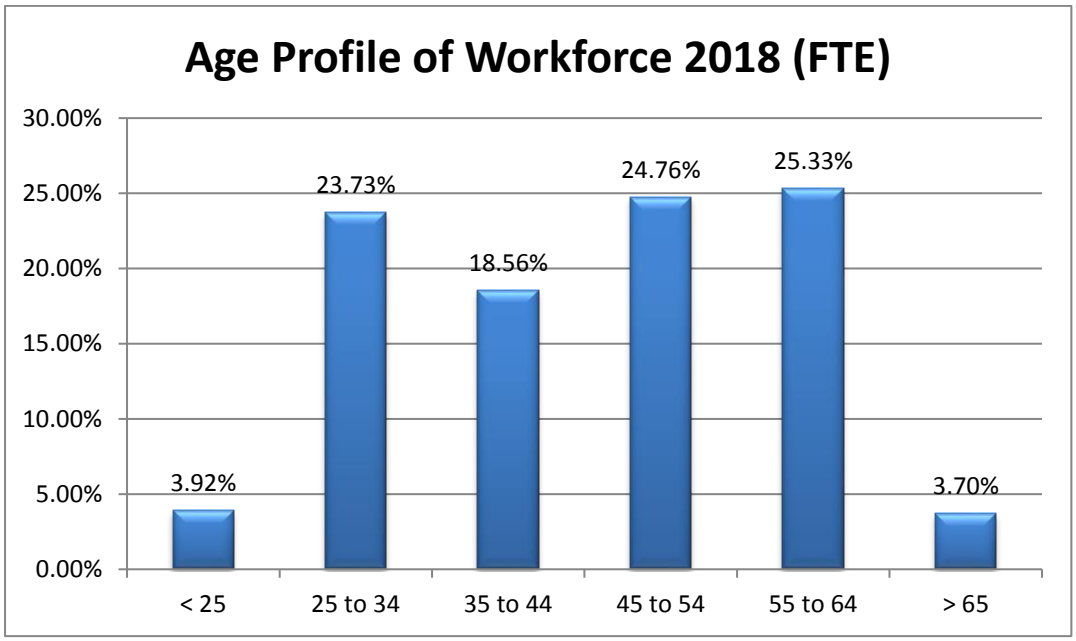
The DHB has provided training for its health and safety representatives and has recently reviewed the terms of reference of its workplace health and safety committee and worker engagement, participation and representation structure and processes. Changes being introduced will ensure staff and managers have increased opportunity to participate in and lead health and safety practices within the DHB. We have undergone two audits to our Health and Safety systems and once again have successfully maintained our tertiary status on the ACC Partnership Programme.

WORKFORCE PROFILE

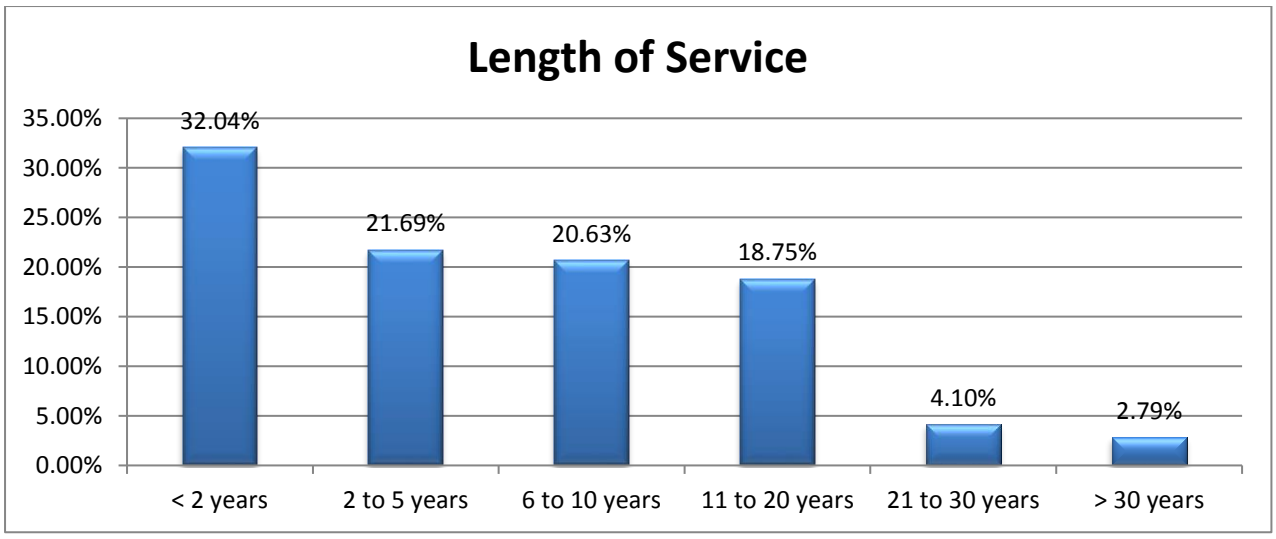
Full Time Equivalent Staff Numbers

	2018	**2017**	**2016**	**2015**	**2014**	**2013**	**2012**
Medical	268	244	236	246	232	232	238
Nursing	709	696	696	755	717	708	712
Allied Health	410	395	401	440	428	435	422
Other	450	427	410	442	434	467	480
Total	1837	1762	1743	1,883	1,811	1,841	1,851

