# ANNUAL REPORT 2015

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# ACRONYMS USED IN THIS REPORT

| | |
|---|---|
| BMI | Body Mass Index |
| CE | Chief Executive |
| DHB | District Health Board |
| DNA | Did Not Attend |
| FSA | First Specialist Assessment |
| FTE | Full time equivalent |
| GP | General Practitioner |
| GST | Goods and services tax |
| HBDHB | Hawke's Bay District Health Board |
| HHB | Health Hawke's Bay |
| HR | Human Resources |
| IFRS | International Financial Reporting Standards |
| KPI | Key Performance Indicator |
| MoH | Ministry of Health |
| NGO | Non Government Organisation |
| NZIFRS | International financial reporting standards |
| PHO | Primary Health Organisation |
| The Board | Hawke's Bay District Health Board's governing body |
| The CE Act | Crown Entities Act 2004 |
| The NZPHD Act | New Zealand Public Health and Disability Act 2000 |

## TECHNICAL REFERENCE SOURCES

| Measure | Description | Source of information |
|---|---|---|
| New Zealand Deprivation Index - quintiles | A measure of socio-economic deprivation from 1-10 reduced to a five point scale (quintiles) with Quintile 1 being the least deprived 20 percent and Quintile 5 being the most deprived 20 percent. | Ministry of Health |
| Life expectancy | Life expectancy at birth | NZ Mortality Collection, Ministry of Health |
| Obesity rate | Body Mass Index ≥30, population prevalence rate | NZ Health Survey 2012 |
| Age standardised mortality rates | Death from circulatory system diseases.<br>Death from all causes | NZ Mortality Collection, Ministry of Health. Data is provisional and subject to change. |
| Working age people in receipt of sickness benefits | Number of working age people in receipt of a sickness benefit for between one and four years | Ministry of Social Development, Benefit Factsheet |
| Smoking prevalence | Proportion of regular smokers amongst the adult (> 15 year old) population | NZ Census 2001, 2006, 2013 |
| Ambulatory sensitive hospitalisations | Directly standardised ambulatory sensitive hospitalisation rate per 100,000 population | Ministry of Health |
| Acute rheumatic fever hospitalisations | A crude rate acute rheumatic fever hospitalisations per 100,000 population | Ministry of Health |
| Older people supported to live in their own homes | Proportion of clients over 65 years of age in aged residential care compared to those receiving home-based support | Hawke's Bay District Health Board and NZ Statistics |

# Message from the Chair and Chief Executive

The 2014/15 year has continued to see significant change throughout the Hawke's Bay Health Sector as the five year strategic vision for the health system, Transform and Sustain is actioned.

In 2014 we published the first Health Inequity report for the region. Its significant findings of health inequity across the region are being addressed through a Health Equity champion.

Smoking is the biggest cause of inequity in death rates in Hawke's Bay and is the single most important cause of preventable ill health and premature mortality. Work to address this especially amongst Māori women giving birth is a priority considering the long term health effects it has on the health of the next generation.

A significant amount of time and money has gone into empowering clinical leaders and distributing leadership through the clinical community.

Examples of this are in AIM24/7, which is the work to improve hospital flow, improve the quality of care we provide our patients while at the same time improving the working environment for our staff. Clinically led this has resulted in some key achievements to improve hospital flow and managing the increase in Emergency Department presentations.

Another example has focused on increasing operating theatre productivity through Operation Productivity. While there is still more work to do in these areas our patients are benefiting through better access and improved hospital management that has enhanced the quality of our services.

Financially we are pleased we continue to offer our community all the benefits of a financial surplus so we can continue to invest in improving our services, our buildings, developing staff competencies and encouraging clinical leadership through a transformational leadership programme. Posting another significant surplus of just over $3 million for the fifth consecutive year in a row highlights the commitment of our staff and the health system working together to contribute to a quality health service for our community.

We are working on a new programme for our frail elderly to help them remain independent in their own homes for longer through a work plan called engAGE. This work relies on mutli disciplinary teams working outside of the hospital to support general practice manage their elderly patients more supportively and effectively to minimise hospital admissions.

This work will be an important focus for the coming year as the pilot programme is rolled out into more general practices in Hawke's Bay. Working together with our health partners and working as one system is making real inroads. The engAGe programme will see some firsts for New Zealand in helping our frail elderly remain greater independence and stay supported in their own homes for longer. Multi agencies and disciplines working together as one remains the core focus for the coming year as we further develop a culture of collaboration and cooperation.

In November we reopened our refurbished Napier Health centre, which now offers more specialist outpatient services to the people of Napier, we have begun the transition of mental health services into a new community based model of care that will culminate with the opening of the new $20 million Mental Health unit early in 2016.

A summary of our success and progress against our key performance measures is provided in the statement of service performance section of this our 2014 Annual report.

This has been another year of hard work and we take this opportunity to thank our staff and our health and social sector partners for their contribution and dedication over the past year.

**Kevin Snee**
Chief Executive

**Kevin Atkinson**
Chair

# Organisation profile

Hawke's Bay District Health Board
Corner Omahu Road and McLeod Street
Private Bag 9014
Hastings 4156
Phone: 06 878 8109
Fax: 06 878 1648
Email: ceo@hawkesbaydhb.govt.nz

**PUBLIC HOSPITAL AND HEALTH FACILITIES**

**Hawke's Bay Fallen Soldiers' Memorial Hospital**
**Omahu Road**
**Private Bag 9014**
**Hastings**
**Phone: 06 878 8109**

Napier Health
Wellesley Road
PO Box 447
Napier
Phone: 06 878 8109

**Central Hawke's Bay Health Centre**
**Cook Street**
**PO Box 521**
**Waipukurau**
**Phone: 06 858 9090**

Wairoa Health
Kitchener Street
PO Box 84
Wairoa
Phone: 06 838 7099

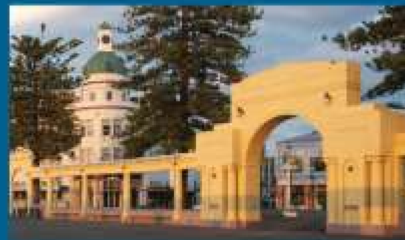
**Chatham Islands Health Centre**
**PO Box 21**
**Chatham Islands**
**Phone: 03 305 0035**
***Note: From 30 June 2015 Canterbury DHB is responsible for Chatham Islands health care.***

