Hutt Valley District Health Board

Annual Report 2021-2022

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

HUTT VALLEY DHB

Contents

Glossary of acronyms:
CCDHB – Capital & Coast District Health Board
HVDHB – Hutt Valley 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: Three local women who have shared their journeys of getting tested to keep themselves and their whānau safe. Read about Cervical and Breast screening at: https://www.timetoscreen.nz/.

Chair and Chief Executive's Foreword

I am pleased to present Hutt Valley District Health Board's Annual Report for 2021-2022. This report outlines the progress we have made over the past 12 months towards putting patients, their whanau and the wider communities we serve at the heart the healthcare we provide.

Together with Capital & Coast District Health Board as 2DHB, and from 1 July as Te Whatu Ora – Health New Zealand, we have been working hard to further embed our partnership approach across the district, with a shared focus on safe, high-quality services and equitable health outcomes for all those in our care.

There has been considerable change over the past 12 months, with the formal disestablishment of 20 District Health Boards across the motu, including our own, and the establishment of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority. Throughout, our hospitals have continued to manage winter illnesses, further COVID-19 peaks, disruptions to planned care and high occupancy levels, and demand for services. Our kaimahi have maintained the same high level of professionalism and dedication in providing care to communities in the face of all these pressures.

I would also like to acknowledge the work of our Board and thank members for their service. Their commitment to ensuring a sustainable financial position and the optimisation of resources has once again had a huge impact on our ability to deliver care over the past 12 months and has set us up well to make the transition to Te Whatu Ora and Te Aka Whai Ora.

The COVID-19 pandemic continued to disrupt our activities and brought unprecedented pressure onto all health care providers across the district. Throughout the 12 months, we went through two large peaks of infection that meant we had to care for more patients with COVID-19 with fewer staff, as many of our people also caught it. Our successful vaccination and Care in the Community programmes, achieved in partnership with primary care providers, community organisations and health sector partners, meant the impact was lessened in our hospitals and the community. This success built on the partnerships that had been established in the previous year between the 2DHBs and other health and community providers and groups.

With our change over to Te Whatu Ora and Te Aka Whai Ora, our vision and strategic direction has changed to reflect a regional and national view of our health system and the changes that need to happen to bring the Pae Ora (Healthy Futures) Act 2022 to life. In October 2022, Te Whatu Ora released Te Pae Tata – the Interim New Zealand Health Plan, which sets out the next two years of action to transform healthcare in Aotearoa New Zealand. This plan ensures the health system continues to provide care to New Zealanders, while we start to implement improvements in the way services are delivered and work towards the first full New Zealand Health Plan for 2024-2027.

In closing, I would like to extend a huge thanks to all our kaimahi for their incredible contribution over the past 12 months. Ehara taku toa i te toa takitahi, engari he toa takitini.

John Tait,
Interim District Director

Introduction

This final annual report of the Hutt Valley District Health Board outlines progress towards meeting its priorities and intentions under its Health System Plan 2030 and the New Zealand Health Strategy, while preparing to hand over its roles and responsibilities to Te Whatu Ora — Health New Zealand and Te Aka Whai Ora — Māori Health Authority.

Although the DHB's disestablishment and the formal establishment of the new entities did not occur until the end of this reporting year, the 12 months were a period of transition towards the new entities. We continued to integrate our services across the 2DHBs and three hospitals, along with the Kāpiti Health Centre and Rātonga-Rua-O-Porirua mental health campus through unified leadership teams and clinical collaboration. We believe this approach sets us up well for future integration of services at district and regional levels under the health reforms.

Our pro-equity approach continues to underpin the implementation of many of our services by deliberately commissioning activities and services that disrupt inequities. Distributing resources to community NGOs and services targeted at improving equity supports plans for integrated locality-based networks in primary and community care that operate to keep people well in their community. This is allowing us to prepare for the creation of localities as a fundamental part of the health system.

Maternity and neonatal care continue as a focus and saw the adoption of the 2DHB Maternity and Neonatal Health System Plan to improving these services across the region. A central feature is the redevelopment of maternity facilities at Hutt Hospital in four stages over 2022 and 2023. The Community Midwifery service moved into new office and clinical spaces this year, and construction of the Maternity Assessment Unit was well advanced. The next steps are the redevelopment of the Maternity ward (birthing and postnatal) and the Special Care Baby Unit. This work is ongoing and will be a significant improvement to maternity and neonatal services in the region.

This year we made progress on a work programme to implement the Life Lived Well mental health and addiction strategy to support the complete range of care from primary and community care through to intensive inpatient services. This has the potential to be transformational in how we support the people in our care, and we are committed to working with our partners to co-design this new approach. We finished the year preparing to open our new Manawai Mental Health, Addiction and Intellectual Disability Services facility where we will support clients with an intellectual disability or mental health condition and offending needs, who require a specialised individual living environment.

Our COVID-19 Community Response expanded this year to include boosters and tamariki 5–11-year-old vaccinations, Rapid Antigen Testing (RAT) and our Care in the Community programme. We established our Care in the Community programme in January 2022 to look after people in isolation and deliver care packages as needed. As COVID-19 cases rose, our teams distributed nearly three million RATs to community providers (1 March and 30 June 2022). With an equity approach, we continue to support our providers including outreach, mobile vaccinations, in home vaccinations, school pop-up clinics and tailored events for our Māori, Pacific, Disability and ethnic communities.

The community COVID-19 outbreaks put our hospital system under considerable pressure, particularly during the peaks in March and mid-2022. There were increasing numbers of COVID-positive patients in our hospitals, which reduced our ability to provide planned care and eventually led to the temporary suspension of most of it as a result of limited capacity in our wards. At the same time, many of our clinical and non-clinical staff were absent from work after catching COVID-19 or having to isolate as close

household contacts. Our staff responded magnificently, and many people worked outside their normal areas to ensure our critical clinical services continued to provide patients with the care they needed.

We have been creating detailed plans to ensure we deliver equitable and contemporary models of care in modern spaces, in a clinically and financially sustainable way. We are addressing issues of inequitable access and health outcomes, an ageing population, and increasing complexity and demand for healthcare. These issues are compounded by capacity constraints and ageing infrastructure. We are taking a whole-of-system approach that involves collaboration with partners across both Hutt Valley and Capital & Coast DHBs, to support the development of a Hospital Network that brings together systems and services.

The news that a seismic assessment of the Heretaunga Building in Hutt Hospital showed it would be considered earthquake prone under law was unexpected. Heretaunga Block accounts for 25 percent of adult inpatient spaces across Hutt, Wellington Regional and Kenepuru Community Hospitals. It also houses the bulk of Hutt Hospital's services so major remedial work on the building could have an impact on services across the region. Our clinical, operational and technical staff began work with hospital design consultants on options for delivering our services while remediating or replacing the building. Any solution is likely to be costly and will be considered alongside all national infrastructure projects by Te Whatu Ora, who are leading the hospital infrastructure investigation, design, and delivery across the motu.

We were very pleased to announce the opening of Te Wao Nui in October 2022. Te Wao Nui is our new integrated Child Health Service for the region based in Wellington's new children's hospital. It has modern facilities and equipment and is designed to place tamariki, rangatahi and whānau at the centre of the service.

The staff in the organisation, and our community and other partners, remain committed to providing the best healthcare possible. There are numerous challenges, but the dedication and commitment of our people mean we remain in a good position to respond to the changes resulting from the establishment of Te Whatu Ora — Health New Zealand and Te Aka Whai Ora — Māori Health Authority.

Our Vision and Strategic Direction

Note – this covers the period 1 July 2021 – 30 June 2022.

During this year, HVDHB's focus was 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.

Our Vision for Change includes a focus on the following key strategic goals:

- Support people to live well
- Shift care closer to home
- Deliver shorter, safer, smoother care.

Our focus on achieving equity and providing an integrated seamless service is embedded in the work we do toward these strategic goals. Our Vision for Change is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

People

We are committed to developing people-focused service delivery models. There are three broad service delivery models for the main users of our health services:

- Core health care service users. Those who require any form of urgent and planned care. The health system will be acting early to prevent illness and disability and save lives.
- Maternity services users and children, young people, and their families and whānau. The health system will be providing support in these key life transitions, with a strong focus on children and young people where early action has benefits across the life course.
- People who require system coordination - including those who have long-term conditions, are becoming frail or are at the end of their life. These people have multiple needs from the health system and require the system to be easily and effectively navigated to enable them to lead their own health care.

This means recognising those who may need more help including Māori and Pacific peoples in our region, people with disabilities, people with an enduring mental illness and/or addiction, refugees and those who have fewer resources available to them.

Place

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths. It makes it easier to recognise and value community diversity, while organising a consistent system across many groups.

Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Health care has always been delivered in a variety of settings. The places where care is organised and delivered, together with increased access to better and cheaper technologies, provide the platform for a comprehensive system of care. The plan centres on the following three core care settings:

- People's homes and residential care facilities.
- Community Health Networks.
- Wellington Regional, Kenepuru Community, Hutt Valley hospitals providing specialist care for the region.

Strategic framework

We are guided by a series of strategies and plans to improve the performance of our health care system and encourage better health and wellbeing and more equitable health outcomes for all our communities. These plans keep us focused on people and places, and providing care in the appropriate settings. These strategies are available online through our websites.

Health Equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes. Achieving equity in health and wellness is a focus for HVDHB. We know that we do not do as well for Māori, Pasifika People, disabled people, those who have fewer resources available to them, and those with enduring mental illness. We are committed to improving their health outcomes and achieving equity for them. We will continue to deliver against:

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

Our focus is on improving performance, ensuring we make the best use of our available resources, and achieving equity amongst our populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we will intensify resources and support for those who need us the most, and simplify for those who need us the least.

HVDHB has a fundamental role in enabling and facilitating the health system to achieve equitable health outcomes. Partnership is key to success in achieving equitable health outcomes. We collaborate with Te Upoko O Te Ika Māori Council, the Sub-Regional Pacific Strategic Health Group, and the Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We measure and report on our progress regularly.

Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities to Māori through Te Tiriti o Waitangi, the founding document of Aotearoa. The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal, underpin the DHB's commitment to Te Tiriti, and guide the actions outlined in this annual plan. The 2019 Hauora report recommends a series of principles be applied to the primary health care system. These principles are applicable to the wider health and disability system as a whole. HVDHB values Te Tiriti and applies these the principles to our work across the health and disability system.

- **Tino rangatiratanga**: Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity**: Being committed to achieving equitable health outcomes for Māori.
- **Active protection**: Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

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. We aim to address this through targeting and driving our health services to create equity of health care for Māori, while developing partnerships with the wider social sector to support whole of system change.

Māori representation has been provided on all advisory committees and our Alliance Leadership Team, the Integrated Care Collaborative. We also have a 2DHB (HVDHB and CCDHB) Māori Council to formalise the relationship between local iwi and the DHB, build on relationships, and share aspirations and strategic directions.

Te Upoko O Te Ika Māori Council

Te Upoko O Te Ika Māori Council (TUI MC) was established in 2021 to represent hauora Māori across both HVDHB and CCDHB. TUI MC replaces both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). The purpose of TUI MC is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within HVDHB, CCDHB, and the community. TUI MC has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi.

TUI MC comprises up to two representatives each of the following iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. The Chair is appointed by TUI MC members.

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 about five years behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas. Disability is a significant issue for Māori. Nationally, approximately 200,000 Māori (26%) report having a disability.

In July 2019 HVDHB launched Te Pae Amorangi, HVDHB's Māori Health Strategy to 2027. Te Pae Amorangi is supported by this tūruapō (vision):

Mauri Ora – Whānau Ora – Wai Ora
(Healthy People – Healthy Families – Healthy Communities)

Te Pae Amorangi is centred on achieving Māori health equity, and advancing Tiriti 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.

We need to be bold and implement actions that will make a significant impact towards achieving our vision. However, we also need to be flexible enough to change direction if something is not working. There is a need to work across our communities to address the underlying causes of poor health and build a health system that achieves equitable Māori health outcomes. Progressing the implementation of Te Pae Amorangi was a focus for 2021/22.

About Hutt Valley DHB

Note – this covers the period 1 July 2021 – 30 June 2022 - before formal disestablishment of 20 District Health Boards across the motu, and the establishment of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority.

HVDHB is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000) to fund and provide health services. HVDHB funds and provides services to residents living in the Hutt Valley.

Who we are

Hutt Valley DHB covers the Te Awakairangi area – the Hutt Valley and serves approximately 161,680 people. Our District Health Board covers both Upper Hutt City and Lower Hutt City. People under 25 years of age account for 31% of the Hutt Valley population and those aged 65 years and over of age account for approximately 15%. 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; 19% of the population identify as Māori (29,960), 8% as Pacific peoples (12,910) and 73% as New Zealand European, Asian and Other (118,810).

There are 35,000 people estimated to live with a disability in the HVDHB region. This is expected to increase by 2030/31 and partially reflects our ageing 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. This is particularly so for Māori, Pacific people, refugees, disabled people and those living with a mental illness.

Our total population is expected to grow over the next 10 years (5% or 8,500 people), although there are both short- and long-term plans for housing development in Lower Hutt and Upper Hutt. However, there will be a significant increase in the number of older people, with current projections suggesting that in 2030/31 almost one in five people will be aged over 65 years. The population aged over 80 will grow by almost 41%. The overall number of children is expected to decline.

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 45% between 2000 and 2018, and more than half of our population (51%) 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. 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. We have a range of contracts 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 over 1,700 FTE and has an annual budget of $665 million.

Sub-Regional services

HVDHB provides services to the people of Capital & Coast District Health Board (CCDHB) and Wairarapa District Health Board (WrDHB) under 2DHB (HVDHB and CCDHB) and 3DHB (WrDHB, HVDHB and CCDHB) models.

HVDHB and CCDHB serve populations that are geographically co-located. CCDHB provides more services to the HVDHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at HVDHB.

An estimated 327,540 people live in CCDHB. This is projected to grow by 17,160 people by 2030/31; a 5% increase. CCDHB's population has less ethnic diversity compared to HVDHB. In contrast to HVDHB, CCDHB has relatively low proportions of people who live in the most deprived neighbourhoods.

A further 49,140 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 2,015 people (4%) by 2030/31.

Response to COVID-19

Our COVID-19 Community Response expanded this year to include boosters and tamariki 5-11 year old vaccinations, Rapid Antigen Testing (RAT) and our Care in the Community programme.

In mid-February 2022, we reached our goal of 90 percent of eligible Māori in the Hutt Valley DHB who have had their second dose. This is a testament to the hard work from Primary Health Providers, Māori Providers, Pacific Providers, Aged Residential Care (ARC) and pharmacies along with many vaccinating general

practices.

We established our Care in the Community programme in January 2022, working closely with providers, local government and the Ministry for Social Development to look after people in isolation and to deliver care packages as needed.

As COVID-19 cases rose, our testing programme ramped up with the change to RAT testing (also continuing some PCR testing). Between 1 March and 30 June 2022 we distributed nearly 3 million RAT tests to community providers including RAT distribution sites, Māori Health providers, Marae, Pacific Providers, NGO's, Pharmacies, Community Hubs, Libraries and businesses.