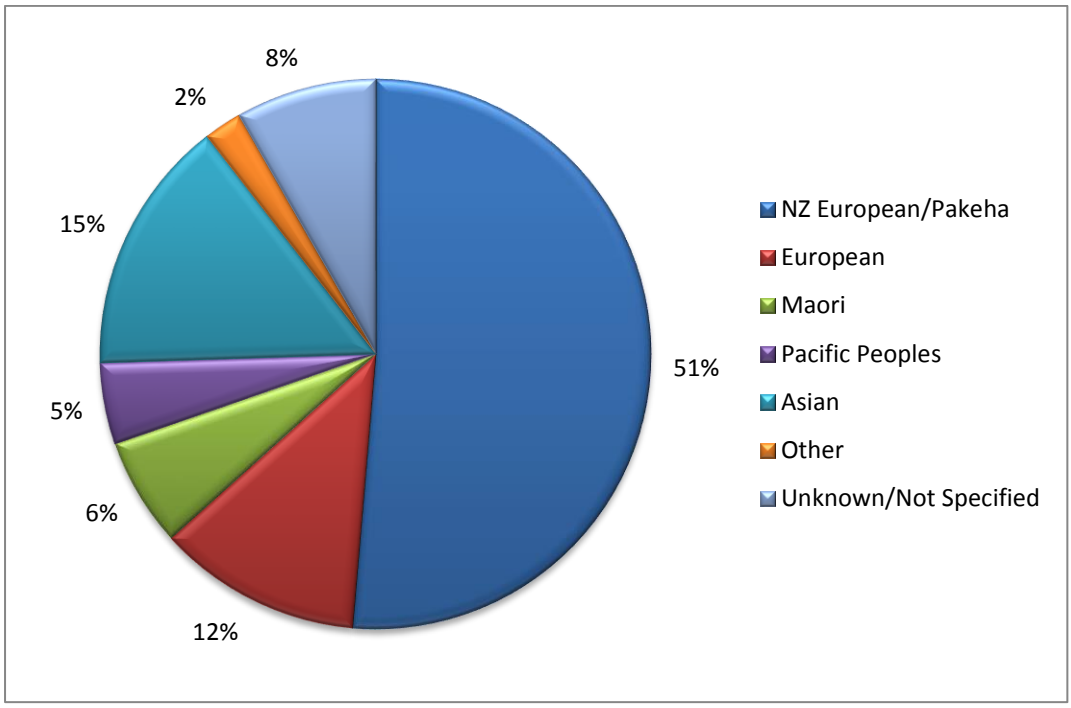
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2018	2017	2016	2015	2014	2013	2012
Female	82.51%	80.56%	81.05%	81.65%	81.89%	82.41%	81.95%
Male	18.48%	19.44%	18.95%	18.35%	18.11%	17.59%	18.05%

TERMINATION PAYMENTS

During the year ended 30 June 2018, 10 (2017: 23) employees received compensation and other benefits in relation to cessation totalling $512,993 (2017: $401,089). The payments were in the nature of redundancy or retirement gratuities.

REMUNERATION OF EMPLOYEES

Annual remuneration	2018	2017	2016
100,000-109,999	48	40	40
110,000-119,999	29	26	29
120,000-129,999	19	17	19
130,000-139,999	13	15	14
140,000-149,999	10	10	15
150,000-159,999	12	16	11
160,000-169,999	13	11	2
170,000-179,999	13	12	8
180,000-189,999	8	7	9
190,000-199,999	11	6	7
200,000-209,999	6	6	5
210,000-219,999	10	4	6
220,000-229,999	6	9	7
230,000-239,999	6	6	3
240,000-249,999	8	9	13
250,000-259,999	7	4	5
260,000-269,999	4	8	7
270,000-279,999	7	6	3
280,000-289,999	4	4	6
290,000-299,999	2	3	1
300,000-309,999	3		2
310,000-319,999			3
320,000-329,999	1		1
330,000-339,999	2	3	
340,000-349,999	3	2	2
350,000-359,999		1	
360,000-369,999			
370,000-379,999			
380,000-389,999	1	1	1
390,000-399,999			
400,000-409,999	2		
420,000-429,999		1	
430,000-439,999		1	
440,000-449,999			1
450,000-459,999	1		
460,000-469,999	1		
470,000-479,999	1		
560,000-569,999			1
Grand Total	**251**	**223**	**221**