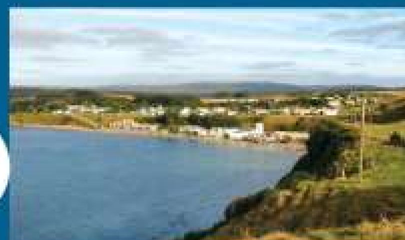
# Hawke's Bay DHB vision, values and structure

## Our vision

HEALTHY
HAWKE'S BAY
TE HAUORA O TE
MATAU-Ā-MĀUI

***Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.***





## Our values

**Tauwhiro** – delivering high quality care to patients and consumers

**Rāranga te tira** – working together in partnership across the community

**He kauanuanu** – showing respect for each other, our staff, patients and consumers

**Ākina** – continuously improving everything we do

## Hawke's Bay District Health Board

***Board Chair Kevin Atkinson***

**Māori Relationship Board**
**Hawke's Bay Clinical Council**
**Hawke's Bay Health Consumer Council**
**Finance Risk and Audit Committee**
**Combined Committees:**
**Community and Public Health Advisory Committee**
**Disability Support Advisory Committee**
**Hospital Advisory Committee**

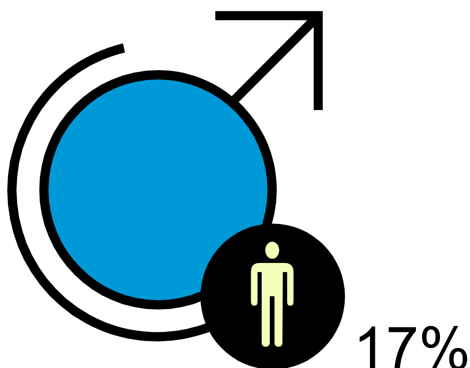
## Hawke's Bay District Health Board

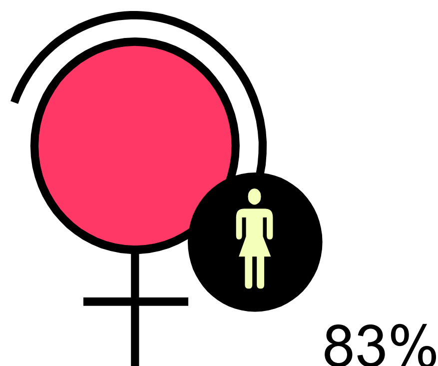
***Chief Executive Dr Kevin Snee***

**Chief Operating Officer**
**Director of Allied Health**
**Chief Medical Officer – Primary**
**Chief Medical Officer – Hospital**
**Chief Nursing Officer**
**General Manager Māori Health**
**Director of Population Health / Health Equity Champion**
**General Manager Human Resources**
**General Manager Planning, Informatics and Finance**
**Director Quality Improvement and Patient Safety**
**Chief Executive Officer Health Hawke's Bay PHO**
**Company Secretary**

# About Hawke's Bay District Health Board

The DHB currently employs **2604** people, a number of whom are multi-jobbed; with **2861** positions held throughout the organisation. Of these **2861** positions:

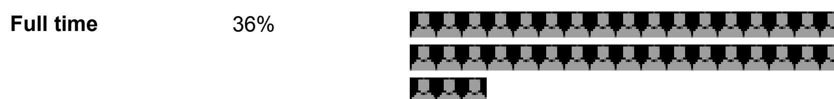



| WORKFORCE PROFILE – by age bands | |
|---|---|
| <25 | 4.3% |
| 25 - 35 | 15.2% |
| 35 - 45 | 20.8% |
| 45 - 55 | 30.2% |
| 55 - 64 | 22.4% |
| 65+ | 7.1% |

| WORKFORCE PROFILE – by occupational group | |
|---|---|
| Medical staff | 9.0% |
| Nursing staff | 50.8% |
| Allied Health staff | 18.5% |
| Non-clinical support staff | 6.3% |
| Management & admin staff | 15.4% |

| WORKFORCE PROFILE – by ethnicity | |
|---|---|
| NZ European | 64.7% |
| NZ Māori | 12.3% |
| Pacific Island | 1.4% |
| British & Irish | 6.9% |
| Other ethnicities | 11.8% |
| Not known | 2.9% |

| EMPLOYEE STATUS | | |
|---|---|---|
| **Casual** | 13% | |
| **Full time** | 36% |  |
| **Part time** | 51% | |

‘There is an active commitment to equal opportunity and the removal of institutional barriers to prevent discrimination. HBDHB takes seriously its legal and moral obligation to be a good employer.’

# Report on good employer obligations

HBDHB's employment approach is to recruit the best person for the role based on professional and general competencies, key accountabilities and organisational fit. Our Human Resource (HR) policies and systems are continuously reviewed and updated to ensure legal compliance, best practice and reinforce consistency and fairness in applying good employer practices.

Our recruitment and employment procedures are both fair and equitable. There is an active commitment to equal opportunity and the removal of institutional barriers to prevent discrimination. HBDHB takes seriously its legal and moral obligation to be a good employer.

Underpinning our Transform and Sustain agenda is an organisational development programme to support the workforce so they are highly skilled, empowered and enabled to fulfil their roles.

The focus for the organisational development programme to support transformational change is:

- Service directorate partnerships
- Clinical leadership and engagement
- Transformational management and leadership capability
- Staff engagement, health and wellbeing
- High-performing teams –including re-skilling and up-skilling of staff
- Building capability – developing talent, succession planning and recruitment
- Increasing Māori staff representation
- Union engagement
- Workforce and high performance team development

**Leadership, Accountability and Culture:**

Investing in its people and developing leadership capability, remains a priority for Hawke's Bay DHB. Leadership is visible, and celebrated, through monthly executive briefings, monthly CEO report to all staff, annual Hawke's Bay health sector awards. Our Transformational Leadership and Basics Management programmes have continued to develop our Managers and Clinical Leaders and have been very well received. Our Transformational Leadership programme has been run for third and fourth tier Clinical leaders and Managers and recently extended to Primary sector.

The Hawke's Bay Consumer Council (established June 2013) continues to meet monthly and ensures health consumers have an effective voice in health planning and how it is delivered in Hawke's Bay. The Consumer Council and the DHB's sector-wide Clinical Council has a leadership role in monitoring quality of health services delivered throughout Hawke's Bay. The DHB is adopting principles of consumer co-design in service planning to ensure the consumer voice is heard, and heard early.