With an equity approach, we continued to support our providers including outreach, mobile vaccinations vans, in home vaccinations, school pop-up clinics and specific events for our Māori, Pacific, Disability and ethnic communities.

Māori-led clinics continued to operate effectively, providing a Kaupapa Māori approach to vaccinating, testing and care in the community, incorporating an all-of-whānau approach. Tailored events made vaccinations as accessible as possible, including the drive-through event at SKY stadium in August 2021. Over 42 accessible, low sensory events were held across 2DHB for disabled people and those with impairments or long-term conditions. These events offered more space, with fewer people and NZSL interpreters.

Our district is diverse with people from across the MELAA (Middle East, Latin American, and Africa) and Asian communities. We worked closely with the Ministry for Ethnic Communities and established ongoing relationships with community groups and organisations to deliver vaccinations, RATs and masks to the community including former refugees with the help of organisations like Red Cross, Kiwi Class and ChangeMakers.

Vaccination remains an important tool to protect our people from getting very sick with COVID-19. At 6 June 2022, we reached over 74 percent for the Hutt Valley DHB and 79 percent for boosters across the Capital and Coast DHB. While 68 percent of tamariki 5-11 year olds in Capital and Coast DHB had their first dose and 64 percent in the Hutt Valley. 51 percent of Māori and 51 percent of pacific children had their first dose in Capital and Coast DHB, with 46 percent Māori and 54 percent pacific people in the Hutt Valley DHB.

A pop-up clinic at St Bernadette's School in Naenae, by Kōkiri Marae Health Services proved popular with parents. Jo Buckley, Principal, said, "Our school community looks after each other, and the school wanted to offer additional vaccination opportunities this winter."

Vaccination and testing data is available on page 43.

Governance of Hutt Valley DHB

Role of the Board

The Hutt Valley District Health Board was responsible for the governance of the organisation and was accountable to the Minister of Health until the Board was disestablished on 30 June 2022. It has been replaced by Te Whatu Ora Health New Zealand, which has taken over the planning and commissioning of services and the functions of the 20 former DHBs.

The DHB's governance structure was set out in the New Zealand Public Health and Disability Act 2000. The Board had eleven members. Seven were elected. Four were appointed by the Minister of Health (including the Chair and Deputy Chair).

Role of the Chief Executive

The board delegated to the chief executive on such terms and conditions as were 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 endorsed 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 took a whole-of-health-system approach, including integrating clinical and support services where this provided benefits across the health system. Each board provided governance of local services and all three boards provided 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 to progress service design.

Our People

Against the backdrop of COVID-19, the Government Mandates and the Health Sector reforms our focus and priorities were on operational excellence, staff wellbeing and developing our Māori cultural competence and confidence.

Operational excellence

This included continuing to align our systems and processes across Hutt Valley and Capital, Coast Districts, many of which are significantly disparate; transitioning our training and learning programmes from predominantly face to face delivery to an e-learning and online environment; streamlining staff access to our Learning Management systems and improving their user experience; and redeveloping and realigning our Orientation programmes across both site to reflect a more consistent experience, a clear focus on Equity, cultural safety and ensuring our strategic, organisational and legislative training and learning obligations are fulfilled.

Staff wellbeing

A significant focus has been on supporting the wellbeing of our staff including development of policies and procedures that provide for more flexible working conditions and staff safety (such as Family Violence and de-escalation training). We have also increased our accessibility to our Employee Assistance Programme (EAP) and as part of our commitment to improve options, care, experience and outcomes for Māori and Pasifica staff we are in the early stages of piloting Mirimiri wellbeing services which is complementary to our EAP service (see photo below). Mirimiri is culturally grounded care that weaves a te ao Māori approach through all aspects of the service.

In addition, during 2022 we established a six month pilot programme of influential Wellbeing whakaihuwaka (champions) whose primary role is to effectively drive holistic staff wellbeing and assist staff to manage COVID-19 psychosocial fatigue.

Cultural Competence and Confidence

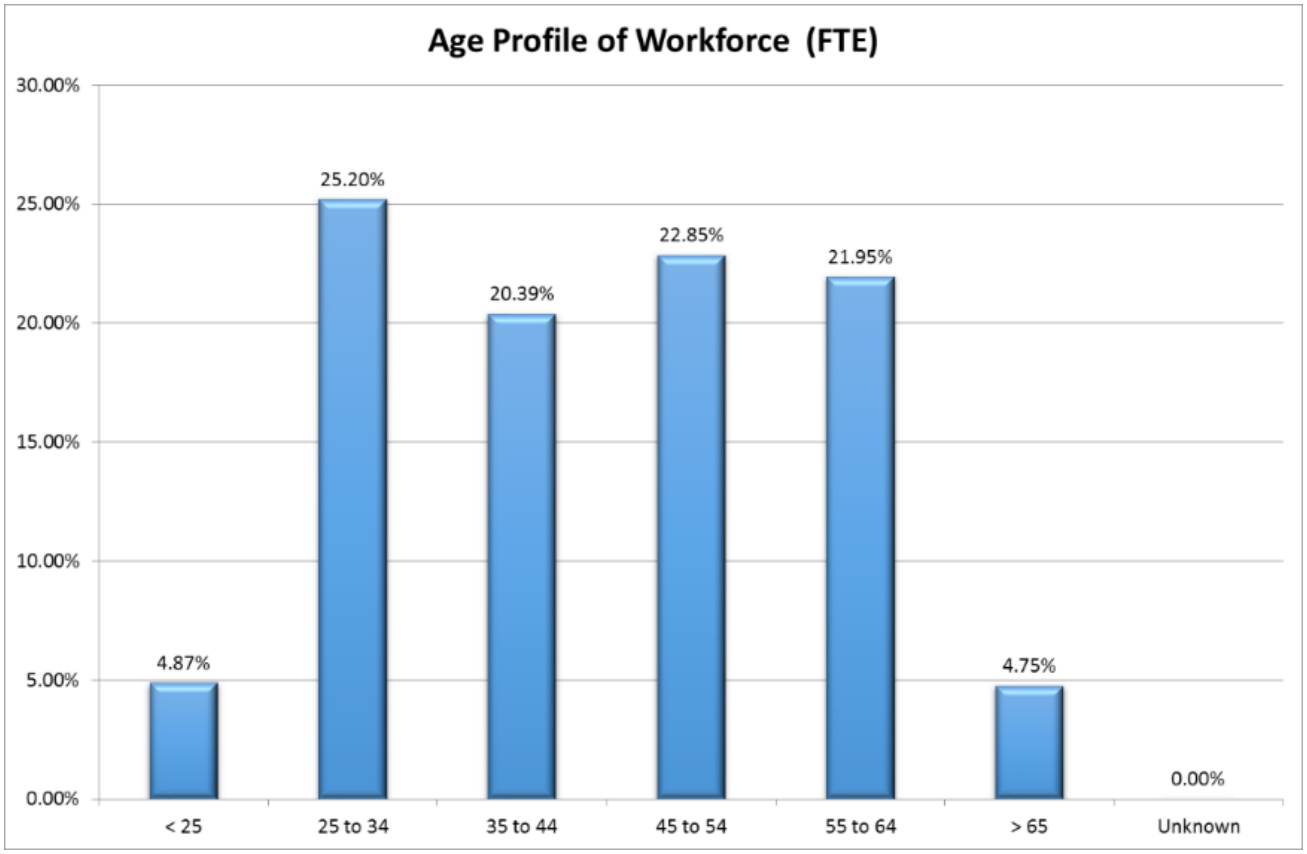
Early in 2022 all Executive Leadership Team (ELT) and senior staff were invited to attend the "Wall Walk"– a unique Māori Cultural workshop designed to raise collective awareness of key events in the history of New Zealand's bi-cultural relations. We also conducted our first Cultural Capability and Confidence survey underpinned by the Te Arawhiti Cultural Capability Framework.

Results will be used to inform our District cultural capability and development programme for the 2022/23 financial year.

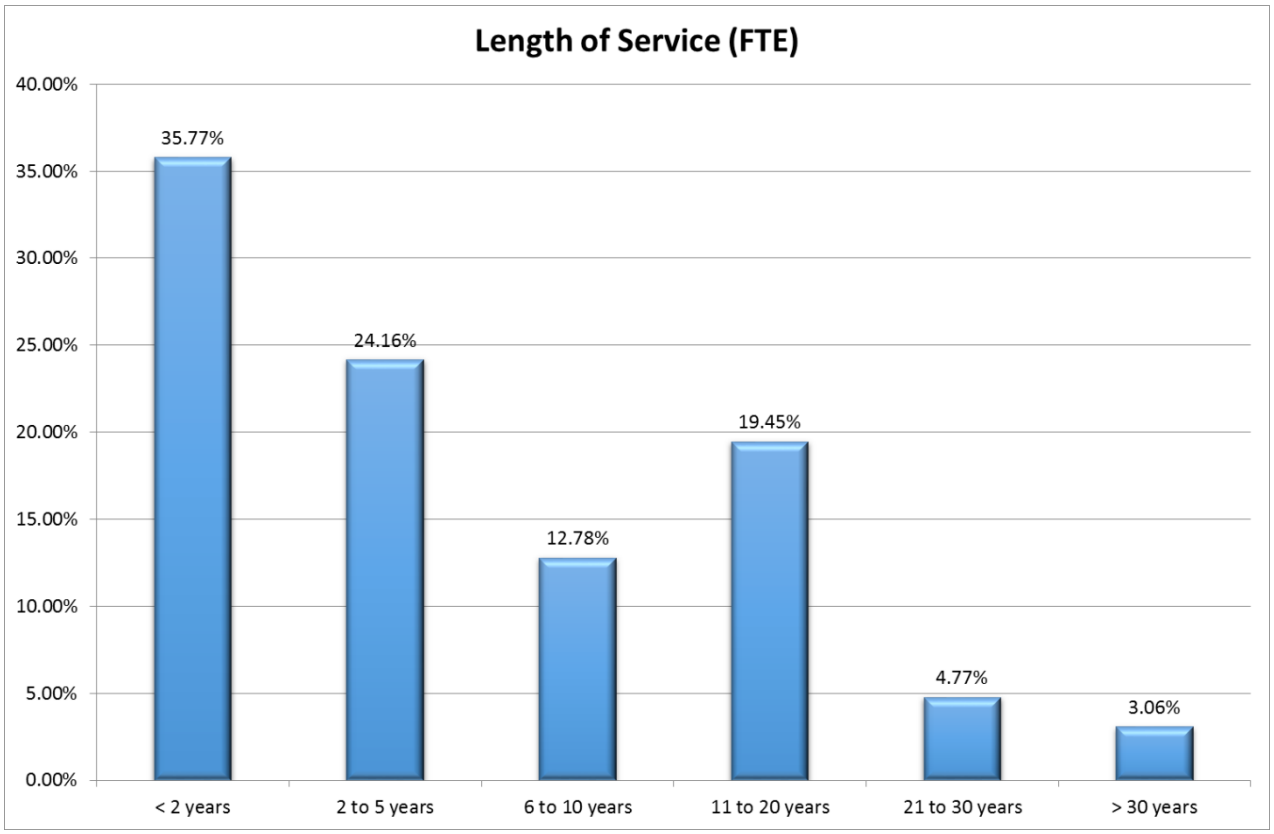
Workforce Profile

Full Time Equivalent staff numbers

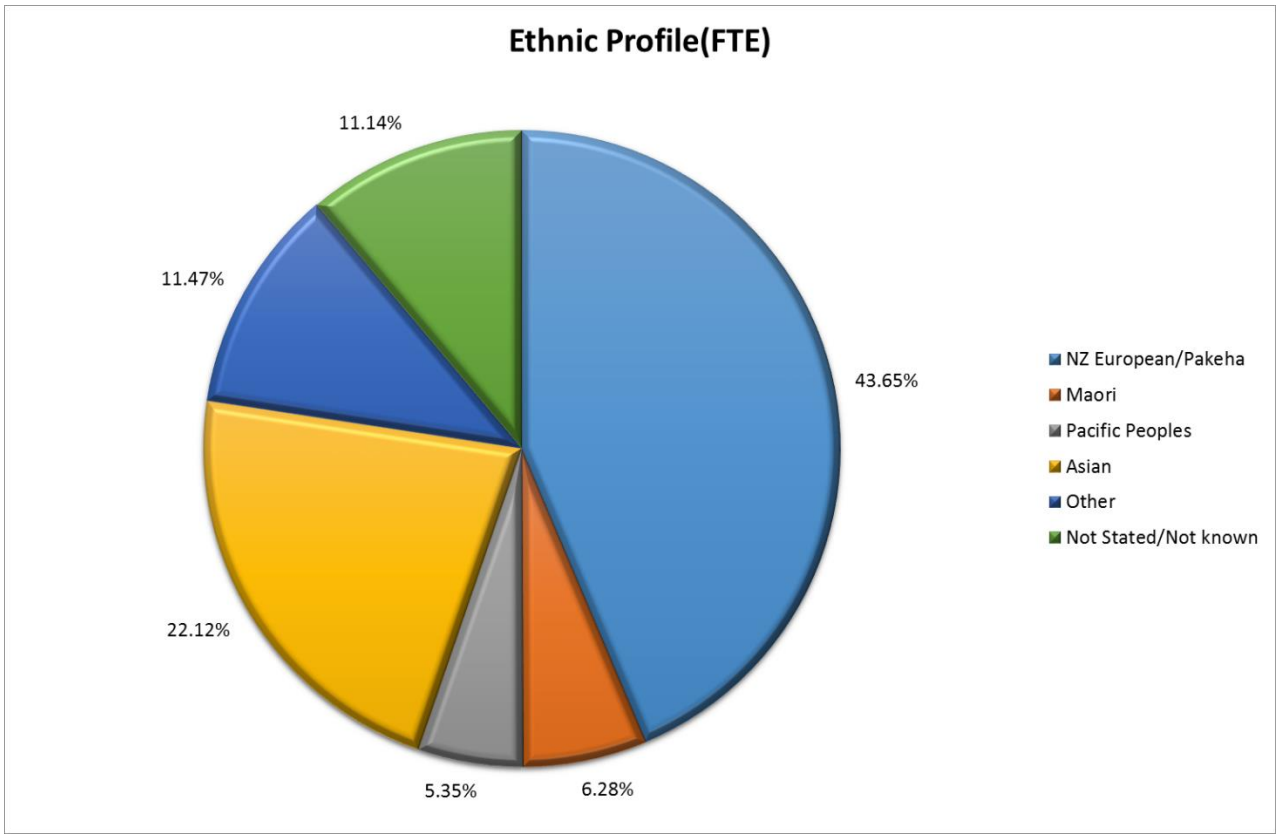
	2022	2021	2020	2019	2018	2017	2016	2015	2014
Medical	265	259	297	253	268	244	236	246	232
Nursing	701	683	735	707	709	696	696	755	717
Allied Health	347	370	398	409	410	395	401	440	428
Other	397	421	461	457	450	427	410	442	434
Total	1710	1,733	1,891	1,826	1,837	1,762	1,743	1,883	1,811



Length of Service



Statistics by Ethnicity



Statistics by gender

Gender	2022	2021	2020	2019	2018	2017	2016	2015	2014
Female	80 %	81 %	79 %	81%	82%	80%	81%	81%	81%
Male	19 %	18%	20%	18%	18%	19%	18%	18%	18%

Being a Good Employer

Hutt Valley DHB are committed to being a good employer that provides equal opportunities and create an environment where employees feel valued and respected, and where difference is celebrated and diversity encouraged.

