Hutt Valley District Health Board

# Annual Report 2019-2020

**E84**

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

HUTT VALLEY DHB

# Contents



**Glossary of acronyms:**
HVDHB – Hutt Valley District Health Board
CCDHB – Capital & Coast District Health Board
2DHB – Hutt Valley and Capital & Coast District Health Boards
3DHB – Wairarapa, Hutt Valley and Capital & Coast District Health Boards
MHAIDS - Mental Health, Addictions and Intellectual Disability Service

**Cover photo:** Generations of a Samoan family gather at home for a Sunday lunch in the Hutt Valley.

# Chair and Chief Executive's Foreword

What an astonishing year it has been. Shortly after the new Board took office late last year, the health landscape was changed forever with the emergence of COVID-19. While we are in a comparatively fortunate position globally, the pandemic has had a huge impact, and will affect the way we deliver services and work with our communities for a long time to come.

At Hutt Valley DHB we are focused on providing safe, quality health services, and strive to achieve equitable health outcomes for all. We provide a range of services across our community including outpatient clinics, maternity, and mental health services. The new Board has a commitment to making sure we are in a sustainable financial position, and work continues to make sure we are living within our means while meeting our obligations and continuing to deliver good quality care.

We are proud of how our people stood strong and supported the 'team of five million' to stop community transmission of COVID-19 in Aotearoa. Together with Capital & Coast DHB, we delivered a coordinated response to the pandemic, from establishing Community Based Assessment Centres (CBACs) across the region, to providing support to Managed Isolation Facilities (MIFs), to helping provide emergency supplies to people struggling as a result of the outbreak.

During lockdown in April a significant number of elective procedures were deferred, resulting in an influx of patients after lockdown was lifted. Ensuring that we catch up and respond to our patients requiring treatment and care will be a priority over the next year.

We continue to maintain our readiness to respond should anything change. In the meantime we are able to focus our attention on our plans for the future. New ways of working that developed during COVID-19 are now being embedded into our business-as-usual practice. This includes greater use of telehealth and increasing the availability of specialist support and advice to primary care.

Together with Capital & Coast DHB, we have been working to bring our partnership as a 2DHB organisation to fruition following appointment of a joint Chief Executive last year. Over the last year we have recruited a number of 2DHB Executive Leadership Team positions, while also welcoming a joint Chair and more closely aligning the two Boards.

The release this year of the Health and Disability System Review has signalled change for DHBs. Our strategic approaches align with the direction articulated in the recommendations. Hutt Valley DHB's *Vision for Change* strategy describes our future direction, focusing on supporting people to live well, shifting care closer to home, creating an adaptable workforce, effective commissioning, smart infrastructure, and delivering shorter, safer, smoother care.

A year of unprecedented challenges has underscored the importance of our equity work. Outbreaks of infections like COVID-19 disproportionately impact our priority populations, and key health messages can struggle to reach our Māori, Pacific and Disability communities. Our expert teams continue to work with providers and use tried-and-tested communications tools to reach these communities, from Pacific Radio broadcasts to sign-language video translations.

Historical disadvantage and alienation, poverty, and poor living environments lead to sustained poor health outcomes. This applies to many Māori and whānau. Life expectancy for Māori living in the Hutt Valley area continues to lag behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas.

Hutt Valley DHB has developed a long-sighted Māori health strategy to tackle these inequities, with *Te Pae Amorangi*, released in 2018. It challenges HVDHB to tackle inequity, in the context of the founding document of Aotearoa - Te Tiriti o Waitangi.

Our Pacific Directorate is also preparing to release its long-term health strategy. Its team members have led the way ensuring equity of messaging, and strengthened relationships with and between providers, to reach Pacific communities during the COVID-19 outbreak.

Our Mental Health, Addictions and Intellectual Disability Service (MHAIDS) team is working through a process of change to shape the services it provides our communities. As part of that, MHAIDS launched a GP Liaison service this year to ensure provision of specialist mental health and addictions advice to general practices across the 3DHBs (including Wairarapa).

Tremendous work has also been done this year by our 3DHB Disability Strategy team. Its ongoing role is to ensure disabled people have ready access to information, but also that barriers experienced in their daily lives are addressed. Team members continue to work with people across the 3DHBs to achieve this goal, and this year were seconded to the Ministry of Health to assist with communications during the first COVID-19 outbreak.

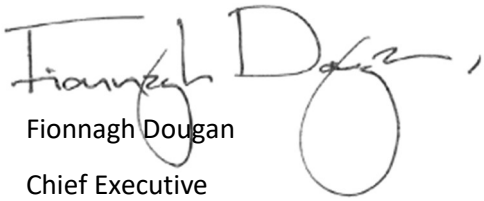
While it has been a challenging year, our people have risen to the challenge, and we are optimistic about the potential of working together across our 2DHBs for a stronger healthcare system. We are very pleased to present our annual report for the year ending June 2020.

Ma tini, ma mano, ka rapa te whai – by joining together, we will succeed.

David Smol

Board Chair

18 December 2020



Fionnagh Dougan

Chief Executive

18 December 2020

# Introduction

This annual report outlines Hutt Valley District Health Board's (DHB) progress towards meeting the intentions and priorities as outlined in the New Zealand Health Strategy and our Board's vision: *Healthy people, healthy families and healthy communities - Whānau Ora ki te Awakairangi*.

To deliver our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means using our resources in the most effective manner. We want to ensure that service delivery occurs in the most appropriate setting for our people and communities, and achieves equitable and improved health outcomes.

We recognise the role of many people in our success: our communities, families, workforce, provider partners, Ministry of Health and our social service partners. At the heart of this approach is *enabling people* and their whānau to take the lead in their own health and wellbeing. As we implement our Vision for Change and long-term vision of how services will be delivered for our population, we are well positioned to successfully deliver against the New Zealand Health Strategy's objectives. We have a work programme that builds on existing successes and finds new ways of using existing resources wisely.

Overall, Hutt Valley DHB's population is experiencing good health. Our residents are living longer and experiencing better health. However, inequities remain a significant challenge. Achieving equity is a priority for us. We know that we do not do as well for Māori, Pacific peoples, people with disabilities, those who have fewer resources available to them and those with enduring mental illness. We can see this in our measurement of health system performance, impacts and outcomes. We are committed to improving health outcomes and achieving equity for our communities. Our focus is on improving performance ensuring we make best use of our available resources and, ultimately, achieving equity for our populations.

We will continue to focus on:

- *Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy 2018-2027*
- *Pacific Health and Wellbeing Strategic Plan 2020–2025*
- *Sub-Regional Disability Strategy 2017–2022*
- *Living Life Well – A Strategy for Mental Health and Addiction 2019–2025.*

Achieving equitable health outcomes for our communities requires a broader approach than the traditional boundaries of health. To respond to the inequalities, partnerships are required with local councils, government agencies, non-governmental organisations and community organisations. We support these partnerships through local approaches with our Hutt Valley communities.

We collaborate with our Iwi Relationship Board, Sub-Regional Pacific Strategic Health Group and Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent.

In July 2019 Hutt Valley DHB launched *Te Pae Amorangi – Hutt Valley DHB's Māori Health Strategy 2018-2027. Te Pae Amorangi* is supported by this tūruapō (vision):

*Tā Mātou Matakite*
*Mauri Ora – Whānau Ora – Wai Ora*
*Healthy People – Healthy Families – Healthy Communities*

*Te Pae Amorangi* is centred on achieving Māori health equity, and advancing Treaty relationships and Māori participation across the health system. Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is most cohesively described in the *Ministry of Health's He Korowai Oranga: Māori Health Strategy.*

*Te Pae Amorangi* has been developed to transform our health and disability services to achieve Māori health equity and outcomes by 2027.

The pathway to achieving health equity for Māori requires significant shifts, not just in the way we operate and in the processes and policies we follow, but also in our attitude and our thinking. Delivering on the key outcomes outlined in *Te Pae Amorangi* is fundamental to achieving equitable health outcomes for Māori.

To meet our responsibilities to the Minister, the region and our communities, we use our resources wisely and strategically to:

- promote health and wellbeing
- achieve equitable health outcomes
- prevent the onset and development of avoidable illness
- strengthen the wellbeing and health outcomes of people who are experiencing illness
- support dignity at the end of life.

We operate with a long-term view and have a programme of work that builds on existing successes and finds new ways to:

- work with communities to improve health and wellbeing with a focus on preventing or delaying the onset of avoidable illness or disability
- simplify service delivery for those people who don't have good health literacy and health behaviours
- intensify service delivery for those who are more vulnerable and have greater health needs to reduce inequalities and improve health gain
- implement models of care that promote early intervention closer to home and result in improved health outcomes
- organise technology and interdisciplinary teams in communities, people's homes, community health networks and our hospitals to ensure resources are used efficiently by reducing duplication and improving integration.

# Our Vision and Strategic Direction

Hutt Valley is committed to meeting the Minister of Health's expectations and continue our commitment to deliver Hutt Valley DHB's vision of *Healthy People, Healthy Families, Healthy Communities (Whānau Ora ki te Awakairangi).*

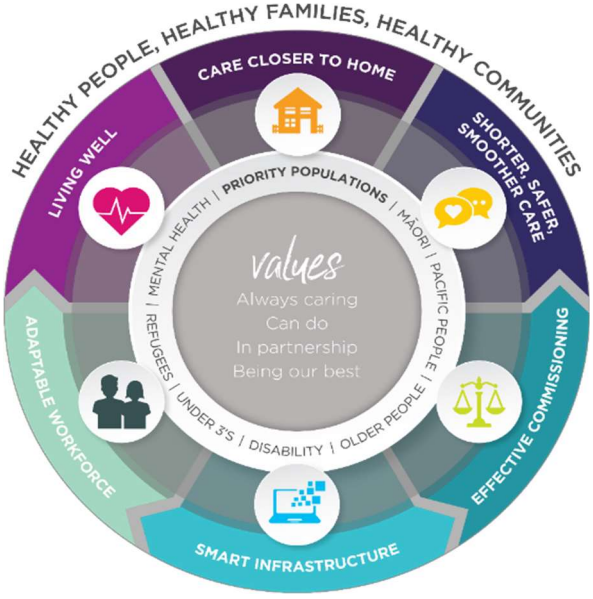
To deliver on our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means applying our resources in the most effective manner to achieve equitable health outcomes and to advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate setting for our people and communities.

We recognise the role of many people in our success: our communities, our families, our workforce, our provider partners, our Ministry and our social service partners. Enabling people and their whānau to take the lead in their own health and wellbeing is at the heart of this approach.

## Our Vision for Change

In 2017, we introduced *Our Vision for Change – How We Will Transform the Health System 2017-2027*. Our people, whānau and communities have told us what is needed from the Hutt Valley health system in order to achieve *Our Vision for Change*. These strategic objectives include services being organised and delivered equitably, whānau being owners of their care, a focus on prevention and early intervention, care delivered closer to home, coordinated health and social services, and a health system that is clinically and financially sustainable.

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.

## Strategic Framework

We have developed a number of plans to support us to meet the challenges ahead and achieve *Our Vision for Change*. Together these plans reflect Hutt Valley DHB's strategic framework.


Read the strategies on our website – [www.huttvalleydhb.org.nz](http://www.huttvalleydhb.org.nz)

- ***Clinical Services Plan 2018-2028*** provides an outline of how we will need to reconfigure our clinical services over the next 5-10 years to address growing health demands. Achieving equity is a focus throughout the Clinical Services Plan. Other areas of particular focus include:
  - **Community Integration**: integrating hospital and primary care services, including the provision of specialist advice to primary care so that general practice can better support people to stay well.
  - **First 1,000 Days of Life**: ensuring that our women's health, maternity, and child health services provide high-quality, safe and culturally-responsive care.
  - **Acute Flow**: improving patient flow through the hospital, including efficient triage and coordination of patients when they present to the Emergency Department, improving our assessment and response to frailty, enhancing the pre-surgery assessment process and theatre productivity, and an efficient discharge planning that supports patients to transition back into primary and community care.

- ***A Thriving Hutt Valley*** is our wellbeing plan focussing on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that impact our physical and mental wellbeing.

- ***Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy 2018- 2027***, details our commitment to improving the health of Māori in our district through five priority areas: workforce, organisational development and cultural safety, commissioning, mental health and addictions, and the first 1,000 days of life. Te Pae Amorangi provides a clear direction and leadership across our DHB to achieve equity of health and wellbeing for Māori.

- ***Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025*** aims to improve Pacific health and reduce health inequities through six priorities: child health and wellbeing, young people, adults and aging well, the health workforce and Pacific providers and NGOs, the social determinants of health, and developing a culturally responsive and integrated health system.

- ***Living Life Well – A Strategy for Mental Health and Addiction 2019-2025***, sets the direction for mental health and addiction care to improve outcomes for our people, their whānau, and our wider communities.

- ***Sub-Regional Disability Strategy 2017-2022*** provides a clear strategic direction for leaders within the health sector working with disability communities to address inequities across the population and ensure better health outcomes.

The work of implementing our strategic plans has begun. Hutt Valley DHB has established a Project Management Office, which is supporting a number of projects to improve hospital integration with community services, and enhance patient flow and efficiency within our hospital.

## Health Equity

Achieving equity in health and wellness is a focus for Hutt Valley DHB. We know that we do not do as well for Māori, Pacific People, people with disabilities, those who have fewer resources available to them, and those with enduring mental illness. We are committed to improving health outcomes and achieving equity for them.

Our focus is on improving performance ensuring we make best use of our available resources and ultimately achieving equity amongst our populations. We will continue to deliver against:

- *Te Pae Amorangi, Hutt Valley DHB Māori Health Strategy 2018-2027*
- *Pacific Health And Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025*
- *Sub-Regional Disability Strategy 2017-2022*
- *Living Life Well – A Strategy for Mental Health and Addiction 2019-2025.*

We will develop models of care and commission services that achieve equity for our people. We will also prioritise investment into services that have the greatest impact on health outcomes for Māori, Pacific people, people with disabilities, those who have fewer resources available to them, and those with enduring mental illness.

We are seeking to achieve a workforce that is reflective of the populations we serve. We are focussed on the recruitment and retention of Māori and Pacific staff, as well as our staff with disabilities, to help ensure we have the right mix of staff and skills in the places where they are needed most to achieve equitable health outcomes.

Partnership is key to success in achieving equitable health outcomes. We collaborate with our Mana Whenua Relationship Board, our Sub-Regional Pacific Strategic Health Group, and Sub-Regional Disability Advisory Group, who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We also work closely with Central Region DHBs, particularly Capital & Coast DHB and Wairarapa DHB, to coordinate our planning and development, and share learnings about innovations and interventions that achieve equitable outcomes.

## Māori Health

Historical disadvantage and alienation, poverty and poor living environments lead to sustained poor health outcomes. This applies to many Māori individuals and whānau. Life expectancy for Māori males and females living in the HVDHB area continues to lag behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas.

In July 2019 Hutt Valley DHB launched *Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy 2018-2027. Te Pae Amorangi* is supported by this tūruapō (vision):

Tā Mātou Matakite
Mauri Ora – Whānau Ora – Wai Ora
Healthy People – Healthy Families – Healthy Communities

*Te Pae Amorangi* is centred on achieving Māori health equity, and advancing Treaty relationships and Māori participation across the health system.

Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is most cohesively described in the Ministry of Health's *He Korowai Oranga: Māori Health Strategy.* This overarching framework and its underlying themes of Pae Ora (healthy futures) founded on Whānau Ora (healthy families), Mauri Ora (Healthy individuals) and Wai Ora (healthy environments) guide our activity.

*Te Pae Amorangi* is consistent with *He Korowai Oranga* and has been developed to transform our health and disability services over the next nine years to achieve Māori health equity and outcomes.

Implementation of *Te Pae Amorangi* is being progressed, and we have a number of initiatives underway that demonstrate our commitment to *Te Pae Amorangi* and achieving equitable Māori health outcomes.

## Te Tiriti o Waitangi

In planning and providing health services, we pay particular attention to the health needs and aspirations of our Māori population. There are well-documented and preventable inequities in the determinants of health between Māori and non-Māori, and these flow through to inequities in health outcomes. Our intention is that we will target, plan and drive our health services to create equity of health care for Māori to attain good health and well-being, while developing partnerships with the wider social sector to support whole of system change.

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through the founding document of Aotearoa, 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.

Māori representation has been provided on Hutt Valley DHB's advisory committees and its Alliance Leadership Team. Hutt Valley DHB has also established an Iwi Relationship Board to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

# Let's kōrero: Māori cultural safety sessions to benefit Hutt Valley DHB staff and patients

*Hutt Valley DHB Pou Tikanga Rawiri Hirini*

"We want a conversation that adds value for both tangata tiriti (non-Māori) and tangata whenua, and our active partnership to make a rocking country: Aotearoa", says Hutt Valley DHB Pou Tikanga Rawiri Hirini.

This year, Rawiri launched the first module of the Te Kawa Whakaruruhau Māori cultural safety training programme **for all Hutt Valley DHB staff**.

Te Kawa Whakaruruhau translates as a safe place made from principles.

The programme's first module, Te Tiriti o Waitangi, will be an opportunity for staff to learn more about New Zealand from a Māori perspective, through the lens of Te Tiriti o Waitangi (The Treaty of Waitangi).

"You could argue we already are – but for who? Because there's a large percentage of people within New Zealand who wouldn't say we are a rocking country, and it tends to be more so Māori and Pasifika."

About 23 per cent of Māori live in the Hutt Valley's most deprived areas compared to 15 per cent of all residents. About a third of all hospital admissions for people under 25 were Māori this year.

Staff will learn about pre- and post-colonial New Zealand history including a breakdown of Te Tiriti articles, themes of racism, and bi-cultural themes for active partnership, Rawiri said.

"I think one of the outcomes Māori want to see within the health sector is to be spoken with not spoken to - that they get a say in how it goes. I know what they want might not always be what's best for them, but I think they want to be understood that health is not just the physical health.

"That actually having someone with them the whole time is part of their mental health - we all want to feel supported. I think that's a start."

Last year, the health board launched its 2018-2027 strategy for Māori health, *Te Pae Amorangi*, which aims to achieve equity for Māori and non-Māori health within nine years.

"We want whānau to feel safe when they go through the journey of the hospital, and their outcome.

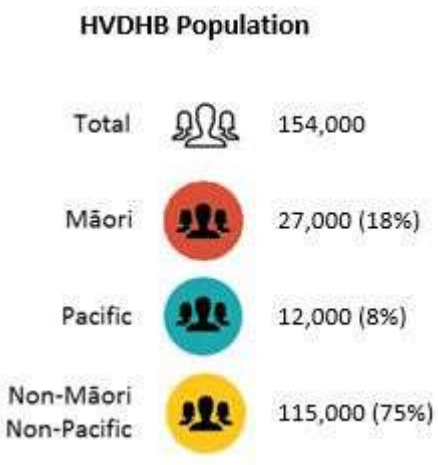
"It's also about supporting our staff. We need to be safe in accommodation and navigating new Māori concepts to staff."

# About Hutt Valley DHB

Hutt Valley DHB is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services for people in the Hutt Valley.

## Who we are

Hutt Valley DHB covers the Te Awakairangi area – the Hutt Valley – and serves approximately 150,000 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. 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.




The Hutt Valley's population is ethnically diverse; 18% of our population identify as Māori, 8% as Pacific peoples and 75% as New Zealand European, Asian and Other.

## Disabilities

There are 35,000 people with a disability living in our district. More than half of the disabled population have a physical disability (58%), 20,200 people. With age, the prevalence of disability increases, and the type of impairment changes.

Our development and delivery of Planned Care takes into account the diversity in ethnicity, age, and ability of our population.

## A changing population

As our population ages, we are seeing more people with long-term health conditions and multi-morbidities. People are living longer than previous generations, but are living longer in poorer health.[1] This is particularly so for Māori, Pacific people, refugees, disabled people and those living with a mental illness.

Our total population is not expected to grow substantially over the next 20 years (just under 5% or around 7,000 people), although there are both short- and long-term plans for housing development in Lower Hutt and Upper Hutt cities. However, there will be a significant increase in the number of older people, with current projections suggesting that in 2038 almost one in four people will be aged over 65 years. The population aged over 80 will double. The overall number of children and working-age adults is expected to decline.

[1] http://www.who.int/news-room/fact-sheets/detail/ageing-and-health Ministry of Health. 2018. *Health and Independence Report 2017. The Director-General's Annual Report on the State of Public Health.* Wellington: Ministry of Health.

As a consequence of our changing population, increased demand will occur across our health system in community care, primary care, aged residential care and in the hospital at the same time as our working-age population decreases. We have a significant challenge ahead to achieve the best and fairest outcomes for our population whilst responding to demographic change and other demand pressures.

## The health of our population

Compared to New Zealand as a whole, we are relatively 'healthy and wealthy'. We have a high life expectancy at 81 years, rates of premature deaths from conditions amenable to healthcare have declined by 33% between 2000 and 2015, and the majority of our population (60%) live in areas of low deprivation.

However, we also have groups who experience inequitable health outcomes; in particular, Māori, Pacific peoples, those experiencing disabilities and those who live in highly deprived areas, concentrated in Wainuiomata, Naenae and Taita.

## What we do

HVDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. These expectations are reflected in our vision:

*"Healthy People, Healthy Families, Healthy Communities (Whānau Ora ki te Awakairangi)"*

The objectives of DHBs are outlined within the *Health and Disability Act (2000)*. These objectives include:

- Improve, promote, and protect the health of communities;
- Reduce inequalities in health status;
- Integrate health services, especially primary and hospital services; and,
- Promote effective care or support of people needing personal health services or disability support.

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets.

## Local Services

Hutt Valley DHB provides community and hospital services throughout the region.

Hutt Valley DHB has a range of contract with community providers, such as primary health organisations, pharmacies, laboratory, and community NGOs.

Hutt Valley DHB operates one hospital: Hutt Hospital in Lower Hutt. We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services. Hutt Valley DHB also provides sub-regional and regional services for other DHBs.

Hutt Valley DHB employs around 1,900 FTE and has an annual budget of $600 million in 2019/20.

## Sub-Regional Services

Hutt Valley DHB provides services to the people of Capital & Coast DHB and Wairarapa DHB under 2DHB (CCDHB and Hutt Valley DHB) and 3DHB models.

Hutt Valley DHB and Capital & Coast DHB serve populations that are geographically co-located. Hutt Valley DHB provides services to both populations, either at Capital & Coast DHB or at Hutt Valley DHB.

In 2019/20, an estimated 324,500 people lived in Capital & Coast DHB. Capital & Coast's population has less ethnic diversity and is slightly older compared to Hutt Valley DHB. Capital & Coast DHB's population is predicted to grow by 7% or 22,000 people by 2029/30.

A further 46,500 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 1,700 people (4%) by 2029/30.

## Response to COVID-19

We delivered a coordinated response to the pandemic in partnership with Capital & Coast DHB, Wairarapa DHB, and the Wellington Regional Emergency Management Office. Ten Community Based Assessment Centres (CBACs) were established across the region to test for COVID-19 and support general practice. Emergency packages of care and support were delivered to Māori, Pacific, and disabled people.

New ways of working that developed during COVID-19 are now being embedded into business as usual. This includes greater use of telehealth and increasing the availability of specialist support and advice to primary care; working across agencies to look after our most vulnerable populations, including homeless people; and supporting our Māori and Pacific community providers to work alongside whānau and achieve equitable outcomes for our priority populations. For Regional Public Health, which is the lead public health agency in a pandemic response, this includes implementing national system changes to improve our capacity for contact tracking.