FINANCIAL STATEMENTS

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STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Revenue				
Operating Revenue	2	549,848	540,395	525,996
Interest		597	550	551
Total Revenue		**550,445**	**540,945**	**526,547**
Expenditure				
Personnel Costs	3	175,326	173,581	168,950
Depreciation, Amortisation & Impairment expense	10-11	13,673	13,593	13,306
Outsourced Services		17,002	10,617	15,740
Clinical Supplies		26,153	24,546	24,588
Infrastructure and Non-Clinical expenses		15,532	13,105	14,735
Other District Health Boards		93,040	91,935	89,238
Non-Health Board Providers		202,382	199,926	191,450
Capital Charge	4	10,092	10,138	5,864
Finance costs	5	51	93	2,277
Other expenses	6	4,085	5,514	4,198
Total Expenditure		**557,336**	**543,048**	**530,346**
Net (deficit) / surplus		**(6,891)**	**(2,103)**	**(3,799)**
Other comprehensive revenue and expense				
Gain on property revaluations		38,246		4,010
Total comprehensive revenue and expense for the Year		**31,355**	**(2,103)**	**211**

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 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Balance at 1 July		170,458	166,554	91,454
Total comprehensive revenue and expense		(6,891)	(2,103)	(3,799)
Revaluation Surplus		38,246	-	4,010
Owner transactions				
Conversion of Crown loan to equity		-	-	79,000
Return of capital		(207)	(207)	(207)
Equity as at 30 June	17	**201,606**	**164,244**	**170,458**

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 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	15,443	11,188	13,237
Debtors and other receivables	8	18,093	18,609	19,499
Inventories	9	1,387	1,489	1,443
Total Current Assets		**34,923**	**31,286**	**34,179**
Non-Current Assets				
Property, Plant and Equipment	10	223,284	192,447	191,759
Intangible Assets	11	20,470	14,635	19,475
Investments in Joint Ventures	12	850	-	550
Trust and bequest funds	13	1,389	1,373	1,369
Total Non-Current Assets		**245,993**	**208,455**	**213,153**
Total Assets		**280,916**	**239,741**	**247,332**
Liabilities				
Current Liabilities				
Creditors and other payables	14	37,802	31,482	36,913
Employee entitlements and provisions	15	31,766	28,921	30,278
Borrowings	16	509	400	471
Total Current Liabilities		**70,077**	**60,803**	**67,662**
Non-Current Liabilities				
Employee entitlements and provisions	15	7,617	7,634	7,181
Borrowings	16	221	79	663
Trust and bequest funds	13	1,395	6,981	1,368
Total Non-Current Liabilities		**9,233**	**14,694**	**9,212**
Total Liabilities		**79,310**	**75,497**	**76,874**
Net Assets		**201,606**	**164,244**	**170,458**
Equity				
Crown equity	17	124,330	124,330	124,538
Revaluation reserves	17	133,597	91,341	95,352
Accumulated deficit	17	(56,321)	(51,427)	(49,432)
Total Equity	17	**201,606**	**164,244**	**170,458**

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 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Cashflows from Operating Activities				
Cash receipts		548,294	542,010	523,654
Payments to providers		(294,279)	(291,861)	(280,688)
Payments to suppliers & employees		(233,277)	(228,961)	(225,379)
Goods and Services Tax (net)		(128)	-	744
Capital charge paid		(10,092)	(10,138)	(5,864)
Net cash flows from Operating Activities	18	**10,518**	**11,049**	**12,467**
Cashflows from Investing Activities				
Interest Received		597	550	551
Proceeds from sale of property, plant and equipment		-	(1)	-
Purchase of property, plant and equipment and Intangible assets		(7,947)	(11,835)	(7,436)
Investments		(300)	(300)	(150)
Net cash flows from Investing Activities		**(7,650)**	**(11,586)**	**(7,035)**
Cashflows from Financing Activities				
Equity Contribution		-	-	-
Loans and finance lease raised/(paid)		-	-	-
Interest paid		(51)	(93)	(2,630)
Payment of Finance Leases		(404)	(496)	98
Repayment of Equity		(207)	(207)	(207)
Net cash flows from Financing Activities		**(662)**	**(796)**	**(2,739)**
Net (Decrease) / Increase in Cash and Cash Equivalents		**2,206**	**(1,333)**	**2,693**
Cash and cash equivalents at beginning of year	7	13,237	13,237	10,544
Cash and Cash Equivalents at end of year		**15,443**	**11,904**	**13,237**

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 2018

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 2018, and were approved by the Board on 31 October 2018.

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 2017/18 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 years 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

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to Hutt Valley DHB are:

Impairment of revalued assets

In April 2017, the External Reporting Board (XRB) issued *Impairment of revalued assets,* which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards, Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class of asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of Hutt Valley DHB adopting this amendment will be guided by when Treasury and the Ministry of Health adopt these standards.

Financial Instruments

In January 2017 the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1

January 2021, with earlier application permitted. The main changes under the standard relevant to Hutt Valley DHB are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. Hutt Valley DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. Hutt Valley DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, Hutt Valley DHB anticipates that the standard will not have a material effect on Hutt Valley DHB's financial statements.