Hutt Valley DHB aspires 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.

The heart of the health system is its people. A safe and supporting environment enables the delivery of high quality, compassionate and safe care to our communities.

Our Progress

This section outlines our activities and progress under the three key strategic directions in *Our Vision for Change* [1]: Support People Living Well; Shift Care Closer to Home; Deliver Shorter, Safer and Smother Care.

Support People Living Well

Supporting people living well means

- We invest in helping people and whānau 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

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.

Increasing our Māori Workforce

Māori and Pacific workforce development and recruitment is a national priority. We aim to actively grow a Māori workforce that reflects our population. We have developed a Māori Workforce Recruitment Policy that operates across HVDHB and CCDHB. This has improved the way we recruit by making the process culturally appropriate. The policy ensures that all advertisements are designed to attract Māori applicants and 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.

Pro-Equity Commissioning

We have developed and begun to implement a Pro-Equity People Based Commissioning Policy, which is focussed on commissioning activities and services to disrupt inequities. The policy includes a focus on achieving equitable access and outcomes for our Māori, Pacific, and disabled populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we intensify resources and support for those who need us the most, and simplify for those who need us the least. In line with this approach, we have begun to redistribute resources to community NGOs

[1] Our Vision for change is located on the DHB website. https://www.huttvalleydhb.org.nz/about-us/vision-mission-values/our-vision-for-change-2017-2027/

and services targeted at improving equity. Implementing the Pro-Equity Commissioning across both DHBs has helped us provide plans for integrated locality-based networks in primary and community care.

Agreement recognising Te Tiriti o Waitangi

We work closely with Māori to achieve jointly agreed goals and we value partnership with Iwi. Te Upoko O Te Ika Māori Council has represented Hauora Māori and contributed to planning and developing our services across HVDHB and CCDHB. Last year an agreement was signed between Te Rūnanganui o Āti Awa ki te Upoko o te Ika a Maui Inc, Te Rūnanga o Ngāti Toa Rangatira, and the two DHBs. This agreement recognises the two parties to Te Tiriti o Waitangi – iwi/hapū Māori, in this case represented by mana whenua, and the Crown as represented by the two DHBs. Te Whanganui a Tara Mana Whenua Health Working Group is established under the partnership agreement and has helped us implement initiatives and projects to reduce the health inequities that exist between Māori and non-Māori within the rohe of Ngāti Toa and Āti Awa ki te Upoko o Te Ika a Māui.

Mothers, babies, children and young people

We are focused on improving health outcomes for mothers, babies, children and young people, alongside strengthening the quality of the overall system of care available to keep families well. While many mothers, babies, children and young people across our DHBs enjoy better health outcomes than those people in other parts of New Zealand, there are some groups, in some localities, who experience persistent inequitable outcomes. We actively prioritise initiatives that redress these inequities. This involves adopting a range of approaches, including consumer-led procurement; co-design of services; pro-equity approaches to resource allocation; and using person-centred insights, analytics and evaluations to inform future commissioning decisions.

We recognise the need to lift our childhood immunisation rates, particularly for tamariki Māori. In 2021, we commissioned a review of the 2DHB immunisation service delivery model, which has provided recommendations to deliver a more integrated, whānau-centred immunisation delivery model across all immunisation programmes.

Maternity and Neonatal Health

Our 2DHB Maternity and Neonatal Health System Plan was endorsed by the 2DHB Board in December 2021. The System Plan will deliver a whole-of-system approach to improving maternal and neonatal care for all families in our region, with a pro-equity focus on actions to improve outcomes for Māori and Pacific whānau and families, and disabled women and babies with impairments.

We have contributed to the establishment of the Hapū Whānau maternity hub in Porirua being led by Ngāti Toa to deliver community-based maternal care for Hapū Whanau. In addition, we contracted a provider to develop a 3DHB web-based resource on the Pēpē Ora website that provides information on DHB and community maternity and neonatal services, to improve access to these services and enable families to make informed decisions about their care.

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 are focused on lifting our breast and cervical screening rates for Māori and Pacific women. Breast and cervical screening is provided at Wellington Regional Hospital, and we fund general practices to provide free cervical screening.

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 have been well attended and helped women access screening.

Mental Health and Addictions Strategy

Living Life Well – A Strategy for Mental Health and Addiction 2019-2025 sets the direction for mental health and addictions services across Wellington, the Hutt Valley and Wairarapa. 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.

Improving sustainability and reducing carbon emissions

We continue to make positive changes that reduce carbon emissions and improve recycling. We purchase 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 have also moved 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 hospital fleet petrol vehicles with more environmentally friendly hybrid vehicles. Additionally we now have Electric Bikes for staff use, reducing the need to use cars even further.

HVDHB is in a Collaborative Partnership with EECA and set an estimated target of energy savings or renewable energy conversion in the order of 2 gigawatt hours per year. As part of this Collaboration Partnership, EECA is assisting with part funding of the investigation and implementation of opportunities, such as completing the replacement of fluorescent lights with LED lights, improving building management system control of heating and cooling plant, and ground source heat pumps and electric heat pumps to replace gas fired equipment.

3DHB[2] Sub-regional Pacific Strategic Advisory Group

Our Pacific Health directorate works with our Pacific communities to improve health outcomes and reduce inequalities experienced by Pacific peoples. We have a 3DHB Sub-regional Pacific Strategic Advisory Group

[2] 3DHB refers to three district health boards; Capital and Coast DHB, Hutt Valley DHB, and Wairarapa DHB.

that provides strategic support, advice and advocacy regarding Pacific people's health outcomes. Through extensive consultation with our Pacific communities, in 2020 we developed a *Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025*, which has guided the development of pro-equity actions to improve Pacific health and wellbeing. We have directed additional resources to embed learnings from the Pacific COVID-19 response and enhance our community services to Pacific peoples. New services commissioned include a Pacific community nursing service, health promotion and service information targeted to Pacific communities, affordable after hour's health care for Pacific people, a culturally responsive Stroke prevention and treatment service, and additional Pacific disability support service capacity.

3DHB Disability working group

Our 3DHB disability working group is highly regarded amongst the local disability community. The group helps us to apply a disability perspective into the development and delivery of health services for equitable outcomes. We are working with healthcare providers to rethink what 'access' means for disabled people. Commissioned services are now reporting on their actions to improve access for disabled people in their services. This mechanism has encouraged collaboration with providers to make our services more accessible for disabled people in the community.

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.

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. The team also provides a pre-visit to early childhood centres to familiarise and socialise the children to its staff and provide information to teachers and parents. This helps 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 75,000 school children every year.

Progress Measures to Support People Living Well

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not Achieved, but progress made	≤10% of target	●
Not Achieved	≥ 10.1% of target	●
Demand-drive measure	No rating applied	●

Progress Measure	Baseline	Target 2021/22	Actual 2021/22	Trends – including equity gap	
Amenable mortality rates (rate per 100,000)	2017: Māori: 195.6 Pacific:* Total: 98.2	Reducing Trend (Māori and Pacific)	2018: Māori: 144.3 Pacific:* Total: 80.1	Māori	🟢
				Pacific	-
Babies breastfed at 3 months	2020/21 Māori: 47% Pacific: 45% Total: 58%	≥70%	Māori: 56% Pacific: 50% Total: 61%	Māori	🔴
				Pacific	🔴
				Total	🟠
Children fully immunized at 2 years	2020/21 Māori: 81% Pacific: 90% Total: 89%	≥95%	Māori: 75% Pacific: 81% Total: 86%	Māori	🔴
				Pacific	🔴
				Total	🟠
Children with no cavities at 5 years of age	2020: Māori: 46% Pacific: 27% Total: 60%	≥65%	2021 Māori: 50% Pacific: 34% Total: 64%	Māori	🔴
				Pacific	🔴
				Total	🟠
Average number Diseased, Missing and Filled Teeth (DMFT) at age 5	2020: Māori: 2.43 Pacific: 4.50 Total: 0.64	<0.59	2021 Māori: 2.31 Pacific: 3.78 Total: 1.65	Māori	🟢
				Pacific	🟢
				Total	🔴
Reduced burden of tooth decay at year 8 (DMFT)	2020: Māori: 0.88 Pacific: 1.10 Total: 0.67	≤0.59	2021 Māori: 1.01 Pacific: 0.98 Total: 0.72	Māori	🔴
				Pacific	🔴
				Total	🔴
Women screened for cervical cancer	2020/21 Māori: 65% Pacific: 67% Total : 71%	≥80%	Māori: 60% Pacific: 60% Total: 67%	Māori	🔴
				Pacific	🔴
				Total	🔴
Women screened for breast cancer	2020/21 Māori 66% Pacific 68% Total : 72%	≥70%	Māori: 65% Pacific: 63% Total: 71%	Māori	🟠
				Pacific	🟠
				Total	🟢
PHO enrolled patients who smoke and are offered help to quit	2020/21 Māori: 86% Pacific: 88% Total: 87%	≥90%	Māori: 80% Pacific: 79% Total: 81%	Māori	🟠
				Pacific	🔴
				Total	🟠
% of babies living in Smokefree homes at 6 week check	2020 Māori 42% Pacific 38% Total : 58%	Improved performance	Māori: 39% Pacific: 35% Total: 56%	Māori	🟠
				Pacific	🟠
				Total	🟠
% of eligible population having cardiovascular disease (CVD) risk assessment in last 5 years	2020/21 Māori: 79% Pacific: 80% Total: 80%	≥90%	Māori: 76% Pacific: 80% Total: 78%	Māori	🔴
				Pacific	🟠
				Total	🟠

*Suppressed due to actual volume being below 30.

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.

Supporting the development of Localities

The Pae Ora (Healthy Futures) Act 2022 enables the establishment of localities as the mechanism to align services to the particular needs of a community. Localities are geographically defined areas that are determined by Te Whatu Ora (Health New Zealand), in agreement with Te Aka Whai Ora (Māori Health Authority) and locality stakeholders, for the purpose of arranging services. Around 60 to 80 localities will be established in communities around the Aoteroa by July 2024.

We are supporting the development of localities by providing start-up funding and staff expertise. Our learnings from COVID have provided us with a strong foundation to develop localities. Through the COVID experience we have strengthened relationships with our communities, particularly our Māori and Pacific providers and the disability community. We have also developed a successful Care-in-the-Community' model that is 'equity driven, locality led, and manaaki focused'. We are building on this model, supporting the newly appointed Iwi Māori Partnership Board - Āti Awa Toa Hauora Partnership Board, and working with our communities to develop our localities.

Porirua has been confirmed as one of the first areas in New Zealand to roll out the locality approach (with eight other areas). Planning for the establishment of the Porirua locality prototype is underway, including for governance, operating model and the development of a detailed project plan. We are also supporting the Kāpiti Community Health Network to transition to a locality under the new system, and working with Te Āti Awa and Kōkiri Marae to set up locality functions in Hutt Valley.

Three Year Plan for Planned Care Services

We are implementing our Three Year Plan for Planned Care Services, which was developed 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 care across the system, and removing financial disincentives for delivering planned care outside of the hospital setting.

The plan was developed in collaboration with CCDHB 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, encouraging provision non–surgical care alternatives in community settings, creating incentives to implement innovative models of care, and increasing the volume and range of interventions to meet changing population health needs.

Health Care Homes

We have invested in the sustainability and enhancement of primary care through the Health Care Home (HCH) model of care across CCDHB and HVDHB. The HCH is a team-based health care delivery model, led by primary health clinicians. The evaluation of the model suggests that acute need is being prevented or successfully dealt with out of hospital by HCH practices.

One of the key aims behind the Health Care Home is to support practices to create more capacity to better manage growing patient demand, and to more proactively manage those patients with complex needs alongside community services teams, who may also be high users of acute hospital services.

The HCH model includes a telephone triage service, where patients calling the practices may talk directly to a registered health professional, typically a general practitioner. Talking to a health professional means some issues may be resolved over the phone, saving people the time and effort 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. HCH practices also offer telehealth options as alternatives to face-to-face appointments where appropriate, making healthcare more affordable and accessible.

Providing better support for people experiencing family violence

We commissioned ThinkPlace to help us design better support for health professionals and people with lived experience of family violence, post-disclosure in our hospitals. The design team included Equity Leads for Hauora Māori, Pacific Health and Disability.

A report has been completed with recommendations to improve support to victim/survivors. Recommendations include extending availability of social work after hours at Wellington Regional Hospital and Hutt Hospital, and establishing a new District-wide Family Violence specialist social worker role to lead improvements in consistent, culturally responsive, helpful responses to disclosures.

We have also worked with the People and Culture team to develop a new staff policy for employees who are experiencing family violence. The policy will be released with a suite of education and messaging to support the new policy.

Progress Measures for Shifting Care Closer to Home

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not Achieved, but progress made	≤10% of target	●
Not Achieved	≥ 10.1% of target	●
Demand-drive measure	No rating applied	●

Progress Measure	Baseline	Target 2021/22	Actual 2021/22	Trends – including equity gap	
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	Māori: 6862 Pacific: 9381 Total: 5951	Māori ≤11,277 Pacific ≤17,021 Total ≤8,505	Māori:7534 Pacific:12828 Total:7139	Māori	🟢
				Pacific	🔴
				Total	🟢
ASH Rates (avoidable hospitalisations) for 45-64 years	Māori: 6887 Pacific: 7564 Total: 4179	Māori ≤4340 Pacific ≤4340 Total ≤4340	Māori:6879 Pacific:6288 Total:4285	Māori	🔴
				Pacific	🔴
				Total	🟢
Well-managed diabetes in primary care	Māori: 48% Pacific: 47% Total: 58%	≥70%	Māori: 49% Pacific: 46% Total: 57%	Māori	🔴
				Pacific	🔴
				Total	🔴
Acute hospital bed days per 1,000	Māori: 497 Pacific: 495 Total: 324	Māori: ≤ 542 Pacific: ≤ 596 Total: ≤ 386	Māori:514 Pacific:476 Total:350	Māori	🟢
				Pacific	🟢
				Total	🟢
Acute readmissions to hospital	Māori: 14% Pacific: 11% Total: 12%	Reducing Rate	Māori: 12% Pacific: 11% Total: 12%	Māori	🟢
				Pacific	🟢
				Total	🟢
Acute readmissions to hospital age 0-4	Māori: 14% Pacific: 17% Total: 15%	Reducing Rate	Māori: 14% Pacific: 11% Total: 14%	Māori	🟢
				Pacific	🟢
				Total	🟢
PHO enrolment	Māori: 84% Pacific: 94% Total: 94%	≥95%	Māori: 83% Pacific: 93% Total: 93%	Māori	🔴
				Pacific	🟠
				Total	🟠
Newborn PHO enrolment	91%	≥85%	88%	Total	🟢
Proportion of dispensed asthma medications that were a preventer rather than reliever	58%	Increasing Trend	60.5%	Total	🟢
Cancer mortality	2014-2018 222	Decreasing Trend	2018: 509	Total	🔴
Decrease in avoidable hospitalisation for cardiovascular disease	Māori: 346 Pacific: 225 Total: 2,468	Decreasing Trend	Māori: 407 Pacific: 233 Total: 3732	Māori	🔴
				Pacific	🟠
				Total	🔴
Decrease in avoidable hospitalization for Chronic Obstructive Respiratory Disease	Māori: 95 Pacific: 24 Total: 373	Decreasing Trend	Māori: 94 Pacific: 28 Total:405	Māori	🟢
				Pacific	🔴
				Total	🟠

Deliver Shorter, Safer and Smoother Care

Shorter, safer and smoother care means:

- People and whānau can communicate with a wider range of health providers electronically
- Patients, their whānau 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 whānau
- 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.