Our new service directorate partnerships support medical, nursing and allied health leaders to have more time to lead and drive up clinical quality and improve patient safety and puts greater focus on integration across primary and secondary care through clinical integration.

The DHB has introduced a Talent Management programme to identify high performing and high potential individuals for the DHB to further develop and invest in. This programme has focused on the third and fourth tier of talent but will be extended to identify emerging talent and to the primary sector.

**Recruitment, Selection and Induction:**

The DHB has centralised recruitment functions ensuring robust recruitment processes are consistently managed across the DHB. The Taleo applicant management system ensures consistent candidate care. Hawke's Bay DHB has a particular concern focus on increasing Māori uptake into health careers and development of Māori health professionals.

Hiring managers are supported through the recruitment and on-boarding process to ensure efficiency and consistency of recruitment and will be better supported as we move to introduce electronic on boarding. Our HR foundations training programmes are made available for managers, team leaders , clinical leaders and staff to attend, The four modules focus on: Recruitment, Selection and Onboarding; Performance Appraisals; Leave Management and Performance Management/Disciplinary Processes.

**Employee Development, Promotion and Exit:**

HBDHB has a fair and equitable performance appraisal system in place which is supported by our policies. The Employment Relations Act, and Health and Safety in Employment Amendment Act 2002 continue to reinforce the need to maintain strong relationships with employees and unions. The Bipartite Union Committee continues to be the forum for Union delegates to be engaged on the Transform and Sustain agenda to discuss common issues.

The DHB's performance appraisal process is well documented and available to all staff on its intranet. Training sessions for managers are to ensure consistent and transparent staff development processes.

The health workforce is a diverse, highly qualified and often highly specialised workforce. The training and development needs reflect this diversity. HBDHB is committed to supporting all staff to access the appropriate training in accordance with their needs. This is in multiple forms including face to face, assessments and online learning through our online learning system, Ko Awatea. This blended approach provides HBDHB greater ability to provide training opportunities which are more effective and efficient for our clinical and non-clinical staff.

HBDHB ensures that its training is quality assured to deliver optimal learning outcomes which are able to be applied back in the workplace. Increasingly the DHB's training and development is being delivered online.

**Flexibility and Work Design:**

The DHB gives consideration to flexible work practices to accommodate staff wherever practical. Guidelines to assist managers to respond to requests for flexible work arrangements requests are available on the DHB's intranet.

The DHB's Human Resource Service also works closely with managers and the Bipartite Union Committee as required to implement change in work practice that meets the needs of staff and assists the organisation to achieve its service and financial performance objectives.

**Remuneration, Recognition and Conditions:**

Our objective is to build organisational capability through the provision of best practice and create a place of work which attracts, develops and retains talented people. Its remuneration processes are transparent and based in being equitable while also recognising performance.

HBDHB has a number of communication medium which are delivered to all staff and key local health sector leaders which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through our monthly Transform and Sustain seminars, monthly Chief Executive In Focus newsletter and annual health sector –wide health awards where success and achievement is celebrated.

**Harassment and Bullying Prevention:**

HBDHB has a zero tolerance to bullying policy which is supported with resources such as clearly defined process supported by policy, manager and staff training, posters throughout the organisation which emphasise respect and acceptable and unacceptable behaviours, and intranet resources provide a centralised information resource for all staff to access.

**Safe and Healthy Environment:**

The DHB is well ready to implement the new Health and Safety legislation and has completed a readiness assessment to identify key risks and put in place mitigation actions.

HBDHB promotes and provides opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via workplace representatives from each service and active participation within the Health and Safety Committee.

HBDHB maintains entry into the ACC partnership programme at tertiary level which recognises that appropriate systems support a safe environment and are implemented throughout the organisation. HBDHB retains its tertiary status as an outcome of the last audit.

The Occupational Health and Safety team in conjunction with Population Health will launch a new Healthy @ Work programme for our staff focussed on promotion of being active, non-smoking, a balanced lifestyle, quality sleep and a healthy diet.

**Staff Ethnicity:**

Increasing the number of Māori employees is a priority for HBDHB. A KPI measuring the number of positions where incumbents identify as Māori is reported the DHB's Board on a quarterly basis. The target is set at 10% improvement on previous year with the ultimate aim that the percent Māori more closely reflect the overall Hawke's Bay population mix where it is estimated the Māori population for Hawke's Bay is 23.0 percent.

As at the end of the 2014/15 year the target of 12.97 percent of staff identifying as Māori was not reached although there had been a significant improvement on the previous year being as at 30 June 2015 12.27 percent Māori compared to June 2014 10.83 percent .

| | Positions filled | % of Total |
|---|---|---|
| NZ & European | 2167 | 75.74% |
| Māori | 351 | 12.27% |
| Pacific Islands | 39 | 1.36% |
| Other | 220 | 7.69% |
| Not known | 84 | 2.94% |
| **Total** | **2861** | |

June 2015 breakdown

- Support staff (27.62%), Allied Health staff (13.07%) and Management & Admin staff (17.73%) exceed the DHB target.
- Medical (2.70%) and Nursing staff (10.12%) are below the target. Nursing has been the primary focus for recruitment and has increased from 8.1% to 10.1% in the last two years.

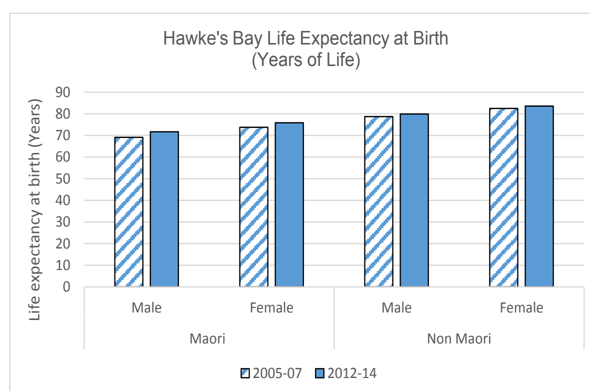
# What are the health trends of our population?

**In Hawke's Bay District Health Board's 2014-18 Statement of Intent, a number of population health indicators were identified that we use to assess the outcomes and impact of our work. Most of these indicators take some time to influence as they are the result of effort from a number of sources. Measurement is often delayed as it relies on national surveys, census data and official mortality statistics, for example. A summary of up to date data for a number of these outcomes is provided below.**

**Better Health for our Population**

Our key indicator of better health is life expectancy. Changes in life expectancy take some time to effect but, as a result of numerous initiatives, we would expect to see a steady improvement in this measure over time.