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.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted.

Hutt Valley DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. Hutt Valley DHB has not yet assessed the effects 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 revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Rental revenue 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 revenue and expense 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	1.0% 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 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

The Board 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 REVENUE

	2018 Actual $000	2017 Actual $000
Ministry of Health contract funding	429,555	412,240
ACC Contract revenue	6,221	5,542
Other Government	1,483	727
Revenue from other District Health Boards	105,904	100,762
Other patient care related revenue	6,026	5,967
Other Revenue:		
Donations and bequests received	280	446
Rental revenue and services	379	312
Total Operating Revenue	**549,848**	**525,996**

3 PERSONNEL COSTS

	2018 Actual $000	2017 Actual $000
Salaries and wages	169,411	162,539
Defined contribution plan employer contributions	3,991	3,834
Increase/(decrease) in liability for employee entitlements	1,924	2,577
Total Personnel Costs	**175,326**	**168,950**

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 was 6% for the year ended 30 June 2018 (2017: 7% for 1 July 2016 to 31 December 2016 and 6% for 1 January 2017 to 30 June 2017).

5 FINANCE COSTS

	2018 Actual $000	2017 Actual $000
Interest on Crown Loans	-	2,228
Interest on finance leases	51	49
Total Finance Costs	**51**	**2,277**

6 OTHER EXPENSES

	2018 Actual $000	2017 Actual $000
Audit Fees for financial statement audit	162	142
Audit-related fees for internal audit services	96	109
Operating lease expense	3,443	3,526
Impairment of debtors	93	126
Board member fees	290	286
Loss on disposal of property, plant and equipment	1	9
Total Other expenses	**4,085**	**4,198**

7 CASH AND CASH EQUIVALENTS

	2018 Actual $000	2017 Actual $000
Call Deposits with NZ Health Partnerships Ltd	5,874	7,134
Cash at bank and on hand	9,569	6,103
Total Cash and cash equivalents	**15,443**	**13,237**

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 (2017: 20.1m).

8 DEBTORS AND OTHER RECEIVABLES

	2018 Actual $000	2017 Actual $000
Ministry of Health	8,300	8,217
Other DHBs	1,154	3,078
PHARMAC	6,171	4,191
Trade debtors - other	2,023	1,652
Other Departments	140	191
Provision for doubtful debts	(366)	(311)
	17,422	**17,018**
Prepayments	671	2,481
Total Debtors and other receivables	**18,093**	**19,499**
Total Debtors and other receivables comprises:		
Debtors and other Receivables from the sale of goods and services (exchange transactions)	9,489	9,112
Debtors and other Receivables from grants (non-exchange transactions)	8,604	10,387
Total Debtors and other receivables	**18,093**	**19,499**

The carrying value of receivables approximates their fair value.

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

	2018			2017		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	14,279	-	14,279	14,366	-	14,366
Past due 1-30 days	321	(10)	311	168	(8)	160
Past due 31-60 days	188	(25)	163	694	(16)	678
Past due >60days	3,000	(331)	2,669	2,101	(287)	1,814
Total	**17,788**	**(366)**	**17,422**	**17,329**	**(311)**	**17,018**

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:

	2018 Actual $000	2017 Actual $000
Balance at 1 July	(311)	(226)
Provisions write back/(made)	(94)	(126)
Receivables written off during the year	39	41
Closing Balance	**(366)**	**(311)**

9 INVENTORIES

	2018 Actual $000	2017 Actual $000
Pharmaceuticals	137	119
Surgical and medical supplies	1,260	1,324
	1,397	**1,443**
Provision for obsolescence	(10)	-
Total Inventories	**1,387**	**1,443**

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 (2017: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2017: 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 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
Balance 1 July 2017	20,040	2,634	171,343	42,746	2,062	2,291	241,116
Additions	-	9	3,889	1,929	809	-	6,636
Disposals			-	(51)	-	-	(51)
Adjustments	-	-	(4,595)	(3,169)	-	-	(7,764)
Revaluation increase/(decrease)	8,010	52	6,638	(1,123)	(587)	-	12,990
Work In progress	-	-	2,279	3,486	-	-	5,765
Balance at 30 June 2018	28,050	2,695	179,554	43,818	2,284	2,291	258,692

Accumulated depreciation and impairment losses							
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
Balance at 1 July 2017	-	268	16,486	29,900	1,104	1,599	49,357
Depreciation expense	-	146	8,315	2,409	213	275	11,358
Depreciation on disposals	-	-	-	(51)	-	-	(51)
Elimination on revaluation	-	(401)	(23,807)	(625)	(423)	-	(25,256)
Balance 30 June 2018	-	13	994	31,633	894	1,874	35,408
Carrying Amounts							
At 1 July 2016	16,030	2,179	161,989	13,024	1,136	966	195,324
At 30 June 2017 and 1 July 2017	20,040	2,366	154,857	12,846	958	692	191,759
At 30 June 2018	28,050	2,682	178,560	12,185	1,390	417	223,284

The net carrying amount of assets held under finance leases is $0.7m (2017: 1.00m) 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 $7.17m was included in the 2018 land and building revaluation.