2DHB Work Programme

2DHB is a joint programme of work currently underway between HVDHB and CCDHB. This work is focussed on 3 major themes:

1. Improving patient access to healthcare - including making the system more equitable for Māori and Pacific patients
2. Working together across the two DHBs and making the most of limited resources
3. Planning together for the region, with a joined-up leadership and vision for healthcare.

Five Communities, One Vision

At the core of this change is the "five communities" vision. This is an approach that focuses on the communities that make up the communities with our DHB boundaries - Kāpiti, Upper and Lower Hutt, Porirua and Wellington. Each of these communities has its own specific set of needs and challenges, and our vision is that by planning more effectively across the whole region, we can better serve our patients and clients and improve the equitability of our system.

In this vision, our patient pathway will be simplified, particularly for patients who would previously have had to cross DHB boundary lines to receive care. At the same time we hope to make life simpler for our clinical and administrative staff, by removing some red tape along the way.

Making the most of a limited resource

Both DHBs have been making the most of what they can with the resources available to them, but it is clear that this approach will not continue to be sustainable into the future. In order to maximise the resource available to our staff and patients, CCDHB and HVDHB will be looking at areas where it makes sense to work together. This may be in areas like human resources or communications, where having a common work approach will also help in other ways.

Planning together

One of the ways we will work towards a more sustainable and equitable service is through joined-up leadership and planning. The boards of HVDHB and CCDHB have appointed a single CEO, Fionnagh Dougan, to oversee both organisations. We also have a new 2DHB leadership team that has responsibility for

healthcare in both DHBs and supports the CEO. The leadership team takes a community-focussed approach to planning. The specific needs of each community in the region are considered, and we take a patient-centric approach to service planning that ensures services are well joined-up and seamless.

The changes we are making are about making sure healthcare is easy to access and effective for all people in our five communities. We will work with everyone involved as we design the new approach. This means not just doctors and nurses, but all hospital staff, the five communities, families, patients, and external experts. The most effective change will happen when we listen to and learn from feedback.

Te Wao Nui - Child Health Service

Te Wao Nui is the name for our integrated Child Health Service that is housed in Wellington's new children's hospital building. Te Wao Nui is a new purpose-built facility that will place our child health services under one roof for the very first time.

The new children's services and inpatient facilities will offer a number of benefits, including:

- improved quality and experience of care for children and family/whānau
- a more child and adolescent friendly environment with ability for a parent/caregiver to stay by every bedside
- a larger, more functional unit for observing and assessing children
- co-location of children's services in one facility to improve coordination and teamwork
- increased ensuite bathrooms, and greater numbers of single bedrooms, to better support patient care.

The new hospital has been designed with tamariki, rangatahi and whānau at the centre. Te Wao Nui allows for the provision of high-quality services and brand new equipment. It includes an outdoor Playscape, providing a play area as well as rehabilitation. Interactive features include bongos, a climbing frame, a fort and a slide. The name, Te Wao Nui, reflects the ecosystem of integrated health services designed for tamariki, rangatahi and whānau of central New Zealand. We acknowledge Mark Dunajtschik's unprecedented and incredibly generous donation that has allowed this wonderful project to come to fruition. Te Wao Nui opened in late 2022.

New procedure suite to increase surgical capacity

We have begun constructing a new purpose-built procedure suite at Hutt Hospital. The new facility will increase the capacity of the hospital's surgical services by freeing up space in the main operating theatres. The development will include five procedure rooms (one of which is larger for laser use), dedicated patient change facilities for each procedure room, a central three lazi-boy chair recovery room with a beverage bay, and a main waiting room.

The purpose-built facility will improve patient experiences when undergoing surgical procedures under local anaesthetic. It is expected that approximately 500 surgical procedures will be undertaken in the procedure suite per year—increasing the capacity for minor surgery across the region. The new procedure suite will improve outcomes for people across the wider region and ensure that services are accessible and delivered in the most appropriate setting. The additional capacity created will address the increased demand from an ageing and growing population and improve elective surgery and cancer treatment timeframes.

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. 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).

Variance Response Management 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.

Community Mental Health and Addiction Project

This project will implement a new integrated and collaborative way of working to meet the needs of local communities. Five key changes, which will be underpinned by a pro-equity approach to commissioning:

1. Establishment of locality focussed mental health and wellbeing hubs.
2. Transforming community mental health teams into integrated locality mental health and wellbeing teams.
3. Transforming the pathways between primary care and the secondary mental health and addiction system.
4. Building peer support capability into service delivery.
5. Creating mental health and addiction locality network leadership.

Once the consultation process is completed, an implementation plan outlining the change programme for the next 12 months will be finalised. These recommendations and the implementation plan will feed into work to implement the Porirua locality prototype, which is part of the Community & Commissioning work stream.

Progress Measures for Delivering Shorter, Safer and Smoother Care

Criteria Description	Rating	Rating System
Achieved	At or above target	
Not Achieved, but progress made	≤10% of target	
Not Achieved	≥ 10.1% of target	
Demand-drive measure	No rating applied	

Progress Measure	Baseline 2020/21	Target 2021/22	Actual 2021/22	Trends – including equity gap	
Length of inpatient stay in hospital (average days)	Acute: 2.23 Elective: 1.69	Acute: 2.4 Elective: 1.5	Acute: 2.4 Elective: 1.4	Acute	
				Elective	
Time patient is in ED (6 hour discharge or transfer)	84%	95%	78%		
Waiting time to access Mental Health/ Addiction Services. (Referred and seen within 3 and 8 weeks)	Mental Health 70% < 3 wks 90% < 8 wks Addiction services 25% < 3 wks 89% < 8 wks	3 weeks: 80% 8 Weeks: 95%	<3 wks: 86% <8 wks: 96%	3 weeks	
				8 weeks	
Readmission to Mental Health services within 28 days	8%	<9%	14.1%		
Access to electives	101%	100%	107%		
Percentage of patients receiving their first cancer treatment within 31 days of decision to treat	90%	≥85%	90%		
Age of entry into age Residential Care	83.8	Increasing Trend	84		

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. Each output class includes measures that help to evaluate our performance over time, recognising the funding received, government priorities, national decision-making and board priorities.

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 HVDHB health system and help us to monitor that we are on track to achieve positive long-term outcomes.

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 following tables, we note the types of output measure, and where appropriate the results are detailed for different ethnicities.

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not Achieved, but progress made	≤10% of target	●
Not Achieved	≥ 10.1% of target	●
Demand-drive measure	No rating applied	●
No data available	No rating applied	○

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.

Output Class 1: Prevention Services

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

Immunisation					
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of eight month olds fully vaccinated	Māori	81%	≥95%	78%	●
	Pacific	86%		88%	●
	Non-Māori, Non-Pacific	95%		95%	●
	Total	90%		90%	●
% of two year olds fully immunised	Māori	81%	≥95%	75%	●
	Pacific	90%		81%	●
	Non-Māori, Non-Pacific	92%		92%	●
	Total	89%		86%	●
% of five year olds fully immunised	Māori	85%	≥95%	77%	●
	Pacific	86%		82%	●
	Non-Māori, Non-Pacific	88%		88%	●
	Total	87%		85%	●

Immunisation					
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of children aged 11 years provided Boostrix vaccination	Māori	70%	≥70%	69%	
	Pacific	66%		72%	
	Non-Māori, Non-Pacific	93%		76%	
	Total	73%		74%	
% of children (girls and boys aged 12 years) provided HPV vaccination (*one dose)	Māori	54%	≥75%	74%	
	Pacific	66%		64%	
	Non-Māori, Non-Pacific	67%		76%	
	Total	64%		74%	
% of population aged 65 years and over immunised against influenza	Māori	62%	≥75%	67%	
	Pacific	71%		69%	
	Non-Māori, Non-Pacific	62%		73%	
	Total	62%		72%	

Health Promotion Services					
These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of infants fully or exclusively breastfed at 3 months	Māori	47%	≥70%	56%	
	Pacific	45%		50%	
	Non-Māori, Non-Pacific	60%		65%	
	Total	58%		61%	
% of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention	Māori	95%	≥95%	97%	
	Pacific	95%		81%	
	Non-Māori, Non-Pacific	90%		83%	
	Total	92%		87%	
% of PHO-enrolled patients who smoke and have been offered help to quit by a health practitioner in the last 15 months	Māori	86%	≥90%	80%	
	Pacific	88%		79%	
	Non-Māori, Non-Pacific	87%		83%	
	Total	87%		81%	

Health Promotion Services					
These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of pregnant women who identify as smokers upon registration with a DHB midwife or Lead Maternity Carer offered advice to quit	Māori	65%	≥90%	54%	●
	Total	64%		50%	●

Population-based Screening Services					
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of eligible children receiving a B4 School Check	Māori	70%	≥90%	33%	●
	Pacific	80%		33%	●
	Non-Māori, Non-Pacific	92%		58%	●
	Total	86%		49%	●
% of eligible women (25-69 years old) having cervical screening in the last 3 years	Māori	65%	≥80%	60%	●
	Pacific	67%		60%	●
	Non-Māori, Non-Pacific	73%		69%	●
	Total	71%		67%	●
% of eligible women (50-69 years old) having breast cancer screening in the last 2 years	Māori	66%	≥70%	65%	●
	Pacific	68%		63%	●
	Non-Māori, Non-Pacific	74%		73%	●
	Total	72%		71%	●

Oral Health Services					
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of children under 5 years enrolled in DHB-funded dental services	Māori	94%	≥95%	93%	●
	Pacific	93%		96%	●
	Non-Māori, Non-Pacific	97%		92%	●
	Total	96%		93%	●
% of children caries free at 5 years	Māori	46%	≥65%	50%	●
	Pacific	27%		34%	●
	Non-Māori, Non-Pacific	71%		72%	●
	Total	60%		64%	●
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8	Māori	0.88	≤0.59	1.01	●
	Pacific	1.10		0.98	●
	Non-Māori, Non-Pacific	0.53		0.56	●
	Total	0.67		0.72	●
% of children (0-12) enrolled in DHB oral health services overdue for their scheduled examinations	Māori	19%	≤10%	12%	●
	Pacific	18%		9%	●
	Non-Māori, Non-Pacific	24%		10%	●
	Total	22%		11%	●
% of adolescents accessing DHB-funded dental services	Māori	53%	≥85%	50%	●
	Pacific	65%		57%	●
	Non-Māori, Non-Pacific	79%		80%	●
	Total	71%		69%	●

Output Class 2: Early Detection and Management

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.

Primary Care Services					
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of newborn enrolment with general practice by three months of age	Māori	74%	≥85%	79%	🟠
	Pacific	87%		92%	🟢
	Non-Māori, Non-Pacific	101%		91%	🟢
	Total	91%		88%	🟢
% of the DHB-domiciled population that is enrolled in a PHO	Māori	84%	≥95%	83%	🔴
	Pacific	94%		93%	🟠
	Non-Māori, Non-Pacific	97%		96%	🟢
	Total	94%		93%	🟠
% of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol	Māori	48%	≥60%	49%	🔴
	Pacific	46%		46%	🔴
	Non-Māori, Non-Pacific	62%		61%	🟢
	Total	58%		57%	🟠
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Māori	6862	<11277	7534	🟢
	Pacific	9381	<17021	12828	🟢
	Non-Māori, Non-Pacific	5008	<6009	6017	🟠
	Total	5951	<8505	7139	🟢
Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people)	Māori	6887	≤4,340	6879	🔴
	Pacific	7564		6288	🔴
	Non-Māori, Non-Pacific	3488		3663	🟢
	Total	4179		4285	🟢
Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years age	Māori	7.23	≤11.9	12.4	🟠
	Pacific	7.29		15.0	🔴
	Non-Māori, Non-Pacific	3.58		6.5	🟢
	Total	4.99		9.0	🟢
Primary Care Patient Experience scores					No Longer Reported

Pharmacy Services					
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
Age-standardised rate of initial prescription items dispensed per 1,000 population	Māori	8070	Demand Driven	8060	●
	Pacific	8320		8501	●
	Non-Māori, Non-Pacific	7667		7681	●
	Total	9651		9716	●
Patients registered with CPAMS per 1,000 people dispensed warfarin	Māori	381	≥190	469	●
	Pacific	392		595	●
	Non-Māori, Non-Pacific	220		270	●
	Total	256		323	●
LTC registrations per 1,000 people	Māori	30	≥41	34	●
	Pacific	46		51	●
	Non-Māori, Non-Pacific	44		44	●
	Total	41		43	●

Output Class 3: Intensive Assessment and Treatment

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.

Acute and Urgent Services					
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
Number of POACs delivered in community settings across 2DHB	Total	529	≥529	1659	
Number of zero-fee consultations at after-hours services by children under 14 years	Māori	2340	≥1053	1652	
	Pacific	1903	≥409	1320	
	Non-Māori, Non-Pacific	7768	≥4768	8232	
	Total	12011	≥6,230	11204	
Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals	Māori	343	≤238	202	
	Pacific	359		235	
	Non-Māori, Non-Pacific	259		171	
	Total	280		181	
% of patients admitted, discharged or transferred from ED within 6 hours	Māori	85%	≥95%	81%	
	Pacific	86%		76%	
	Non-Māori, Non-Pacific	84%		78%	
	Total	84%		78%	
Standardised acute readmission rate within 28 days	Total	12%	11.8%	11.8%	

Elective and Arranged Services					
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
Number of planned care interventions – inpatient surgical discharges	Total	5845	5808	5349	●
Number of planned care interventions – minor procedures	Total	3951	2676	3799	●
% of patients given a commitment to treatment but not treated within four months	Total	35%	0%	50%	●
% of "DNA" (did not attend) appointments for FSA (first specialist appointments)	Māori	15%	Planned Care Funding Schedule 2021/22	15%	○
	Pacific	14%		14%	○
	Non-Māori, Non-Pacific	4%		4%	○
	Total	7%		7%	○
% of patients waiting longer than four months for their first specialist assessment	Total	14%	0%	15%	●
% of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Total	90%	≥90%	84%	●
% of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat	Total	90%	≥85%	90%	●

Mental Health, addictions and wellbeing services						
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service.		Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
Mental Health Access Rates[3]		Māori	NM	≥3.5%	6.1%	●
		Pacific	NM		2.9%	●
		Non-Māori, Non-Pacific	NM		3.4%	●
		Total	NM		3.9%	●
% of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks:	Mental Health Services	Māori	90%	≥95%	92%	●
		Pacific	94%		97%	●
		Non-Māori, Non-Pacific	81%		82%	●
		Total	84%		85%	●
	Addiction Services	Māori	92%		100%	●
		Pacific	83%		N/A	○
		Non-Māori, Non-Pacific	94%		100%	●
		Total	91%		100%	●
% of people admitted to an acute mental health inpatient service that were seen by mental health community team:	7 days prior to the day of admission	Māori	80%	≥75%	72%	●
		Pacific	68%		61%	●
		Non-Māori, Non-Pacific	81%		68%	●
		Total	79%		68%	●
	7 days following the day of discharge	Māori	78%	≥90%	73%	●
		Pacific	65%		68%	●
		Non-Māori, Non-Pacific	80%		73%	●
		Total	78%		73%	●
% of clients with a transition (discharge) plan		Community	51%	≥95%	58%	●
		Inpatient	79%		77%	●
% of clients with a wellness plan		Community	47%	≥95%	50%	●
Rate of Māori under the Mental Health Act: Section 29 community treatment orders		Māori	316	Reduce by 10%	362	●

[3] NM: measure is new with previous year's data unavailable

Quality, safety, and patient experience					
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
Rate of in-hospital falls with fractured neck of femur, per 100,000 admissions	Total	0.53	≤23.2	11.4	●
Rate of staphylococcus aureus bacteraemia, per 1,000 bed days	Total	0.15	≤0.1	0.18	●
Rate of surgical site infections for hip and knee operations, per 100 procedures	Total	5.2	0	0	●
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, per 1,000 admissions	Total	2.08	≤1.4	1.9	●
Rate of rapid response escalations, per 1000 admissions	Total	52.4	≤43	80	●
Rates of deep vein thrombosis/pulmonary embolus	Total	22	≤12	5	●
The weighted average score in the Inpatient Experience Survey by domain					No Longer Reported

Output Class 4: Rehabilitation and Support

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.