Life expectancy at birth has increased in all regions in New Zealand since 2005–07, with Hawke's Bay increasing the most, by 1.5 years for males and 1.2 years for females. Analysis of trends in life expectancy between 2005-06 and 2012-14 by ethnicity and gender shows that the biggest gains in life expectancy were for Māori males and Māori females[1]

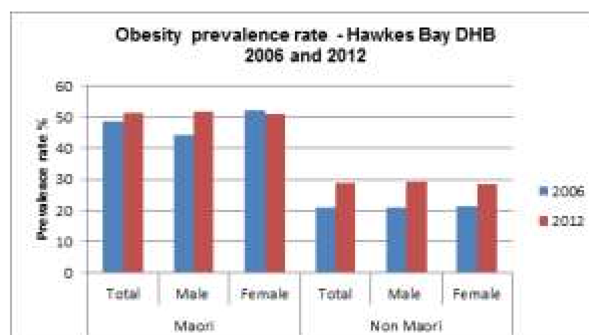


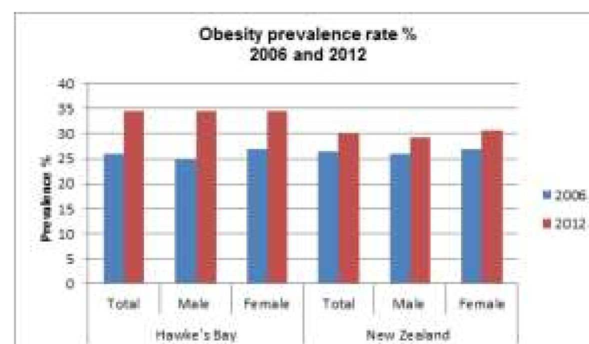

Source: Statistics New Zealand Subnational Life Expectancy 2015

Better health also means reducing health risks. We monitor obesity rates in our population as obesity is a risk factor for several diseases and prevalence is rising in Hawke's Bay. Reducing obesity rates and reducing the disparity between Māori and non-Māori in Hawke's Bay is an indicator of the success of population health programmes.

Nationally there is an increasing trend in obesity prevalence. Hawkes Bay's overall age standardised obesity prevalence rate has increased from 25.2 % in 2006 to 33.3 % in 2012. The increase in prevalence was more significant in males than in females.

The age standardised rates for Hawke's Bay Māori males Māori females are statistically significantly higher than their non-Māori counterparts[2].




Source: National Health Survey 2011-13

[1] http://www.statistics.govt.nz/browse_for_stats/health/life_expectancy/SubnationalPeriodLifeTables_HOTP12-14.aspx
[2] Health Equity in Hawke's Bay Technical Report 2014

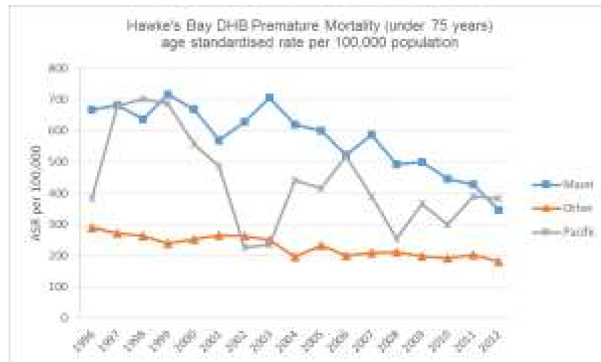
## Equitable Health Status for All

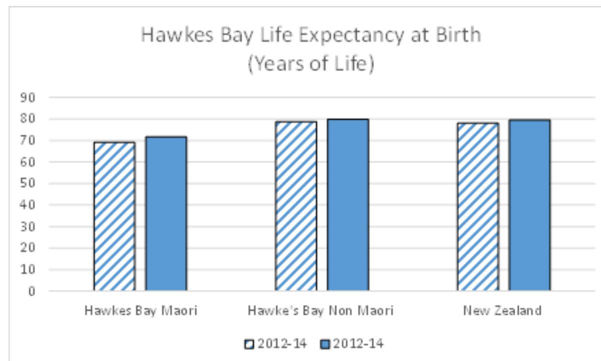
Hawke's Bay DHB is committed to reducing inequity in health and social outcomes. In 2014, a Health Equity in Hawke's Bay Report was published outlining the major inequities in health behaviours and outcomes that require attention.

Premature (death before age 75) all cause mortality rate is a key headline indicator for which there are significant disparities. The disparity between Māori and Non-Māori is reducing which we would expect to see as a result of targeted, effective activities.

Life expectancy for Māori has increased and the gap in life expectancy between Māori and Non-Māori has reduced. The rate of premature mortality in Pacific peoples is also reducing[3]. These indicate a positive trend towards health equity.

Whilst improvements have been seen in Hawke's Bay, recent figures have confirm that the variation in the gap in life expectancy is heavily influenced by socioeconomic factors. To further reduce this gap, we must continue to focus on improving these factors across Hawke's Bay.

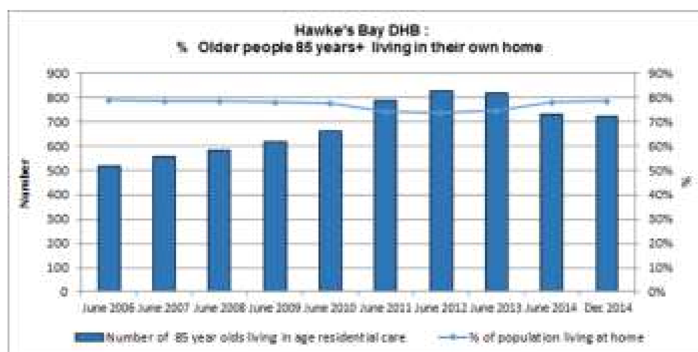



Source: Statistics New Zealand Subnational Life Expectancy 2015

## More Participation and Independence

HBDHB aim to support those who have enduring health conditions or disabilities to maintain maximum function with the least restriction. We monitor the proportion of people over 85 years that remain living in their own homes as an indicator of effective support for the elderly and of equitable care according to need. It is pleasing to see that the number of 85 year olds living in age residential care has not increased in the past year and the % of the population living at home has remained at 78%.