To help mitigate the economic fallout from COVID-19, we are now prioritising the psychosocial response to the pandemic. This includes a comprehensive programme of work delivering our 3DHB Mental Health and Addictions Strategy: *Living Life Well – A Strategy for Mental Health and Addiction 2019 – 2025*, which aligns with the recommendations in *He Ara Oranga - Report of the Government Inquiry into Mental Health and Addiction.*

The Health Emergency Plan and the Pandemic Plans (both hospital and community) have been reviewed across the three DHBs to incorporate learnings from the COVID-19 response and ensure we are even better prepared for future events.

## Our Public Health response to COVID-19

Since the first whisperings of a potential global pandemic in early January 2020, Regional Public Health (RPH) has been in full preparation and response mode. In February, RPH stood-up its Incident Management Team (IMT) to respond to the pandemic. This saw the majority of the RPH workforce of 125 staff redeployed to focus on protecting our communities from COVID-19.

As part of this response, a key tool utilised to control the spread of COVID-19 was contact tracing. Contact tracing is a concept that prior to COVID-19, many New Zealanders will not have been familiar with. However, contact tracing is bread-and-butter work for public health nurses, who carry out the same process for cases of many different communicable diseases. Contact tracing aims to establish a potential source of infection and to look for close contacts who interacted with a case while they were considered infectious. Through a phone interview, contact tracers capture details such as the history of illness, travel, any contact with a known case. Individuals who are identified as having close contact with the case during this period are then followed up.

Liz MacDonald, RPH Clinical Nurse Specialist, says "The contact tracing aspect of our work is really interesting. It sometimes feels like you're both public health nurse and private investigator as you work to

track people down, and attempt to identify links between cases. Sometimes people choose to share some entertaining anecdotes with us and we find out what interesting lives people lead, even during their illness. We prefer people to over-share with us, in the pursuit of getting the most accurate information and again, the information people share with us is treated with sensitivity and the individual's right to privacy at front of mind".

Another key aspect of RPH's pandemic response was at the border. During the initial stages of the COVID-19 outbreak in New Zealand, RPH staff were present at Wellington Airport to provide health screening for returning passengers. This saw our staff collaborating with Wellington International Airport, NZ Customs and Aviation Security to ensure that returnees were aware of COVID-19, and knew what to do if they became symptomatic during the first 14 days following their return.

Similarly, the RPH health promotion workforce were involved in range of activities alongside community organisations which included providing information and resources to the community, as well as packaging and distributing food and hygiene packages. They also connected with small business owners who ran essential services to make sure they were aware of effective hygiene practices to keep themselves and their customers safe.

Preventing COVID-19 is an all-of-community effort. Having strong connections with the community and key agency partners has played a vital part of RPH's response. These ties to the community have strengthened during the pandemic response. The Māori whakatauki, or saying, is relevant to RPH's work: Nāu te rourou, nāku te rourou, ka ora ai te iwi. With your food basket and my food basket the people will thrive. This whakatauki talks to community, to collaboration and a strengths-based approach. An approach that has been utilised by RPH, with the understanding that everybody has something to offer, a piece of the puzzle, and by working together we can all thrive.

# Newborn hearing screening team praised for commitment during COVID-19


Hutt Valley DHB's newborn hearing screening team has been praised by the National Screening Unit for commitment and innovation demonstrated during the COVID-19 response.

The National Screening Unit's principal advisor Dr Samantha Everitt described the team's effort during the pandemic response as exceptional and high-functioning. "The team's early responsiveness to a rapidly changing environment helped ensure everything was in place and maximised effective and safe service delivery during a difficult period," she said.

"I am truly blown away by how far newborn hearing screening services have come. Hutt Valley's response is a classic example of a really exceptional, high functioning team that can and did respond effectively in the most challenging situations."

Congenital hearing loss is one of the most common conditions a baby can be born with—there is an incidence of one to three per 1000 births, according to national children's health organisation Starship Child Health. Identifying hearing loss and providing multidisciplinary support early, and in partnership with whānau, is important for supporting language, learning and social development outcomes for children. The Hutt Valley service turned 11 years old in July.

The mother of a newborn who recently visited the service described them as "the absolute best". The unit received similarly high praise for its work during a nationwide audit in 2017. "The success of the service at Hutt Valley DHB is underpinned by an experienced newborn hearing screening coordinator and lead Audiologist, who work closely to ensure effective service delivery", a National Screening Unit spokesperson said.

# 2019-2020 a year at HVDHB

**4,726**
diabetes checks

**1,000**
people in residential care

**42,284**
people presented to the emergency department at Hutt Hospital

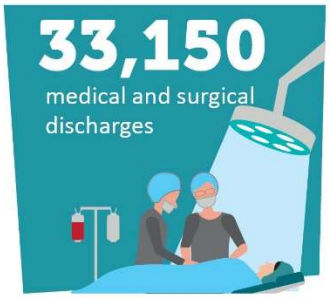
**139,161**
primary health nurse visits

**1,961**
babies were born

**3,758**
people accessed mental health services

**342,153**
GP visits

**26,423**
children had a free dental check




**141,123**
outpatient appointments

**2.5million**
items dispensed by community pharmacies

Results in infographic are unaudited

# Governance of Hutt Valley DHB

## Role of the Board

The Hutt Valley District Health Board is responsible for the governance of the organisation and is accountable to the Minister of Health. The DHB's governance structure is set out in the New Zealand Public Health and Disability Act 2000.

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 February 2020.

## Role of the Chief Executive

The board delegates to the chief executive on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the board's agreed strategic direction as set out in the Annual Plan. It endorses the chief executive, assigning defined levels of authority to other specified levels of management within Hutt Valley DHB's structure.

## Governance Philosophy

Over the past few years, the Wairarapa, Hutt Valley and Capital & Coast DHBs boards have taken a whole-of-health-system approach, including integrating clinical and support services where this provides benefits across the health system. Each board provides governance of local services and all three boards provide collective governance over services that are shared or integrated, ensuring local accountability.

Integrated service approaches are intended to provide:

- preventative health and empowered self-care
- relevant services close to home
- quality hospital care, including highly complex care, for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design.

# Hapū Ora service redefining maternity care for Māori


*Hutt Maternity midwife Ronnie Jayaprakash, left, with kaiārahi Esther Lambert from Te Rūnanganui o Te Atiawa ki te Upoko o Te Ika a Maui.*

Hapū Ora, a drop-in clinic based at Lower Hutt's Waiwhetu Marae, is a collaborative Māori maternity service for whānau expecting a new baby. The drop-in service provides a continuum of care covering everything from midwifery to breastfeeding for new mothers and their whānau.

"Māori can feel whakamā at hospital, but feel comfortable at a marae," said lactation consultant Maria Hakaraia.

"The advantage of offering all the services for whānau at a place where they may feel more comfortable than in a more mainstream clinical setting has seen demand grow steadily".

The free services are run by mana whenua Te Runanganui O Te Atiawa with support from Hutt Maternity and Hutt Valley DHB. Demand for Hapū Ora's services has grown steadily since opening in 2017, with many Māori whānau finding the marae environment an ongoing source of comfort.

The breadth of the Māori cultural knowledge available helps connect whānau with traditional practises such as ipu whenua, or the importance of tūpuna, and the natural benefits of generations of wahine breastfeeding."

There can be lifelong benefits to helping whānau build a strong foundation early-on — our role is to partner with them on this journey," Maria said.

Hutt Maternity midwife Ronnie Jayaprakash runs a weekly clinic at the marae where she sees about six or seven clients.

"Some of the mums that come here can be on the more vulnerable side of society," she says. "It's not just about mum and baby, it's also about the wider whānau.

"By encouraging whānau to engage with health services, they can connect them with a wide range of support including scans and medical tests.

Service co-ordinator Miri Luke says their focus is ensuring whānau engage early with lead maternity carers, offering long term contraception postnatally, and carrying out appropriate referral to other services.
"Our main priority is getting our people access to the services they need – the health of the people here has dramatically improved."

# Our People

At Hutt Valley DHB we have an aspiration to create a thriving culture for our people that values who they are, nurtures skill development and provides an environment for them to do their best in every way, every day. By unleashing the potential of our people we can create a dynamic, high performing and empowered workforce who are supported to deliver high quality, compassionate and safe care to our communities.

## Our values

Our values at Hutt Valley DHB are:

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

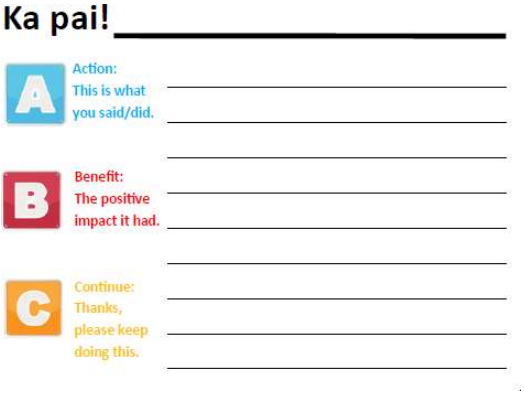
## Bringing our values to life

Our values, and the behaviours that underpin them, are at the heart of everything we do. They set expectations around how we behave, work together, support and treat each other, and ultimately how we care for our communities.

This year we have continued our focus of embedding our values. To strengthen the meaning we have translated them into Te Reo Māori and renewed the koru design. We have also continued to support people leaders with running interactive workshops to create a values-led culture in their teams.

Staff recognition is an important element which supports our desire of encouraging more of the behaviours we want to see. In response to employee feedback, two new staff recognition elements have been introduced:

**Values postcards** provide staff with a simple, informal and effective way to show appreciation with one another.

The **'Te tohu o nga uara / Living our values awards'** recognise employees who demonstrate and live our values everyday - those who go above and beyond to deliver great service to our patients, whānau, community and each other.

With 101 nominations since inception in October 2019, coming from a wide range of roles and services across the DHB, these awards are a tangible demonstration that our employees see the importance of living our values.


## Nurturing wellbeing through Mauri Ora

Mauri Ora relates to the holistic essence of a person in relation to being alive, well, healthy and safe. In our context this was a natural name for our staff wellbeing programme as we are committed to nurturing the wellbeing of our people so they are best placed to deliver quality health outcomes for our communities.

Since launching in February 2019, Mauri Ora has gone from strength to strength delivering a range of employee wellbeing related activities and initiatives.

For example, to support our focus of achieving equity, a dedicated wellbeing day was run especially for Domestic Services employees (Kitchen, Orderlies and Cleaners). In a safe and comfortable environment, employees were able to:

- have a basic wellbeing check performed by second year students enrolled in the Bachelor of Nursing Pacific programme
- receive information about the community based healthy lifestyle programmes on offer to support their wellbeing and that of their fanau / whānau.

The success of Mauri Ora was confirmed with the programme being assessed and awarded Bronze Standard Accreditation from the Ministry of Health supported WorkWell programme.

*Assessor: "I would like to acknowledge the commitment of Hutt Valley DHB to intentionally target the harder to reach staff members and those with the greater health and wellbeing needs. In terms of addressing health inequities, a goal of the WorkWell programme, it's pleasing to see the Hutt Valley DHB prioritise this in their Mauri Ora programme."*

## Supporting our people to bring their 'whole selves' to work

The DHB is committed to Te Tiriti o Waitangi and building an inclusive, equitable and positive culture where all people feel safe, valued and respected, regardless of age, sex, gender identity, sexual orientation, ability, or cultural background.

We continue to weave values throughout our recruitment and selection processes, and have reviewed policies and processes to support our goal of achieving a more ethnically diverse workforce, reflective of our population and communities. This has included the delivery of an updated recruitment policy designed to attract and recruit a diverse mix of staff, a new set of guidelines for the attraction and recruitment of Māori staff, and the translation of job titles into te reo Māori.

One of the ways we celebrate diversity is to encourage employees to turn the DHB into a 'sea of pink' for Pink Shirt Day to show our commitment to creating a positive workplace environment that is safe, welcoming and inclusive of everyone.

## Workforce

Most staff employed in the 2DHBs are covered by Collective Employment Agreements. This means that their terms and conditions of employment are primarily set out in Multi-Employer Collective Agreements (MECA).

This year saw the Clinical Physiology, Medical Imaging Technologists, Psychologists, Sonographers and Senior Medical Officers Multi-Employer Collective Agreements settled. A number of the remaining collective agreements are due to be renegotiated over coming months, including nursing, junior doctors, allied and technical workforces and single employer collective agreements for our ICT staff and the pharmacy, building services and store persons at Hutt Valley DHB.

Work continues nationwide for pay equity for our administration, clerical and nursing workforces.

The first steps towards an IEA remuneration strategy have been completed. The strategy is designed to ensure alignment across the 2DHBS with MECAs, relativity between staff and roles, recruitment and retention and affordability. The strategy's initial focus has centred on several key roles/job families. In ICT this work is supported by the SFIA (Skills Framework for the Information Age) competency system. In 2020, the strategy has also factored in the Government request for pay restraint, given the economic impact of COVID-19.

A union-DHB partnership approach to workforce concerns is supported by monthly Bi-partite Action Group meetings with the unions and the quarterly Joint Consultative Committee meeting with the Association of Salaried Medical Specialists (ASMS).

# 2DHB People, Culture & Capability

In late 2019 the Hutt Valley DHB Human Resources and Capital & Coast DHB People & Capability leadership teams came together to explore opportunities where the teams could collaborate and work more closely together.

While formal structural changes are currently being progressed, the arrival of COVID-19 led to a significant alignment and connection across the 2DHBs. Teams from each DHB collaborated closely to provide services to our people during COVID-19.

## Welfare and wellbeing

COVID-19 has meant our people and their loved ones have experienced anxiety, navigated uncertainty and had their lives disrupted. Given the magnitude and far reaching impacts of the pandemic, a holistic response to the welfare and wellbeing of our people was critical.

To ensure consistency, a dedicated staff welfare and wellbeing stream of work was established across our 3DHBs. Integral was the creation of a staff wellbeing framework which applied the principles of readiness, response and recovery to ensure our plan was phased, agile and adaptable given the changing situation. At the core of the framework, Māori health model Te Whare Tapa Whā made sure wellbeing initiatives were delivered in a holistic way.

Some of the ways we focussed on wellbeing were to:

- **Make sure our people sustained their wellbeing** through a suite of resources such as self-care, where to go for support, staying calm, mindfulness, resilience strategies, personal safety.
- **Support our leaders to lead through wellbeing** with a series of webinars and resources that provided tools on connecting and leading their teams, completing wellbeing check in's, looking after their own wellbeing, flexible working tips, effective communication and psychological first aid training.
- **Strengthen and connect our teams, whānau and community** by harnessing the positivity that shone through such as supporting our values, highlighting the different ways are working together, and celebrating successes.
- **Provide focused intervention and wellbeing support** with the introduction of the Kotahi team (defusing/debriefing team)**.** Accessed by over 30 teams, skilled volunteers worked with managers and teams to identify useful wellbeing strategies.

COVID-19 has also been a catalyst for the DHB to continuously evolve how we work in the new normal. Several wellbeing initiatives born out of necessity during the pandemic are now being progressed into business as usual. Flexible working guidelines which align with the State Services Commission's 'flexible by default' approach are in development. A formal framework is also being shaped to improve how we provide ongoing wellbeing support at all levels to our leaders and teams.

Although COVID-19 has meant unprecedented times, we have come together as one and risen to the challenge. Our people have shown dedication, kindness and the ability to adapt to ensure colleagues, patients, whānau and our community remain safe.

## OUR PEOPLE SHARE THEIR EXPERIENCES

### CONNECTIONS AND COLLABORATION

"The flexibility, camaraderie and teamwork shown has been tremendous."
*(Jon, physiotherapist, CCDHB)*

"I've really enjoyed the passion and support my colleagues have brought to the table through this challenging time."
*(Business partner, 3DB ICT)*

"It's been a fantastic opportunity to make connections with colleagues and work with different people."
*(Project coordinator, CCDHB)*

### TAUTOKO/SUPPORT

"Support from senior staff has been incredible."
*(Sarah, Oral health therapist, Regional Bee Healthy Service)*

"Working with a wonderful cohesive leadership team who have supported each other."
*(Charge nurse manager, HVDHB)*

"A kind, caring and supportive culture where there is appreciation of everyone's presence and contribution."
*(Allied health clinician, CCDHB)*

### INNOVATION

"[There's been] development and implementation of new solutions at pace"
*(Business partner, 3DHB ICT)*

"Some of the new systems and processes implemented have been great and have led to staff working together effectively."
*(Security orderly, CCDHB)*

### STEPPING UP

"This situation has allowed people to shine."
*(Clinical nurse manager, HVDHB)*

"I've been witnessing inspirational leadership."
*(Tutangi, associate allied health director - Pasifika, CCDHB)*

"This has been an opportunity to stretch and grow."
*(Wendy, educator, MHAIDS)*


Jon


Sarah


Tutangi


Wendy

## Impact of COVID-19 on our workforce

The rapidly changing situation meant that regular, clear communications for all staff was essential and a primary focus has been on collating, translating and condensing the huge amounts of information to create regularly updated FAQs, advice for people leaders and daily communications to all staff.

As part of developing our leaders to lead with confidence during COVID-19 a series of three webinars: "Leading for Wellbeing"; provided information on Occupational Health and Safety through the levels, Sustaining Wellbeing, and Positive Communication to Build Great Teams.

A 2DHB COVID-19 Workforce Office was established during the early stages of the active COVID-19 response to coordinate requests for, and responses to, the need for additional workforce across the health sector i.e. use of casual or agency staff. Support was also provided to Wairarapa DHB.

The office enabled redeployment of staff for the COVID-19 response such as Dental Technicians working as swabbing staff in CBACs. In total over 1000 hours of staff deployment time was managed through the Workforce Office, with over 70% of this being supplied by AHST into non-traditional roles for the staff groups involved.

A 20DHBs Emergency Response Function was established to support the coordinated workforce response for COVID-19. The structure and operating model were identified and stood up during the response. This function remains on standby, to enable rapid response for future pandemic events.

Specific joint Capital & Coast DHB, Hutt Valley DHB and union meetings were introduced to ensure that the unions were fully briefed on COVID-19 related and these proved to be very effective.

# Continuous learning and improvement

COVID-19 has put significant demand on our workforce to learn and refresh their capabilities in order to meet the changing work environment. To ensure the safety of our staff mixed media approaches were utilised to continue core learning and also quickly create COVID-19 specific learning.

Updates included:

- Redesign of protocols and processes to suit COVID-19 such as adapted resuscitation protocols were introduced (with a seven day/week presence of clinical educator support at Hutt Valley DHB); the design of COVID-19 specific PPE training; enhanced personal safety learning, and adapted orientation processes for new staff
- Our reporting on completion rates especially on PPE training were a core metric for maintaining a safe operational workforce
- Guidelines were provided to support educators with holding training and meetings, ensuring physical distancing and hygiene protocols were maintained
- Support was provided for employees to utilise and fully embrace Zoom as a way of communicating. The Māori Health Team and nursing leadership, have both since adopted this technology as a permanent solution for workshops and networking
- At Capital & Coast DHB, innovative virtual simulation technology was used to support the delivery of training where physical distancing was required
- It was important to continue to develop our leaders; our leadership programmes were converted to small group sessions using Zoom. This meant learning was captured in real-time and new leaders were supported through the rapidly changing times.

## Employee Health and COVID-19 Risk Management

To reduce the risk of COVID-19 transmission in our workforce, while also maximising staff availability, the 2DHB Occupational Health services collaborated with a range of partners to establish a 3DHB COVID-19 Employee Response function, which included:

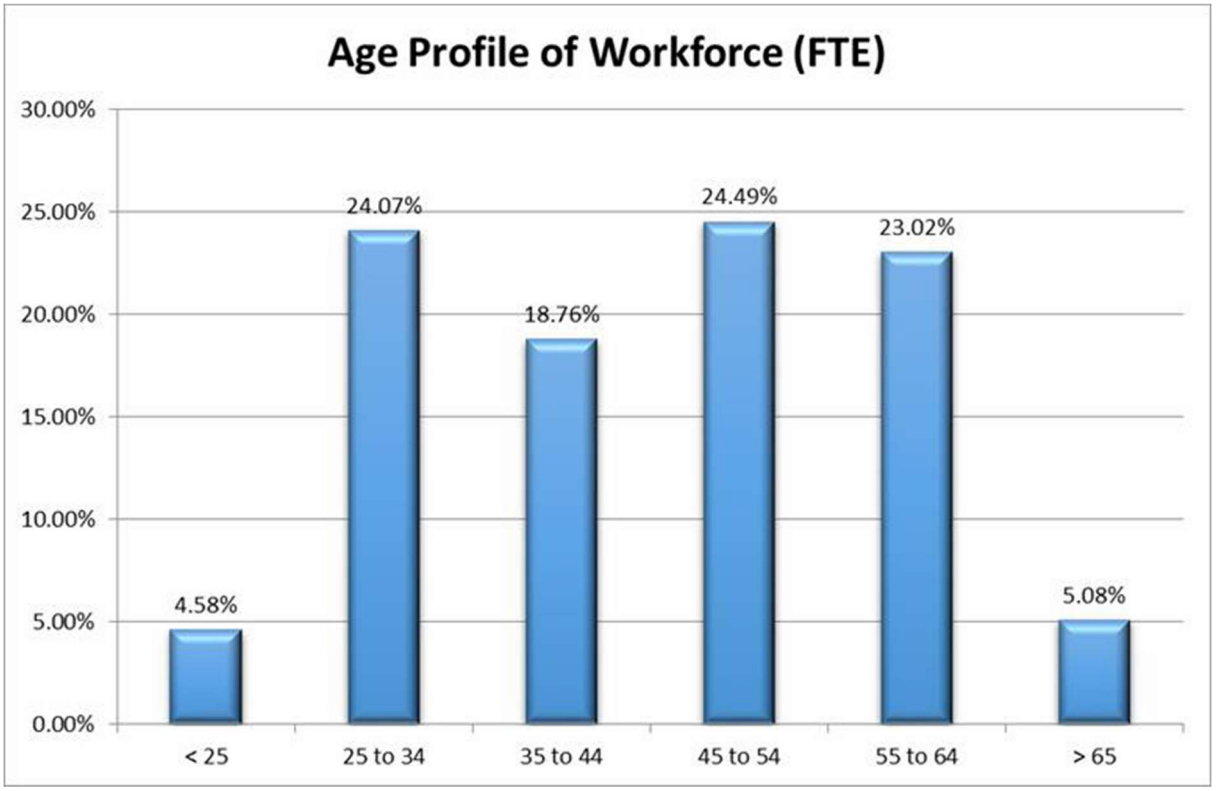
- A Response Centre staffed by senior clinicians was established to take health enquires from employees and provide advice on testing, isolation and related matters for employees
- Dedicated COVID-19 swabbing facilities were set up for 2DHB employees, to reduce pressure on public testing facilities and minimise delays in returning employees to work
- Adoption of the 20DHB Vulnerable Worker process enabled assessment of workers against a nationally agreed framework. Workers with pre-existing health conditions were assigned a Vulnerable Worker category which determined the type and area of work appropriate to their health status
- An information management system was built to allow the identification, assessment and reporting of employee COVID-19 enquiries
- An early and aggressive Influenza campaign targeting employees reduced the risk of influenza during the COVID-19 crisis
- N95 Disposable Mask Fit Testing programmes have been implemented as an ongoing initiative for all frontline employees, COVID-19 stream employees and those working with airborne precautions. This was coupled with Fit Checking education to ensure consistency.