Valuation

Land and building valuations are done on a five year cycle. Desktop valuation updates are done in the interim years between full valuations. A full valuation was done in 2018, 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 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
Balance 1 July 2017	21,744	1,910	6,551	30,205
Additions	784	-	-	784
Adjustments	(1,986)	-	(964)	(2,950)
Work In progress	3,592	-	1,688	5,280
Balance 30 June 2018	24,134	1,910	7,275	33,319
Accumulated amortisation and impairment losses				
Balance at 1 July 2016	8,930	-	-	8,930
Amortisation expense	1,800	-	-	1,800
Balance 30 June 2017	10,730	-	-	10,730
Balance at 1 July 2017	10,730	-	-	10,730
Amortisation expense	2,119	-	-	2,119
Balance 30 June 2018	12,849	-	-	12,849
Carrying Amounts				
At 1 July 2016	10,283	1,910	5,587	17,780
At 30 June 2017 and 1 July 2017	11,014	1,910	6,551	19,475
At 30 June 2018	11,285	1,910	7,275	20,470

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 2018, capital payments remain at a total of $1.91m (2017: $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 were reclassified as Work in Progress from 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.

12 INVESTMENTS IN COMPANIES & JOINT VENTURES

	2018 Actual $000	2017 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares – Allied Laundry Limited	850	550
Closing Balance	**850**	**550**

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.

	2018 Actual $000	2017 Actual $000
Opening balance	1,369	1,419
Funds received	321	272
Interest received	22	27
Funds disbursed	(322)	(349)
Closing Balance	**1,389**	**1,369**

14 CREDITORS AND OTHER PAYABLES

	2018 Actual $000	2017 Actual $000
Payables under exchange transactions		
Creditors	3,046	2,526
Accrued expenses	23,386	21,798
Inter-district flows	(2,227)	2,324
Interest	-	-
Revenue in advance	2,015	2,400
Total payables under exchange transactions	26,220	29,048
Payables under non-exchange transactions		
Taxes	2,025	1,737
Trusts	9,557	6,128
Total payables under non-exchange transactions	11,582	7,865
Total Creditors and other payables	**37,802**	**36,913**

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

	2018 Actual $000	2017 Actual $000
Current provision		
Salary and Wages Accrued	6,558	6,287
Annual leave	17,989	17,077
Long Service Leave	2,402	2,090
Retirement Gratuities	332	487
Continuing Medical Education Leave and Expenses	995	1,057
Other Entitlements	3,490	3,280
Total Current provision	**31,766**	**30,278**
Non-current provision		
Long Service leave	1,908	1,757
Retirement Gratuities	648	670
Continuing Medical Education Leave and Expenses	2,969	2,826
Other Entitlements	2,092	1,928
Total Non-current provision	**7,617**	**7,181**
Total Employee Entitlements and Provisions	**39,383**	**37,459**

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% (2017: 4.75%) and an inflation factor of 2.0% (2017: 2.0%) has been used.

16 BORROWINGS

	2018 Actual $000	2017 Actual $000
Current portion		
Finance Leases	509	471
	509	**471**
Non-current portion		
Finance Leases	221	663
	221	**663**
Total borrowings	**730**	**1,134**

Finance lease liabilities are effectively secured as the rights to the leased asset that 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 $0.730m (2017: 1.134m). Fair value is estimated at the present value of future cash flows.

Analysis of Finance Lease

	2018 Actual $000	2017 Actual $000
Minimum lease payments payable:		
Not later than one year	532	492
Later than one year and not later than five years	223	736
Later than five years	-	-
Total minimum lease payments	755	1,228
Future finance charges	(25)	(94)
Present value of minimum lease payments	730	1,134
Present value of minimum lease payable:		
Not later than one year	509	471
Later than one year and not later than five years	221	663
Later than five years	-	-
Total present value of minimum lease payments	730	1,134

Description of finance leasing arrangements

Hutt Valley DHB did not enter into any new finance leases during 2018 (2017: three new leases at $2.7m). 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

		Land Revaluation Reserve	Buildings Revaluation Reserve	Equipment Revaluation Reserve	Retained Earnings/ (Deficit)	
	$000	$000	$000	$000	$000	$000
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 surplus	-	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**
Balance at 1 July 2017	**124,539**	**15,679**	**79,672**	**-**	**(49,432)**	**170,458**
Crown Loan converted into Equity	-	-	-	-	-	-
Repayment of Equity	(207)	-	-	-	-	(207)
Revaluation Reserve	-	8,010	30,898	(662)	-	38,246
Surplus/(deficit) for the year	-	-	-	-	(6,891)	(6,891)
Balance at 30 June 2018	**124,332**	**23,689**	**110,570**	**(662)**	**(56,321)**	**201,606**