[3] http://www.statistics.govt.nz/browse_for_stats/health/life_expectancy/SubnationalPeriodLifeTables_HOTP12-14.aspx

# Hawke’s Bay District Health Board Governance

### Role of the Board

Under Section 25 (1) of the Crown Entities Act 2004 (the CE Act), the Board is the governing body of HBDHB, with the authority, in HBDHB’s name, to exercise the powers and perform the functions of HBDHB. Under section 25 (2) of the CE Act, all decisions relating to the operation of HBDHB must be made by, or under the authority of, the Board in accordance with the CE Act and the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).

The focus of the Board is on governance and policy issues. The Board’s primary responsibilities are:

- Representing the ‘owner’ (the Crown)
- Setting strategic direction and policies for HBDHB
- Appointing and resourcing the CEO
- Delegating responsibility to the CEO and monitoring the CEO’s performance
- Monitoring the implementation and performance of plans that will have a significant effect on HBDHB
- Ensuring compliance with the NZPHD Act, the CE Act and all other relevant legislation
- Fostering community participation in health improvement, including participation by Māori.

### Role of the CEO

The Board delegates to the CEO, on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the Board’s agreed strategic direction as set out in the Annual Plan. It endorses the CEO, assigning defined levels of authority to other specified levels of management within the organisational structure.

### Statutory Advisory Committees

The Board is required to establish three statutory advisory committees: Community and Public Health Advisory Committee; Disability Support Advisory Committee; Hospital Advisory Committee. The Board may assign defined levels of authority to them. Advisory committees operate under terms of reference and comprise of Board members only  and may advise the Board on issues which have been referred to them.

These three Committees may meet collectively as required to discuss the Annual Plan and other Strategic issues.

These three committees no longer routinely meet, with the HBDHB Board obtaining stakeholder and community input and advice directly and indirectly from the Māori Relationship Board, Hawke’s Bay Clinical Council and the Hawke’s Bay Heatlh Consumer Council and the Pasifika Heatlh Leadership Group.

### Advisory Committees – other

**Māori Relationship Board** through its integrated relationships with the HBDHB Board and committees, Ngāti Kahungunu Iwi Inc, the Māori Relationship Board (MRB) advises the HBDHB Board and assists program development to improve the health of Māori and to assist in the monitoring of health improvement for the Māori population of Hawke’s Bay and the Chatham Islands.

**Finance Risk and Audit Committee** This committee is responsible for monitoring and oversight of the management of the HBDHB’s strategic, operational, clinical and financial risks, the control environment, financial and non-financial performance reporting, audit processes and compliance with regulatory matters and standards.

## Meeting Information & Disclosure of Interests

Number of Board Meetings held 11

**KEVIN ATKINSON – Chair**

**Meetings attended 11 of 11**

Chairman, Unison Networks Limited

Director, Unison Fibre Limited

Trustee HB Medical Research Foundation (until 20 August 2014)

Director, Hawke's Bay Rugby Football Union

Principal Shareholder / MD of Information Management Services Limited

Trustee Te Matau ā Māui Health Trust

**NGAHIWI TOMOANA - Deputy Chair**

**Meetings attended 7 of 11**

Chairman, Ngāti Kahungunu Iwi Inc

Member, Treaty Tribes Coalition

Brother of employee of HBDHB

Brother is employee of Cranford Hospice

Two nephews are employees of HBDHB

**BARBARA ARNOTT**

**Meetings attended 9 of 11**

Trustee Hawke's Bay Air Ambulance Trust

Husband, was Maxillofacial Surgeon (until 26 November 2014)

Daughter, Commercial Manager Food for Health Benefits Limited (from 27 May 2015)

**PETER DUNKERLEY**

**Meetings attended 11 of 11**

Trustee Hawke's Bay Rescue Helicopter Trust

**HELEN FRANCIS**

**Meetings attended 11 of 11**

Patron and Lifetime member of Alzheimers Society Napier

Employee of Hastings Health Centre

Trustee Hawke's Bay Power Consumers' Trust

Trustee of HB Medical Research Foundation (from 20 August 2014)

**DIANA KIRTON**

**Meetings attended 11 of 11**

Practicum Manager, EIT School of Health and Sport Science (from 16 January 2014)

Husband, CEO of the Cancer Society, Central District (until 19 July 2014)

Son is a GP in Wairoa

Daughter-in-law is a Paediatric Registrar at HBDHB

Son was a Medical Registrar at HBDHB, on Short Term Contract (until 11 September 2014)

Brother is a surgeon for HBDHB

Trustee Hawke's Bay Power Consumers' Trust (from October 2014)

Trustee HB Medical Research Foundation (from 20 August 2014 until 25 February 2015)

**DAN DRUZIANIC**

**Meetings attended 11 of 11**

Director Markhams Hawke's Bay Limited

Director Hawke's Bay Rugby Football Union (HBRFU)

**DENISE EAGLESOME**

**Meetings attended 11 of 11**

Deputy Mayor, Wairoa District Council

Trustee Te Matau ā Māui Health Trust

Coordinator of heatlh contract with Wairoa Rugby (from 27 May 2015)

**ANDREW BLAIR**

**Meetings attended 10 of 11**

*Andrew Blair was not able to attend a Board meeting during the year as he was representing the Board in the Chatham Islands at the time the meeting was held.*

Beneficial shareholder of Acurity Heatlh Limited (until 15 January 2015)

Chairman Cancer Control New Zealand (from 18 August 2014)

Owner of Andrew Blair Consulting Limited

**JACOBY POULAIN**

**Meetings attended 11 of 11**

Board Member Eastern Institute of Technology

Councillor Hastings District Council

Columnist for Hawke's Bay Today (until 27 August 2014)

**HEATHER SKIPWORTH**

**Meetings attended 10 of 11**

Mother is a Kaumatua – Kaupapa Māori HBDHB

Trustee of Te Timatanga Ararau Trust holding several contracts with DHB

## Membership of Advisory Committees - statutory

### DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)
### COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC); and
### HOSPITAL ADVISORY COMMITTEE (HAC)

No specific meetings were held for the statutory committees, DSAC, CPHAC and HAC. All of the statutory committees comprise Board members only. Meetings of statutory committees are incorporated as part of the board meetings. Refer Board interests disclosed.

**Diana Kirton – Chairperson of DSAC**

**Barbara Arnott – Chairperson of CPAC**

**Peter Dunkerley – Chairperson of HAC**

**Helen Francis**

**Denise Eaglesome**

**Kevin Atkinson**

**Ngahiwi Tomoana**

**Dan Druzianic**

**Andrew Blair**

**Jacoby Poulain**

**Heather Skipworth**

## Membership of Advisory Committees - other

### MĀORI RELATIONSHIP BOARD (MRB)

Number of MRB and Annual Planning Meetings held 7.