Disability Support Services					
These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of hospital staff that have completed the Disability Responsiveness eLearning Module	Total	10%	≥80%	29%	

Home-based and Community Support Services					
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of people 75+ living in their own home	Māori	91%	≥94%	92%	
	Pacific	91%		90%	
	Non-Māori, Non-Pacific	90%		91%	
	Total	90%		91%	
Acute bed day rate per 1000 for people 75+	Māori	2944	≤1,643	1582	
	Pacific	1857		2243	
	Non-Māori, Non-Pacific	1943		1930	
	Total	1981		1925	

Home-based and Community Support Services					
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
Standardised acute readmission rate for people 75+	Māori	14%	≤12 .4	9.4%	●
	Pacific	14%		12.3%	●
	Non-Māori, Non-Pacific	12%		12.8%	●
	Total	12%		12.6%	●
Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+[4]	Total	1.2	≤2.9	2.2	●

Aged Residential Care Services					
With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care	Target Group	HVDHB Baseline 2020/21	HVDHB Target 2021/22	HVDHB 2021/22 Result	Achievement
% of residential care providers meeting four year certification standards	Total	100%	≥95%	47%	●

[4] Data suppressed due to low numbers.

COVID-19 Vaccine Data at 30 June 2022

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant. Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Hutt Valley, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.5

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

[5] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[6] (HSU 2021 vs HSU 2020)

Year[7]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	9.86%	10.20%
2021/2022	82.86%	85.76%
Total	92.72%	95.96%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 93%, compared with 96% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Hutt Valley during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[8]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[9]
2020/21	18,812	13,175	0	0	31,987
2021/22	116,013	115,965	87,496	683	320,157
Total	134,825	129,140	87,496	683	352,144

By 30 June 2022, a total of 352,144 COVID-19 vaccinations had been administered, of which 91% were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated

[6] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[7] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.
[8] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[9] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[10]

Age group	Primary course				
(years)[11]	Dose 1	Dose 2	Booster 1	Booster 2	Total[12]
0 to 11	9,630	5,091	0	0	14,721
12 to 15	8,215	7,945	3	0	16,163
16 to 19	6,483	6,536	2,239	1	15,259
20 to 24	7,823	7,875	4,433	2	20,133
25 to 29	9,254	9,289	5,743	2	24,288
30 to 34	10,428	10,572	7,529	10	28,539
35 to 39	9,732	9,851	7,758	7	27,348
40 to 44	8,723	8,913	7,535	10	25,181
45 to 49	8,600	8,807	7,723	12	25,142
50 to 54	8,442	8,817	8,201	28	25,488
55 to 59	7,491	7,988	7,834	44	23,357
60 to 64	6,887	7,453	7,822	62	22,224
65 to 69	4,716	5,428	6,237	98	16,479
70 to 74	3,799	4,491	5,359	137	13,786
75 to 79	2,518	3,015	3,845	97	9,475
80 to 84	1,817	2,182	2,835	80	6,914
85 to 89	975	1,151	1,506	49	3,681
90+	480	561	894	44	1,979
Total	116,013	115,965	87,496	683	320,157

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

[10] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[11] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[12] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 people vaccinated by age group during 2021/22[13]

Age group[14] (years)	Partial [15]		Primary course [16]		Booster course			
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	8,221	33%	4,486	18%	0	0%	0	0%
12 to 15	7,320	88%	6,460	78%	0	0%	0	0%
16 to 19	6,881	92%	6,863	91%	1,246	49%	0	0%
20 to 24	7,854	85%	7,915	86%	4,361	53%	0	0%
25 to 29	8,636	79%	8,734	80%	5,319	56%	0	0%
30 to 34	10,474	83%	10,677	84%	7,392	64%	0	0%
35 to 39	9,939	84%	10,111	85%	7,793	71%	0	0%
40 to 44	9,095	85%	9,275	87%	7,584	75%	0	0%
45 to 49	8,408	81%	8,633	83%	7,541	80%	0	0%
50 to 54	8,627	81%	8,937	84%	8,210	82%	24	3%
55 to 59	7,616	78%	8,102	83%	7,810	85%	42	5%
60 to 64	7,157	77%	7,700	83%	7,944	90%	62	7%
65 to 69	5,292	72%	5,909	81%	6,520	92%	89	10%
70 to 74	3,880	64%	4,592	76%	5,399	94%	138	16%
75 to 79	2,858	67%	3,393	79%	4,185	96%	106	14%
80 to 84	1,980	63%	2,364	76%	2,972	98%	83	14%
85 to 89	1,113	67%	1,314	79%	1,665	100%	47	15%
90+	604	60%	712	71%	1,005	103%	46	16%
Total	115,955	73%	116,177	73%	86,946	77%	637	10%

[13] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[14] Age groupings in this table reflect age of the persons at end of financial year.
[15] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[16] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[17] administered by ethnicity[18] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	17,999	17,640	13,543	38	49,220
European/other	71,821	72,332	59,194	597	203,944
Māori	17,204	16,921	9,074	37	43,236
Pacific peoples	8,639	8,718	5,367	10	22,734
Unknown	350	354	318	1	1,023
Total	116,013	115,965	87,496	683	320,157

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[19]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated(12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster,50+	Received second booster (% eligible, 50+)
Asian	16,303	84%	16,738	86%	13,521	78%	28	7%
Māori	15,766	78%	16,320	81%	9,029	59%	32	6%
European /other	67,358	80%	69,752	83%	58,733	81%	568	12%
Pacific peoples	7,944	76%	8,486	81%	5,338	65%	9	3%
Unknown	363	78%	395	85%	325	68%	0	0%
Total	107,734	80%	111,691	83%	86,946	77%	637	10%

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

[17] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.

[18] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

[19] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	18,890	98%	18,719	97%	13,521	78%	28	7%
Māori	18,370	91%	17,714	88%	9,029	59%	32	6%
European /other	79,348	94%	78,565	93%	58,734	81%	568	12%
Pacific peoples	9,737	93%	9,484	91%	5,338	65%	9	3%
Unknown	503	108%	494	106%	325	68%	0	0%
Total	126,848	94%	124,976	93%	86,947	77%	637	10%

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :20

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:

[20] https://www.stats.govt.nz/methods/population-statistics-user-guide.

a. National population estimates (produced quarterly)

b. Subnational population estimates (produced every year)

3. Population projections which give an indication of the future size and composition of the population:

   a. Official national and subnational projections

   b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [21]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

[21] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 159,601 health service users in the HSU 2021. This is an increase of 4,159 people from the HSU 2020 (an approximate 3% increase), and 699 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[22]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	26,530	29,200	2,670
Pacific peoples	12,905	12,700	-205
Asian	23,907	24,200	293
European/other	95,774	94,200	-1,574
Unknown	485	0	-485
Total (Note 1)	159,601	160,300	699

Note 1: The national total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[23]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	25,567	28,500	2,933
Pacific peoples	12,410	12,550	140
Asian	21,365	23,800	2,435
European/other	95,710	94,000	-1,710
Unknown	390	0	-390
Total (Note 1)	155,442	158,800	3,358

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv24 and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality

[22] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

[23] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

[24] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Capital, Coast and Hutt Valley (deaths data has been combined for these districts) by age group at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	1
40 to 49	2
50 to 59	3
60 to 69	7
70 to 79	17
80 to 89	41
90+	33
Total	104

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Capital, Coast and Hutt Valley by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	
Asian	8
European/other	79
Māori	5
Pacific peoples	12
Unknown[25]	0
Total	104

[25] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

Centre of Clinical Excellence

In 2020 the 2DHB CEO proposed that a Centre of Clinical Excellence (CoCE) should be formed combining the functions of QIPS at CCDHB and QSII at HVDHB. This resulted in an expansion of clinical governance to clinical excellence; by a change in focus from structure and systems to the continual pursuit of excellence resulting from innovation, continuous improvement and empowering patients and their whānau.

On 1 December, 2021 the 2DHB Centre of Clinical Excellence was launched. The first six months of the CoCE were focussed on identity formation (both within the centre bringing two teams together and external to CoCE raising awareness of the CoCEs functions) and aligning systems and processes across the 2DHBs. On 1 June 2022 the Clinical Training team was formed in the CoCE. This team is a combination of the Simulation Centre, Resuscitation and Moving and Handling teams from both DHBs.

Improvement and innovation

The Improvement & Innovation (I&I) team work to create a continuous improvement and innovation culture across the Capital, Coast and Hutt Valley district and enable and support staff to make meaningful and sustainable change.

Since the CoCE was established, the I&I team have worked to embed a culture of continuous improvement by offering three improvement training courses. These build improvement capability and support 2DHB staff with their improvement projects. Improvement training and policies have been aligned across the 2DHBs. The I&I team presented at multiple forums to raise awareness of improvement training, including the 2DHB Clinical Forum, 2DHB Allied Professions Education Forum, 2DHB Allied Health Leaders meeting and Victoria University for Masters Nursing students.

In addition to projects supported through training programmes, the I&I advisors have led and supported 37 larger 2DHB projects such as improving the completion rate of Patient Goals of Care Forms and Clinical Documentation Improvement Programme.

Consumer engagement

Consumer advisory groups

Consumer advisory groups (CAG) have been established at Wellington and Hutt sites. These groups meet every six weeks and membership continues to be stable and diverse with representation from Māori, Pacifica, Disability, Rainbow, Youth, MHAIDS, African and Asian communities. Consumers are embedded at many levels of the organisation including: involvement with serious event reviews, members of sub-committees, participation in service credentialing, supporting co-design projects and being part of strategic groups.

Feedback

The feedback team and processes across the 2DHBs were reviewed and a 2DHB team was developed, which work across the District. The complaint process (HDC and non-HDC) have aligned, and HDC and non HDC complaint reports are auto-generated and provided to hospital services to support complaint management. Additionally, services are offered to provide personalised support to respond to complaints, e.g. coaching on writing a patient centred complaint response.

National in-patient survey

Previously the in-patient survey has been promoted by consumers in the hospitals, however this has not been able to occur this year, due to COVID-19 restrictions. Promoting the survey by consumers at the bedside increased the response rate to more than forty percent compared to the national average return rate of around twenty-four percent.

Health Quality and Safety Commission Consumer Engagement Quality & Safety Maker (QSM)

The QSM is a self-rated evaluation framework with the requirement to provide evidence to support the rating. Capital and Coast hospitals submitted a rating of four on all aspects of consumer engagement which is the highest rating. Hutt hospital submitted a rating of a mixture of two and three which was an increase on previous ratings of one for all domains.

Consumer involvement

Consumers are involved in many areas of our hospital. Examples include the Front of Whare project at Wellington hospital, shared goals of care project and the Hutt Valley Breast Screening review. There are consumer representatives on many clinical governance committees such as Serious Events Review Committee, Safety Incident Review Committee and the Clinical Boards. The consumer advisory group members take part in other quality improvement activities such as credentialing and safety walk-rounds.

Clinical Governance

Clinical governance systems

In March 2022, the '2DHB Clinical Board' was formed, across the former Hutt Valley and Capital Coast DHBs. The Board meets bi-monthly and membership consists of senior clinicians and operational leadership from the district, as well as consumer representatives. The 2DHB Clinical Board is chaired by the 2DHB Director, Clinical Excellence.

With the formation of the 2DHB Clinical Board, work has progressed to align the sub-committees that report to the Clinical Boards.

Controlled documents

Hutt Valley and Capital and Coast DHBs have separate controlled documents systems. In 2021, a risk was highlighted that the Hutt Valley system was not sufficiently robust to meet the requirements under Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. Earlier this year, a project commenced to implement a single system for the 2DHBs. This system has been built, with documents expected to be migrated onto the platform by the end of the year.

Service credentialing

Service credentialing, is an expectation of the Ministry of Health. The primary objective is to credential each service every five years to understand the skill mix of its staff, whether it meets clinical needs, and to identify any risks and opportunities for improvement. There has been a variable approach to service credentialing across the district.

A 2DHB service credentialing process has been agreed, with a single process for all services across the district. The new process is designed to review similar services at the same time to best utilise external reviewers where possible. Technology and innovation has also been a key factor in re-designing the process, using systems such as Survey Monkey and Sharepoint to reduce burden on services under review and the reviewers.

Clinical training

The Wellington Regional Centre for Simulation and Skills Education (WRSSCE) moved into the Centre of Clinical Excellence on 1st June 2022. The primary function of this service is to support the health workforce to provide excellence in clinical care through quality simulation-based education.

The team includes expert simulation educators and technical specialists, and as a result of the restructure, is part of the Clinical Training team which includes resuscitation, intravenous (IV) and cannulation and moving and handling educators. The team provides core requirement learning opportunities to 2DHB staff as well as specialist courses and programmes that support national and international specialist medical workforce credentialing such as the Effective Management of Anaesthetic Crisis (EMAC) course.

Quality and patient safety

The quality and patient safety team support managers and clinicians to achieve quality outcomes for patients, and the efficient functioning of services. The team's aim is to build a strong safety culture across 2DHB, bringing people together with a shared purpose and vision for the future.

Standardised process for adverse events across Hutt and Wellington hospitals

Quality Advisors now support mirrored services across Hutt Valley and Capital & Coast (e.g. the same people support surgical services at both Hutt and Wellington hospitals). The adverse event review (AER) processes aligned across the 2DHBs using the best methodologies from both sites to develop an effective, efficient and sustainable system. Clinical Excellence staff are members of both Hutt and Wellington Serious Event Review Committees (SERC) with the aim of ensuring alignment of process across the committees. Continuing education was provided to all SERC members to ensure they are all aware of modern, effective review techniques.