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

	2018 Actual $000	2017 Actual $000
Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities		
Net surplus/(deficit)	(6,891)	(3,799)
Add/(less) non-cash items:		
Depreciation and amortisation expense	13,673	13,306
Increase/(decrease) in Provisions	1,978	2,662
Total non-cash items	**15,651**	**15,968**
Add/(less) items classified as investing or financing activity:		
(Gains)/losses on sale of property, plant and equipment	1	9
Net interest paid	(546)	1,677
Total items classified as investing or financing activity	**(545)**	**1,686**
Add/(less) movements in statement of financial position items:		

(Increase)/decrease in debtors and other receivables	1,352	(4,058)
(Increase)/decrease in inventories	56	37
Trust Movement	3,435	(360)
Increase/(decrease) in creditors and other payables	(2,540)	2,993
Net movements in Working Capital items	**2,303**	**(1,388)**
Net cash flow from Operating Activities	**10,518**	**12,467**

19 CAPITAL COMMITMENTS AND OPERATING LEASES

	2018 Actual $000	2017 Actual $000
Capital commitments	5,097	4,002
Operating Leases as lessee		
Not later than one year	1,599	1,784
Later than one year and not later than five years	3,235	2,028
Later than five years	68	6
Total Non-cancellable Commitments	**9,999**	**7,820**

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

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

- The Regional Public Health premises in Porirua are leased for six years with one right of renewal in March 2021 and a final expiry date of March 2025.
- The Community Mental Health premises in Lower Hutt are leased for six years with two rights of renewal in September 2023 and September 2026 and a final expiry date of August 2029.
- The Community Mental Health premises in Upper Hutt are leased for six years with two rights of renewal in June 2021 and June 2027 and a final expiry date of August 2029.
- The CT scanner and four ultrasound machines are leased for five years with an expiry date of August 2022.
- The Magnetic Resonance Imaging (MRI) machine is leased for three years with an expiry date of September 2019.

20 CONTINGENCIES

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2018 (2017: 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.

	2018 Actual $000	2017 Actual $000
Salaries and other short-term employee benefits	2,377	1,871
Full time equivalent	11.33	10.30

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 $77.43m (2017: 72.30m), with total expenditure of $84.91m (2017: 83.70m). The amount owing to Hutt Valley DHB by Capital & Coast DHB at the end of the financial year was $2.73m (2017: 2.17m), and the amount Hutt Valley DHB owed to Capital & Coast DHB was $3.31m (2016: 5.27m).

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 $11.26m (2017: 11.90m), with total expenditure of $0.57m (2017: 0.80m). The amount owing to Hutt Valley DHB by Wairarapa DHB at the end of the financial year was $0.97m (2017: 0.60m), and the amount owing to Wairarapa DHB was $0.01m (2017: 0.005m).

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 (2017: 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	2017/18 actual ($000)	2016/17 actual ($000)
Andrew Blair	Chair (since December 2016)	45	26
Wayne Guppy	Deputy Chair	28	29
David Ogden	Current Member	23	23
John Terris	Current Member	22	23
Ken Laban	Current Member	23	23
Yvette Grace	Current Member	22	21
Tim Ngan-Kee	Current Member (since December 2016)	23	13
Kim von Lanthen	Current Member (since 9 May 2017)	23	3
Prue Lamason	Current Member (since December 2016)	23	12
Lisa Bridson	Current Member (since December 2016)	22	12
Peter Douglas	Member until 31 August 2017	6	22
Previous Board Members (until new Board elected December 2016)			
Dr Virginia Hope	Chair until 4 December 2016	-	20
David Bassett	Member until 4 December 2016	-	10
Kathryn Austin	Member until 4 December 2016	-	10
Sandra Greig	Member until 4 December 2016	-	9
Total Board member remuneration		260	256
Total full time equivalent		**1.29**	**0.97**

Board and committee meeting attendances in the year to 30 June 2018:

Board Member	Position	Meetings Attended				Meetings held			
		Board	FRAC	HAC	CPHAC-DSAC	Board	FRAC	HAC	CPHAC-DSAC
Andrew Blair	Board Chair	9	9	0	2	10	11	0	7
Wayne Guppy	Deputy Board Chair	7	11	0	0	10	11	0	7
David Ogden	Current Member	8	10	0	0	10	11	0	7
John Terris	Current Member	9	0	0	5	10	11	0	7
Ken Laban	Current Member	9	10	0	0	10	11	0	7
Yvette Grace	Current Member	8	0	0	4	10	11	0	7
Tim Ngan Kee	Current Member	10	11	0	2	10	11	0	7
Kim von Lanthen	Current Member	9	10	0	0	10	11	0	7
Prue Lamason	Current Member	10	2	0	7	10	11	0	7
Lisa Bridson	Current Member	10	0	0	5	10	11	0	7
Peter Douglas	Member until 31 August 2017	1	1	0	0	10	11	0	7
Previous board and committee members									
Roger Jarrold	FRAC Chair until 1 November2017	0	4	0	0	0	11	0	0

Roger Jarrold was the external chair of the Finance Risk & Audit Committee (FRAC) for HVDHB.