# Workforce Profile

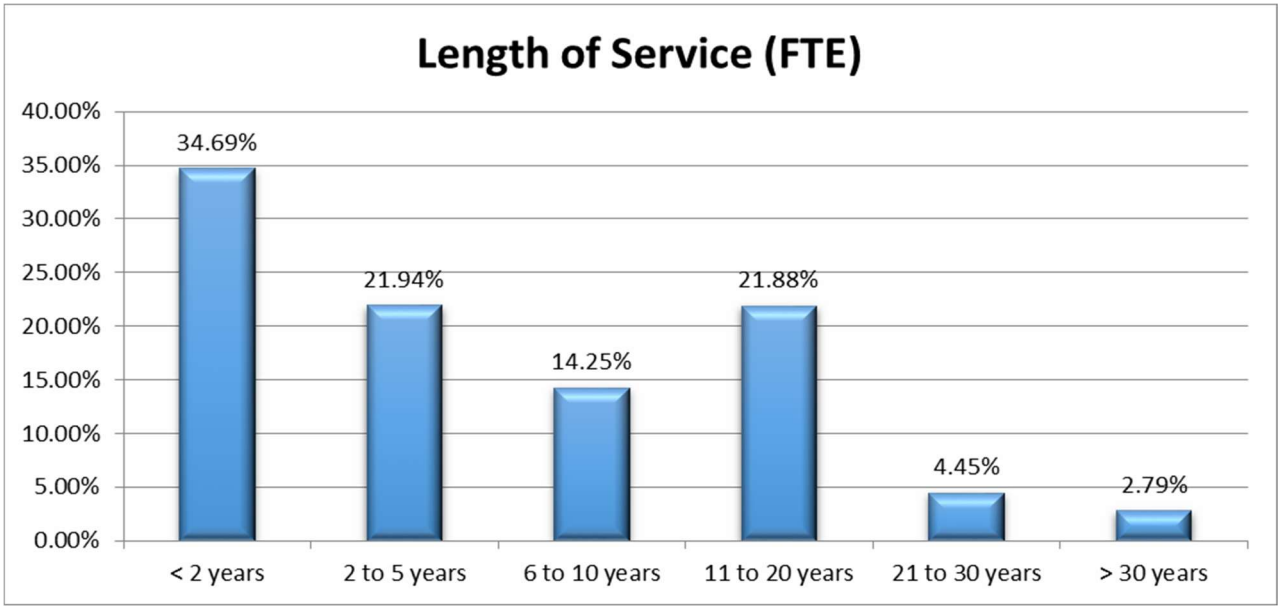
## Full Time Equivalent Staff Numbers

| | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 |
|---|---|---|---|---|---|---|---|---|
| **Medical** | 297 | 253 | 268 | 244 | 236 | 246 | 232 | 232 |
| **Nursing** | 735 | 707 | 709 | 696 | 696 | 755 | 717 | 708 |
| **Allied Health** | 398 | 409 | 410 | 395 | 401 | 440 | 428 | 435 |
| **Other** | 461 | 457 | 450 | 427 | 410 | 442 | 434 | 467 |
| **Total** | 1,891 | 1,826 | 1,837 | 1,762 | 1,743 | 1,883 | 1,811 | 1,841 |

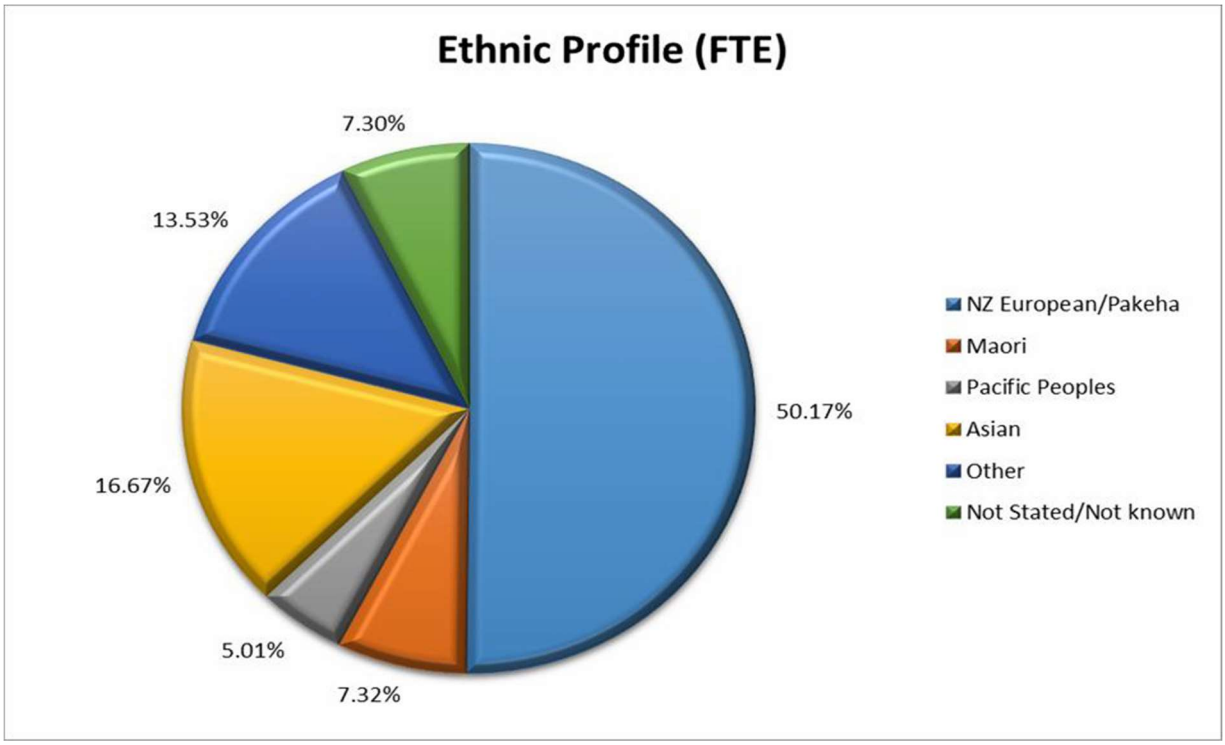
## Age Profile of Workforce



## Length of Service




## Statistics by Ethnicity




## Statistics by Gender

| | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 |
|---|---|---|---|---|---|---|---|---|
| **Female** | 79.63% | 81.31% | 81.51% | 80.56% | 81.05% | 81.65% | 81.89% | 82.41% |
| **Male** | 20.37% | 18.69% | 18.48% | 19.44% | 18.95% | 18.35% | 18.11% | 17.59% |

# Activities

## Our progress

This section outlines what we've done 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

### Māori Health Strategy - Te Pae Amorangi

In July 2019 we launched *Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy 2018-2027. Te Pae Amorangi* 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).

*Te Pae Amorangi* details our commitment to improving the health of Māori in our district through five priority areas: workforce, organisational development and cultural safety, commissioning, mental health and addictions, and the first 1,000 days of life. The strategy also seeks to address systemic issues and unconscious bias that can affect decision making and contribute towards the health inequities Māori experience. We want to transform the Hutt Valley health system to eliminate inequities and accelerate improvements in Māori health outcomes. Work to date on implementing Te Pae Amorangi is outlined below.

- **Te Pae Aronga Tuatahi - increasing our Māori Workforce**
  Māori and Pacific workforce development and recruitment is a national priority for all DHBs. We aim to actively grow a Māori workforce that reflects our population. We are developing a Māori Workforce Recruitment Policy that will operate across both Hutt Valley DHB and Capital & Coast DHB. This will to improve the way we recruit by making the process culturally appropriate. The policy will ensure that all advertisements are designed to attract Māori applicants and will include an organisation diversity statement, a Māori welcome, a whakataukī and a DHB kowhaiwhai. New guidelines and policies are being developed to enhance both DHBs' ability to attract, appoint and retain Māori staff.

- **Whakapumautia te Aroha Tuakana Teina Kaupapa**
  We have launched Whakapumautia te Aroha, a tuakana teina kaupapa developed by Māori for Māori at Hutt Valley DHB to invest, grow and develop our Māori workforce. It is based on the tuakana-teina (elder and younger brother/sister) mentoring relationship, kanohi ki te kanohi (face-to-face) engagement, and whānaungatanga (meaningful connections). The programme is closely linked to traditional whānau practices and is an effective method for developing trust and teaching new skills. Strong relationships, based on respect, reciprocity and trust are essential. We have a total of seven tuakana in various roles such as nurses, social workers, and support workers.

- **Te Kawa Whakaruruhau – Māori Cultural Safety Training**
  We have developed Te Kawa Whakaruruhau, Hutt Valley DHB's Māori cultural safety training programme. The first module, Te Tiriti o Waitangi, was launched at a powhiri in July 2020 and provides an opportunity for staff to learn more about New Zealand from a Māori perspective through the lens of Te Tiriti o Waitangi (the Treaty of Waitangi). The training will help us improve health outcomes for Māori patients by empowering staff with cultural knowledge. Staff learn about pre- and post-colonial New Zealand history including a breakdown of Te Tiriti articles, themes of racism, and bi-cultural themes for active partnership. All Hutt Valley DHB staff are required to attend at least one two-hour session in the Hutt Hospital Learning Centre, which can be accredited to professional development.

  Staff are also invited to attend Te Pumaomao workshops, which is an immersive and holistic experience, allowing staff members to gain a new depth of insight into the Māori world. Te Pumaomao is a cultural conscientisation (consciousness raising) programme that deepens understanding of Māori world views, laws and philosophies.

- **Matariki Achieving Excellence in Māori Health Awards**
  Hutt Valley DHB's first ever Matariki Achieving Excellence in Māori Health Awards were held in July 2019. The annual awards, led by Hutt Valley DHB's Māori Health Team, celebrated everything our people do to improve whānau experience of care, eliminate health inequities for Māori, and develop the Māori workforce. Held in Lower Hutt, the awards were timed to coincide with the rising of the Matariki (star cluster) marking the Māori New Year. Nominations were open to Kaupapa Māori providers, primary care organisations, GP practices, NGOs and Hutt Valley DHB employees and contractors who provide services to the Hutt Valley DHB population to improve Māori health outcomes. There were two Te Mana Whakahaere (supreme awards), which recognised the recipients' ability to demonstrate excellence across Te Ao Māori and Te Ao Hurihuri.

## Mental Health and Addictions Strategy

In May 2019 we launched *Living Life Well – A Strategy for Mental Health and Addiction 2019-2025* Mental Health and Addictions Strategy for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards. The direction set out in *Living Life Well* is strongly aligned with the Government's future direction for mental health and addiction services and provides a strong platform to respond to new national priorities.

*Living Life Well* supports the complete continuum of care, from primary and community care through to intensive inpatient services. The strategy recognises the need to sustain specialist mental health and addiction services, while improving our early response and intervention when things start to go wrong. The strategy also focuses attention on those with inequitable health outcomes.

A work programme has being developed in partnership with lived-experience leaders, Māori, Pacific, primary care, NGOs, and specialist mental health and addiction providers. Through this co-design process, we aim to create a transformational approach to shared leadership, decision making, design, delivery and funding of services over the next five years. This work includes a new sub-regional Integrated Primary Mental Health and Addiction Service, and a GP Liaison Consultant Psychiatrist Service, which began operating in July 2020.

## Our Wellbeing Plan

Our Wellbeing Plan for the Hutt Valley 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: wellbeing at work, housing, healthy lifestyles and physical activity, alcohol and other drugs, tobacco, 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.

We are taking a collaborative approach and working closely with key partners – including local councils, Māori health providers, and other social sector agencies to implement the Wellbeing Plan.

## Smokefree Action Plan

We have developed a Smokefree Action Plan with key providers and community partners, focussing on target populations, cessation, and strengthening smokefree environments. This has already refocussed some of the DHB's tobacco funding to new areas. For example, the DHB is supporting the continued development and expansion of our smoke-free workforce within the Hutt Valley health system with the appointment of a Smokefree role for Upper Hutt City Council in partnership with Healthy Families Hutt Valley. Hutt Valley DHB has also invited two staff from the Regional Stop Smoking Service provider, Takiri Mai te Ata, to work in Hutt Hospital to help Māori and Pacific patients who smoke to consider quitting and to support them in their cessation journey.

There has been an improved quantity and quality of referrals to cessation services resulting from increased focus and promotion on services available and referral process. A Hutt Valley-wide vaping policy was developed and signed off by all members of the Hutt Valley Smokefree Stakeholder Group. We have worked with Upper Hutt Council to develop a new Smokefree Outdoor Public Places Policy and also we funded a role at Healthy Families Hutt Valley to increase smokefree environments across the Hutt Valley.

Hutt Valley DHB supports the amendments made this year to the Smoke-free Environments Act 1990 through the Smokefree Environments and Regulated Products (Vaping) Amendment Bill. These amendments regulate vaping products and heated tobacco devices. The amendments ensure that vaping products are still available to smokers who want to quit by switching to a less harmful alternative, but also ensure they cannot be sold or marketed to children.

## Bowel, breast, and cervical screening

Screening and early detection of cancer gives people the best chance of successful treatment. We have 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.

We are focused on lifting our breast and cervical screening rates for Māori and Pacific women. Breast screening is provided at Hutt Hospital's Breast Centre and we run five cervical screening sites across Hutt Valley DHB. We also fund general practices to provide free cervical screening in the Hutt Valley.

We have been data matching with general practices to identify women who have not been screened, and then following-up with them to offer screening and support. This includes booking clinic appointments, arranging transport and support, and referral to support services. We're continuing to open weekend and after-hours clinics to improve accessibility. Combined breast and cervical screening days on Saturdays at Hutt Valley DHB have been well attended and helped women access screening.

We are also providing more smear services in the home. After-hours smear clinics have been provided at Kokiri Puketapu Hauora Clinic, Waiwhetu 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.

*Patient: "My family and I applaud the nursing team and we are incredibly grateful for their knowledgeable and empathetic service."*

## Well Homes - Healthy Housing

We have 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 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, social support agencies, and local councils to encourage and support the development of health-focused policy and healthy environments. For example, Regional Public Health represents Hutt Valley DHB at council working group meetings to support collaborative activities that strengthen safe water delivery. 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 fund a free healthy eating and exercise programme, Pre-School Active Families, through Sport Wellington that incentivises whānau with obese pre-school children (identified through the B4 School Check) to enrol in and complete the programme. We also fund Sport Wellington to deliver a Maternal Green Prescription programme and the Active Families programme. The Maternal Green Prescription programme supports pregnant women to maintain healthy weight gain in pregnancy and promotes healthy eating, exercise, breastfeeding and the introduction of solids in the postpartum period. The Active Families programme helps children and their whānau create a healthier lifestyle by becoming more active and learning about healthy eating. These programmes are successfully engaging with Māori and Pacific families.

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. 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.

## Oral health services to children

The Bee Healthy Regional Child Oral Health Service provides free community-based dental services to children across the Wellington Region. The service operates from 13 fixed sites in the community, and it also has 12 mobile clinics that travel to the majority of primary schools across the region. While the service has good coverage, it continues to use new approaches to increase access so that all children receive dental care. Last year the service was provided with an additional mobile dental van, which meant an additional 3600 children were seen in the school environment this year.

The Regional Child Oral Health Service has an Early Intervention Team that provides oral health checks to pre-school children at early childhood centres in high need areas. It also provides health education and information to teachers, support staff, students and families to raise awareness of the importance of teeth and key prevention messages. Last year the team introduced a pre-visit to early childhood centres to familiarise and socialise the children to its staff and provide information to teachers and parents. This has helped to build understanding and increase the effectiveness of the free oral health checks.

Other initiatives include the introduction of digital radiography which enables point-of-care diagnosis and care planning for all our children, drop-in dental check-ups to children in community settings during school holidays, and working with Māori and Pacific providers and local councils to promote the service and increase its coverage. The Bee Healthy service is continuing to increase the number of children seen each year, and the service now reaches around 74,000 primary and intermediate school children every year.

## Improving sustainability and reducing carbon emissions

Our Sustainability Committee continues to support the organisation to make positive changes that reduce carbon emissions and improve recycling. Changes already made include purchasing biodegradable paper medication cups and drinking cups, instead of polystyrene cups. Medical staff are provided with re-usable water bottles to reduce our use of plastic water bottles. A water fountain has been installed in the Hutt Hospital cafeteria, which complements our healthy food and drink (water only) policy. We are cutting back on the use of disposable coffee cups with donated reusable coffee cups. The meals we provide in the hospital are now being served on crockery plates instead of plastic. We are also moving to reusable Personal

Protective Equipment (PPE) gowns rather than disposable gowns. All these changes mean we will be sending 94,000 fewer plastic containers to landfill each year.

We are steam-cleaning all clinical areas of the hospital and eliminating chemical cleaners. We have replaced thirty hospital fleet petrol vehicles with more environmentally friendly hybrids. Finally, Hutt Valley DHB applied and to become a member of the Certified Emissions Measurement and Reduction Scheme and is committed to lowering its greenhouse gas emissions.

| Progress Measure | 2018/19 Performance | Target 2019/20 | 2019/20 Performance | Trends – including equity gap [2] |
|---|---|---|---|---|
| Amenable mortality rates (rate per 100,000) | Deaths in 2012-2016<br>Total 94<br>Māori 175<br>Pacific 147 | Māori 162<br>Pacific 132 | No new mortality data | No new mortality data |
| Babies breastfed at three months | Total 54%<br>Māori 46%<br>Pacific 43% | ≥70% | Not Available | Performance data not available as ministry was unhappy with quality |
| Children fully immunised at two years | Total 92%<br>Māori 88%<br>Pacific 91% | ≥95% | Total 93%<br>Māori 89%<br>Pacific 92% | Target not met. Our rates have improved |
| Children with no cavities at five years of age | 2018 Calendar[3]<br>Total 63%<br>Māori 47%<br>Pacific 47% | 66% | 2019 Calendar<br>Total 65%<br>Māori 52%<br>Pacific 48% | Target not met. Performance has improved in this measure over the last year. |
| Average number Diseased Missing and Filled Teeth (DMFT) at age five | 2018 Calendar<br>Total 1.04<br>Māori 2.09<br>Pacific 2.55 | Reducing trend | 2019 Calendar<br>Total 1.37<br>Māori 1.89<br>Pacific 2.60 | There has been an improvement in score for Māori however scores for Pacific and overall children have deteriorated. |
| Reduced burden of tooth decay at year eight (DMFT) | 2018 Calendar<br>Total 0.65<br>Māori 1.01<br>Pacific 1.02 | Reducing trend | 2019 Calendar<br>Total 0.63<br>Māori 0.81<br>Pacific 0.69 | Target met with notable improvement to Māori and Pacific. |
| Women screened for cervical cancer | Total 75%<br>Māori 68%<br>Pacific 69% | 80% | Total 69%<br>Māori 63%<br>Pacific 64% | Did not meet target. Total rates have also decreased. |
| Women screened for breast cancer | Total 75%<br>Māori 69%<br>Pacific 69% | 70% | Total 71%<br>Māori 67%<br>Pacific 68% | Overall there has been a reduction, however the significant decline was due to COVID-19 |

[2] 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.

[3] Child Dental data is only published by Calendar year

| Progress Measure | 2018/19 Performance | Target 2019/20 | 2019/20 Performance | Trends – including equity gap 2 |
|---|---|---|---|---|
| PHO enrolled patients who smoke and are offered help to quit | Total 91%<br>Māori 91%<br>Pacific 90% | 90% | Total 89%<br>Māori 86%<br>Pacific 87% | Rates have reduced slightly and have dipped below target. |
| Hospital patients who smoke and are offered help to quit | Total 91%<br>Māori 91%<br>Pacific:89% | 95% | Total 95.8%<br>Māori 95.7%<br>Pacific 95.5% | Target Met |
| % of babies living in Smokefree homes at six week check[45] | Dec-18<br>Total 64%<br>Māori 44%<br>Pacific 56% | Improved performance | Dec-19<br>Total 64%<br>Māori: 52%<br>Pacific: 40% | There has been an Increase in smokefree homes for Māori but a decrease Overall and for Pacific. |
| % of eligible population having CVD risk assessment in last five years | Total 82%<br>Māori 80%<br>Pacific 83% | 90% | Total 75%<br>Māori 57%<br>Pacific 55% | Not meeting target and performance reducing across all ethnic groups especially Pacific |

## 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.

### Three Year Plan for Planned Care Services

We have completed a Three Year Plan for Planned Care Services in consultation with hospital services and community providers. Planned Care encompasses all non-acute (non-urgent) health care activity delivered in hospitals, primary care, and community settings. One of the key initiatives in this area is a renewed focus on

[5] This measure replaces mothers smokefree at two weeks postnatal which is no longer provided by the Ministry of Health

care across the system, and removing financial disincentives for delivering planned care outside of the hospital setting.

The plan was developed in collaboration with Capital & Coast DHB to ensure a coordinated approach to the development of planned care services across both DHBs. The plan outlines how the DHB intends to address five nationally-set strategic priorities: understanding health need, balancing national consistency and local context, simplifying pathways for service users, optimising sector capacity and capability, and delivering sustainable and 'fit for future' services. The changes that will be progressively enabled by the new approach to planned care include:

- improvements in equity of access and outcomes of care
- improving the experience of service users and their whānau
- creating incentives to implement innovative models of care
- an increase in the volume and range of interventions to meet changing population health needs
- encouraging provision non–surgical care alternatives in community settings
- increasing the focus on prevention and early intervention programmes to improve wellbeing and reduce the need for more complex and expensive interventions.

## Health Care Homes

We have enhanced primary care by progressing the Health Care Home (HCH) patient-centered model of care across the Hutt Valley. The HCH is a team-based health care delivery model, led by primary health clinicians. Although implementation of the HCH model is in its infancy in New Zealand, the evaluation of the model is promising and suggests that a significant proportion of acute need is being prevented or successfully dealt with out of hospital by HCH practices.[6]

During COVID-19, greater use of telehealth services were adopted by general practices. We leveraged off this new way of working by fast-tracking the roll-out of the Health Care Home model of care, which includes a telehealth component. Fifteen general practices have now adopted the HCH model, representing approximately 85% of Hutt Valley DHB's 'enrolled population' - those enrolled with a general practice.

The HCH model includes 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. The HCH practices also 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 a further two practices expected to adopt the HCH model.

## Specialist support for general practice

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.[7]

[6] *Health Care Home evaluation - updated analysis, April-September 2017*. Auckland: Ernst & Young, 2018.

[7] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), *Shifting the balance of care: great expectations.* Research report. Nuffield Trust.

We have improved patient care in the community by setting up a process where general practice staff can phone a senior medical specialist for urgent (same day) advice. This is now available for general medicine, geriatrics, diabetes, respiratory, rheumatology, cardiology, mental health, palliative care and paediatrics. General Medicine, the specialty with the highest proportion of patients presenting acutely unwell (40%), now staff daily acute clinics where patients can receive referrals from Primary Care and a specialist review without needing an admission. The on call general medicine physician is based in our Medical Assessment and Planning Unit (MAPU) every weekday afternoon and can provide acute advice to 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 chronic respiratory problems have a personalised plan to facilitate accessing urgent (acute) medical services in the community when needed via an ambulance and primary care pathway. The plan will include techniques and tools the patient can use to help self-manage an acute episode. The plan also records what is 'normal' for the patient, which has been proven to be extremely useful for ambulance staff when determining an appropriate response.