Research

The Research Office is the centralised function established under the auspices of the Centre of Clinical Excellence that provides guidance and support for those undertaking research. The Research Office holds the 2DHB register of projects with the objective of delivering and coordinating quality research activity in CCDHB and HVDHB.

The Research Office has been actively involved with the Māori consultation process for research and in the development of Tikanga resources. Working closely with the Maori Health Services on this project justifies our focus that will lead to better engagement from staff across the 2DHBs.

Risk

The Enterprise Risk team is a small centralised function within the Centre of Clinical Excellence that provides advice, support and reporting to support the effective management of key risks across the 2DHB. The team also supports and administers the CCDHB and HVDHB operational risk registers.

The primary purpose of the team's role is to strengthen risk management maturity across the organisation through refreshed policies and frameworks that clarify accountabilities for different types of risk, targeted advice and reporting that support staff in making informed decisions and practical guidance and tools that support staff apply risk management in their work.

Clarifying and articulating the 2DHB's key strategic and enterprise risks to support the Executive Leadership Team's responsibilities has been a key area of work. Working directly with Executive members, this has involved

re-setting how these risks are identified and reported to better support the Executive Leadership Team's oversight and monitoring of them.

Strengthening operational and enterprise risk management engagement has been another area of focus. This has involved prioritising risk management advice, support and reporting in those key operational areas of the business alongside those enterprise areas who manage key risks on behalf of the whole organisation. It has also involved preparing new online guidance and tools to embed a consistent approach to risk management and build 2DHB risk management capability.

Audit

The 2DHB system tracer was established in February 2021 with a tracer audit schedule implemented across the inpatient areas, development of training and tools, online solutions and a policy to guide and support practice. It has been expanded to both ambulatory care and MHAIDS with a focus on improvement of monitoring and transparent self-audits. In order to align current process with the new Ngā Paerewa Health and Disability Services Standard (2021), work continues with improvement of monitoring:

- Pathways to Wellbeing (currently Continuum of Care),
- Patient-Centered and Safe Environment and
- Infection Prevention and Anti-Microbial Stewardship.

Financial Statements

Statement of comprehensive revenue and expense

For the year ended 30 June 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Revenue				
Operating revenue	2	694,305	666,933	650,262
Interest		490	250	285
Dividends		-	-	-
Total revenue		**694,795**	**667,183**	**650,547**
Expenditure				
Personnel costs	3	220,248	206,370	200,068
Depreciation and amortisation	10-11	14,942	15,996	15,028
Outsourced services		27,229	22,772	37,634
Clinical supplies		28,902	30,698	31,198
Infrastructure and non-clinical expenses		27,030	16,294	24,748
Other district Health Boards		143,182	143,894	108,813
Non-health board providers		237,254	231,201	223,654
Capital charge	4	8,612	8,301	8,482
Finance costs	5	-	24	13
Other expenses	6	4,506	5,745	10,408
Total expenditure excluding Holidays Act		**711,905**	**681,296**	**660,046**
Surplus/(deficit) excluding Holidays Act		**(17,110)**	**(14,113)**	**(9,499)**
Holidays Act Provision	15	19,896	2,726	2,727
Surplus/(deficit) for the year		**(37,006)**	**(16,839)**	**(12,226)**
Other comprehensive revenue and expense				
Gain/(loss) on property revaluations		82,283	-	-
Total comprehensive revenue and expense		**45,277**	**(16,839)**	**(12,226)**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 23.

Statement of financial position

As at 30 June 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	21,844	14,643	28,126
Debtors and other receivables	8	35,515	27,192	34,698
Inventories	9	2,093	2,614	2,322
Total Current Assets		**59,452**	**44,449**	**65,146**
Non-Current Assets				
Property, plant and equipment	10	308,895	269,296	223,548
Intangible assets	11	10,484	9,041	9,410
Investments in joint ventures	12	1,150	1,150	1,150
Trust and bequest funds	13	1,190	1,266	1,221
Total Non-Current Assets		**321,719**	**280,753**	**235,329**
Total Assets		**381,171**	**325,202**	**300,475**
Liabilities				
Current Liabilities				
Creditors and other payables	14	44,848	47,812	47,437
Employee entitlements and provisions	15	102,335	67,402	64,700
Borrowings	16	42	3	42
Total Current Liabilities		**147,225**	**115,217**	**112,179**
Non-Current Liabilities				
Employee entitlements and provisions	15	9,452	8,972	9,150
Borrowings	16	94	178	136
Trust and bequest funds	13	1,190	1,266	1,221
Total Non-Current Liabilities		**10,736**	**10,416**	**10,507**
Total Liabilities		**157,961**	**125,633**	**122,686**
Net Assets		**223,210**	**199,569**	**177,789**
Equity				
Crown equity	17	158,853	202,035	158,709
Revaluation reserves	17	228,571	146,289	146,289
Accumulated deficit	17	(164,214)	(148,755)	(127,209)
Total Equity	17	**223,210**	**199,569**	**177,789**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 23.

Statement of changes in equity

For the year ended 30 June 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Equity as at 1 July		177,789	173,291	155,222
Repayment of equity to the Crown		(207)	-	(207)
Contribution of equity from the Crown		351	43,117	35,000
Revaluation reserves		82,283	-	-
Total comprehensive revenue and expense for the year		(37,006)	(16,839)	(12,226)
Equity as at 30 June	17	**223,210**	**199,569**	**177,789**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 23.

Statement of cash flows

For the year ended 30 June 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Cash flows from Operating Activities				
Cash receipts		695,237	663,883	644,562
Payments to providers		(378,551)	(375,095)	(334,684)
Payments to suppliers & employees		(295,052)	(284,605)	(291,072)
Goods and services tax (net)		30	-	(436)
Capital charge paid		(8,612)	(8,301)	(8,482)
Net cash flows from Operating Activities		**13,052**	**(4,118)**	**9,888**
Cash flows from Investing Activities				
Interest received		490	250	285
Dividends received		-	50	-
Proceeds from sale of property, plant and equipment		1	-	-
Purchase of property, plant and equipment and intangible assets		(19,576)	(61,176)	(10,717)
Net cash flows from Investing Activities		**(19,085)**	**(60,876)**	**(10,432)**
Cash flows from Financing Activities				
Contribution from the Crown		-	43,117	35,000
Repayment of equity to the Crown		(207)	-	(207)
Repayment of finance leases		(42)	-	(42)
Interest paid		-	(24)	(22)
Net cash flows from Financing Activities		**(249)**	**43,093**	**34,729**
Net (Decrease) / Increase in Cash and Cash Equivalents		**(6,282)**	**(21,901)**	**34,185**
Cash and cash equivalents at beginning of year	7	28,126	28,126	(6,059)
Cash and Cash Equivalents at end of year		**21,844**	**6,225**	**28,126**

Reconciliation of movements in liabilities arising from financing activities:

	Finance Leases $000
Balance as at 1 July 2021	178
Cash outflows	(42)
New leases	-
Balance as at 30 June 2022	**136**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 23.

Reconciliation of net deficit to net cash flows from operating activities

For the year ended 30 June 2022

	2022 Actual $000	2021 Actual $000
Reconciliation of net deficit to net cash flows from operating activities		
Net surplus/(deficit)	(37,006)	(12,226)
Add/(less) non-cash items:		
Depreciation and amortisation expense	14,942	15,028
Impairment on intangibles	408	6,520
Increase/(decrease) in Provisions	37,738	551
Loss on disposal of property, plant and equipment	87	2
Total non-cash items	**53,175**	**22,101**
Add/(less) items classified as investing or financing activity:		
Proceeds from sale of property, plant and equipment	(1)	-
Dividends received	-	-
Net interest received	(490)	(272)
Total items classified as investing or financing activity	**(491)**	**(272)**
Add/(less) movements in statement of financial position items:		
(Increase)/decrease in debtors and other receivables	(266)	(6,253)
(Increase)/decrease in inventories	229	(124)
Increase/(decrease) in creditors and other payables	1,117	6,352
Trust Movement	(3,706)	309
Net movements in Working Capital items	**(2,626)**	**285**
Net cash flow from Operating Activities	**13,052**	**9,888**

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

For the year ended 30 June 2022

1 Statement of accounting policies

Reporting Entity

Hutt Valley District Health Board (DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. The 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.

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. The DHB does not operate to make a financial return.

The DHB is designated as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for the DHB are for the year ended 30 June 2022, and were approved for issue by the Health New Zealand Board on 31 May 2023.

Basis of Preparation

Disestablishment of DHBs

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms replace all 20 DHBs and the Health Promotion Agency with a new Crown Entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Maori Health Authority (Te Aka Whai Ora) to monitor the state of Maori health and commission services directly, and the Publich Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Hutt Valley DHB's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the distestablishment basis of preparation.

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 includes 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 (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

There have been no changes in accounting policies during this financial year.

Standards issued and not yet effective and not early adopted

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 *Financial Instruments* and is effective for the year ending 30 June 2023, with early adoption permitted. 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 *Presentation of Financial Statements* and is effective for the year ending 30 June 2023, with earlier adoption permitted. Hutt Valley DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

Summary of Significant Accounting Policies

Significant accounting policies are included in the notes to which they relate.
Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

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

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 provision has been made for income tax.

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 DHB for the preparation of these 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 in respect of:

- Estimating the fair value of land and buildings – refer to note 10.
- Impairment of intangible assets – refer to note 11.
- Measuring the liabilities for long service leave, retirement gratuities, sabbatical leave, sick leave and continuing medical education leave – refer to note 14.
- Measuring the liability for Holidays Act 2003 remediation – refer to note 15.

New amendment applied - 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. The new information required by this amendment has been disclosed in the Statement of cash flows.

2 Operating income

Accounting policy
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.

Interest revenue
Interest revenue is recognised using the effective interest method.

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

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

Donations and bequests
Donations and bequests which have restrictive conditions are recognised as liabilities of the DHB. They are recognised as revenue in the surplus or deficit when the funds are spent in accordance with the conditions.

	2022 Actual $000	2021 Actual $000
Ministry of Health contract funding	550,623	510,793
ACC contract revenue	7,383	7,129
Other Government	1,692	1,662
Revenue from other district health boards	130,712	125,142
Other patient care related revenue	3,065	3,931
Other revenue:		
Gain on Sale of Fixed Assets	1	-
Donations and bequests received	499	1,270
Rental revenue and services	331	336
Total Operating Income	**694,306**	**650,263**

Revenue from other DHBs includes inter district patient inflow revenue. 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.

3 Personnel costs

Accounting policy

Salary and wages
Salary and wages are recognised as an expense as employees provide services.

Superannuation schemes
Defined contribution schemes
Employers contributions to KiwiSaver, the Government Superannuation Fund, and other State Sector Retirement Savings Schemes are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

	2022 Actual $000	2021 Actual $000
Salaries and wages	203,088	197,228
Defined contribution plan employer contributions	5,539	4,964
Increase/(decrease) in liability for employee entitlements	11,621	(2,124)
Total Personnel Costs	**220,248**	**200,068**

4 Capital charge

Accounting policy
The capital charge is recognised as an expense in the financial year to which the charge

Hutt Valley DHB pays a capital charge to the Crown every six months. The charge is based on the actual closing equity balance excluding the value of donated assets. The capital charge rate was 5% for the year ending 30 June 2022 (2021: 5%).

5 Finance costs

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

	2022 Actual $000	2021 Actual $000
Interest on overdraft facility	-	13
Total Finance Costs	**-**	**13**

6 Other expenses

Accounting policy

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.

	2022 Actual $000	2021 Actual $000
Audit Fees for financial statement audit	190	177
Audit-related fees for internal audit services	116	52
Operating lease expense	3,393	3,290
Allowance for credit losses on receivables	(13)	66
Board member and committee fees	323	301
Loss on disposal of property, plant and equipment	87	2
Write-down on initial recognition of intangible assets	408	6,520
Total Other expenses	**4,506**	**10,408**

See note 11 for detail of the intangible asset write-down.

7 Cash and cash equivalents

Accounting policy

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.

	2022 Actual $000	2021 Actual $000
Call deposits/(overdraft) with NZ Health Partnerships Ltd	20,304	22,874
Cash at bank and on hand	1,539	5,252
Total Cash and cash equivalents	**21,843**	**28,126**

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 borrowing facility 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 $24.2m (2021: $24.2m).

While cash and cash equivalents at 30 June 2022 are subject to the expected credit loss requirement of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

8 Debtors and other receivables

Accounting policy

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.

	2022 Actual $000	2021 Actual $000
Ministry of Health	18,015	12,635
Other DHBs	5,857	13,478
PHARMAC	7,077	5,937
Trade debtors - other	1,749	1,535
Other Departments	575	238
	33,273	**33,823**
Less: Allowance for credit losses	(167)	(366)
	33,106	**33,457**
Prepayments	2,409	1,241
Total Debtors and other receivables	**35,515**	**34,698**
Total Debtors and other receivables comprises:		
Revenue from the sale of goods and services (exchange transactions)	17,667	22,429
Revenue from grants (non-exchange transactions)	17,848	12,269
Total Debtors and other receivables	**35,515**	**34,698**

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:

	2022 Actual $000	2021 Actual $000
Opening allowance for credit losses as at 1 July	(366)	(419)
(Increase)/Decrease in loss allowance made during the year	58	(45)
Receivables written off during the year	141	98
Balance as at 30 June	**(167)**	**(366)**

9 Inventories

Accounting policy

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.

	2022 Actual $000	2021 Actual $000
Pharmaceuticals	168	213
Surgical and medical supplies	1,935	2,119
	2,103	**2,332**
Provision for obsolescence	(10)	(10)
Total Inventories	**2,093**	**2,322**

The amount of inventories recognised as an expense during the year ended 30 June 2022 was $15.75m, which is included in the clinlical supplies line item of the statement of comprehensive revenue and expense. All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $10k. There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2021: nil), however some inventories are subject to retention of title clauses.

10 Property, plant and equipment

Accounting policy

Property, plant, and equipment consist of the following asset classes:

- land;
- building structure, services, fit out and site improvements;
- 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 and impairment losses. 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.

Land and building 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 or deficit in equity.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to Hutt Valley DHB and the cost of the item can be measured reliably.
The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The estimated useful lives and associated depreciation of major classes of property, plant and Equipment were reviewed during the year and have been estimated as follows:

Site Improvements	10 to 100 years	1.0% to 10.0%
Building structure, services and fit out	5 to 50 years	2.0% to 20.0%
Plant and equipment	5 to 25 years	4.0% to 20.0%
Computer equipment	5 to 10 years	10.0% to 20.0%
Leased assets	7 years	14.3%
Motor vehicles	5 to 10 years	10.0% to 20.0%

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

Capital work in progress is not depreciated. The total cost of a project is transferred to a fixed asset category on its completion and is then depreciated.

Impairment of property, plant and equipment

Property, plant, and equipment 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 regarded as 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.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

Land and building valuations are done on a five year cycle or more often as required. Desktop valuation updates are done in the interim years between full valuations. Capital work in progress is not subject to revaluation. The DHB engaged an Independent Registered Valuer (CBRE Limited) to revalue land and buildings to fair value as at 30 June 2022. The land was valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. The hospital buildings were 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.