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 50 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:

	2018	2017

	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	$000	$000	$000	$000
Cash and cash equivalents	15,443	15,443	13,237	13,237
Debtors and other receivables	18,093	18,093	19,499	19,499
Creditors and other payables	37,802	37,802	36,913	36,913
Finance leases	730	730	1,134	1,134
	72,068	**72,068**	**70,783**	**70,783**

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 2018, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2018/19, 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:

	2018 Actual $000	2017 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
AA+	10,958	7,472
AA-	-	-
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	5,874	7,134
Total	**16,832**	**14,606**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	15,443	13,237
Trust and bequest funds	1,389	1,369
Debtors and other receivables	18,093	19,499

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
2017					
Creditors and other payables	32,776	32,776	32,776	-	-
Finance leases	1,134	1,485	591	569	325
Total	**33,910**	**34,261**	**33,367**	**569**	**325**

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2018					
Creditors and other payables	33,762	33,762	33,762	-	-
Finance leases	730	755	277	254	224
Total	**34,492**	**34,517**	**34,039**	**254**	**224**

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 2018 are provided below.

Statement of Comprehensive revenue and expense

The Hutt Valley DHB recorded a deficit of $6.891m compared with a budget deficit of $2.103m. The major variances were:

- Higher nursing costs in General Medical and OPRS for patient minders and other areas to covering workloads.
- Higher costs in outsourced medical personnel due to cover required for vacancies and sickness and the introduction of new RMO rosters.
- Outsourcing of clinical services was required for both elective surgery and radiology to meet waiting times and manage volumes.
- Additional hospital pharmaceutical costs were partially offset by additional hospital rebates.
- Inter District Flows increased in June relating to a high cost patient being treated in another DHB.

Statement of Financial Position

Property, Plant and Equipment (PPE) and Equity are both higher than budget because Land and Buildings were revalued. The revaluation resulted in an increase of $38.2m to both PPE and Equity.

Statement of Cash Flows

The net cash flow was more than budgeted because less was spent on Purchase of PPE than was budgeted.

28 COST OF SERVICE STATEMENTS FOR OUTPUT CLASSES

For the year ended 30 June 2018

$000s	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
	2017\18 Actual	2017\18 Budget	2016\17 Audited	2017\18 Actual	2017\18 Budget	2016\17 Audited	2017\18 Actual	2017\18 Budget	2016\17 Audited	2017\18 Actual	2017\18 Budget	2016\17 Audited	2017\18 Actual	2017\18 Budget	2016\17 Audited
Income															
Operating Income	20,307	19,761	22,037	252,288	253,161	164,747	204,785	203,460	268,139	72,468	64,013	71,073	549,848	540,395	525,996
Interest Income	30	27	28	20	17	18	546	505	504	1	1	1	597	550	551
Total Income	20,337	19,788	22,065	252,308	253,178	164,765	205,331	203,965	268,643	72,469	64,014	71,074	550,445	540,945	526,547
Expenditure															
Personnel Costs	12,797	12,406	12,780	10,369	11,181	9,698	147,843	145,943	142,378	4,317	4,051	4,094	175,326	173,581	168,950
Depreciation	463	206	273	930	788	776	12,262	12,581	12,236	18	18	21	13,673	13,593	13,306
Outsourced Services	1,346	1,174	1,347	1,272	693	1,459	14,220	8,595	12,621	164	155	313	17,002	10,617	15,740
Clinical Supplies	504	418	501	446	516	497	23,764	22,468	22,174	1,439	1,144	1,416	26,153	24,546	24,588
Infrastructure and Non Clinical Expenses	530	498	395	1,091	770	733	13,741	11,749	13,531	170	88	76	15,532	13,105	14,735
Other District Health Boards	0	0	59	88,441	87,618	18,765	0	0	67,036	4,599	4,317	3,378	93,040	91,935	89,238
Non Health Board Providers	0	0	2,006	143,338	147,074	127,627	0	0	4,339	59,044	52,852	57,478	202,382	199,926	191,450
Capital Charge	470	471	253	1,031	1,031	992	8,575	8,620	4,610	16	16	9	10,092	10,138	5,864
Interest Expense	0	0	39	0	0	26	51	93	2,212	0	0	1	51	93	2,278
Other	881	1,016	1,073	516	533	530	2,610	3,914	2,484	78	51	111	4,085	5,514	4,198
Internal Allocations	4,501	4,525	3,632	3,973	3,975	3,062	(9,420)	(9,549)	(8,654)	946	1,049	1,960	0	0	0
Total Expenditure	21,492	20,714	22,358	251,407	254,179	164,165	213,646	204,414	274,967	70,791	63,741	68,857	557,336	543,048	530,347
Net Surplus / (Deficit)	(1,155)	(926)	(293)	901	(1,001)	600	(8,315)	(449)	(6,324)	1,678	273	2,217	(6,891)	(2,103)	(3,800)

29 COMPLIANCE WITH HOLIDAYS ACT (2003)

Many public and private sector entities, including Hutt Valley DHB, are continuing to investigate historic underpayment of holiday entitlements. For employers such as Hutt Valley DHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Holidays Act (2003) (the Act) and determining the underpayment is time consuming and complicated.