The model has been incorporated into our planning for the winter period when hospital demand peaks. In autumn, general practices are sent a list of their patients who had two or more presentations to the emergency department for acute respiratory and breathing problems in preceding 12 months. General practices can then work with these patients to develop a care plan for them. 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.

## 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 have 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, headaches and migraines, dehydration, iron infusions, and long-acting reversible contraceptives.

## Falls prevention and management

We have partnered with ACC to establish and embed 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 risk-of-falling screening, assessment, triage and management of frail elderly delivered in primary care; a 10 week in-home strength and balance programme delivered by our community physiotherapy team; and group-based strength and balance classes, provided at various locations across the district, delivered by local providers and coordinated by Sports Wellington. We are working to improve access to strength and balance activities and programmes, particularly for Māori and Pacific older peoples.

## Community-based support for people with mental health or addiction issues

In addition to providing our specialist mental health and addiction treatment services, we also fund a number of support services in community settings for people with mental health or addiction issues. Our

services are tailored to people across the life course, including maternal, child, youth, and family mental health services.

- **New Integrated Primary Mental Health and Addiction Service**
  In July 2020 we began operating a new sub-regional Integrated Primary Mental Health and Addiction Service. This service will improve access to primary mental health services for people with mild to moderate mental health issues. It includes the use of health improvement (mental health) practitioners, health coaches, and support workers.

- **'Mental health 101' training sessions**
  Over the last year, we have also worked with local council to deliver 'mental health 101' training sessions for key stakeholders around suicide prevention and supporting first symptoms of mental health. These training sessions better equip community-based workers and volunteers to engage with people experiencing mental health difficulties.

- **Maternal and Child Mental Health**
  We fund Hutt Women's Centre to provide maternal mental health care to assist support women with mental health needs, and Nāku Ēnei Tamariki to provide an intensive community-based maternal mental health and social support service targeting Māori, Pacific, and low income pregnant women, new mothers, and their whānau.

  Through Atareira we provide and deliver an eight week community based children's programme called 'Children Understanding Mental Health' for approximately six young people aged 8 to 12 years once a term. The programme is delivered by a trained counsellor who is able to see the children individually if needed. During the eight week programme families are contacted weekly and if they identify they have their own support needs, they can be referred to Atareira's Hutt Valley family/whānau worker.

- **Youth Mental Health**
  In 2019 the Piki pilot was launched. This initiative provides free mental health support to young people aged 18 to 25 years old with mild to moderate mental health needs across Hutt Valley, Capital & Coast, and Wairarapa DHBs. This initiative aims to intervene early to support good mental health and wellbeing. It is designed to strengthen other existing services and expand access options and the range of therapies available for young people.

- **Occupation and housing support**
  Our Occupational Service assists 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 also fund a dedicated housing co-ordination service to assist people with mental health or addiction needs overcome housing issues and sustain secure housing.

Patient: "From start to finish everyone I met was calm, kind, informative and efficient."

# Co-response pilot extended to Hutt Valley


This year the Wellington District Police/Health Co-Response pilot was extended to the Hutt Valley. The pilot provides emergency front-line support for people who ring 111 requiring an urgent mental health response. The Wellington Co-Response Team deploys staff from Wellington District Police, Wellington Free Ambulance (WFA) and DHB Mental Health services to attend events requiring an urgent mental health intervention.

Prior to its extension into the Hutt Valley, the pilot had been operating successfully in the Wellington region for six months and attended over 90 mental health events in the community. It also assisted in the coordination of around 300 other events, resulting in timely and improved outcomes for those in crisis. The team's interventions include face-to face care, collaboration with other units and services, and providing advice over the phone. The service enables people presenting in mental health crisis to receive the most appropriate response in the right setting for their needs, and is therefore expected to reduce the number of crisis presentations to the Emergency Department.

"The pilot's success in Wellington provides us with a great opportunity to extend the initiative to the Hutt Valley, where we expect to see a very positive impact," says Nigel Fairley, General Manager Mental Health Addictions and Intellectual Disability Service.

"The Co-Response Team delivers timely, coordinated and specialist care at home or in a community setting, with an experienced mental health clinician as part of the team".

This service provides another layer of crisis support for people in the Wellington and Hutt Valley region, and complements our 24/7 mental health and addictions crisis contact centre, Te Haika, contactable on 0800 745 477."

## Community-based care for pregnant women

Lead Maternity Carers work in the community providing continuity of care and support to women throughout their pregnancy and labour, until the handover to a Well Child/Tamariki Ora provider at six weeks post-partum.

In addition to the great work that our Lead Maternity Carers do in the community, the DHB's Community Midwives Team runs a midwifery drop-in service, called Hapū Ora, at Lower Hutt's Waiwhetu Marae. Hapū Ora is a collaborative Māori maternity service for whānau expecting a new baby. The free services are run by mana whenua Te Runanganui O Te Atiawa with support from Hutt Maternity and Hutt Valley DHB. The drop-in service provides a continuum of care covering everything from midwifery to breastfeeding for new mothers and their whānau.

Hapū Ora was set up in partnership with Māori in an effort to reduce inequity for our Māori wāhine and whānau. The service provides wrap-around care for pregnant women - many of whom have complex social needs - in partnership with other relevant health and social services. By encouraging whānau to engage with health services, the Hapū Ora midwives can connect whānau with a wide range of support including scans and medical tests. The main priority of Hapū Ora is getting people access to the services they need.

Hutt Valley DHB also established a presence at the local Te Rā o Te Raukura cultural festival in February 2020. This helped increase the visibility of maternity services and encouraged pregnant women to make contact with a Lead Maternity Carer. The team also promoted and encouraged pregnant women to get their free flu and whooping cough immunisations. To help improve the uptake, we set up outreach 'pop-up' immunisation clinics throughout the Hutt Valley region, including clinics at supermarkets, malls, libraries, WINZ offices, and on local marae.

| Progress Measure | 2018/19 Performance | Target 2019/20 | 2019/20 Performance | Trend – including equity gap |
|---|---|---|---|---|
| ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000) | Year end March 2019<br>Total 8,354<br>Māori 10,517<br>Pacific 14,396 | Total ≤ 7,886<br>Māori ≤ 9,722<br>Pacific ≤ 11,272 | Year end March 2020<br>Total: 9,337<br>Māori 12,394<br>Pacific 15,158 | All rates have increased, significantly for Māori and Pacific. |
| ASH Rates (avoidable hospitalisations) for 45-64 years | 12 Months to Mar 2019<br>Total 4,840<br>Māori 7,928<br>Pacific 9,561<br>Other 3,852 | Total ≤ 4,764<br>Māori ≤ 7,800<br>Pacific ≤ 7,528<br>Other ≤ 4,023 | 12 Months to March20<br>Total 4,512<br>Māori 7,654<br>Pacific 8,060<br>Other 3,748 | Not Achieved. Total and Pacific rate increasing but Māori rate has decreased |
| Well managed diabetes in primary care | Total 57%<br>Māori 46%<br>Pacific 44% | ≥70% | Total 50%<br>Māori 42%<br>Pacific 41% | Not Achieved. Total Māori and Pacific numbers have decreased |
| Acute hospital bed days per capita | Total 375<br>Māori 321<br>Pacific 479 | Total 386<br>Māori 542<br>Pacific:596 | Total 361<br>Māori 323<br>Pacific 354 | Target met |

| Progress Measure | 2018/19 Performance | Target 2019/20 | 2019/20 Performance | Trend – including equity gap |
|---|---|---|---|---|
| Acute readmission to hospital | Year to March 2019<br>Total 13%<br>Māori 14%<br>Pacific 13% | Not applicable | Year to June 2020<br>Total 12%<br>Māori 13%<br>Pacific 11% | Acute readmissions to hospital have been relatively static over last year three years.<br>The national average standardised rate is 12%. |
| Acute readmission to hospital Age 0-4 | Year to June 2019<br>Total 14%<br>Māori 14%<br>Pacific 15% | Not applicable | Year to March 2020<br>Total 14%<br>Māori 14%<br>Pacific:15% | Acute readmissions to hospital have been relatively static over last year three years.<br>The national average standardised rate is 13%. |
| PHO Enrolment | Total: 98%<br>Māori: 91%<br>Pacific: 98% | Increased enrolment | Total: 96%<br>Māori: 88%<br>Pacific: 100% | Enrolment rates fell except for Pacific. This partially due to an increase in our expected population with little change in number enrolled |
| Newborn PHO enrolment | 75% | Increased enrolment | 93% | The newborn enrolment rate has improved |
| Proportion of dispensed Asthma medications that were preventer rather than reliever | 55% | Increasing trend | 55% | There has been no change in the proportion of preventers |
| Cancer Mortality | 2016<br>286 | Decreasing trend | 2016[8]<br>286 | Mortality data is published up to five years later - 2016 is the latest available |
| Decrease in hospitalisation for cardiovascular disease | Total: 1,738<br>Māori: 212<br>Pacific: 156 | Decreasing trend | Total: 1,967<br>Māori: 254<br>Pacific: 169 | Hospitalisations for the total population and Pacific have increase. They have fallen for Māori however, these changes are not significant |
| Decrease in hospitalisations for Chronic Obstructive Respiratory Disease | Total: 364<br>Māori: 102<br>Pacific: 39 | Decreasing trend | Total: 350<br>Māori: 82<br>Pacific: 41 | Overall hospitalisations are down. There was a small rise for Pacific and higher for Māori, however these changes are not significant |

[8] Latest information available

# 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.

## Improvements to our Women's Health Service

Our Women's Health Service is critical to the wellbeing of mothers - mama, babies-pepe and their whānau across our region. In 2019 we commenced an improvement journey following a 2018 external review of Hutt Valley DHB's Women's Health Services. Significant changes have been made across the service to address staff shortages, a high rate of complaints, and serious adverse outcomes.

During this process we listened, engaged and worked with our staff and stakeholders on getting solutions underway to address the issues identified. The review identified that we needed to do more for our staff and community in a few key areas. Improving our environment, strengthening our workforce, reviewing our policy, training and educating our staff and ensuring that we have adequate resources and equipment. This review process has involved a significant amount of work and dedication from staff, consumers and stakeholders from across our region.

All of the recommendations identified in the review have now been completed or are underway. We have strengthened our medical and midwifery workforce and leadership, embedded new monitoring and quality improvement mechanisms, and provided cultural safety training.

This year the Government also announced a $9.4 million investment in Hutt Hospital's maternity services and facilities. A number of upgrades to the equipment and physical environment have already taken place, and more upgrades are planned to improve patient outcomes, privacy, and comfort.

## Choosing Wisely

We have 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).

Patient: "Without fail, every single person I came into contact with was incredibly helpful, kind, caring, empathetic and professional."

## Red2Green Initiative (improving patient flow)

Under the 'Red2Green' 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, will help clinicians and managers clear the blockages and improve care.

'Red2Green' has been operating in the medical ward at Hutt Hospital since 2018. This year the initiative was implemented in the Older Persons and Rehabilitation Service wards.

## 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). 'Capacity at a Glance' screens are used to monitor current capacity (the staff) against demand (the patients in the ward), visualise the performance of the ward at a glance, and identify opportunities for improvement. 'Variance Response Management' processes and tools enable the DHB to quickly respond to workforce demands and therefore improve patient flow. The CCDM programme helps the hospital run more effectively, improves our patients' experience and outcomes, and makes working at Hutt Valley DHB more satisfying for our staff.

## Health Pathways

We have 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 more than 502 conditions are now live. Recent pathways have been developed for COVID-19, termination of pregnancy, wound care, varicose veins and chronic venous insufficiency, snoring and sleep apnoea in children, restless legs syndrome and periodic limb movements of sleep, pre-exposure prophylaxis (PrEP), palliative care in adults, lymph node enlargement, and analgesia in adults/children with acute pain. Multiple pathways are also under development.

We have also recently completed full detailed reviews of some of the existing pathways and updated them as needed. The pathways reviewed include: cervical screening, eczema in children, lymphocytosis, gout, abdominal aortic aneurysm, intermittent claudication, and cannabis-based products.

[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.

## Improved care for frail and elderly patients

Our Emergency Department has introduced an electronic screening tool to identify frail patients early and provide them with appropriate care and support, including activities to reduce deconditioning (loss in muscle strength). We have 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.

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 also has a 'Close Care' programme for older patients with mental health or neurological conditions, such delirium or dementia, encouraging engagement and activities. Last year OPRS piloted animal assisted therapy with a Labrador to support stroke rehabilitation. The pilot resulted in positive outcomes for stroke patients and animal assisted therapy is being incorporated into business as usual. A training package with associated guidelines and policies is being developed.

A programme called 'Whānau as Partners' has been developed at Hutt Hospital to encourage family/whānau 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. The programme has received positive feedback from whānau, patients and staff.

## Early recognition and response to patient deterioration

Hutt Valley DHB has implemented the National Early Warning Score (EWS) in all adult inpatient areas of Hutt Hospital. EWS is 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 also have a '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.

## Laboratory Services

This year our Pulmonary Function Laboratory in the Respiratory Department was re-accredited for a further five years by the Thoracic Society of Australia and New Zealand. This is an exacting standard for pulmonary function laboratories. It means that our patients and referrers can have the highest level of confidence that they are receiving a high quality lung function test. We are one of only three New Zealand laboratories to hold this accreditation in the North Island.

| Progress Measure | 2018/19 Performance | Target 2019/20 | 2019/20 Performance | Trend – including equity gap |
|---|---|---|---|---|
| Length of inpatient stay in hospital (average days) | Acute 2.1<br>Elective 1.4 | Acute 2.4<br>Elective 1.5 | Acute 2.23<br>Elective 0.71 | Target achieved. |

| Progress Measure | 2018/19 Performance | Target 2019/20 | 2019/20 Performance | Trend – including equity gap |
|---|---|---|---|---|
| Time patient is in ED (discharged or transferred with six hours) | 89% | 95% | 86% | Target not met. Performance is falling |
| Waiting time to access mental health / addiction services (Referred to service and seen within three weeks and within eight weeks) | 48% < 3 wks<br>89% < 8 wks | Targets<br>80% < 3 wks<br>95% < 8 wks | 34%/68% < 3 wks<br>81%/88.0% < 8 wks | Targets were not achieved but waiting times are reducing and have improved significantly. |
| Readmission to Mental health services within 28 days | 8% | <9% | 8% | Target achieved |
| Access to electives[10] | 101% | 100% | 98% | This was impacted by Covid - 19 |
| Patient experience in hospital<br><br>(Average patient score out of 10 across four domains) | Communication 8.7<br>Coordination 8.6<br>Partnership 8.7<br>Physical and emotional needs 8.7 | Average of 8.8 across the four domains | Communication 8.1<br>Coordination 8.2<br>Partnership 8.4<br>Physical and emotional needs 8.6 | We have not met the target and performance has reduced |
| Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat. | 93% | ≥85% | 92% | Achieved |
| Age of entry into Age Residential Care | 83.46 | Increasing trend | 81.75 | The average age of entry has reduced |

[10] Includes both inpatient surgical discharges and minor procedures

# 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.

Hutt Valley DHB is a good employer and aims to ensure that our employment practices attract and retain top health professionals and support staff - who are adaptable and embody our values and culture. Hutt Valley DHB employs over 2600 staff, making us the largest single employer in the Hutt Valley (Te Awakairangi).

## Mauri Ora - Making Wellbeing Meaningful

We've developed and launched a dedicated staff wellbeing programme, Mauri Ora, to help build a healthy workplace culture that promotes wellbeing and supports the DHB's values. Staff have been involved in the development of a Mauri Ora Action Plan, which includes a range of activities and events for staff that promote mental health and wellbeing, healthy eating, and physical activity.

In August 2020, the DHB partnered with a range of community providers to present a Mauri Ora Staff Wellbeing Expo. The expo offered a range of free wellbeing and lifestyle programmes, as well as free basic health checks, to support staff and their whānau.

Staff member: "The work we do is meaningful and our values of caring and collaborative working are embedded in the work culture"

## Building workforce diversity

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. In June 2019 all 20 DHB Chief Executives committed to introducing targets for DHBs to increase Māori participation in the workforce.

To meet this commitment and enhance our ability to attract, appoint and retain Māori staff, Hutt Valley DHB is working with Capital & Coast DHB to develop a 2DHB Māori Workforce Recruitment Policy. We are also developing a pipeline programme to help mentor and expose rangatahi Māori to a wide range of health careers. A 'by Māori for Māori' mentoring programme has also been implemented to help grow and develop our Māori workforce.

Hutt Valley DHB's Māori cultural safety training programme, Te Kawa Whakaruruhau, is also being rolled out for staff to learn more about New Zealand from a Māori perspective through the lens of Te Tiriti o Waitangi. All HVDHB staff are required to attend at least one two-hour session

### Nursing Strategy: 'Nursing at its Best'

Nursing at its Best, Hutt Valley DHB's five-year nursing workforce strategy (2018-2023), aims to ensure that all people and their families/whanau accessing health care in the Hutt Valley will receive excellent nursing care from a competent, culturally responsive, evidence-based and person-centred workforce. We are now progressing implementation of the strategy. Key pieces of work being progressed under the four nursing strategic priorities include:

- Nursing Workforce - implementing the Care Capacity Demand Management project – to match care capacity with care demand
- Clinical Leadership - increasing senior nurse participation in the Professional Development and Recognition Programme. This programme provides a framework to help nurses develop their professional practice and assist them on a career pathway.
- Education and Professional Practice - implementing the Nurse Entry to Practice (NETP) Programme, which provides graduate Registered Nurses support and professional development to facilitate their transition during their first year of practice.
- Quality, Patient Safety and Innovation - implementing Lippincott's Nursing Procedures and Skills across the sector. This provides real-time access to step-by-step guides for evidence-based procedures and skills in a variety of specialty settings.

## 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.

## Future Pharmacist Services 2018–2023

In 2018/19 we launched a five year pharmacist services strategy for the Hutt Valley. The strategy builds on other strategic work guiding the future direction of pharmacist services, including the national Pharmacy Action Plan[11] and Integrated Pharmacist Services in the Community[12].

The health sector faces several challenges. There are material gaps in how we deliver services to meet the needs of some population groups and communities, and demand for health services continues to increase due to the growing and ageing population and the growing numbers of people experiencing long-term and increasingly complex health conditions. The Future Pharmacist Services Strategy focusses on unlocking the full potential of this highly qualified health workforce so that they can help us address the challenges we face.

We need an adaptable pharmacist workforce, where pharmacists can work in a way that better serves community needs. Changes in technology allow us to realise this vision of freeing pharmacists from the medication supply process allowing them to spend more time providing advice and information to patients. Many pharmacies are small, and appear constrained in their ability to provide higher value services.

We need to better integrate pharmacists into the wider care team including primary care, DHBs, community health, mental health and aged residential care providers. We also need more community pharmacists located where our population need is highest. Effective planning and purchasing will be important in leading pharmacists to provide the services that make the most difference to patient health.

Over the last year we have made progress implementing the pharmacist services strategy. For example, we have implemented a DHB contracting policy for pharmacies, which is designed to align the location of any future pharmacies in the Hutt Valley with population needs. We have also increased the number of pharmacies providing flu-vaccination, making it easier for people to get themselves protected from influenza.

## Partnership with Iwi

We've established a Mana Whenua 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 2018-2028

Our Clinical Services Plan for the Hutt Valley provides a high-level understanding of our clinical needs and demands across the system over time. Analysis of the demands on the heath system in the future shows that Hutt Hospital will run out of inpatient beds if it keeps on doing things the same way. Its bed use rate will exceed beyond capacity, and operating costs will become increasingly unaffordable unless changes are made. The Clinical Services Plan provides options on how we can best plan and address the challenges we will face. 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.

[11] https://www.health.govt.nz/publication/pharmacy-action-plan-2016-2020

[12] https://tas.health.nz/assets/Pharmacy/Evolving-Consumer-Pharmacist-Services.pdf

We've started implementing the Clinical Services Plan through a number of initiatives aimed at strengthening primary and community services, keeping people well and out of hospital, and constraining the growing demand on hospital services. This has included roll out of the Health Care Home model of care, the provision of timely specialist advice to general practice, and the development of 'Neighbourhood Teams' where DHB services (older persons, community nursing, allied health and assistant workforce) support general practice teams. Hutt Valley DHB has also established a Project Management Office to support the changes needed. The Project Management Office is supporting a number of projects to improve hospital integration with community services, and enhance patient flow and efficiency within hospital.

## 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 completed the replacement of all the heavy plaster ceiling tiles with lightweight tiles in our main inpatient block. We are in the process of improving bracing and restraints to ensure 'non-structural' items are all well restrained in the event of an earthquake. We have installed an earthquake monitoring system which serves dual functions one as an early warning device that can enable predetermined systems to be shut down and the other to remotely send building structural health information to our structural engineers post-earthquake.

We've also installed a generator for Pilmuir House (so our management and administration teams can still operate in a power failure) and upgraded the Control Panel to two of our main generators. We have 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. We have also installed bladders across the site to increase our capacity to store wastewater in the event of isolation from the Council connection.

## Consumer Involvement

We want the consumer perspective to become part of the way we do things. In 2018/19 we developed and delivered a training programme to staff on 'consumer co-design' methodology for use in service improvement projects, and service development and commissioning. Nursing staff have also been implementing the Patient Care Planning Project, which is focussed on including patient goals in care planning and involving their whānau in the process. Patient goals are documented and monitored and shared with the patient, their whānau, and the team involved in their care.

*Staff member: "The overall purpose of the Patient Care Planning Project is to ensure that patients receive the best possible, safe and timely care, and achieve improved health outcomes that are individualized and goal-driven. Letting patients write down their goals involves them in their care, and empowering them in this way promotes positive outcomes."*

We also established a Consumer Council with members from diverse backgrounds, experiences and knowledge. The Consumer Council gives our patients, whānau and communities, a strong voice in planning, designing and delivering great services across the Hutt Valley. Hutt Valley DHB also 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.

### 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 Mental Health Network. 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 and a mix of both hospital and community practitioners. The clinical networks make recommendations to Hutt Inc. on the best use of resources to achieve the optimal outcomes.

## 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.

We have developed a digital strategy for the sub-region, including specific plans for Hutt Valley DHB. The strategy sets out the direction of travel of future Information, Communications, and Technology (ICT) work across the 3DHBs, ensuring the work aligns with the digital needs of our hospitals and primary care and community providers. The strategy also balances the digital needs of clinical services and corporate services, which are both critical for meeting our strategic objectives. To help implement the digital strategy, our 3DHB ICT service has made organisational changes and aligned roles, reporting lines, and workforce development programmes with the digital strategy.

An Architectural Governance Board has been established to ensure investments in digital and data technologies are sustainable and aligned with our strategic goals. The Architecture Board provides guidance to programmes and projects to ensure that technology decisions are aligned with the overall technology direction. A Digital and Data Intelligence Governance Group (DDIGG) has also been established to prioritise and approve digital and data projects and oversee implementation of the digital strategy.