**Ngahiwi Tomoana – Chairperson**
**Meetings attended 6 of 7**
Refer Board interests disclosed

**Denise Eaglesome**
**Meetings attended 3 of 7**
Refer Board interests disclosed

**Helen Francis**
**Meetings attended 6 of 7**
Refer Board interests disclosed

**Diana Kirton**
**Meetings attended 5 of 7**
Refer Board interests disclosed

**Heather Skipworth**
**Meetings attended 7 of 7**
Refer Board interests disclosed

**Tatiana Cowan-Greening**
**Meetings attended 2 of 7**
Ngāti Kahungunu Iwi Inc representative
Trustee, Te Matau ā Māui Health Trust
Husband is Manager of Te Kupenga Hauora

**Kerri Nuku**
**Meetings attended 5 of 7**
Ngāti Kahungunu Iwi Inc representative
Kaiwhakahaere New Zealand Nurses Association
Director Hei Nursing
Trustee of Maunga Haruru Tangitu Trust

**Des Ratima**
**Meetings attended 6 of 7**
Representative of Ahuiriri District Heatlh (Wai 692)
Chairperson, Ahuriri District Health Trust
Chairperson, Te Whanantahi Trust
Chairperson, Takitimu Māori Wardens Trust
Chair Kaupapa Māori Committee
Chair Takatimu Māori District Council

**Trish Giddens**
**Meetings attended 7 of 7**
Ngāti Kahungunu Iwi Inc representative
Manager Services to Older People, Waiapu Anglican Social Services (until 18 September 2014)
Trustee, HB Air Ambulance Trust
Contractor Te Taitimu Trust (until April 2015)
Assistant Director Rotary District 9930 (from 15 April 2015)
Manager, Taruna College (from 15 April 2015)
Member of the Lotteries Board (from 15 April 2015)

**Patrick LeGeyt** (Resigned April 2015)
**Meetings attended 5 of 7**
Ngāti Kahungunu Iwi Inc representative
Employee of Te Taiwhenua o Heretaunga
Trustee of Omahu Marae
Wife works for Central Health

**Na Raihania**
**Meetings attended 6 of 7**
Ngāti Kahungunu Iwi Inc representative
Wife employed at Te Taiwhenua o Heretaunga
Member Tairawhiti DHB Māori Relationship Board

**George Mackey**
**Meetings attended 3 of 7**
Ngāti Kahungunu Iwi Inc representative
Trustee of Te Timatanga Arararau Trust
Wife employed at Te Timatanga Ararau Trust
Employee of Te Puni Kokiri (from 19 June 2014)

**Lynlee Aitcheson**
**Meetings attended 6 of 7**
Ngāti Kahungunu Iwi Inc representative
Chair of Māori Party, Heretaunga Branch

## FINANCE RISK AND AUDIT COMMITTEE (FRAC)

Number of FRAC Meetings held 11

**Dan Druzianic - Chairperson**
**Meetings attended 11 of 11**
Refer Board interests disclosed

**Kevin Atkinson**
**Meetings attended 11 of 11**
Refer Board interests disclosed

**Barbara Arnott**
**Meetings attended 9 of 11**
Refer Board interests disclosed

**Peter Dunkerley**
**Meetings attended 11 of 11**
Refer Board interests disclosed

**Andrew Blair**
**Meetings attended 10 of 11**
*Andrew Blair was not able to attend a FRAC meeting during the year as he was representing the Board in the Chatham Islands at the time the meeting was held.*
Refer Board interests disclosed

**Jacoby Poulain**
**Meetings attended 11 of 11**
Refer Board interests disclosed

**A year of growth, remembrance, change and celebration 1.** Chaplaincy service committed to film **2.** 2014 Countdown Kids Hospital Appeal **3.** All Blacks visit a hit with patients, visitors and staff **4.** Tremains Triathlon 2015 **5.** Bill Stirling remembered **6.** Hawke's Bay Fallen Soldiers' Memorial Hospital **7**. Immunisation teamwork **8.** Pink Shirt Day celebrations **9.** Te Pare Meihana, Wairoa Health manager **10.** 2015 International Nurses and Midwives Day celebrations **11.** New Mental Health unit takes shape **12.** Napier Health opening

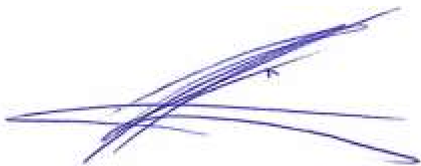
# Statement of Responsibility

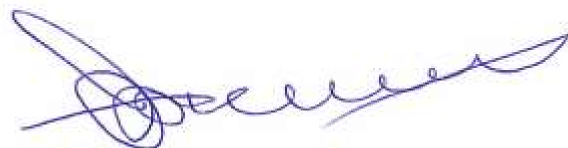
The board and management of Hawke's Bay District Health Board are responsible for the preparation of the financial statements and statement of service performance and the judgements in them;

The board and management of Hawke's Bay District Health Board are responsible for any end-of-year performance information provided by the district health board under section 19A of the Public Finance Act 1989;

The board and management of Hawke's Bay District Health Board 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, and;

In the opinion of the board and management of Hawke's Bay District Health Board the financial statements and statement of service performance for the year ended 30 June 2015, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.





| **Kevin Atkinson**<br>*Chair* | **Peter Dunkerley**<br>*Board Member* |
|---|---|

28 October 2015

# Independent Auditor's Report

**To the readers of Hawke's Bay District Health Board's financial statements and performance information for the year ended 30 June 2015**

The Auditor-General is the auditor of Hawke's Bay District Health Board (the Health Board).The Auditor-General has appointed me, Chrissie Murray, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 48 to 87, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expenditure, 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 including the information on outcomes on pages 11 and 12 and the Statement of Service Performance on pages 24 to 46.

**Unmodified opinion on the financial statements**

In our opinion:

- the financial statements of the Health Board:
  - o present fairly, in all material respects:
    - its financial position as at 30 June 2015; and
    - its financial performance and cash flows for the year then ended; and
  - o comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity standards.

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

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators}, rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on performance information of the Health Board for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, including:
  - o for each class of reportable outputs:
    - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;

- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 2 November 2015. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and explain our independence.