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

In the interim Hutt Valley DHB performed a self-assessment on compliance with the Act. The outcome of the self-assessment was that Hutt Valley DHB does not have any material liabilities arising from misinterpretation of the Act. The self-assessment was reviewed by PricewaterhouseCoopers.

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 2018.

Signed on behalf of the Board:

Andrew Blair
Board Chair
31 October 2018

Wayne Guppy
Deputy Board Chair
31 October 2018

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 2018

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 appropriations, of the Health Board on his behalf.

Opinion

We have audited:

- the financial statements of the Health Board on pages 56 to 91 that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 29 to 49.

In our opinion:

- the financial statements of the Health Board on pages 56 to 91:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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 Public Benefit Entity Reporting Standards; and

- the performance information of the Health Board on pages 29 to 49:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2018, 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; and
        - 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 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw your attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 29 on page 91. Our opinion is not modified in respect of this matter.

Failure to complete the statement of performance expectations for the reporting period beginning 1 July 2018

We draw your attention to the disclosures made on page 49 about the failure to comply with section 149C of the Crown Entities Act 2004, which requires the Health Board to complete its statement of performance expectations before the start of the financial year. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

Basis for our 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 determines 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 obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the Health Board audit. We remain solely responsible for our audit opinion.

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.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 28, 50 to 55, 92 and 98 to 101 but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

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 issued 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 Dec 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 and the former two apply to DHBs.
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable 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 (to 25 June 2018) Bank of New Zealand (from 26 June 2018)	**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). The Board currently has one position vacant following the resignation of one of the appointed members in August 2017.

Andrew Blair, Chair	**Lisa Bridson**
Wayne Guppy, Deputy Chair	**David Ogden**
Tim Ngan Kee	**John Terris**
Kim von Lanthen	**Ken Laban**
Yvette Grace	**Prue Lamason**
Peter Douglas **(until 31 August 2017)**	

Executive Leadership Team for Hutt Valley DHB *as at 30 June 2018*

Dale Oliff	Acting Chief Executive Officer	**Judith Parkinson**	General Manager – Finance and Corporate Services
Peng Voon	Acting 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

3DHB Disability Support Advisory Committee			
The Disability Support Advisory Committee advises the Boards on the disability support needs of the resident populations of the DHBs and the priorities for the use of the disability support funding provided. This is a joint committee with Wairarapa, Hutt Valley, and Capital & Coast District Health Boards.			
Dame Fran Wilde (Chair)	Capital & Coast	**Yvette Grace (Deputy)**	Hutt Valley
Sue Kedgley	Capital & Coast	**Andrew Blair**	Capital & Coast / Hutt Valley
Sue Driver	Capital & Coast	**Eileen Brown**	Capital & Coast
'Ana Coffey	Capital & Coast	**Dr Tristram Ingham**	Capital & Coast
Lisa Bridson	Hutt Valley	**Prue Lamason**	Hutt Valley
John Terris	Hutt Valley	**Derek Milne**	Wairarapa
Alan Shirley	Wairarapa	**Jane Hopkirk**	Wairarapa
Kim Smith	Iwi Kainga Chairperson, Wairarapa	**Fa'amatuainu Tino Pererira**	Chair, Sub-regional Pacific Strategic Health Group
Bob Francis	Chair, Sub-regional Disability Advisory Group		

Community & Public Health Advisory Committee	
The Community & Public Health Advisory Committee advises the Board on the health needs and status of our population.	
Yvette Grace (Chair)	**Andrew Blair**
Lisa Bridson	**Prue Lamason**
John Terris	**Tim Ngan Kee**
Ken Laban	

Finance Risk and Audit Committee	
Roger Jarrold (Chair) **(until 1 November 2017)**	**Wayne Guppy (Deputy and Chair)** **(Deputy until 1 November 2017, Chair from 2 November 2017)**
Andrew Blair	**David Ogden**
Tim Ngan Kee	**Kim von Lanthen**
Prue Lamason **(from 4 May 2018)**	**Ken Laban**
Pru Peter Douglas **(until 31 August 2017)**	

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.	
Andrew Blair, Chair	**Lisa Bridson**
Wayne Guppy, Deputy Chair	**David Ogden**
Tim Ngan Kee	**John Terris**
Kim von Lanthen	**Ken Laban**
Yvette Grace	**Prue Lamason**
Peter Douglas (until 31 August 2017)	