A comprehensive assessment of the ICT digital maturity across our DHBs and PHOs has been undertaken. This assessment allows us to compare our maturity with other DHBs within New Zealand and other health care organisations worldwide. The maturity assessment also allows us to determine where we are lacking in capability so these gaps can be addressed.

Over the last year, our 3DHB ICT service has completed a number of projects that directly affect Hutt Valley DHB staff. These programmes projects include the following:

- Windows 7 to Windows 10 upgrade
- Intune mobile device management
- Exchange Online
- Care Capacity Demand Management screens
- Netscaler project to improve the performance and security of our Citrix environment.
- Surgical instrument tracking
- New dental imaging capability.

Our 3DHB ICT service has also initiated following projects:

- Digital Workplace Programme
- Single 3DHB Clinical Portal
- Replace single 3DHB telephony an contact centre platform
- Rollout of a new WAN for the 3DHB's in order to increase performance and resilience
- Ongoing cybersecurity improvements to ensure patient and DHB data is secure inclusive of leadership training.
- Initiation of a Teleheath programme of work to support delivery of outpatient care to patients at home in response to COVID-19.
- Selected Nervecentre Software as the platform for patient observations, assessments and task management
- Initiated the upgrade of the WebPAS database from the legacy Informix system.

COVID-19 has had a significant impact on ICT's work programme. COVID-19 necessitated a rapid shift to work from home and the introduction of new tools to allow the DHB to cater for a predicted surge in patients and also to allow staff to continue corporate and clinical functions from home.

As a result of COVID-19, staff have continued working in a more flexible manner, based either at home or the office. Further work is continuing so that we can optimise productivity with fit for purpose devices and tools.

## ICT asset performance measures

| Measure | Indicator | 2019/20 | 2019/20 |
|---|---|---|---|
| ICT asset portfolio | | Target | Outcome |
| % availability of critical systems | Functionality | ≥99.9% | 99.59% |
| % of ICT hardware at a condition level of 'Acceptable' or better (a rating of 3 or lower) | Condition | ≥80% | 67% |
| % usage of storage data network (SAN) | Utilisation | ≥75% peak | 70% |

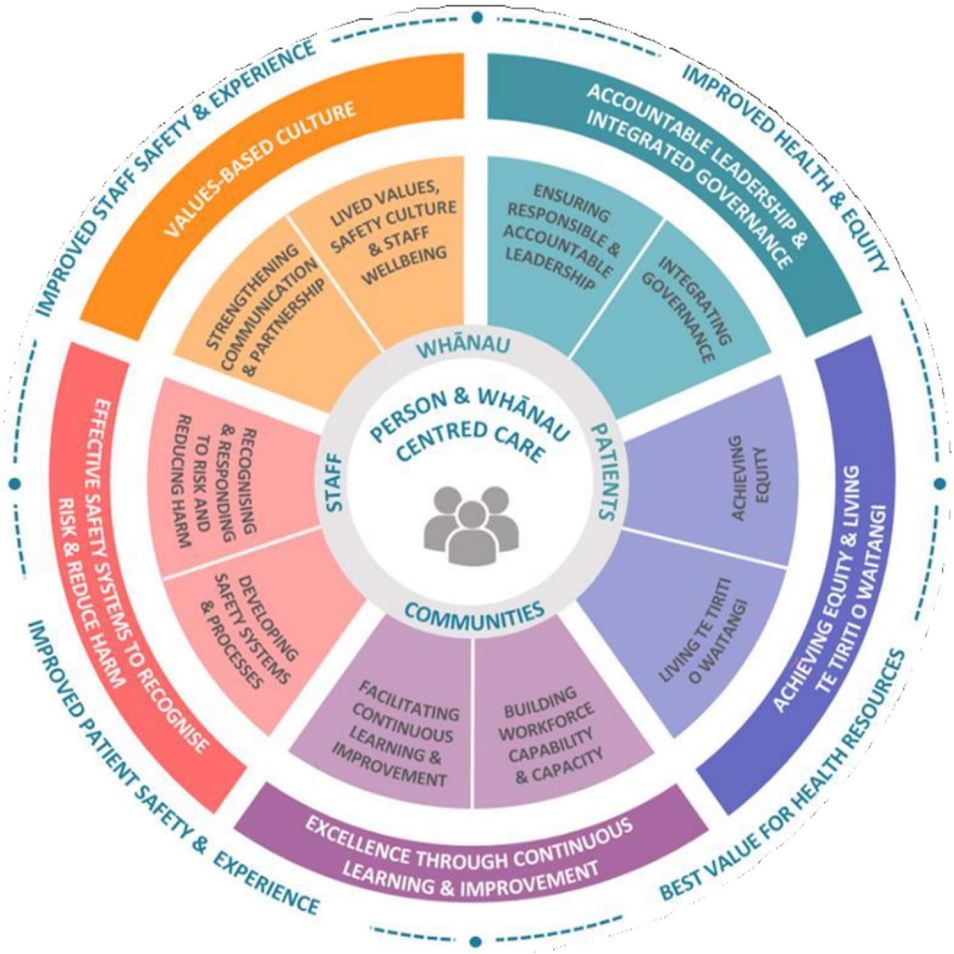
# Quality Improvement and Patient Safety

The Quality Improvement and Patient Safety Directorate leads and supports the quality improvement and patient safety work across the DHB using quantitative and qualitative measures to support evidence-based decision making and practice change, as well as streamlining systems and data reporting mechanisms.

## 2DHB Quality and Safety Framework

In February 2020 a new 2DHB Quality and Safety framework was rolled out across Hutt Valley and Capital & Coast DHBs. The framework established a clear direction for the DHBs to deliver safe services that reduce harm to staff and patients, improve the quality of care and drive clinical excellence. The Framework introduced six quality and safety domains, goals and measures supported by a focus on learning and improvement, to ensure quality and safety is a top priority and is effectively embedded from ward to Board. The six domains:

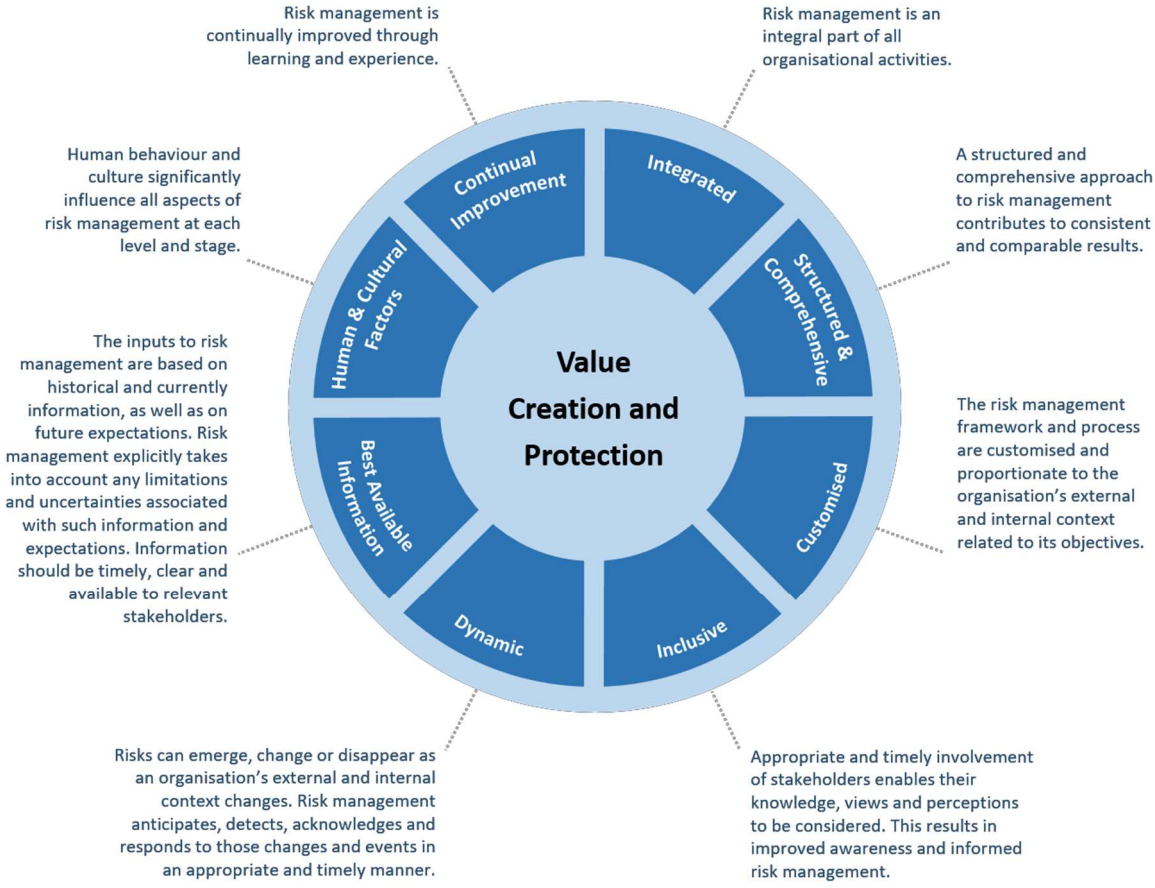
- Person and whānau centred care
- Accountable leadership and integrated governance
- Living Te Tiriti o Waitangi
- Excellence through continuous learning and improvement
- Effective safety systems to recognise risk and reduce harm
- Values-based culture



The expectation is that quality and safety initiatives, projects and programmes will align to the domains of the Framework. For each domain there is a corresponding patient and staff safety measure, and progress against the measures is reported to the 2DHB Board.

## 2DHB Risk Process

Risk management is an integral part of everything we do. Hutt Valley and Capital & Coast DHBs are developing a Risk Management Approach, which will be supported by the Risk Management policy, Risk Management procedure, and Risk Management training manual and is underpinned by the International Standard 31000:2018 Risk Management – Guidelines and best practice. Risk Management enables the delivery of well-informed, innovative care and provide best possible outcomes for patients. The following principles of risk management are taken from the ISO 3100:2018 standard:




The aim of the Approach is to further embed risk management at a group / division, service and ward level, and ensure appropriate escalation of risks through the organisation to the Board. In addition, promote local level ownership of risk, enhance clarity regarding roles and responsibilities and strengthen governance to support delivery.

The key objectives of the Risk Management Approach are to:

- Embed risk management at all levels of the organisation
- Create a culture where risk management is transparent, inclusive, integrated and is responsive to change
- Provide the tools and training to support risk management

- Embed the DHB's risk appetite in decision making
- Measure the impact of implementation and the effectiveness of the system to ensure continuous improvement
- Meet best practice standards for risk management

## Serious Adverse Events

At HVDHB improving the quality and safety of care we provide to our patients and whānau is a key priority. Early detection and review of adverse events that are the result of a health care system or process failure is therefore essential. By learning from these reviews we can reduce the risk of similar adverse events recurring and causing avoidable harm to our patients.

A formal review is conducted for each adverse event to better understand what happened and why, and to establish improvements in our systems of care to prevent harm occurring again. Families have input into the reviews and are provided copies of the final report.

The implementation of the Serious Adverse Events Committee (SERC), which forms part of the wider clinical governance structure was formed. SERC's purpose is to monitor and improve clinical safety for patients across the organisation focusing on learning from events to prevent harm. This means improved oversight of serious adverse events and the completion of recommendations to improve systems and processes.

# Statement of Performance

The Statement of Performance Expectations (SPE) presents a snapshot of the services provided for our population and how these services perform. The SPE is grouped into four output classes: prevention services; detection and management; intensive assessment and treatment; and rehabilitation and support services. Measuring our outputs helps us to understand how we are progressing towards our impacts and outcomes set out in the Improving Outcomes section of this report. Each output class includes measures which help to evaluate our performance over time, recognising the funding received, government priorities, national decision-making and board priorities. These measures include the health targets.

We have a particular focus on improving health outcomes and improving health equity for Māori and Pacific peoples. Therefore, a range of measures are used to monitor progress in improving the health and wellbeing of our Māori and Pacific populations. Equity is a priority and the targets set for Māori and Pacific reflect a pathway to achieving equity, or are universal and apply to all population groups. In some cases, data is not available by ethnicity. We are in the process of developing a programme of work to monitor and report our performance by ethnicity, and understand our performance for our Māori and Pacific populations.

## Output Classes contributing to desired outcomes

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

The four Output Classes and their related services are:

***Prevention Services***
- Health protection and monitoring services
- Health promotion services
- Immunisation services
- Smoking cessation services
- Screening services

***Early Detection and Management services***
- Primary care (GP) services
- Oral health services
- Pharmacy services

***Intensive Treatment and Assessment Services***
- Medical and surgical services
- Cancer services
- Mental Health and Addiction services

***Rehabilitation and Support services***
- Disability services
- Health of older people services

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

## Interpreting our performance

### Types of measures

Evaluating performance is more than measuring the volume of services delivered or the number of patients cared for. In monitoring our progress we want to be sure that the people who most need services are getting

those services in a timely way, and that these services are delivered to the right quality standard. In the tables below we note the types of output measure, and where appropriate the results are detailed for different ethnicities.

| Type of Measure | Abbreviation |
|---|---|
| Coverage | C |
| Quality | Q |
| Volume | V |
| Timeliness | T |
| DHB of Domicile | DoD |
| DHB of Service | DoS |

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

### Standardisation, Targets and Estimates

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

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

### Impact of COVID-19

COVID-19 had a significant impact on the delivery of health care services across the region. During the pandemic and lockdown period a significant number of planned care (elective) procedures were deferred. Many health services operated with reduced capacity during the lockdown period, and some services – for example childhood immunisation outreach services and Well Child/Tamariki Ora providers – could not operate at all. During the lockdown fewer people presented to primary care, accident & medical centres, and emergency departments. This resulted in an influx of patients requiring care after lockdown was lifted. Ensuring that we catch up and respond to our patients requiring treatment and care will be a priority over the next year. For detailed information on the impact of COVID-19 on our performance, please see pages 59 to 75.

## 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. These conditions have a significant impact on peoples' lives, and include diabetes, cancers, cardiovascular diseases, respiratory diseases, mental illness (including depression and anxiety), chronic pain, chronic kidney disease, and musculoskeletal conditions. Māori, Pacific, and people with disabilities are disproportionately affected by many long-term conditions. These conditions are major cause of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services.[13] With an ageing population, the burden of long-term conditions will increase. Multiple long-term conditions are more common in older people.

Research suggests that over one-third (38%) of all health lost by the New Zealand population as a whole is caused by known modifiable risk factors (i.e., is potentially preventable through reducing exposure to these hazards).[14] 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.

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 preventing family violence require a joined-up approach to address the wider determinants of health, such as childhood experiences, housing, employment, gender inequality, and racism;

[13] Ministry of Health. 2016. Health Loss in New Zealand 1990–2013: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study. Wellington: Ministry of Health.
[14] Ibid.

our DHB and Regional Public Health work with other sectors (e.g. justice, education, housing, and the social sector) 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:[15] 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.

| Outputs Measured by | | | | 2018/19 Baseline | Target /Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Output 1 Prevention Services** | | | | | | | | | | | |
| **Immunisation** | | | | | | | | | | | |
| Percentage of 8-month olds fully immunised | C | HT4 | CW05 | Total 90%<br>Māori 83%<br>Pacific 90% | ≥95% | Total 91%<br>Māori 82%<br>Pacific 88% | Total 91%<br>Māori 89%<br>Pacific 98% | Total 92%<br>Māori 86%<br>Pacific 94% | Target not met | | Target not Met |
| Percentage of 2-year olds fully immunised. | C | PP21 | CW08 | Total 92%<br>Māori 88%<br>Pacific 91% | ≥95% | Total 93%<br>Māori 90%<br>Pacific 90% | Total 93%<br>Māori 89%<br>Pacific 100% | Total 93%<br>Māori 89%<br>Pacific 92% | Target not Met | | Target not Met |
| Percentage of 5-year olds fully immunised. | C | PP22 | CW05 | Total 90%<br>Māori 84%<br>Pacific 95% | ≥95% | Total 89%<br>Māori 85%<br>Pacific 85% | Total 90%<br>Māori 82%<br>Pacific 82% | Total 89%<br>Māori 85%<br>Pacific 84% | Target not Met | | Target not Met |
| Percentage of population aged 65 years and over immunised against Influenza Annually. | C | PP21 | CW05 | Total 55%<br>Māori 48%<br>Pacific 57% | ≥75% | Only reported as an annual result | | Total 55%<br>Māori 60%<br>Pacific 58% | Target not Met | | Target not Met |
| **Smoking Cessation** | | | | | | | | | | | |
| Percentage of PHO enrolled patients who smoke and have been offered help to quit by a health practitioner in last 15 months. | C | HT5 | PH04 | Total 91%<br>Māori 90%<br>Pacific 89% | ≥90% | Total 90%<br>Māori 86%<br>Pacific 86% | Total 88%<br>Māori 86%<br>Pacific 89% | Total 89%<br>Māori 86%<br>Pacific 87% | Target met for Total but not Māori or Pacific | | Target not Met |

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

| Outputs Measured by | | | | 2018/19 Baseline | Target /Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of hospitalized smokers offered advice and help to quit. | Q | PP31 | SS06 | Total:90%<br>Māori: 91%<br>Pacific: 88% | ≥95% | Total 95%<br>Māori 95%<br>Pacific 96% | Total 97%<br>Māori 97%<br>Pacific 95% | Total 96%<br>Māori 96%<br>Pacific 96% | Target met for all Ethnicities | | Target met for all Ethnicities |
| **Breastfeeding** | | | | | | | | | | | |
| Percentage of infants fully or exclusively breastfed at 3-months. | Q | PP37 | CW06 | HVDHB 54%<br>Māori 46%<br>Pacific 43% | ≥70% | Results not published by Ministry of Health due to data quality issues | | | | | No results published |

| Outputs Measured by | | | | 2018/19 Baseline | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Population based Screening Services** | | | | | | | | | | | |
| Ensuring service coverage - Percentage of eligible children receiving a B4 School Check before they are 4½ years old. | C | HVPI | CW10 | 98%<br>High Dep 99% | ≥90% | Total 43%<br>High Dep 46% | Not Available | Total 43%<br>High Dep 46% | Target not met | | Target not met. |
| Healthy weight (age 4): Number of B4 school check participants identified with BMI range between 5th and 84th percentile. | C | HVPI | CW11 | 73% | ≥95% | | | Q4 result<br>Total 87%<br>Māori 82%<br>Pacific 61% | | | Target not met |
| Percentage of eligible women (25-69 years) having cervical screening in last 3 years. | C | SI10 | PV02 | Total 76%<br>Māori 68%<br>Pacific 69% | >70% | Total 69%<br>Māori 63%<br>Pacific 64% | Not available | Not available | Target not met | | Target not met impacted by Covid-19 |
| Percentage of eligible women (50-69 years) having breast screening in the last 2 years. | C | SI11 | PV01 | Total 75%<br>Māori 69%<br>Pacific 69% | >80% | Total 73%<br>Māori 69%<br>Pacific 70% | Not available | Not available | Target not Met | | Target not met impacted by Covid-19 |

# Comments on Performance

### Immunisation Services

The immunisation coverage for eight month year olds and two year old children improved slightly against the baseline, including improved coverage for Māori and Pacific children. However, coverage for five year olds decreased against the baseline, especially for Pacific children. Immunisation numbers remain an area of focus for the DHB and actions are monitored through the Hutt Valley DHB Immunisation Steering Group.

We are continuing to implement a number of strategies to lift our immunisation rates. A process is in place to identify and respond to children not up to date with immunisations who present at Hutt Hospital. The Hutt Valley DHB NIR administrator monitors live daily NIR reports of unimmunised children, including children presenting at HVDHB hospital. This information is provided to the Immunisation Co-ordinator who visits the relevant department for follow up. In the Paediatrics and the Special Care Baby Unit (SCUBU) departments, children may also be immunised by staff or the Immunisation coordinator, with parental consent. The potential for Emergency Department staff to carry out the vaccination is currently being explored.

In the community, Te Awakairangi Health Network (TeAHN) provides facilitation support to assist general practices to reach and maintain high immunisation coverage. General practices are also provided with fortnightly lists of the children that are due to be immunised. This enables the practices to be proactive and follow-up with the relevant families. Kōkiri Marae Health and Social Services delivers our Outreach Immunisation Service, which follows-up with whanau/families who are not well engaged with their general practice. The Outreach Immunisation Service makes contact with these families and works closely with them to get their children immunised.

Our response to COVID-19 has had a positive impact on flu vaccination coverage for over 65 year olds. We improved access by significantly increasing the number of pharmacies providing flu-vaccination. We are closing the gaps between ethnic population groups. Our coverage for Māori has increased from 48% to 60% coverage, and Pacific rates are also trending upwards. Year-to-date data for 2020 shows a dramatic 20% increase in Pacific coverage. Our work to improve access and raise awareness around the importance of vaccination has paid off in terms of increasing our flu vaccination coverage.

# The Show goes on! School immunisation team on track amongst COVID-19 school closures

Every year the Child Health, School Based Immunisation team at Regional Public Health (RPH) set about the considerable task of immunising 7,500 children in years 7 and 8 (ages 10 to 12) in 113 schools across Wellington, Hutt Valley, Porirua and Kapiti. The team deliver the Boostrix and HPV vaccines to these students.

For Maureen Stringer, Child Health Immunisations team leader, 2020 has seen her team lose eight available weeks to administer immunisations due to COVID-19. “As soon as there were confirmed cases of COVID-19 in New Zealand, we had a number of schools contacting us saying, ‘put the immunisations for our school on hold, we don’t want any external visitors at the moment.’ We could understand why they wanted to take every precaution to keep their tamariki safe,” Maureen said.

By late March, under alert level 4 lockdown, all schools closed and the school immunisation programme went on hold. The immunisation team were redeployed within RPH as part of the pandemic response, which included completing daily monitoring of COVID-19 cases and assisting the wider team with contact tracing.

On the other side of the COVID-19 response, the team faced condensing the school immunisation programme into a much shorter timeframe. It was vital that all HPV round one immunisations were completed by the middle of the year, to allow for a minimum of 22 weeks before round two can be administered.*

Maureen’s “D-Day whiteboard” – the whiteboard used when planning school immunisation visits – went into overdrive as a number of quick revisions to schedules were made. With great working relationships already established with schools and flexibility shown from both sides, new schedules were completed. “Our team of 5.2 FTE staff wasn’t going to get through the workload. Luckily we’re a collaborative bunch here at RPH so we called on support from the wider team of public health nurses to help us out,” said Maureen.

From there, round one of the HPV vaccine was delivered to all schools. “Thankfully, we are now on track to deliver HPV round two, on time, by the end of the year,” said Maureen.

*Public Health Nurses – Immunisation, Child Health, Regional Public Health. Left to right - Jodie Kelly, Melanie Kennedy, Patricia Batchelor, Nicole Lynch, Lynne Knowles, Christine Hughes.*

## Smoking cessation services

Smoking is a major risk factor for many cancers and for respiratory and cardiovascular disease. It is one of the leading modifiable risks to health accounting for about 9 percent of all illness, disability and premature mortality.[16] 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.[17]

We are 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, continuing the brief advice and cessation support by general practices, and implementing the Hapu Mama programme at Kokiri Marae. The Hapu Mama programme is an incentivised programme that encourages pregnant women and their partners to give up smoking.