The valuation undertaken at June 2022 considered the following proposed changes to the DHB's buildings:

- Kowhai House and Pilmuir House are to be demolished to accommodate construction of a new mental health facility. The initial work to demolish Kowhai House commenced January 2023 and at the end of February 2023 the scaffolding and wrapping was completed. Work on Pilmuir House is programmed to begin April 2023. As a result both buildings were deemed to be of nil value for the purpose of valuation.
- The latest seismic assessment received by the DHB found the Heretuanga Block to be earthquake prone. Under leglislation, the DHB has until 2029 to strengthen or demolish the building. As a result the remaining useful life of this building and its components has been reduced to 7 years for the purpose of valuation.
- Te Whare Ahuru no longer meets the intended functional purpose as a mental health facility. Whilst planning is yet to be completed, the likely alternative use for this building is an administration block. As a result the remaining useful lives of the service and fitout has been reduced to 4 years pending removal for the alternative use.

Movements for each class of property, plant and equipment are as follows:

	Land	Buildings	Plant & Equipment	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance 1 July 2020	30,050	180,927	51,027	2,577	2,505	267,086
Additions	-	2,189	5,132	-	-	7,321
Disposals	-	-	(4)	-	-	(4)
Revaluation increase/(decrease)	-	-	-	-	-	-
Work in progress adjustment		(1,653)	(1,851)	-	-	(3,504)
Work In progress closing balance	-	2,864	2,773	-	-	5,637
Balance at 30 June 2021	30,050	184,327	57,077	2,577	2,505	276,536
Balance 1 July 2021	30,050	184,327	57,077	2,577	2,505	276,536
Additions	-	2,552	6,830	-	53	9,435
Disposals	-	(1)	(835)	-	(15)	(851)
Revaluation increase/(decrease)	6,010	59,616	-	-	-	65,626
Work in progress adjustment		(2,864)	(2,773)	-	-	(5,637)
Work In progress closing balance	-	7,599	3,936	-	-	11,535
Balance at 30 June 2022	36,060	251,229	64,235	2,577	2,543	356,644

	Land	Buildings	Plant & Equipment	Leased Assets	Motor Vehicles	Total
	$000	$000	$000	$000	$000	$000
Accumulated depreciation and impairment losses						
Balance 1 July 2020	-	392	36,761	1,677	2,286	41,116
Depreciation expense	-	8,328	3,130	366	50	11,874
Depreciation on disposals	-	-	(2)	-	-	(2)
Adjustment	-			-	-	-
Elimination on revaluation	-	-	-	-	-	-
Balance at 30 June 2021	-	8,720	39,889	2,043	2,336	52,988
Balance 1 July 2021	-	8,720	39,889	2,043	2,336	52,988
Depreciation expense	-	8,442	3,606	107	27	12,182
Depreciation on disposals	-	-	(821)	-	(16)	(837)
Elimination on revaluation	-	(16,584)	-	-	-	(16,584)
Balance 30 June 2022	-	578	42,674	2,150	2,347	47,749
Carrying Amounts						
As at 1 July 2020	30,050	180,535	14,266	900	219	225,970
As at 30 June 2021	30,050	175,607	17,188	534	169	223,548
As at 30 June 2022	36,060	250,651	21,561	427	196	308,895

Finance leases

The net carrying amount of assets held under existing finance leases is $0.17m (2021: $0.21m) for plant and equipment. Note 16 provides further information about finance leases.

Restrictions on title

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.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2022 was $nil (2021: $nil).

Seismic Status of Buildings

The DHB's buildings have had detailed seismic assessments. All the assessed buildings meet the current minimum of 34% of the New Building Standard, with the exception of the Heretaunga Block which is considered earthquake prone. The Heretaunga Block (IL3) will operate as normal whilst plans are finalised to demolish or remediate. There is uncertainty around the future of some of the other buildings on site due to their relatively low NBS rating, assessed importance level (IL), age and fit for purpose such as the 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.

11 Intangible assets

Accounting policy

Software acquisitions 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 17 years	6% to 21%

Impairment of intangible assets
Refer to the policy for impairment of property, plant and equipment in Note 10. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is an indication of impairment.

	Acquired Software $000	Investment In RHIP $000	Total $000
Cost or valuation			
Balance 1 July 2020	27,522	9,066	36,589
Additions	1,661	-	1,661
Impairment	-	(6,520)	(6,520)
Work in progress adjustment	(1,432)	(9,066)	(10,498)
Work In progress closing balance	312	9,789	10,101
Balance 30 June 2021	28,063	3,269	31,333
Balance 1 July 2021	28,063	3,269	31,333
Additions	434	-	434
Impairment	-	(408)	(408)
Work In progress adjustment	(312)	(3,269)	(3,581)
Work In progress closing balance	3,444	3,946	7,390
Balance 30 June 2022	31,629	3,538	35,168
Accumulated amortisation and impairment losses			
Balance at 1 July 2020	18,768	-	18,768
Amortisation expense	3,154	-	3,154
Balance 30 June 2021	21,922	-	21,922
Balance at 1 July 2021	21,922	-	21,922
Amortisation expense	2,761	-	2,761
Balance 30 June 2022	24,683	-	24,683
Carrying Amounts			
At 1 July 2020	8,754	9,066	17,820
At 30 June 2021	6,141	3,269	9,410
At 30 June 2022	6,946	3,538	10,484

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

Regional Health Informatics Programme (RHIP)

RHIP is a programme to move the six central region District Health Boards from a current state of disparate and fragmented clinical and administrative information systems to a regional solution that would integrate patient administration and clinical functionality through single clinical applications.

As at 30 June 2022, Hutt Valley DHB had contributed $4.329 million (2021: $9.789m) towards central region software systems which has been recognised as work in progress in respect of intangible assets. This investment has been tested for impairment during the year by DHB management and $.408 million (2021: $6.520m) was written off to correct the remaining useful life of the regional Clinical Portal, WebPAS and RADA IT applications.

12 Investments in companies and joint ventures

	2022 Actual $000	2021 Actual $000
Carrying Amount of Investment		
Advance on redeemable preference shares – Allied Laundry Services Limited	1,150	1,150
Closing Balance	**1,150**	**1,150**

Allied Laundry Services has a total share capital of 6,900,000 of which the DHB's share is 1,150,000 (16.67%). The shares have been fully paid.

13 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 restricted fund balances.

	2022 Actual $000	2021 Actual $000
Opening balance	1,221	1,347
Funds received	235	389
Interest received	8	1
Funds disbursed	(274)	(516)
Closing Balance	**1,190**	**1,221**

14 Creditors and other payables

Accounting policy
Short-term payables are measured at the amount payable.

	2022 Actual $000	2021 Actual $000
Payables under exchange transactions		
Creditors	1,995	3,168
Accrued expenses	33,026	31,596
Inter-district flows	(1,290)	(1,173)
Interest	-	-
Income in advance	6,826	5,880
Total payables under exchange transactions	40,557	39,471
Payables under non-exchange transactions		
Taxes	2,761	2,731
Trusts	1,530	5,236
Total payables under non-exchange transactions	4,291	7,967
Total Creditors and other payables	**44,848**	**47,438**

See note 22 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

Accounting policy

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.

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 employee 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, such as sabbatical leave, long service leave, retirement gratuities, continuing medical education and expenses, 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 also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions

Sabbatical leave, long service leave, retirement gratuities and continuing medical education.

The present value of long service leave, retirement gratuities, sabbatical leave, sick 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 3.84% (2021: 1.71%) and a salary growth factor of 2.5% (2021: 2.5%) has been used.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the actuarial valuation would be an estimated $0.3m (2021: $.04m) higher/lower.

Holiday Act 2003 remediation

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 all 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.

The remediation project associated with the MOU is a significant undertaking and the final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the Hutt Valley DHB recognises it has an obligation to address any historical non-compliance under the MOU and 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. This may result in further adjustment to the carrying amount of the liability within the next financial year.

	2022 Actual $000	2021 Actual $000
Current provision		
Salary and Wages accrued	12,354	3,515
Annual leave	25,361	22,234
Holidays Act 2003 remediation	56,534	30,218
Long service leave	1,258	1,219
Retirement gratuities	231	253
Continuing medical education leave and expenses	2,254	1,937
Other Entitlements	4,343	5,324
Total Current provision	**102,335**	**64,700**
Non-current provision		
Long Service leave	1,653	1,949
Retirement Gratuities	678	718
Continuing Medical Education Leave and Expenses	4,944	4,205
Other Entitlements	2,177	2,278
Total Non-current provision	**9,452**	**9,150**
Total Employee Entitlements and Provisions	**111,787**	**73,850**

16 Borrowings

Accounting policy

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.

Critical judgements in applying accounting policies

Classification of leases

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Hutt Valley DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

Hutt Valley DHB has exercised its judgement on the appropriate classification of leases, and has determined that there were no new arrangements during the year to June 2022 considered to be finance leases.

	2022 Actual $000	2021 Actual $000
Current portion		
Finance leases	42	42
	42	**42**
Non-current portion		
Finance leases	94	136
	94	**136**
Total borrowings	**136**	**178**

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment. The net carrying amount of assets held under finance lease is disclosed in note 10.

The fair value of finance leases is $0.136m (2021: $0.178m). Fair value is estimated at the present value of future cash flows.

Analysis of finance lease

	2022 Actual $000	2021 Actual $000
Minimum lease payments payable:		
Not later than one year	42	42
Later than one year and not later than five years	94	136
Later than five years	-	-
Total minimum lease payments	136	178
Future finance charges	-	-
Present value of minimum lease payments	136	178
Present value of minimum lease payable:		
Not later than one year	42	42
Later than one year and not later than five years	94	136
Later than five years	-	-
Total present value of minimum lease payments	136	178

Description of finance leasing arrangements

Hutt Valley DHB holds 1 (2021: 1) finance lease. The finance lease is for medical equipment. There are no restrictions placed on Hutt Valley DHB by this finance leasing arrangement.

17 Equity

Accounting policy

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.

	2022 Actual $000	2021 Actual $000
Contributed equity		
Balance at 1 July	158,709	123,916
Equity contributions from the Crown	351	35,000
Repayment of equity to the Crown	(207)	(207)
Balance at 30 June	158,853	158,709
Revaluation reserves		
Balance at 1 July	146,289	146,289
Revaluations	82,283	-
Balance at 30 June	228,571	146,289
Revaluation reserves consist of		
Land	31,699	25,689
Buildings	197,460	121,263
Equipment	(588)	(663)
Total revaluation reserves	228,571	146,289
Accumulated surplus/(deficit)		
Balance at 1 July	(127,209)	(114,983)
Deficit for the year	(37,006)	(12,226)
Balance at 30 June	(164,214)	(127,209)
Total equity	223,210	177,789

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.

18 Capital commitments and operating leases

Accounting policy

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.

	2022 Actual $000	2021 Actual $000
Capital commitments	29,608	10,366
Operating leases as lessee		
Not later than one year	2,507	2,540
Later than one year and not later than five years	3,804	4,110
Later than five years	-	-
Total Non-cancellable Commitments	**35,919**	**17,016**

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

The DHB leases a number of premises, vehicles, EFTPOS machines and a variety of medical equipment and imaging machines under operating leases.

19 Contingencies

Hutt Valley DHB has no contingent liabilities or assets at 30 June 2022 (2021: Nil).

20 Related party transactions

Hutt Valley DHB is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other Government agencies (for example, government departments and Crown entities) 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.

	2022 Actual $000	2021 Actual $000
Leadership team		
Salaries and other short-term employee benefits	$1,425	$2,595
Less: Amount paid by Capital & Coast DHB	(30)	(452)
Amount paid by Hutt Valley DHB	**$1,395**	**$2,143**
Full-time equivalent members	***4.90***	***7.42***

During the year, Hutt Valley DHB, Capital & Coast DHB and Wairarapa DHB share some leadership team members, and recharge or recover the remuneration between DHBs.

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 (2021: nil).

21 Events after balance date

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Health New Zealand (Te Whatu Ora) and the Maori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

Kowhai House and Pilmuir House are to be demolished to accommodate construction of a new mental health facility. The initial work to demolish Kowhai House commenced January 2023 and at the end of February 2023 the scaffolding and wrapping was completed. Work on Pilmuir House is programmed to begin in April 2023.

22 Financial instruments

Fair Values

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

	2022		2021	
	Carrying Amount $000	Fair Value $000	Carrying Amount $000	Fair Value $000
Cash and cash equivalents	21,843	21,843	28,126	28,126
Debtors and other receivables	35,515	35,515	34,698	34,698
Creditors and other payables	44,848	44,848	47,438	47,438
Borrowings	136	136	178	178
	102,342	**102,342**	**110,440**	**110,440**

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 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 2021, it is estimated that a general increase of one percentage point in interest rates would have a minimal impact on earnings in 2020/21, 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 obligation 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 or NZHPL.

In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, 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 DHB places its cash and short term deposits with high quality financial institutions and the DHB has a policy that limits the amounts of credit exposure to any one financial institution. 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 gross carrying amount of financial assets, excluding receivables, by credit rating is provided below by reference to Standard & Poor's credit ratings (if available) or to historical information about counterparty default rates:

	2022 Actual $000	2021 Actual $000
Counterparties with Credit Ratings		
Cash and cash equivalents including trust funds		
AA-	2,729	6,473
Counterparties without Credit Ratings		
Existing counterparty with no defaults in the past	20,304	22,874
	23,033	**29,347**
Maximum exposure for each class of financial instrument:		
Cash and cash equivalents	21,843	28,126
Trust and bequest funds	1,190	1,221
Debtors and other receivables	35,515	34,698

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

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 (NZHPL) as described in Note 7.

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1 - 2 years $000	More than 2 years $000
2022					
Creditors and other payables	35,261	35,261	49,421	-	-
Finance leases	136	136	42	42	52
Total	**35,397**	**35,397**	**49,463**	**42**	**52**
2021					
Creditors and other payables	38,827	38,827	38,827	-	-
Finance leases	178	178	42	42	94
Total	**39,005**	**39,005**	**38,869**	**42**	**94**

23 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 2022 are provided below.

Statement of comprehensive revenue and expense

The DHB recorded a deficit of $17.110m (excluding one off exceptional items) compared with a budget deficit of $14.113m.

Operating revenue was higher than budget by $27.372m (4.1%). This is largely driven by additional revenue received from the Ministry of Health which included: $12.668m in relation to COVID-19 funding, $8.962m for staff MECA costs, $2.802m for Planned Care Services and $0.921m for NGO (Non Government Organisation) pay equity funding.

Expenditure, excluding provision for Holidays Act remediation, was over budget by $30.609m (4.5%). The main variances to budget include:

- Personnel costs were higher than budget due to higher than expected MECA pay settlements as well as overtime and penal costs. The occupation group with the highest variance was Nursing.
- Outsourced services were higher than budget because of additional contract staff employed by the Public Health Unit in response to COVID-19 and the use of external Bureau Nurses and Medical Locums to cover vacancies and volumes.
- Infrastructure and non-clinical expenses is $6.2m higher than budget as a result of project costs for the holidays act remediation project.
- Funder expenditure is $6.1m higher than budget largely due to unbudgeted COVID-19 costs and higher costs for community pharmaceuticals.
- Other expenses were higher than budget due to the write down of intangible assets.