**Basis of opinion**

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board's financial statements and performance information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and the performance information. Also, we did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

**Responsibilities of the Board**

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

- comply with generally accepted accounting practice in New Zealand;
- present fairly the Health Board's financial position, financial performance and cash flows; and

- present fairly the Health Board's performance.

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

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

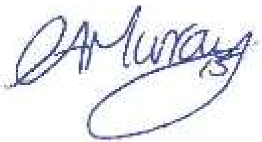
**Responsibilities of the Auditor**

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

**Independence**

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Health Board.



Chrissie Murray
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

# Statement of Service Performance 2014/15

This section outlines Hawke's Bay District Health Board's achievement against the 2014/15 Statement of Performance Expectations. Service performance is grouped into four Output Classes: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and, Rehabilitation and Support Services. Across the output classes, we strive to maintain a balance across the three dimensions of the New Zealand Triple Aim **(Figure 1),** in line with the Health Quality and Safety Commission's drive for quality improvement across the health sector.

**System:** For each output class we show expected funding and expenditure to demonstrate how output class performance will contribute to the outcome of a financially sustainable system.

**Individual:** Ensuring quality and safety, within hospitals and wider health services, is a fundamental responsibility of DHBs. Our Quality Improvement and Patient Safety Framework guides our performance expectations in terms of quality. Measurements in this dimension contribute to clinical sustainability of the system, including how the system responds to health needs and to overall patient and consumer satisfaction.

**Population:** Explaining the contribution that our services make towards achieving the population and system level outcomes outlined in our Statement of Intent, requires consideration of the impacts of our outputs on the population that we serve. There is no single measure for the impacts of the work that we do, so population health indicators are used as proxies where evidence shows that the indicators in question are representative of the impact sought. Impact is related to effectiveness of services and is also closely linked to the purpose of our work.

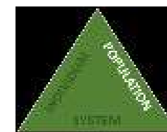
**Figure 1: The New Zealand Triple Aim**

District Health Boards report performance quarterly, semi-annually and annually depending on the availability of data. This Statement of Service Performance relies on our most recent result for each indicator. Technical details along with historical and other in-year results (where available) can be found in **Appendix One**. The symbols F (favourable) and U (unfavourable) have been inserted next to the actual result to clarify whether or not the forecast performance target has been achieved.

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

## Prevention services

*Impact: People are better protected from harm and more informed to support healthier lifestyles and maintenance of wellness.*




**Statement of Service Performance Output Class 1**

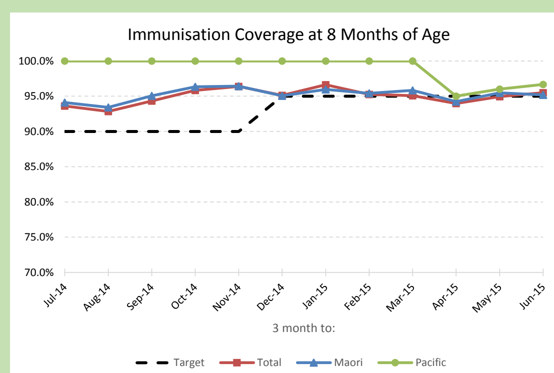
Prevention Services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population, as distinct from treatment services which repair or support health and disability dysfunction. Prevention Services address individual behaviours by targeting population-wide physical and social environments to influence health and well-being. Prevention Services include: health promotion and education services; statutory and regulatory services; population based screening programmes; immunisation services; and, well child and school services.

On the continuum of care, Prevention Services are population-wide and are designed to focus attention on wellness of the general population and on keeping the "at risk" population healthy. It is important to emphasise that the concept of wellness extends to the entire population, including those who already have a health condition or disability.

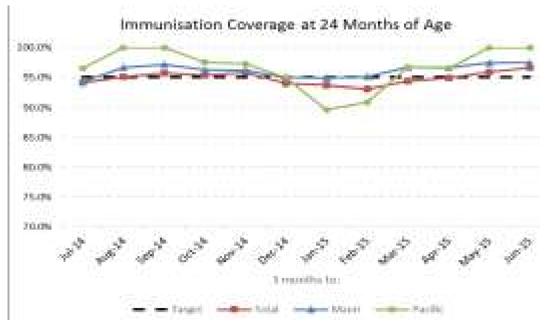
Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise that they often arise out of issues that originate outside the health system. Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health.

**National Health Target: Increased Immunisation**

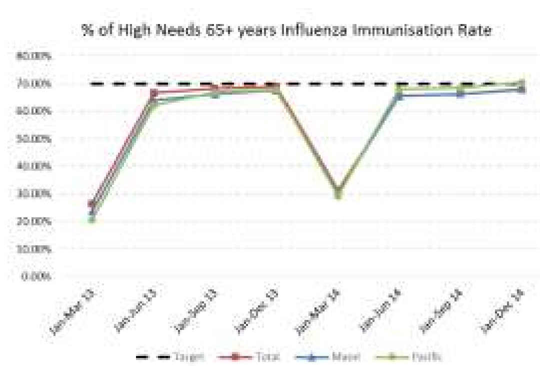
The Increased Immunisation Health Target aims to prevent the outbreak of vaccine preventable disease through improved immunisation coverage. Hawke's Bay DHB is one of only three DHBs to have achieved 95% coverage of 8 month olds by December 2014 and to have maintained it throughout the year for Māori, Pacific peoples and total population. This is an outstanding achievement and we ended the year at 95.5% coverage.



Greater than 95% coverage in 2 year olds was also achieved with 96.6% of 2 year olds fully immunised in Q4 (97.4% Māori). The consistently high rate of coverage at multiple milestones is seen across all ethnicities and is indicative of well-coordinated and targeted services across multiple providers with good systems and processes for identifying issues and early intervention.




Hawkes Bay immunisation services also focus on the older population offering influenza vaccinations for high needs people aged 65 years and over. Seasonal influenza is a contributory factor in the high number of preventable hospitalisations amongst older people, particularly Māori. Immunisation coverage fell just short of the target at 67.9% (target 70%). Immunisation services, the Hawke's Bay PHO Health Hawke's Bay (HHB) and Māori providers are working in collaboration to improve this performance through active recall of eligible patients and improving promotional activity.