We have developed a Hutt Valley Tobacco Control Action Plan with key stakeholders (including RPH, Healthy Families Lower Hutt, Hutt City and Upper Hutt Councils, Takiri Mai te Ata, Cancer Society, Vibe and Quitline). This plan includes initiatives where we can work collectively to make most difference for our priority populations (Māori, Pacific peoples, rangatahi and mental health consumers). This work includes work to decrease smoking rates in the Hutt Valley through:

- Youth appropriate social media and other comms messaging
- Closer working relationships with, support of and links to our local stop smoking provider (including two of their employees working onsite at the hospital, prioritising Māori and Pacific patients)
- A DHB Smokefree coordinator to train hospital staff in the provision of ABC advice, accurate coding and improved referrals
- Support of a role at Healthy Families Hutt Valley to increase smokefree environments across the Hutt Valley
- Development of a Hutt Valley wide Vaping Position Statement
- Support of the Hapu Mama smoking cessation programme at Kokiri Marae to incentivise pregnant women and their partners to give up smoking
- Identifying ways to improve smoking advice and cessation rates in pregnant women.

## Breastfeeding Support

We are 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 Pacific and we are focused on addressing this. Our Lactation Service is working with our Māori Health Unit to develop ways to better meet the needs of Māori women and whānau.

We are reviewing our breastfeeding related policies and new education packages, including online platforms, are being developed. We are also reviewing the training and education needs of all staff who have contact

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

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

with breastfeeding women, and plans are being developed to address any gaps. This includes midwifery and nursing staff, medical staff, theatre staff, health care assistants, administration staff, and newborn hearing screeners.

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

Screening and early detection of cancer gives people the best chance of successful treatment. We have 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 are continuing to focus the programme on improving participation for priority populations.

We are continuing to focus on improving our breast and cervical screening rates for Māori and Pacific women to reduce inequities. Breast screening is provided at Hutt Hospital's Breast Screen Central and we run four 'Free' combined cervical and breast screening sites at Hutt Valley DHB. We also fund 16 afterhours clinics at local Marae and in the community to provide free cervical screening in the Hutt.

We have been data matching with general practices to identify women who have not been screened, and then following-up with them to offer screening and support. This includes booking clinic appointments, arranging transport and support, and referral to support services. We are continuing to open weekend and after-hours clinics to improve accessibility. Combined breast and cervical screening days on Saturdays at Hutt Valley DHB have been well attended and helped women access screening.

We are also providing after-hours smear clinics at Kokiri Puketapu Hauora Clinic, Waiwhetu 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.

## 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 Measured by | | | | 2018/19 Baseline | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Output 2 Early detection and management** | | | | | | | | | | | |
| **Primary Care services / Long term conditions management** | | | | | | | | | | | |
| Newborn enrolment with General Practice by three months of age | C | SI 18 | CW07 | Total 86% | ≥85% | Total 93% Māori 88% Pacific 93% | Total 90% Māori 84% Pacific 94% | Total 93% Māori 88% Pacific 93% | Target met for all ethnicities | Target met for all but Māori | Target met |
| Improving Māori enrolment in PHOs to meet the national average of 90% | C | PP 33 | PH03 | 91% | ≥90% | 88% | 88% | 88% | Target not Met | Target not Met | Target not Met |
| ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000) | V | PP 22 | PH01 | Total 8,354 Māori 10,517 Pacific 14,396 | Total ≤ 7,886 Māori ≤ 9,722 Pacific:≤ 11,272 | Total 8,982 Māori 12,007 Pacific 17,789 | Total 9,337 Māori 12,394 Pacific 15,158 | Total 9,337 Māori 12,394 Pacific 15,158 | Target not Met | Target not Met | Target not Met |

| Outputs Measured by | | | | 2018/19 Baseline | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ASH Rates (avoidable hospitalisations) for 45-64 years (rate per 100,000) | V | SI 1 | SS05 | Total 4,840 Māori 7,928 Pacific 9561 | Total ≤ 4,764 Māori ≤ 7,800 Pacific ≤ 7,528 | Total 4,533 Māori 7,735 Pacific 8,455 | Total 4,512 Māori: 7,654 Pacific 8,060 | Total 4,512 Māori 7,654 Pacific 8,060 | Target met for all but Pacific | Target met for all but Pacific | Target met for all but Pacific |
| Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years age | V | H V PI | HVP I | 318 | No increase from baseline | 338 | 20 | 358 | Target not Met | Target met Low number due to COVID | Target not Met |
| Percentage of eligible population assessed for CVD risk in last 5 years. | C | PP 20 | SS13 FA3 | 82% | ≥90% | 79% | 75% | 75% | Target not Met | Target not Met | Target not Met |
| Percentage of DHB-domiciled population (15-74 yrs) enrolled in a PHO with well managed diabetes (HbA1c ≤ 64 mmol/mol) | C | PP 20 | SS13 FA2 | Total 57% Māori 46% Pacific 44% | ≥70% | Total 57% Māori 47% Pacific 45% | Total 50% Māori 42% Pacific 41% | Total 55% Māori 46% Pacific 43% | Target not Met | Target not Met | Target not Met |

| Outputs Measured by | | | | 2018/19 Baseline | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Oral Health** | | | | | | | | | | | |
| Percentage of children caries free (no cavities) at five years of age | C | PP 11 | CW0 1 | Total63 % Māori 47% Pacific 47% | 66% | Only reported annually | | Total 65% Māori 52% Pacific 48% | | | Target not met |
| Mean DMFT score at school year 8 | C | PP 10 | CW0 2 | Total: 0.65 Māori: 1.01 Pacific: 1.02 | ≤0.61 | Only reported annually | | Total 0.63 Māori 0.81 Pacific 0.69 | | | Target met |
| Percentage of adolescents accessing DHB-funded dental services. | C | PP 12 | CW0 4 | 67% | ≥85% | Only reported annually | | 74% | | | Target not met |

# 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.

Reducing Ambulatory Sensitive Hospitalisation (avoidable hospitalisation) rates and disparities for Māori and Pacific remains our top priority. We have reduced our rates of avoidable hospitalisations for the 45-64 year group over the last year, although significant ethnic disparities remain. Our rates of avoidable hospitalisations for the 0-4 year group have increased, and again there are significant ethnic disparities that we are continuing to address. Our top avoidable hospitalisation conditions for 0-4 year olds continue to be asthma, respiratory infections, dental, and gastro/dehydration.

Significant work has focused on future sustainability of primary care through roll out of the Health Care Home development programme. This work will strengthen the delivery and future sustainability of primary care services in the Hutt Valley. Fifteen general practices have now adopted the HCH model, representing approximately 85 percent of Hutt Valley DHB's 'enrolled population' (those enrolled with a general practice). Our investment in Home Care Homes will improve accessibility of general practice services in the Hutt Valley, which will help reduce avoidable hospitalisations.

We want to ensure that our young children get the best start to life. This means we need to do our best to keep them healthy and well, and work across sectors to improve their living conditions and address the underlying causes of poor health, such as housing conditions. Our System Level Measure Plan for 2020/21 includes actions focussed on reducing our avoidable hospitalisation rates for 0-4 year olds. It includes work to raise the profile and increase referrals to Tū Kotahi and the Well Homes service amongst midwives, LMCs, and WCTO nurses. Tū Kotahi offers a range of interventions tailored to high need populations and the Well Homes service assist families to access healthy housing interventions.

We are concerned about the rates of well managed diabetes within our enrolled population, especially for Māori and Pacific. This is why our annual plan for 2020/21 includes a number of actions to improve the management of diabetes in our DHB. We are reviewing the Diabetes Self-Management education programme and working with our primary health organisations to improve performance of diabetes management across primary care.

## Oral health services

We are continuing to provide knee-to-knee oral health examination programmes focusing on pre-school aged children enrolled in Kohanga and Early Childhood Centres in the Hutt Valley. The knee-to-knee technique does not require a dental chair, as the parent and the health professional sit face to face with their knees touching while the child receives their oral health examination.

Our System Level Measure Plan for 2020/21 includes a focus on improve children's oral health. There is an opportunity to access young Māori and Pacific children at Early Childhood Centres (ECC) and teach young children about the importance of tooth brushing and how to do it correctly. Oral health education and information can also be provided to ECC teachers, support staff, students and families to raise awareness of the importance of teeth and key prevention messages. ECCs can also be supported to develop/review nutrition policies to support oral health.

# 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 and Treatment Services

| Outputs Measured by | | | | 2018/19 Performance | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achieve-ment | COVID-19 Achieve-ment | Overall Achiev-ement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Output 3 Intensive assessment and treatment** | | | | | | | | | | | |
| **Mental Health and Addiction services** | | | | | | | | | | | |
| Access to mental health services: No. of mental health clients seen | C | PP6 | MH01 | Age 0-19 Māori 5% Other 4% Total 4% | Age 0-19 Māori 5% Other 4% Total 4% | Age 0-19 Māori 5% Other 4% Total 4% | Age 0-19 Māori 5% Other 4% Total 4% | Age 0-19 Māori 5% Other 4% Total 4% | Target Met | Target Met | Target Met |
| | C | PP6 | MH01 | Age 20-64 Māori 10% Other 10% Total 5% | Age 20-64 Māori 9% Other 4% Total 5% | Age 20-64 Māori 10% Other 4% Total 4% | Age 20-64 Māori 10% Other 4% Total 5% | Age 20-64 Māori 9 % Other 4% Total 5% | Target Met | Target Met | Target Met |
| | C | PP6 | MH01 | Age 65+ Māori 3% Other 2% Total 2% | Age 65+ Māori 2% Other 2% Total 2% | Age 65+ Māori 3% Other 2% Total 2% | Age 65+ Māori 3% Other 2% Total 2% | Age 65+ Māori 3% Other 2% Total 2% | Target Met | Target Met | Target Met |
| Percentage of clients with transition (discharge) plan | Q | PP7 | MH02 | 52% | ≥95% | 50% | 48% | 48% | Target not Met | Target not Met | Target not Met |
| Percentage of clients with a wellness plan | Q | PP7 | MH02 | 39% | ≥95% | 43% | 43% | 43% | Target not Met | Target not Met | Target not Met |
| Percentage of patients 0-19 yrs referred to non-urgent child & adolescent mental health services & seen within 3 weeks. | T | PP8 | MH03 | 48% | ≥80% | 35% | 32% | 34% | Target not Met | Target not Met | Target not Met |
| Percentage of patients 0-19 yrs referred to non-urgent child & adolescent mental health services & seen within 8 weeks. | T | PP8 | MH03 | 89% | 95% | Q2 – 88% Q3- not reported due to Covid-19 | 81% | 86% | Target Met | Target Met | Target Met |

| Outputs Measured by | | | | 2018/19 Performance | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achieve-ment | COVID-19 Achieve-ment | Overall Achiev-ement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of patients 0-19 years referred to non-urgent child & adolescent Addiction services & seen within 3 weeks. | T | PP8 | MH03 | 76% | ≥95% | 68% | Not available | Not available | Target not Met | | Target not Met |
| Percentage of patients 0-19 years referred to non-urgent child & adolescent Addiction services & seen within 8 weeks. | T | PP8 | MH03 | 93% | ≥95% | 88% | Not available | Not available | Target not Met | Target not Met | Target not Met |
| Planned and Acute (Emergency Department) inpatient/outpatient | | | | | | | | | | | |
| Standardised acute readmission rate to hospital | | OS8 | SS07 | Total 13%<br>Māori 14%<br>Pacific 13% | 12% | Total 12%<br>Māori 13%<br>Pacific 11% | Not available | Year to June 2020<br>Total 12%<br>Māori 13%<br>Pacific 11% | Target met for total and Pacific but not for Māori | Not available | Not available |
| Planned care interventions – Inpatient surgical discharges | V | HT2 | SS07 | 6,238<br>101% | 5,795 | 3,477<br>90% | 4,962<br>86% | 4,962<br>86% | Target not Met | Target not Met | Target not Met |
| Planned care interventions – Minor Procedures | V | PP45 | SS07 | New measure | 2,525 | 2,153<br>136% | 3,163<br>125% | 3,163<br>125% | Target Met | Target Met | Target Met |
| Planned care timeliness: Number of Patients waiting longer than four months for their first specialist assessment (FSA). "ESPI 2" | T | - | ESPI 2 | New measure | 0% | 11% | 11% | 11% | Target not Met | Target not Met | Target not Met |
| Planned care timeliness: Number of Patients given a commitment to treatment but not treated within four months. "ESPI 5" | T | - | ESPI 5 | New measure | 0% | 27% | 49% | 29% | Target not Met | Target not Met | Target not Met |

| Outputs Measured by | | | | 2018/19 Performance | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achieve-ment | COVID-19 Achieve-ment | Overall Achiev-ement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of patients admitted, discharged or transferred from ED within 6 hours. | T | HT1 | SS10 | 89% | 95% | 86% | 92% | 86% | Target not Met | Target not Met | Target not Met |
| Weighted average score in Patient Experience Survey | Q | SI8 | SLM PH01 | Communication 8.7 Coordination 8.6 Partnership 8.7 Physical and emotional needs 8.7 | 8.8 | Communication 8.1 Coordination 8.2 Partnership 8.4 Physical and emotional needs 8.6 | Suspended due to COVID-19 | | Target not Met | Suspended due to COVID-19 | |

| Outputs Measured by | | | | 2018/19 Performance | Target /Est 2019/ 20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achieve-ment | COVID-19 Achieve-ment | Overall Achiev-- ement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer services | | | | | | | | | | | |
| Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat. | T | PP30 | SS01 | 93% | ≥85% | 91% | 92% | 91% | Target Met | Target Met | Target Met |
| Percentage of patients with a high suspicion of cancer and a need to be seen within 2 weeks that received their first cancer treatment (or other management) within 62 days of being referred. | T | HT3 | SS11 | 96% | ≥90% | 93% | 83% | 90% | Target Met | Target Met | Target Met |
| Quality | | | | | | | | | | | |
| Rate of inpatient falls resulting in a fracture per 1,000 bed days | Q | HVPI | HVPI | New measure | ≤ 0.07 | 0.13 | 0.24 | 0.16 | Target not Met | Target not Met | Target not Met |

| Outputs Measured by | | | | 2018/19 Performance | Target /Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achieve-ment | COVID-19 Achieve-ment | Overall Achiev--ement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of hospital acquired pressure injuries per 1,000 bed days | Q | HVPI | HVPI | 0.49 | ≤0.59 | 0.22 | 0.28 | 0.24 | Target Met | Target Met | Target Met |

# Comments on Performance

## Medical and surgical services

The emergency responses to COVID-19 and the Whakaari/White Island disaster impacted on Hutt Valley DHB's ability to meet its target for elective surgeries.

Despite our best efforts to continue to see people and provide care over the year there was a significant decrease in the amount of care we were able to safely provide. As a result Hutt Valley DHB did not meet its target for elective surgeries. The COVID-19 emergency response, while necessary, has also created a backlog of patients waiting to be seen and treated in our system. This will take careful planning and increased effort over a number of years to correct. A Planned Care Waitlist Improvement Action Plan has been developed to address the backlog and get us back on track.

Demand for complex care has been increasing from within our DHB and the region. In recent years the balance of Acute and Planned Care has tipped further towards Acute Care, and elective surgery is being displaced in order for Acute Care to be provided.

We are working to reduce the demand on medical and surgical services through a range of projects, including:

- Specialist support to GPs – so they can access advice for their patients and potentially avoid hospitalisation
- Improved theatre efficiency and safety – the introduction of electronic waitlist management software has improved the tracking/tracing of patients through their elective surgery journey
- Improved flow of acute (unplanned emergency) patients – the introduction of capacity planner software has enabled us to track and predict daily acute demand, and better match expected demand with staff capacity (nursing rosters)
- The Medical Service Improvement Project has enabled a new roster guaranteeing specialist availability to ED and GPs. Patients receive faster access to senior decision makers.
- Digital dental has been introduced at Bee Healthy dental sites – which means children can now have a single appointment for examination, x-rays, diagnosis and prevention
- Community Nursing: Delays accessing District & Specialist Nursing – efficiency gains resulting in fewer patients waiting for care, and increased responsiveness to ward discharges.
- Ophthalmology - Alternative model of care has been introduced to deliver services closer to home and reducing patient travel.
- Maternity - programme to support mothers with higher needs, ward enhancements with safety benefits, and enhanced clinical governance arrangements.
- Health Care Home (HCH) – the HCH patient-centred model of care has been implemented in fifteen general practices, representing 85 percent of Hutt Valley DHB's 'enrolled population' (those enrolled with a general practice).

## 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. However, there were some delays related to surgical capacity and clinical considerations. Work continues to identify targeted areas for further improvement.

### Mental health and addictions services

The demand for mental health services in our district is growing in line with planned development but also affected by the impact of COVID-19. Work is continuing on reducing wait times in key areas, but there has been an increase in acute presentations for some services including child and adolescent services, which has had an impact on meeting non-urgent wait times.

Our inpatient services remain under significant pressure to meet the needs of people requiring intensive psychiatric care. However, we have a number of project underway to help mitigate this demand.

The 3DHB Mental Health, Addictions and Intellectual Disability Service (MHAIDS) has launched a GP Liaison Service to provide specialist mental health and addictions advice to general practices across the Hutt Valley, Wairarapa and Wellington regions. The service strengthens our ability to initiate treatment for people in the community before their condition worsens or becomes acute. It is recognised internationally that the needs of those with mild to moderate mental health and addictions problems are best met in the primary care setting. Early specialised support strengthens the overall continuum of care and supports a collaborative whole-of-sector approach to improving outcomes for our people.

MHAIDS has also commenced a project to introduce efficiencies in the one point of entry service (Te Haika). This service is implementing automatic entry of Te Haika referrals using robot technology. All Te Haika referrals will automatically be entered into WebPas within three minutes of a clinician saving/completing an intake document. This will improve the accuracy of referral and activity data, and reduce wait times for initial entry into the service.

## Output Class 4: Rehabilitation and 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 and Support Services

| Outputs Measured by | | | | 2018/19 performance | Target/Est 2019/20 | Pre-COVID-19 Performance July-Feb/ Q1-3 | COVID-19 Performance March-June/Q4 | 2019/20 Performance | 2019/20 Pre COVID-19 Achievement | COVID-19 Achievement | Overall Achievement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Output 4 Rehabilitation and Support** | | | | | | | | | | | |
| **Disability care services** | | | | | | | | | | | |
| % of hospital staff that have completed the Disability Responsiveness eLearning module | Q | HVPI | HVPI | 20% | 100% | 8% | 3% | 11% | Target not met | Target not met | Target not met |
| Number of HVDHB Disability forums | V | HVPI | HVPI | 2 | 3 | Not completed due to Covid -19 | | | | | |
| Number of sub-regional and HVDHB Disability forums | C | HVPI | HVPI | 2 | 1 | Not completed due to Covid-19 | | | | | |
| % of the HVDHB domiciled population with a Disability Alert who are Māori or Pacific | C | HVPI | HVPI | | Māori: 17% Pacific: 8% | | | Māori: 17% Pacific: 5% | | | Target not met |
| Total number of Disability alert registrations | Q | HVPI | HVPI | 3 DHB 5550 HVDHB 910 | | | | 7,498 | | | Target not met |
| **Health of Older People (HOP) services** | | | | | | | | | | | |
| Number of older people (65 and over, or younger if identified as a falls risk) that have received in-home strength and balance programmes (new starters) | C | PP23 | SS04 | 35 | 70 | 47 | | 62 | Target not Met | Target not Met | Target not Met |
| Number of older people (65 and over, or younger if identified as a falls risk) that have received community/group strength and balance programmes | C | PP23 | SS04 | 450 | 600 | 1710 | | 1883 | Target Met | Target Met | Target Met |

# Comments on Performance

## Disability services

Our focus on increasing the uptake of Disability Alerts is paying off and we achieved our target. Disability Alerts contain specific information provided by the patient on how best to meet their support needs. The Disability Alerts make is much easier for disabled people to communicate their needs to health practitioners.

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

# Appropriation Reporting

| | 2018/19 Actual $000 | 2019/20 Budget $000 | 2019/20 Actual $000 |
|---|---|---|---|
| Appropriation revenue | 396,618 | 416,835 | 416,835 |

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 Class: Financial Performance ($000s)**

| **Revenue** | **2019/20 Actual** | **2019/20 Budget** | **2018/19 Audited** |
|---|---|---|---|
| Prevention | 21,885 | 25,570 | 20,508 |
| Early detection and management | 289,678 | 158,166 | 284,125 |
| Intensive assessment and treatment | 225,147 | 337,693 | 215,091 |
| Rehabilitation and support | 56,710 | 74,695 | 55,162 |
| **Total** | **593,420** | **596,124** | **574,886** |

| ***Expenses** | **2019/20 Actual** | **2019/20 Budget** | **2018/19 Audited** |
|---|---|---|---|
| Prevention | 21,703 | 27,163 | 20,378 |
| Early detection and management | 292,317 | 162,886 | 279,964 |
| Intensive assessment and treatment | 261,571 | 338,636 | 239,256 |
| Rehabilitation and support | 56,613 | 75,580 | 55,164 |
| **Total** | **632,204** | **604,265** | **594,762** |

# Financial Statements

## Statement of comprehensive revenue and expense

For the year ended 30 June 2020

| | Note | 2020 Actual $000 | 2020 Budget $000 | 2019 Actual $000 |
|---|---|---|---|---|
| **Revenue** | | | | |
| Operating Revenue | 2 | 593,152 | 595,574 | 574,391 |
| Interest | | 157 | 550 | 454 |
| Dividends | | 111 | - | 41 |
| **Total revenue** | | **593,420** | **596,124** | **574,886** |
| | | | | |
| **Expenditure** | | | | |
| Personnel Costs | 3 | 204,366 | 198,820 | 190,558 |
| Depreciation and Amortisation | 9-10 | 14,917 | 15,561 | 14,118 |
| Outsourced Services | | 18,386 | 12,462 | 16,478 |
| Clinical Supplies | | 25,790 | 24,402 | 23,475 |
| Infrastructure and Non-Clinical expenses | | 16,904 | 14,111 | 16,427 |
| Other District Health Boards | | 101,298 | 101,203 | 95,136 |
| Non-Health Board Providers | | 218,583 | 219,007 | 211,615 |
| Capital Charge | 4 | 10,257 | 12,720 | 12,022 |
| Finance costs | 5 | 12 | 71 | 23 |
| Other expenses | 6 | 3,521 | 5,907 | 3,373 |
| **Total expenditure excluding Holidays Act and NOS*** | | **614,034** | **604,265** | **583,225** |
| | | | | |
| **Surplus/(deficit) excluding Holidays Act and NOS*** | | **(20,614)** | **(8,141)** | **(8,339)** |
| | | | | |
| Holidays Act Provision | 29 | 18,170 | - | 9,321 |
| National Oracle System (NOS) impairment | | - | - | 2,216 |
| **Surplus/(deficit) for the year** | | **(38,784)** | **(8,141)** | **(19,876)** |
| | | | | |
| **Other comprehensive revenue and expense** | | | | |
| Gain/(loss) on property revaluations | | 19,866 | - | (7,175) |
| **Total comprehensive revenue and expense** | | **(18,918)** | **(8,141)** | **(27,051)** |