The exceptional item was the Holidays Act remediation which included an unplanned adjustment of $17.170m.

Statement of financial position

- Cash and cash equivalents were over budget mainly due to the delay in commencing capital projects.
- Debtors and other receivables were over budget mainly due to the reimbursement of COVID-19 response cost from the Ministry of Health.
- Employee entitlements and provisions were over budget mainly due to the significant increase in the provision to remediate non-compliance with the Holidays Act. (Estimated liability as at 30 June 2022 was $54.534m including programme costs).
- Property, Plant and Equipment (PPE) and Equity are both higher than budget because land and buildings were revalued. The revaluation resulted in an increase of $82.2m to both PPE and Equity. The increase in PPE was partially offset due to unspent capital expenditure. The increase in Equity was partially offset due to an unbudgeted increase to the Holidays Act 2003 remediation provision and the equity injection which was budgeted for but not required or received.

Statement of cash flows

The net cash position is over budget.

- The cash receipts were higher due to additional revenue received from Ministry of Health.
- Purchase of property, plant and equipment was below budget due to unspent capital projects.
- Financing cash flows were below budget as the planned capital injection was not required.

24 Cost of service statements for output classes

Accounting policy

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.

$000s	Prevention			Early Detection & Management			Intensive Assessment & Treatment			Rehabilitation & Support			Hutt Valley DHB		
	2021\22 Actual	2021\22 Budget	2020\21 Audited	2021\22 Actual	2021\22 Budget	2020\21 Audited	2021\22 Actual	2021\22 Budget	2020\21 Audited	2021\22 Actual	2021\22 Budget	2020\21 Audited	2021\22 Actual	2021\22 Budget	2020\21 Audited
Income															
Operating Income	31,471	27,146	22,660	173,971	169,144	309,122	406,619	389,501	259,232	82,245	81,142	59,248	694,306	666,933	650,262
Interest Income	0	0	23	0	0	15	490	250	245	0	0	1	490	250	284
Total Income	31,471	27,146	22,683	173,971	169,144	309,137	407,109	389,751	259,477	82,245	81,142	59,249	694,796	667,183	650,546
Expenditure															
Personnel Costs	16,403	15,276	14,709	6,921	7,981	8,309	191,949	178,381	172,281	4,976	4,732	4,769	220,249	206,370	200,068
Depreciation	342	368	198	621	961	736	13,954	14,644	14,071	24	24	23	14,941	15,997	15,028
Outsourced Services	3,672	2,231	2,307	819	1,166	1,135	22,416	18,914	33,923	322	461	270	27,229	22,772	37,635
Clinical Supplies	464	627	1,059	609	529	779	25,892	27,987	27,649	1,936	1,555	1,711	28,901	30,698	31,198
Infrastructure and Non Clinical Expenses	789	507	473	680	821	562	25,441	14,836	23,638	120	130	75	27,030	16,294	24,748
Other District Health Boards	418	285	0	44,331	44,999	106,078	80,565	80,333	0	17,868	18,277	2,735	143,182	143,894	108,813
Non Health Board Providers	4,427	5,399	0	114,586	109,053	180,260	61,309	59,281	0	56,932	57,468	43,394	237,254	231,201	223,654
Capital Charge	0	0	486	0	0	884	8,612	8,301	7,095	0	0	17	8,612	8,301	8,482
Interest Expense	0	0	0	0	0	0	0	24	13	0	0	0	0	24	13
Other	409	710	390	127	590	188	3,911	4,385	12,509	59	60	47	4,506	5,745	13,134
Internal Allocations	4,703	4,592	4,202	2,241	2,169	2,836	(8,128)	(7,921)	(8,053)	1,183	1,160	1,016	(1)	0	1
Total Expenditure	31,627	29,995	23,824	170,935	168,269	301,767	425,921	399,165	283,126	83,420	83,867	54,057	711,903	681,296	662,774
Net Surplus / (Deficit) Before extraordinary items	(156)	(2,849)	(1,141)	3,036	875	7,370	(18,812)	(9,414)	(23,649)	(1,175)	(2,725)	5,192	(17,107)	(14,113)	(12,228)
Extraordinary Item															
Holidays Act 2003 remediation	0	0	0	0	0	0	19,896	2,726	0	0	0	0	19,896	2,726	0
Net Surplus / (Deficit)	(156)	(2,849)	(1,141)	3,036	875	7,370	(38,708)	(12,140)	(23,649)	(1,175)	(2,725)	5,192	(37,003)	(16,839)	(12,228)

Actual revenue and expenditure has been mapped to output classes in accordance with guidance on classifications from the Ministry of Health. All expenditure paid is matched to a purchase unit code, and then mapped to the relevant output class classification. This is done at a detailed transactional level and accounts for the majority of the DHB's revenue and

expenditure. The DHB's remaining activity is within the Provider arm, and as a result has been assumed to come under the intensive assessment and treatment output class.

25 Impact of COVID-19

In August 2021, New Zealand entered nationwide lockdown (alert level 4) and capacity to provide planned care surgery was reduced.

With new COVID-19 cases peaking in April 2022, a high prevalence of COVID-19 infections impacted both staff and patients. Patients were deferred due to hospital capacity issues and also patient illness itself.

In the year to 30 June 2022, there was $15.6m additional costs from the COVID-19 response. These were mostly external provider costs as well as some additional hospital costs such as security services. These additional costs were largely offset by additional Ministry of Health revenue, resulting in a $1.684m net deficit.

26 Late signing of Annual Report

Hutt Valley District Health Board was required under section 156 (3) of the Crown Entities Act 2004 to adopt its audited financial statements and service performance information by 31 December 2022. This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of COVID-19, including lockdowns.

Statutory Remuneration Disclosures

1 Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more per annum within specified $10,000 bands were as follows:

Annual remuneration	2022	2021	2020	2019
100,000-109,999	146	99	92	77
110,000-119,999	100	60	43	37
120,000-129,999	79	34	27	25
130,000-139,999	29	15	19	13
140,000-149,999	17	17	19	10
150,000-159,999	15	16	11	12
160,000-169,999	7	11	12	7
170,000-179,999	9	5	12	15
180,000-189,999	5	11	15	9
190,000-199,999	10	13	14	10
200,000-209,999	13	10	5	9
210,000-219,999	11	7	9	4
220,000-229,999	8	6	15	8
230,000-239,999	9	8	9	13
240,000-249,999	6	10	5	10
250,000-259,999	6	7	11	4
260,000-269,999	6	6	0	9
270,000-279,999	9	4	8	4
280,000-289,999	4	7	1	4
290,000-299,999	9	7	4	6
300,000-309,999	5	2	8	5
310,000-319,999	2	10	3	3
320,000-329,999	2	5	1	
330,000-339,999	7	1	2	1
340,000-349,999	2	1	1	2
350,000-359,999	2	2	3	1
360,000-369,999	4	1	1	2
370,000-379,999	1		1	
380,000-389,999	1	2	2	
390,000-399,999		2	1	1
400,000-409,999	2		1	1
440,000-449,999	1			
450,000-459,999	1			
510,000-519,999		1		
520,000-529,999				1
Grand Total	**528**	**380**	**355**	**303**

Statutory Remuneration Disclosures

Termination payments

During the year ended 30 June 2022, 11 employees (2021: 9) received compensation and other benefits in relation to cessation totalling $124,940 (2021: $318,138). The payments were in the nature of redundancy or retirement gratuities.

2 Board member remuneration and meetings attended

	2022 Actual $000	2021 Actual $000
Board members		
Remuneration	$306	$300
Full-time equivalent members	*1.32*	*1.19*

The full-time equivalent for Board members has been determined based on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

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

Board Member	Position	2020/22 actual ($000)	2020/21 actual ($000)
Board members as at 30 June 2022			
David Smol	Joint Chair HVDHB & CCDHB	50	50
Wayne Guppy	Deputy Chair	33	34
John Ryall	Current Member	26	27
Josh Briggs	Current Member	25	27
Ken Laban	Current Member	25	27
Keri Brown	Current Member	24	27
Naomi Shaw	Current Member	24	24
Prue Lamason	Current Member	25	26
Richard Stein	Current Member	24	27
Ria Earp	Current Member (from 16 April 2021)	25	4
Yvette Grace	Current Member	25	27
Total Board member remuneration		306	300

Statutory Remuneration Disclosures

Board and committee meeting attendances in the year to 30 June 2022:

Board Member	Position	Meetings Attended				
		Board	FRAC	HSC	DSAC	MCPAC
1 July 2021 to 30 June 2022						
David Smol	Joint Chair HVDHB & CCDHB	10/10	6/6	-	-	8/8
Wayne Guppy	Deputy Chair	10/10	6/6	-	-	8/8
John Ryall	Current Member	10/10	6/6	-	3/4	-
Josh Briggs	Current Member	9/10	-	4/4	-	-
Ken Laban	Current Member	9/10	-	4/4	-	-
Keri Brown	Current Member	7/10	-	1/4	-	-
Naomi Shaw	Current Member	10/10	-	-	4/4	-
Prue Lamason	Current Member	10/10	4/6	-	2/4	-
Richard Stein	Current Member	10/10	-	3/4	-	-
Ria Earp	Current Member	10/10	-	4/4	-	-
Yvette Grace	Current Member	7/10	4/6	-	3/4	-

**Only meetings that occurred while the person was a member are included*

Key:

FRAC	Finance, Risk, Audit Committee
DSAC	Disability Services Advisory Committee
HSC	Health Systems Committee
MCPAC	Major Capital Projects Advisory Committee

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Hutt Valley DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Hutt Valley District Health Board group'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 the Hutt Valley DHB group under section 19A of the Public Finance Act.

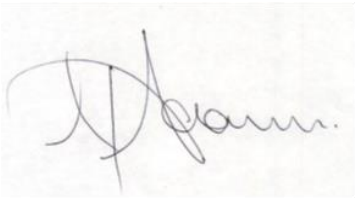
We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Hutt Valley District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson
Acting Chair

Dated: 31 May 2023



Hon Amy Adams
Board member

Dated: 31 May 2023

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 2022

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.

Opinion

We have audited:

- the financial statements of the Health Board on pages 56 to 89, that comprise the statement of financial position as at 30 June 2022, 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 30 to 51, 87 and 88.

In our opinion:

- the financial statements of the Health Board on pages 56 to 89, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2022; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 30 to 51, 87 and 88:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, 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;

- 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 was completed late

Our audit was completed 31 May 2023. This is the date at which our opinion is expressed. We acknowledge that our audit was completed later than required by the Crown Entities Act 2004, section 156(3)(a). This was due to an auditor shortage in New Zealand and the consequential effects of Covid-19, including lockdowns.

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

Emphasis of matters

Without further modifying our opinion, we draw attention to the following matters:

The financial statements have been prepared on a disestablishment basis

Note 1 on page 61 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 15 on pages 76 to 78, which outlines that 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. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $56.5 million, as at 30 June 2022, to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Pages 43 to 51 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 48 to 50. The notes on page 50 outlines that there would be differences in the reported results for the overall population if the Stats NZ

population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 25 on page 89 to the financial statements outlines the ongoing impact of Covid-19 on the Health Board.

Basis for our opinion

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

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

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

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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 of Te Whatu Ora.

- 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 disestablishment basis by the Board of Te Whatu Ora.

- 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 of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 2 to 29, 52 to 55 and 90 to 93, 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: International 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: Hutt Valley District Health Board Private Bag 31-907, Lower Hutt 5040 Website: www.huttvalleydhb.org.nz Facebook: www.facebook.com/TeWhatuOraCapitalCoastHuttValley	**Head Office Physical Address:** Executive Reception, Pilmuir House, Pilmuir Street Hutt Hospital Campus, Lower Hutt 5010 **Phone:** (04) 566 6999
Bankers: Bank of New Zealand	**Auditor:** Audit New Zealand Wellington, on behalf of the Controller and Auditor-General
HVDHB Board Members as at 30 June 2022 The Board has eleven members. Seven are elected. Four are appointed by the Minister of Health *(marked*).*	
David Smol, Chair Hutt Valley and Capital & Coast DHB*	**Richard Stein**
Wayne Guppy, Deputy Chair	**Ken Laben**
Josh Briggs	**Prue Lamason**
Keri Brown	**John Ryall***
Ria Earp*	**Naomi Shaw**
Yvette Grace*	
Executive Leadership Team for Hutt Valley DHB as at 30 June 2022	
Fionnagh Dougan, Chief Executive Officer 2DHB	**Rosalie Percival,** Chief Financial Officer 2DHB
Joy Farley, Director Provider Services 2DHB	**Sarah Jackson,** Acting Director Clinical Excellence 2DHB
Chris Kerr, Director of Nursing 2DHB	**Arawhetu Gray,** Director of Māori Health 2DHB
John Tait, Chief Medical Officer 2DHB	**Junior Ulu,** Director of Pacific People's Health 2DHB
Christine King, Director of Allied Health 2DHB	**Rachel Haggerty,** Director Strategy Planning and Performance 2DHB
Declan Walsh, Director People, Culture & Capability 2DHB	**Steve Earnshaw,** Acting Chief Digital Officer, 3DHB
Karla Bergquist, Executive Director Mental Health, Addictions and Intellectual Disabilities, 3DHB	**Sally Dossor,** Director of the Office of the Chief Executive
Helen Mexted, Director, Communications and Engagement 2DHB	
3DHB Disability Support Advisory Committee as at 30 June 2022	
'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,** Te Upoko o te Ika A Maui Māori Council
Bernadette Jones, Chair, Sub-regional Disability Advisory Group	**Marama Tuuta,** Chair of Kaunihera Whaikaha, Wairarapa
Combined Health System Committee as at 30 June 2022	
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
Ria Earp, Hutt Valley	**Roger Blakeley,** Capital & Coast
Paula King, Te Upoko o te Ika A Maui Māori Council	**Fa'amatuainu Tino Pereira,** Sub-regional Pacific Strategic Health Group
Sue Emirali, Sub-regional Disability Advisory Group	**Bernadette Jones,** Sub-regional Disability Advisory Group
Teresea Olsen, Community Māori Representative, Hutt Valley	
Finance Risk and Audit Committee as at 30 June 2022 - HVDHB	
Wayne Guppy, Chair – HV	John Ryall, Hutt Valley
Yvette Grace, Hutt Valley	David Smol, Hutt Valley
Prue Lamason, Hutt Valley	

Major Capital Projects Advisory Committee as at 30 Jun 2022	
Brendan Boyle, Chair – CC	Wayne Guppy, Hutt Valley
Hamiora Bowkett, Capital & Coast	David Smol, Hutt Valley
Tony Lloyd, Ministry of Health	Bruce McLean,appointed independent expert

Chief Executive Employment Committee (CEEC) as at 30 June 2022. Members are:	
David Smol, Chair CCDHB/HVDHB Boards	
Wayne Guppy,Deputy Chair HVDHB	Stacey Shortall,Deputy Chair CCDHB