*NOS = National Oracle System

*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 2020

| | Note | 2020 Actual $000 | 2020 Budget $000 | 2019 Actual $000 |
|---|---|---|---|---|
| **Equity as at 1 July** | | 174,347 | 193,040 | 201,605 |
| Repayment of equity to the Crown | | (207) | - | (207) |
| Revaluation reserves | | 19,866 | - | (7,175) |
| Net surplus/(deficit) | | (38,784) | (8,141) | (19,876) |
| **Equity as at 30 June** | 17 | **155,222** | **184,899** | **174,347** |

*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 2020

| | Note | 2020 Actual $000 | 2020 Budget $000 | 2019 Actual $000 |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current Assets** | | | | |
| Debtors and other receivables | 7 | 28,393 | 28,917 | 27,822 |
| Inventories | 8 | 2,199 | 1,414 | 1,434 |
| **Total Current Assets** | | **30,592** | **30,331** | **29,256** |
| **Non-Current Assets** | | | | |
| Property, Plant and Equipment | 9 | 225,970 | 227,333 | 210,947 |
| Intangible Assets | 10 | 17,820 | 8,887 | 19,246 |
| Investments in Joint Ventures | 11 | 1,150 | 1,150 | 1,150 |
| Trust and bequest funds | 12 | 1,347 | 1,426 | 1,409 |
| **Total Non-Current Assets** | | **246,287** | **238,795** | **232,752** |
| **Total Assets** | | **276,879** | **269,126** | **262,008** |
| **Liabilities** | | | | |
| **Current Liabilities** | | | | |
| Cash and cash equivalents | 13 | 6,059 | 721 | (3,783) |
| Creditors and other payables | 14 | 40,785 | 31,697 | 39,230 |
| Employee entitlements and provisions | 15 | 64,274 | 35,190 | 42,340 |
| Borrowings | 16 | 42 | 23 | 221 |
| **Total Current Liabilities** | | **111,160** | **67,631** | **78,008** |
| **Non-Current Liabilities** | | | | |
| Employee entitlements and provisions | 15 | 8,972 | 7,846 | 8,245 |
| Borrowings | 16 | 178 | 175 | - |
| Trust and bequest funds | 12 | 1,347 | 8,575 | 1,409 |
| **Total Non-Current Liabilities** | | **10,497** | **16,596** | **9,654** |
| **Total Liabilities** | | **121,657** | **84,227** | **87,662** |
| **Net Assets** | | **155,222** | **184,899** | **174,347** |
| **Equity** | | | | |
| Crown equity | 17 | 123,916 | 123,916 | 124,123 |
| Revaluation reserves | 17 | 146,289 | 133,597 | 126,422 |
| Accumulated deficit | 17 | (114,983) | (72,615) | (76,199) |
| **Total Equity** | 17 | **155,222** | **184,899** | **174,347** |

*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 2020

| | Note | 2020 Actual $000 | 2020 Budget $000 | 2019 Actual $000 |
|---|---|---|---|---|
| **Cashflows from Operating Activities** | | | | |
| Cash receipts | | 592,673 | 595,582 | 564,711 |
| Payments to providers | | (319,709) | (320,154) | (304,063) |
| Payments to suppliers & employees | | (264,789) | (255,768) | (249,482) |
| Goods and Services Tax (net) | | 832 | - | (308) |
| Capital charge paid | | (10,257) | (12,720) | (12,022) |
| **Net cash flows from Operating Activities** | 18 | **(1,250)** | **6,940** | **(1,165)** |
| **Cashflows from Investing Activities** | | | | |
| Interest received | | 157 | 550 | 454 |
| Dividends received | | 111 | | 41 |
| Purchase of property, plant and equipment and Intangible assets | | (8,649) | (13,428) | (9,950) |
| Investments | | - | - | (300) |
| **Net cash flows from Investing Activities** | | **(8,381)** | **(12,878)** | **(9,755)** |
| **Cashflows from Financing Activities** | | | | |
| Interest paid | | (3) | (71) | (23) |
| Payment of Finance Leases | | (1) | - | (510) |
| Repayment of Equity | | (207) | - | (207) |
| **Net cash flows from Financing Activities** | | **(211)** | **(71)** | **(740)** |
| **Net (Decrease) / Increase in Cash and Cash Equivalents** | | **(9,842)** | **(6,009)** | **(11,660)** |
| Cash and cash equivalents at beginning of year | 13 | 3,783 | 3,783 | 15,443 |
| **Cash and Cash Equivalents at end of year** | | **(6,059)** | **(2,226)** | **3,783** |

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

# Notes to the Financial Statements

For the year ended 30 June 2020

## 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 2020, and were approved by the Board on 18 December 2020.

## 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 2019/20 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

### Letter of comfort

The Board has received a letter of comfort dated 29 September 2020 from the Ministers of Health and Finance which states that the Crown acknowledges that equity support will be required and that the Crown will provide such support where necessary to maintain viability.

***Operating and cash flow forecasts***

Taking the Letter of Comfort and Equity injection into consideration, the Board has considered forecast information relating to operational viability and is satisfied that there will be sufficient cash flows from income, including an equity injection and overdraft facilities available to meet the operating and financing cash flow requirements of the 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, excluding any Holiday Act remediation, will not exceed the available borrowing facilities, based

on the assumption that the DHBs approved facility will be available taking into account the needs of the rest of the health sector. Furthermore, the forecast borrowing requirements can be met without breaching covenants of other borrowing restrictions.

## 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 Public Benefit Entity 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 Policy

PBE IPSAS 34-38 replace the existing standards for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019.

Hutt Valley DHB has applied these new standards in preparing the 30 June 2020 financial statements.

## Standards issued and not yet effective and not early adopted

***Amendment to PBE IPSAS 2 Statement of Cash Flows***

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Hutt Valley DHB does not intend to early adopt the amendment.

***PBE IPSAS 41 Financial Instruments***

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Hutt Valley DHB has not assessed the effect

of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

***PBE FRS 48 Service Performance Reporting***

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Although Hutt Valley DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar current presentations.

## Significant Accounting Policies

***Revenue***

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

***Ministry of Health (MoH) revenue***

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

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

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

***ACC contracted revenue***

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

***Revenue from other DHBs***

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

***Interest income***

Interest income is recognised using the effective interest method.

***Rental income***

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

***Provision of services***

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

***Donations and bequests***

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

# Expenses

### Capital Charge

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

## Borrowing costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

## 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

Short-term receivables are recorded at the amount due, less an allowance for credit losses. Hutt Valley DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been aggregated into groups of receivables that share similar credit risk characteristics. They have also been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments.

## 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:

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

| | | |
|---|---|---|
| Site Improvements | 10 to 100 years | 1.0% to 10.0% |
| Building Structure, Services and Fit out | 8 to 53 years | 1.9% to 11.8% |
| Plant and equipment | 2.5 to 20 years | 5.0% to 40.0% |
| Computer equipment | 3 to 25 years | 4.0% to 33.3% |
| Leased assets | 3 to 15 years | 6.5% to 33.3% |
| Motor vehicles | 5 to 10 years | 10.0% to 20.0% |

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.

***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 | 5 to 21 years | 4.8% to 20.0% |

## 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 revenue and expense 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 revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

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

## Creditors and other payables

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

## Borrowings

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

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

## Short-term employee entitlements

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

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

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

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

## Long-term entitlements

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

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

## Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave, vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities

expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

## Superannuation schemes

***Defined contribution schemes***

Employers contributions to KiwiSaver and the Government Superannuation Fund are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

***Defined benefit schemes***

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

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

## Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Provisions are not recognised for future operating losses.

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

## ACC Partnership Programme

Hutt Valley DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility of work related illnesses and accidents of employees that are generally the result of an isolated event to an individual employee. Under the ACC Partnership Programme Hutt Valley DHB is effectively providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which Hutt Valley DHB has responsibility under the terms of the Partnership Programme. Hutt Valley DHB has chosen a stop loss limit of 250% of the standard levy.

### Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Crown equity;
- accumulated deficits; and
- revaluation reserves.

## Revaluation reserves

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

## Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

## Income tax

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

## Budget figures

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

## Cost allocation

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

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

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

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

## Critical accounting estimates and assumptions

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

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

### Estimating the fair value of land and buildings

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

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

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

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

### Critical judgements in applying accounting policies

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

### Classification of Leases

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

## 2 Operating income

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Ministry of Health contract funding | 474,094 | 453,977 |
| ACC Contract revenue | 6,457 | 7,539 |
| Other Government | 1,144 | 2,165 |
| Revenue from other District Health Boards | 106,795 | 106,382 |
| Other patient care related revenue | 4,070 | 3,705 |
| Other Income: | | |
| Donations and bequests received | 255 | 286 |
| Rental income and services | 337 | 337 |
| **Total Operating Income** | **593,152** | **574,391** |

## 3 Personnel costs

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Salaries and wages | 194,998 | 184,284 |
| Defined contribution plan employer contributions | 4,876 | 4,394 |
| Increase/(decrease) in liability for employee entitlements | 4,492 | 1,881 |
| **Total Personnel Costs** | **204,366** | **190,558** |

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 ending 30 June 2020 (2019: 6%).

## 5 Finance costs

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Interest on finance leases | 12 | 23 |
| **Total Finance Costs** | **12** | **23** |

## 6 Other expenses

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Audit Fees for financial statement audit | 173 | 158 |
| Audit-related fees for internal audit services | 146 | 85 |
| Operating lease expense | 2,841 | 2,777 |
| Allowance for credit losses on receivables | 60 | 46 |
| Board member and other fees | 301 | 307 |
| **Total Other expenses** | **3,521** | **3,373** |

## 7 Debtors and other receivables

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Ministry of Health | 10,333 | 9,198 |
| Other DHBs | 8,759 | 5,044 |
| PHARMAC | 6,225 | 8,478 |
| Trade debtors - other | 2,547 | 4,678 |
| Other Departments | 133 | 56 |
| | **27,997** | **27,454** |
| Less: Allowance for credit losses | (419) | (359) |
| | **27,578** | **27,095** |
| Prepayments | 815 | 727 |
| **Total Debtors and other receivables** | **28,393** | **27,822** |
| | | |
| **Total Debtors and other receivables comprises:** | | |
| Revenue from the sale of goods and services (exchange transactions) | 18,480 | 18,912 |
| Revenue from grants (non-exchange transactions) | 9,913 | 8,910 |
| **Total Debtors and other receivables** | **28,393** | **27,822** |

Trade receivables are reported at their face value, less an allowance for expected losses. Expected losses are assessed by aggregating debts into groups of receivables that share similar credit risk characteristics and historical patterns.

The movement in the allowance for credit losses is as follows:

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Opening allowance for credit losses as at 1 July | (359) | (366) |
| Increase in loss allowance made during the year | (125) | (46) |
| Receivables written off during the year | 65 | 53 |
| **Closing Balance** | **(419)** | **(359)** |

## 8 Inventories

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Pharmaceuticals | 196 | 190 |
| Surgical and medical supplies | 2,013 | 1,254 |
| | **2,209** | **1,444** |
| Provision for obsolescence | (10) | (10) |
| **Total Inventories** | **2,199** | **1,434** |

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 (2019: nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2019: nil) however some inventories are subject to retention of title clauses.

## 9 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 2018 | 28,050 | 2,695 | 179,554 | 44,014 | 2,284 | 2,291 | 258,888 |
| Additions | - | 3 | 1,578 | 2,958 | - | - | 4,539 |
| Disposals | - | - | - | (99) | - | - | (99) |
| Adjustments | - | - | (2,279) | (3,682) | - | - | (5,961) |
| Revaluation increase/(decrease) | - | - | (7,175) | - | - | - | (7,175) |
| Work In progress | - | - | 3,284 | 4,135 | - | 195 | 7,614 |
| Balance at 30 June 2019 | 28,050 | 2,698 | 174,962 | 47,326 | 2,284 | 2,486 | 257,806 |
| | | | | | | | |
| Balance 1 July 2019 | 28,050 | 2,698 | 174,962 | 47,326 | 2,284 | 2,486 | 257,806 |
| Additions | - | - | 4,528 | 5,995 | 293 | 214 | 11,030 |
| Disposals | - | - | - | (10) | - | - | (10) |
| Adjustments | - | - | (3,284) | (4,135) | - | (195) | (7,614) |
| Revaluation increase/(decrease) | 2,000 | - | 370 | - | - | - | 2,370 |
| Work In progress | - | - | 1,653 | 1,851 | - | - | 3,504 |
| Balance at 30 June 2020 | 30,050 | 2,698 | 178,229 | 51,027 | 2,577 | 2,505 | 267,086 |
| | | | | | | | |
| **Accumulated depreciation and impairment losses** | | | | | | | |
| Balance at 1 July 2018 | - | 13 | 994 | 31,829 | 894 | 1,874 | 35,604 |
| Depreciation expense | - | 146 | 8,303 | 2,261 | 372 | 271 | 11,353 |
| Depreciation on disposals | - | - | - | (98) | - | - | (98) |
| Elimination on revaluation | - | - | - | - | - | - | - |
| Balance 30 June 2019 | - | 159 | 9,297 | 33,992 | 1,266 | 2,145 | 46,859 |
| | | | | | | | |
| Balance 1 July 2019 | - | 159 | 9,297 | 33,992 | 1,266 | 2,145 | 46,859 |
| Depreciation expense | - | 143 | 8,333 | 2,735 | 411 | 141 | 11,763 |
| Depreciation on disposals | - | - | - | (10) | - | - | (10) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Adjustment | - | - | (44) | 44 | - | - | - |
| Elimination on revaluation | - | (302) | (17,194) | - | - | - | (17,496) |
| Balance 30 June 2020 | - | - | 392 | 36,761 | 1,677 | 2,286 | 41,116 |
| | | | | | | | |
| **Carrying Amounts** | | | | | | | |
| At 30 June 2018 and 1 July 2018 | 28,050 | 2,682 | 178,560 | 12,185 | 1,390 | 417 | 223,284 |
| At 30 June 2019 | 28,050 | 2,589 | 165,665 | 13,334 | 1,018 | 341 | 210,947 |
| At 30 June 2020 | 30,050 | 2,698 | 177,837 | 14,266 | 900 | 219 | 225,970 |

The net carrying amount of assets held under existing finance leases is $0.25m (2019: $0.5m) 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 $7.175m was included in the 2018 land and building revaluation and reversed in the 2019 Financial Accounts.

***Valuation***

Land and building valuations are done on a five year cycle. Desktop valuation updates are done in the interim years between full valuations. Hutt Valley DHB engaged an Independent Registered Valuer (CBRE Limited) to revalue buildings and land to fair value as at 30 June 2020. The Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. The hospital buildings are valued at fair value using optimised depreciated replacement cost because no reliable market data is available for such specialised buildings. Any expected effect on the value of the buildings due to COVID-19 were taken into account by the valuer.

Optimised 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.
- 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 Buildings***

All Hutt Valley DHB's buildings have had detailed seismic assessments. All the assessed buildings meet the current minimum of 34% of the New Building Standard. There is uncertainty around the future of some of the buildings on site due to their relatively low NBS rating, assessed importance level (IL), age and fit for purpose such as the Heretaunga Building (IL3), Kitchen Building (IL2) and Care Building (IL3). Strengthening is on hold until the Master Plan is completed which will give direction as to the future of the buildings on site and what works (if any) are undertaken.

## 10 Intangible assets

| | Acquired Software | NOS Shared Services Rights | Investment In RHIP | Total |
|---|---|---|---|---|
| | $000 | $000 | $000 | $000 |
| **Cost or valuation** | | | | |
| Balance 1 July 2018 | 24,134 | 1,910 | 7,275 | 33,319 |
| Additions | 2,221 | - | - | 2,221 |
| Adjustments | (3,592) | - | (7,275) | (10,867) |
| Impairment | - | (1,910) | | (1,910) |
| Work In progress | 3,760 | - | 8,337 | 12,097 |
| Balance 30 June 2019 | 26,523 | - | 8,337 | 34,860 |
| | | | | |
| Balance 1 July 2019 | 26,523 | - | 8,337 | 34,860 |
| Additions | 3,327 | - | - | 3,327 |
| Adjustments | (3,760) | - | (8,337) | (12,097) |
| Impairment | - | - | - | - |
| Work In progress | 1,432 | - | 9,066 | 10,498 |
| Balance 30 June 2020 | 27,522 | - | 9,066 | 36,588 |
| | | | | |
| **Accumulated amortisation and impairment losses** | | | | |
| Balance at 1 July 2018 | 12,849 | - | - | 12,849 |
| Amortisation expense | 2,765 | - | - | 2,765 |
| Balance 30 June 2019 | 15,614 | - | - | 15,614 |
| | | | | |
| Balance at 1 July 2019 | 15,614 | - | - | 15,614 |
| Amortisation expense | 3,154 | - | - | 3,154 |
| Balance 30 June 2020 | 18,768 | - | - | 18,768 |
| | | | | |
| **Carrying Amounts** | | | | |
| At 30 June 2018 and 1 July 2018 | 11,285 | 1,910 | 7,275 | 20,470 |
| At 30 June 2019 | 10,909 | - | 8,337 | 19,246 |
| At 30 June 2020 | 8,754 | - | 9,066 | 17,820 |

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

## 11 Investments in companies and joint ventures

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Carrying Amount of Investment** | | |
| Advance on redeemable preference shares – Allied Laundry Limited | 1,150 | 1,150 |
| **Closing Balance** | **1,150** | **1,150** |

## 12 Special 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.

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Opening balance | 1,409 | 1,389 |
| Funds received | 474 | 241 |
| Interest received | 9 | 21 |
| Funds disbursed | (545) | (242) |
| **Closing Balance** | **1,347** | **1,409** |

## 13 Cash and cash equivalents

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| Call Deposits with NZ Health Partnerships Ltd | (11,000) | (1,451) |
| Cash at bank and on hand | 4,941 | 5,234 |
| **Total Cash and cash equivalents** | **(6,059)** | **3,783** |

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 $23.0m (2019: 20.1m).

## 14 Creditors and other payables

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Payables under exchange transactions** | | |
| Creditors | 2,974 | 5,539 |
| Accrued expenses | 26,948 | 26,028 |
| Inter-district flows | (1,009) | (159) |
| Interest | 9 | - |

| | | |
|---|---|---|
| Income in advance | 3,770 | 272 |
| **Total payables under exchange transactions** | 32,692 | 31,680 |
| | | |
| **Payables under non-exchange transactions** | | |
| Taxes | 3,166 | 2334 |
| Trusts | 4,927 | 5,216 |
| **Total payables under non-exchange transactions** | 8,093 | 7,550 |
| **Total Creditors and other payables** | **40,785** | **39,230** |

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

| | **2020 Actual $000** | **2019 Actual $000** |
|---|---|---|
| **Current provision** | | |
| Salary and Wages Accrued | 7,599 | 6,449 |
| Annual leave | 21,523 | 19,256 |
| Long Service Leave | 2,125 | 2,252 |
| Retirement Gratuities | 300 | 373 |
| Continuing Medical Education Leave and Expenses | 1,165 | 1,049 |
| Other Entitlements (Including Holiday Pay Provision) | 31,562 | 12,961 |
| **Total Current provision** | **64,274** | **42,340** |
| **Non-current provision** | | |
| Long Service leave | 2,422 | 2,125 |
| Retirement Gratuities | 751 | 755 |
| Continuing Medical Education Leave and Expenses | 3,212 | 3,052 |
| Other Entitlements | 2,587 | 2,313 |
| **Total Non-current provision** | **8,972** | **8,245** |
| | | |
| **Total Employee Entitlements and Provisions** | **73,246** | **50,585** |

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 1.4% (2019: 1.9%) and a salary growth factor of 2.5% (2019: 2.5%) has been used.

## 16 Borrowings

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Current portion** | | |
| Finance Leases | 42 | 221 |
| | **42** | **221** |
| **Non-current portion** | | |
| Finance Leases | 178 | - |
| | **178** | **-** |
| **Total borrowings** | **220** | **221** |

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 9.

The fair value of finance leases is $0.220m (2019: $0.221m). Fair value is estimated at the present value of future cash flows.

**Analysis of Finance Lease**

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Minimum lease payments payable:** | | |
| Not later than one year | 42 | 223 |
| Later than one year and not later than five years | 168 | - |
| Later than five years | 10 | - |
| Total minimum lease payments | 220 | 223 |
| Future finance charges | (0) | (2) |
| Present value of minimum lease payments | 220 | 221 |
| | | |
| **Present value of minimum lease payable:** | | |
| Not later than one year | 42 | 221 |
| Later than one year and not later than five years | 168 | - |
| Later than five years | 10 | - |
| Total present value of minimum lease payments | 220 | 221 |

***Description of finance leasing arrangements***

Hutt Valley DHB holds 1 (2019: 2) finance lease. The finance lease is for medical equipment. There are no restrictions placed on Hutt Valley DHB by any of the finance leasing arrangements.

## 17 Equity

| | $000 | Land Revaluation Reserve $000 | Buildings Revaluation Reserve $000 | Equipment Revaluation Reserve $000 | Retained Earnings/ (Deficit) $000 | $000 |
|---|---|---|---|---|---|---|
| Balance at 1 July 2018 | **124,330** | **23,689** | **110,572** | **(663)** | **(56,323)** | **201,605** |
| Crown Loan converted into Equity | - | - | - | - | - | - |
| Repayment of Equity | (207) | - | - | - | - | (207) |
| Revaluation Reserve | - | - | (7,175) | - | - | (7,175) |
| Surplus/(deficit) for the year | - | - | - | - | (19,876) | (19,876) |
| **Balance at 30 June 2019** | **124,123** | **23,689** | **103,397** | **(663)** | **(76,199)** | **174,347** |
| | | | | | | |
| Balance at 1 July 2019 | **124,123** | **23,689** | **103,397** | **(663)** | **(76,199)** | **174,347** |
| Crown Loan converted into Equity | - | - | - | - | - | - |
| Repayment of Equity | (207) | - | - | - | - | (207) |
| Revaluation Reserve | - | 2,000 | 17,866 | - | - | 19,866 |
| Surplus/(deficit) for the year | - | - | - | - | (38,784) | (38,784) |
| **Balance at 30 June 2020** | **123,916** | **25,689** | **121,263** | **(663)** | **(114,983)** | **155,222** |

## 18 Reconciliation of net surplus/deficit to net cash flow from operating activities

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Reconciliation of Net Operating Surplus with Net Cash Inflow From Operating Activities** | | |
| Net surplus/(deficit) | (38,784) | (19,874) |
| **Add/(less) non-cash items:** | | |
| Depreciation and amortisation expense | 14,917 | 14,118 |
| Impairment expense | - | 2,216 |
| Increase/(decrease) in Provisions | 22,721 | 11,189 |
| **Total non-cash items** | **37,638** | **27,523** |
| **Add/(less) items classified as investing or financing activity:** | | |
| (Gains)/losses on sale of property, plant and equipment | - | - |
| Dividends received | (111) | (41) |
| Net interest received | (145) | (431) |
| **Total items classified as investing or financing activity** | **(256)** | **(472)** |
| **Add/(less) movements in statement of financial position items:** | | |
| (Increase)/decrease in debtors and other receivables | (630) | (9,722) |
| (Increase)/decrease in inventories | (764) | (47) |
| Trust Movement | (289) | (4,341) |

| | | |
|---|---|---|
| Increase/(decrease) in creditors and other payables | 1,835 | 5,769 |
| **Net movements in Working Capital items** | **152** | **(8,342)** |
| **Net cash flow from Operating Activities** | **(1,250)** | **(1,165)** |

## 19 Capital commitments and operating leases

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Capital commitments** | 8,430 | 6,053 |
| **Operating Leases as lessee** | | |
| Not later than one year | 2,061 | 1,626 |
| Later than one year and not later than five years | 3,657 | 2,971 |
| Later than five years | - | - |
| **Total Non-cancellable Commitments** | **14,148** | **10,650** |

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:

- 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.
- 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.
- 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.
- CT scanner and four ultrasound machines are leased for five years with an expiry date of August 2022.
- Orthopaedic tools are leased for seven years with an expiry date of August 2023.
- Magnetic Resonance Imaging (MRI) leased for five years with an expiry date of August 2024.
- Fluoroscopy Combi Diagnost is leased for five years with an expiry date of July 2024.
- Philips Digital Diagnost C90 (two) and R2 (one) are leased for 5 years with an expiry date of January 2025 and June 2025 respectively.

## 20 Contingencies

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2020 (2019: 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, other members of the executive management team, and the Board.

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Leadership Team** | | |
| Salaries and other short-term employee benefits | $2,587 | $2,097 |
| Less: Amount paid by Capital & Coast DHB | (241) | - |
| Amount paid by Hutt Valley DHB | $2,346 | $2,097 |
| *Full-time equivalent members* | *9.78* | *11.08* |
| | | |
| **Board Members** | | |
| Remuneration | $270 | $255 |
| *Full-time equivalent members* | *1.18* | *1.29* |

An analysis of Board member remuneration is provided in Note 22.

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.

During the year Hutt Valley DHB transacted with Wairarapa DHB on normal inter-DHB terms. In addition the DHBs hold combined Community Public Health Advisory Committee meetings.

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 (2019: 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 | 2019/20 actual ($000) | 2018/19 actual ($000) |
|---|---|---|---|
| **Board members as at 30 June 2020** | | | |
| David Smol | Joint Chair HVDHB & CCDHB (from 1 December 2019) | 27 | - |
| Wayne Guppy | Deputy Chair | 30 | 29 |
| Josh Briggs | Current Member (from 1 December 2019) | 14 | - |
| Keri Brown | Current Member (from 1 December 2019) | 14 | - |
| Yvette Grace | Current Member | 23 | 22 |
| Ken Laban | Current Member | 24 | 23 |
| Prue Lamason | Current Member | 24 | 24 |
| John Ryall | Current Member (from 1 December 2019) | 14 | - |
| Naomi Shaw | Current Member (from 1 December 2019) | 14 | - |
| Richard Stein | Current Member (from 1 December 2019) | 14 | - |
| **Board members who left during 2019/20** | | | |
| Andrew Blair | Previous Chair (until 30 November 2019) | 19 | 44 |
| Lisa Bridson | Previous Member (until 30 November 2019) | 9 | 22 |
| Tim Ngan-Kee | Previous Member (until 30 November 2019) | 11 | 24 |
| David Ogden | Previous Member (until 30 November 2019) | 10 | 23 |
| John Terris | Previous Member (until 30 November 2019) | 9 | 21 |
| Kim von Lanthen | Previous Member HVDHB & CCDHB (until 29 February 2020) | 17 | 23 |
| **Total Board member remuneration** | | 273 | 255 |

Board and committee meeting attendances in the year to 30 June 2020:

| Board Member | Position | Meetings Attended | | | | Meetings held | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Board | FRAC | HSC | DSAC | Board | FRAC | HSC | DSAC |
| **1 July 2019 to 30 November 2019** | | | | | | | | | |
| Andrew Blair | Chair – Previous Member | 5 | 4 | 0 | 0 | 5 | 5 | 0 | 2 |
| Wayne Guppy | Deputy Chair – Current Member | 4 | 4 | n/a | n/a | 5 | 5 | 0 | 2 |
| David Ogden | Previous Member | 4 | 3 | n/a | n/a | 5 | 5 | 0 | 2 |
| John Terris | Previous Member | 4 | n/a | 0 | 2 | 5 | 5 | 0 | 2 |
| Ken Laban | Current Member | 5 | 3 | 0 | n/a | 5 | 5 | 0 | 2 |
| Yvette Grace | Current Member | 5 | n/a | n/a | 0 | 5 | 5 | 0 | 2 |
| Tim Ngan-Kee | Previous Member | 5 | 5 | 0 | n/a | 5 | 5 | 0 | 2 |
| Kim von Lanthen | Previous Member | 4 | 4 | n/a | n/a | 5 | 5 | 0 | 2 |
| Prue Lamason | Current Member | 5 | 4 | 0 | 1 | 5 | 5 | 0 | 2 |
| Lisa Bridson | Previous Member | 5 | n/a | 0 | 1 | 5 | 5 | 0 | 2 |
| **1 December 2019 to 30 June 2020** | | | | | | | | | |
| David Smol | Joint Chair HVDHB & CCDHB | 5 | 2 | n/a | n/a | 5 | 4 | 1 | 1 |
| Wayne Guppy | Deputy Chair | 5 | 3 | n/a | n/a | 5 | 4 | 1 | 1 |
| Josh Briggs | Current Member | 5 | n/a | 1 | n/a | 5 | 4 | 1 | 1 |
| Keri Brown | Current Member | 5 | n/a | 1 | n/a | 5 | 4 | 1 | 1 |
| Yvette Grace | Current Member | 4 | 3 | n/a | 1 | 5 | 4 | 1 | 1 |
| Ken Laban | Current Member | 5 | n/a | 1 | n/a | 5 | 4 | 1 | 1 |
| Prue Lamason | Current Member | 4 | 4 | n/a | n/a | 5 | 4 | 1 | 1 |
| Kim von Lanthen | Member until 29 February 2020 | 3 | n/a | n/a | n/a | 5 | 4 | 1 | 1 |
| John Ryall | Current Member | 5 | 4 | n/a | 1 | 5 | 4 | 1 | 1 |
| Naomi Shaw | Current Member | 5 | n/a | n/a | 1 | 5 | 4 | 1 | 1 |
| Richard Stein | Current Member | 4 | n/a | 1 | n/a | 5 | 4 | 1 | 1 |

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

| Annual remuneration | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|
| 100,000-109,999 | 92 | 77 | 48 | 40 |
| 110,000-119,999 | 43 | 37 | 29 | 26 |
| 120,000-129,999 | 27 | 25 | 19 | 17 |
| 130,000-139,999 | 19 | 13 | 13 | 15 |
| 140,000-149,999 | 19 | 10 | 10 | 10 |
| 150,000-159,999 | 11 | 12 | 12 | 16 |
| 160,000-169,999 | 12 | 7 | 13 | 11 |
| 170,000-179,999 | 12 | 15 | 13 | 12 |
| 180,000-189,999 | 15 | 9 | 8 | 7 |
| 190,000-199,999 | 14 | 10 | 11 | 6 |
| 200,000-209,999 | 5 | 9 | 6 | 6 |
| 210,000-219,999 | 9 | 4 | 10 | 4 |
| 220,000-229,999 | 15 | 8 | 6 | 9 |
| 230,000-239,999 | 9 | 13 | 6 | 6 |
| 240,000-249,999 | 5 | 10 | 8 | 9 |
| 250,000-259,999 | 11 | 4 | 7 | 4 |
| 260,000-269,999 | 0 | 9 | 4 | 8 |
| 270,000-279,999 | 8 | 4 | 7 | 6 |
| 280,000-289,999 | 1 | 4 | 4 | 4 |
| 290,000-299,999 | 4 | 6 | 2 | 3 |
| 300,000-309,999 | 8 | 5 | 3 | |
| 310,000-319,999 | 3 | 3 | | |
| 320,000-329,999 | 1 | | 1 | |
| 330,000-339,999 | 2 | 1 | 2 | 3 |
| 340,000-349,999 | 1 | 2 | 3 | 2 |
| 350,000-359,999 | 3 | 1 | | 1 |
| 360,000-369,999 | 1 | 2 | | |
| 370,000-379,999 | 1 | | | |
| 380,000-389,999 | 2 | | 1 | 1 |
| 390,000-399,999 | 1 | 1 | | |
| 400,000-409,999 | 1 | 1 | 2 | |
| 420,000-429,999 | | | | 1 |
| 430,000-439,999 | | | | 1 |
| 450,000-459,999 | | | 1 | |
| 460,000-469,999 | | | 1 | |
| 470,000-479,999 | | | 1 | |
| 520,000-529,999 | | 1 | | |
| **Grand Total** | **355** | **303** | **251** | **228** |

### Termination payments

During the year ended 30 June 2020, 12(2019: 8) employees received compensation and other benefits in relation to cessation totalling $197,102 (2019: $128,849). The payments were in the nature of redundancy or retirement gratuities.

## 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:

| | 2020 | | 2019 | |
|---|---|---|---|---|
| | Carrying Amount | Fair Value | Carrying Amount | Fair Value |
| | $000 | $000 | $000 | $000 |
| Cash and cash equivalents | (6,059) | (6,059) | 3,783 | 3,783 |
| Debtors and other receivables | 28,393 | 28,393 | 27,822 | 27,822 |
| Creditors and other payables | 40,785 | 40,785 | 39,230 | 39,230 |
| Borrowing | 220 | 220 | 221 | 221 |
| | **63,339** | **63,339** | **71,056** | **71,056** |

### 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 2020, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2019/20, 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:

| | 2020 Actual $000 | 2019 Actual $000 |
|---|---|---|
| **Counterparties with Credit Ratings** | | |
| Cash and cash equivalents including trust funds | | |
| AA+ | 6,288 | 6,643 |
| AA- | | - |
| **Counterparties without Credit Ratings** | | |
| Existing counterparty with no defaults in the past | (11,000) | (1,451) |
| | **(4,712)** | **5,192** |
| | | |
| **Maximum exposure for each class of financial instrument:** | | |
| Cash and cash equivalents | (6,059) | 3,783 |
| Trust and bequest funds | 1,347 | 1,409 |
| Debtors and other receivables | 28,393 | 27,822 |

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 |
|---|---|---|---|---|---|
| **2019** | | | | | |
| Creditors and other payables | 36,624 | 36,624 | 36,624 | - | - |
| Finance leases | 221 | 223 | 143 | 80 | - |
| **Total** | **36,845** | **36,847** | **36,767** | **80** | **-** |

Figures for 2019 have been restated due to a reclassification of the Holidays Act Provision.

| | Carrying amount $000 | Contractual cash flows $000 | Less than 6 months $000 | 6-12 months $000 | Later than 1 year $000 |
|---|---|---|---|---|---|
| **2020** | | | | | |
| Creditors and other payables | 33,849 | 33,849 | 33,849 | - | - |
| Finance leases | 220 | 220 | 21 | 21 | 178 |
| **Total** | **34,069** | **34,069** | **33,870** | **21** | **178** |

# 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 2020 are provided below.

**Statement of Comprehensive revenue and expense**

The Hutt Valley DHB recorded a deficit of $20.614 (excluding one off exceptional items) compared with a budget deficit of $8.141m. The major variances were:

- Revenue for the DHB was $2.7m (0.5%) under budget due to fluctuations in the operational funding received during the year
- Expenditure for the DHB was $9.8m (1.6%) over budget due to additional costs in the Outsourced Services and Personnel relating to the cost of nursing one on one care and additional staff requirements for the COVID-19 Pandemic.

Two exceptional items included an increase in the provision for the Holidays Act remediation of $18.170m and a $19.866m increase in the Revaluation reserve for Land and Buildings.

## Statement of Financial Position

- Current Assets were $5.1 (17.1%) lower than budget due to a decrease in the Cash and Cash equivalents on Hand resulting in the increased payments to outsourced suppliers over the COVID-19 Period.
- Non-Current Assets were $7.5m (3.1%) higher than budget due to higher than budgeted spend in the intangible assets ($8.9m) and less in other areas of capex spend ($1.4m).
- Current Liabilities were $39.0m (56.7%) due to the Holiday Act Provision ($27.5), Income in Advance for IDF Movements ($2.4m), increase in the actuarial valuations of leave held ($1.8m) and an increase in creditor relating to the increased expenses as above ($6.9m).
- Non-Current Liabilities were $5.9m (36.0%) lower than budget due to Trust payments being accrued and higher than budget.

## Statement of Cash Flows

Payments to suppliers and staff have been higher than budget as per above hence the decrease in the cash position.

# 28 Cost of service statements for output classes

***For the year ended 30 June 2020***

| $000s | Prevention | | | Early Detection & Management | | | Intensive Assessment & Treatment | | | Rehabilitation & Support | | | Hutt Valley DHB | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2019\20 Actual | 2019\20 Budget | 2018\19 Audited | 2019\20 Actual | 2019\20 Budget | 2018\19 Audited | 2019\20 Actual | 2019\20 Budget | 2018\19 Audited | 2019\20 Actual | 2019\20 Budget | 2018\19 Audited | 2019\20 Actual | 2019\20 Budget | 2018\19 Audited |
| **Income** | | | | | | | | | | | | | | | |
| Operating Income | 21,862 | 25,543 | 20,485 | 289,663 | 158,148 | 284,110 | 225,028 | 337,190 | 214,676 | 56,710 | 74,694 | 55,161 | 593,263 | 595,574 | 574,432 |
| Interest Income | 23 | 28 | 23 | 15 | 18 | 15 | 119 | 503 | 415 | 1 | 1 | 1 | 158 | 550 | 454 |
| **Total Income** | 21,885 | 25,570 | 20,508 | 289,678 | 158,166 | 284,125 | 225,147 | 337,693 | 215,091 | 56,711 | 74,695 | 55,162 | 593,420 | 596,124 | 574,886 |
| **Expenditure** | | | | | | | | | | | | | | | |
| Personnel Costs | 14,062 | 14,281 | 12,680 | 12,758 | 13,655 | 11,638 | 172,447 | 165,983 | 161,708 | 5,097 | 4,901 | 4,532 | 204,364 | 198,820 | 190,558 |
| Depreciation | 349 | 339 | 255 | 733 | 824 | 804 | 13,814 | 14,383 | 13,039 | 21 | 16 | 20 | 14,917 | 15,561 | 14,118 |
| Outsourced Services | 1,253 | 1,564 | 1,520 | 1,274 | 979 | 1,358 | 15,631 | 9,652 | 13,387 | 227 | 268 | 213 | 18,385 | 12,462 | 16,478 |
| Clinical Supplies | 505 | 705 | 503 | 378 | 586 | 537 | 23,288 | 21,786 | 20,884 | 1,619 | 1,325 | 1,551 | 25,790 | 24,402 | 23,475 |
| Infrastructure and Non Clinical Expenses | 618 | 535 | 549 | 761 | 989 | 818 | 31,123 | 12,473 | 24,279 | 120 | 114 | 102 | 32,622 | 14,111 | 25,748 |
| Other District Health Boards | 0 | 238 | 0 | 97,782 | 36,501 | 91,434 | 0 | 49,762 | 0 | 3,516 | 14,702 | 3,704 | 101,298 | 101,203 | 95,138 |
| Non Health Board Providers | 0 | 4,407 | 0 | 173,523 | 103,443 | 167,471 | 0 | 57,789 | 0 | 45,060 | 53,370 | 44,143 | 218,583 | 219,008 | 211,614 |
| Capital Charge | 486 | 525 | 568 | 901 | 1,067 | 1,083 | 8,854 | 11,109 | 10,351 | 17 | 18 | 20 | 10,258 | 12,720 | 12,022 |
| Interest Expense | 0 | 0 | 0 | 0 | 0 | (0) | 12 | 71 | 23 | 0 | 0 | 0 | 12 | 71 | 23 |
| Other | 488 | 554 | 289 | 566 | 578 | 560 | 4,873 | 4,717 | 4,682 | 46 | 58 | 58 | 5,973 | 5,907 | 5,589 |
| Internal Allocations | 3,942 | 4,017 | 4,014 | 3,641 | 4,263 | 4,262 | (8,471) | (9,089) | (9,097) | 890 | 810 | 821 | 2 | (0) | (1) |
| **Total Expenditure** | 21,703 | 27,163 | 20,378 | 292,317 | 162,886 | 279,964 | 261,571 | 338,636 | 239,256 | 56,613 | 75,580 | 55,164 | 632,204 | 604,265 | 594,762 |
| **Net Surplus / (Deficit)** | 182 | (1,593) | 130 | (2,639) | (4,719) | 4,161 | (36,424) | (943) | (24,165) | 98 | (885) | (2) | (38,784) | (8,141) | (19,876) |

## 29 Holidays Act 2003

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, the Hutt Valley DHB recognises it has an obligation to address any historical non-compliance under the MOU it has engaged Ernst & Young (New Zealand) to estimate the value of this liability. This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

## 30 COVID-19

On 11 March 2020 the World Health Organisation declared a global pandemic as a result of the outbreak and spread of COVID-19. Following this, on Wednesday 25 March 2020 the New Zealand Government realised its Alert Level to 4, full lockdown of non-essential services, for an initial four week period. COVID-19 and its effect on the economy has the potential to affect the estimates and assumption used in the determining the carrying value of the DHB's assets and liabilities.

Note 27 includes commentary on major variances against budget, including significant variances as a result of COVID-19.

Note 9 Property, plant and equipment, incudes additional commentary on uncertainty in the carrying value of land and building due to COVID-19.

# Statement of Responsibility

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

We are responsible for any end of year performance information provided by Hutt Valley 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 2020.

Signed on behalf of the Board:

David Smol
Board Chair
18 December 2020

Wayne Guppy
Deputy Board Chair
18 December 2020

# Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

**Independent Auditor's Report**

**To the readers of the**
**Hutt Valley District Health Board's financial statements and performance information for the year ended 30 June 2020**

The Auditor-General is the auditor of the Hutt Valley District Health Board (the Health Board). The Auditor-General has appointed me, Andrew Clark, 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.

We have audited:

- the financial statements of the Health Board on pages 77 to 110, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 54 to 76.

## Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matters described in the Basis for our qualified opinion section of our report, the financial statements of the Health Board on pages 77 to 110:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; 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.

## Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 54 to 76:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2020, 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 appropriations; 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 18 December 2020. This is the date at which our qualified opinion is expressed.

The basis for our opinion is explained below, and we draw 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.

## Basis for our qualified opinion on the financial statements and unmodified opinion on the performance information

As outlined in Note 29 on page 110, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

During the 2019 financial year-end audit, we were unable to obtain sufficient appropriate audit evidence to determine whether the amount of the Health Board's provision of $9 million as at 30 June 2019 was reasonable, because of the work that was yet to be completed to remediate these issues. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

The Health Board made progress during the 30 June 2020 year in estimating the amount of the provision and we have been able to obtain sufficient appropriate audit evidence that the provision of $28 million as at 30 June 2020, is reasonable. However, until the process is completed, there are uncertainties surrounding the amount of the provision.

Our opinion on the current period's financial statements is qualified because of the possible effects of this matter on the comparability of the current period's provision and the 2019 provision.

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 the basis for our qualified opinion on the financial statements and the basis for our unmodified opinion on the performance information.

## Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements.

## The Health Board is reliant on financial support from the Crown

Note 1 on page 81 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Health Board will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Health Board over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

## Impact of Covid-19

Note 30 on page 110 of the financial statements and page 55 of the performance information outlines the impact of Covid-19 on the Health Board.

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

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

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

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

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

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

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

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

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

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

## Other information

The Board responsible for the other information. The other information comprises the information included on pages 2 to 111, 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: 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.

Andrew Clark
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

# Ministerial Directions

Hutt Valley District Health Board complies with the following Ministerial Directions:

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

# Directory

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

**Board Members as at 30 June 2020**

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 February 2020.

| | |
|---|---|
| **David Smol, Joint Chair Hutt Valley and Capital Coast DHBs** | **Ken Laben** |
| **Wayne Guppy, Deputy Chair** | **Prue Lamason** |
| **Josh Briggs** | **John Ryall** |
| **Keri Brown** | **Naomi Shaw** |
| **Yvette Grace** | **Richard Stein** |

**Executive Leadership Team for Hutt Valley DHB as at 30 June 2020**

| | | | |
|---|---|---|---|
| **Fionnagh Dougan** | Chief Executive Officer Hutt Valley and Capital Coast DHBs | **Judith Parkinson** | General Manager – Finance and Corporate Services |
| **Joy Farley** | Director Provider Services Hutt Valley and Capital Coast DHBs | **Debbie Gell** | 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 Hutt Valley and Wairarapa DHBs |
| **Christine King** | Director of Allied Health, Scientific & Technical | **Rachel Haggerty** | Director Strategy Planning and Performance Hutt Valley and Capital Coast DHBs |
| **Declan Walsh** | Director People, Culture and Capability Hutt Valley and Capital Coast DHBs | **Tracy Voice** | Chief Digital Officer, 3DHB |
| **Nigel Fairley** | General Manager, Mental Health, Addictions and Intellectual Disabilities, 3DHB | **Nicola Holden** | Director of the Office of the Chief Executive |
| **Debbie Barber** | Interim Director of Communications Hutt Valley and Capital Coast DHBs | | |

| 3DHB Disability Support Advisory Committee as at 30 June 2020 | | | |
|---|---|---|---|
| **'Ana Coffey (Chair)** | Capital & Coast | **Yvette Grace** | Hutt Valley |
| **Sue Kedgley** | Capital & Coast | **John Ryall** | Hutt Valley |
| **Tristram Ingham** | Capital & Coast | **Naomi Shaw** | Hutt Valley |
| **Vanessa Simpson** | Capital & Coast | **Ryan Soriano** | Wairarapa |
| **Jill Pettis** | Wairarapa | **Jill Stringer** | Wairarapa |
| **Sue Emirali** | Chair, Sub-regional Disability Advisory Group | **Jack Rikihana** | Māori Partnership Board Representative, Capital & Coast |
| **Bernadette Jones** | Chair, Sub-regional Disability Advisory Group | **To be nominated** | Iwi Relationship Board, Hutt Valley |
| **Marama Tuuta** | Chair of Kaunihera Whaikaha, Wairarapa | **To be nominated** | Sub-regional Pacific Strategic Health Group |
| **To be nominated** | Community Māori Representative, Hutt Valley | | |

| Combined Health System Committee as at 30 June 2020 | |
|---|---|
| **Sue Kedgley (Chair), Capital & Coast** | **Ken Laban (Deputy), Hutt Valley** |
| **Josh Briggs, Hutt Valley** | **Keri Brown, Hutt Valley** |
| **'Ana Coffey, Capital & Coast** | **Chris Kalderimis, Capital & Coast** |
| **Vanessa Simpson, Capital & Coast** | **Richard Stein, Hutt Valley** |
| **Ayesha Verrall, Capital & Coast** | **Roger Blakeley, Capital & Coast** |
| **Paula King, Māori Partnership Board Representative, Capital & Coast** | **Fa'amatuainu Tino Pereira, Chair, Sub-regional Pacific Strategic Health Group** |
| **Sue Emirali, Chair, Sub-regional Disability Advisory Group** | **Bernadette Jones, Chair, Sub-regional Disability Advisory Group** |
| **Kuini Puketapu, Chair, Iwi Relationship Board, Hutt Valley** | **Teresea Olsen, Community Māori Representative, Hutt Valley** |

| Finance Risk and Audit Committee as at 30 June 2020 | |
|---|---|
| **Wayne Guppy (Co-Chair)** | **John Ryall** |
| **Yvette Grace** | **David Smol, Hutt Valley and Capital & Coast** |
| **Prue Lamason** | |