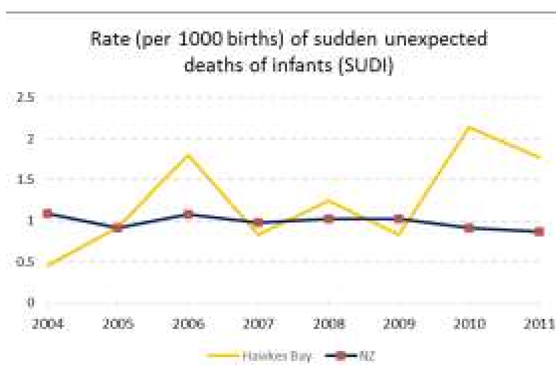

## Rheumatic Fever

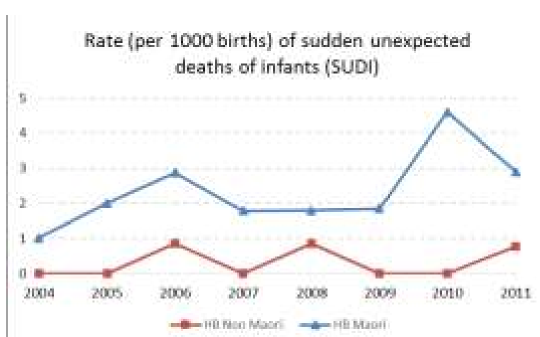
Hawke's Bay has high rates of Rheumatic Fever, a preventable diseases that has serious consequences. Ongoing implementation and review of the Rheumatic Fever Prevention Plan is proving to be effective as rates continue to decline in Hawkes Bay. The latest results show less than 4 cases of first time hospitalisation for rheumatic fever in 2014/15, better than the target rate of ≤2.6 per 100,000. An evaluation of the rheumatic fever prevention programme 'Say Ahh' found it to be 'highly effective' for preventing new cases of rheumatic fever.

Note: Rates cannot be calculated where there are fewer than four cases. This is because the small numbers will result in unreliable estimates of rates

## Sudden Unexplained Death of Infant

Another area of focus in Hawke's Bay is reducing sudden unexplained death of infant (SUDI). HBDHB is committed to reducing risk factors associated with SUDI such as smoking during pregnancy and increasing breastfeeding rates. HBDHB run a safe sleep programme to educate parents on safe sleep, related risk factors and provide safe sleep devices. The SUDI rate has reduced from 2.1 per 1,000 live births to 1.77 per 1,000. This is still higher than the national rate of 0.9 per 1,000 live births. Māori rate has also reduced from 4.6 per 1000 live births to 2.9 per 1,000 (National Māori rate 2.3 per 1,000). In 2015/16 there will be a greater focus on influencing the wider whānau around safe sleep practices.



### Breastfeeding

High rates of breastfeeding not only reduce the risk of SUDI but also lay a foundation for good health in infancy, childhood and into adult life. The measures include exclusive breastfeeding at 6 weeks (Target ≥68%) and 3 months (Target 54%) as well as receiving breast milk either exclusively, fully or partially at 6 months (Target 59%)

For all measures, total Plunket rates are above the targets. Māori rates for all measures are unfavourable however, exclusive breastfeeding at 6 weeks and 3 months for Plunket have increases this year.

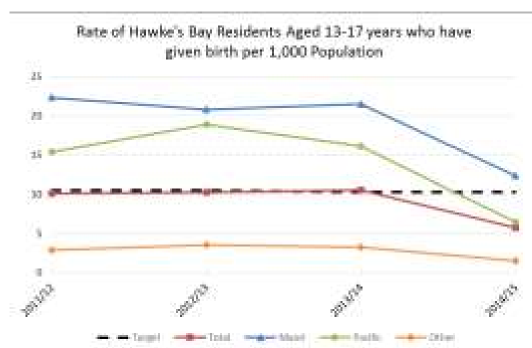
Improving breastfeeding rates requires excellent coordination of breastfeeding activities across the Hawke's Bay health sector and community.

| **Infants are exclusively of fully breastfed at 6 weeks** | | | |
|---|---|---|---|
| **Key Performance Measures** | **Target June 2016** | **Previous 2013/14** | **Actual 2014/15** |
| Māori – Plunket | ≥68% | 58% (U) | 62% (U) |
| Māori – Tamariki Ora | | 54% (U) | 51% (U) |
| Total – Plunket | | 68% (F) | 69% (F) |
| Total – Tamariki Ora | | 56% (U) | 56% (U) |

| **Infants are exclusively of fully breastfed at 3 months** | | | |
|---|---|---|---|
| **Key Performance Measures** | **Target June 2016** | **Previous 2013/14** | **Actual 2014/15** |
| Māori – Plunket | ≥54% | 37% (U) | 42% (U) |
| Māori – Tamariki Ora | | 35% (U) | 33% (U) |
| Total – Plunket | | 52% (U) | 54% (F) |
| Total – Tamariki Ora | | 36% (U) | 36% (U) |

| **Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)** | | | |
|---|---|---|---|
| **Key Performance Measures** | **Target June 2016** | **Previous 2013/14** | **Actual 2014/15** |
| Māori – Plunket | ≥59% | 50% (U) | 49% (U) |
| Māori – Tamariki Ora | | 42% (U) | 42% (U) |
| Total – Plunket | | 62% (F) | 59% (F) |
| Total – Tamariki Ora | | 43% (U) | 45% (U) |

### Rate of Teenage Pregnancy

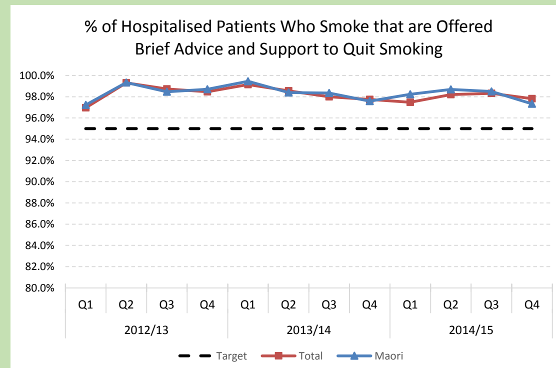



Reproductive health is a district priority targeted at rangatahi Māori. Becoming a parent at an early age reduces the likelihood of achieving level 2 or higher in NCEA, which affects income levels. Health of both the teenage mother and children born to teenage mothers is at greater risk of poor health outcomes. There has been a significant decrease in the rate of pregnancy in under 17 year olds for both Māori and non-Māori. The total rate has reduced from 10.3 to 5.7 (per 1,000) in 14/15. Māori still have much higher rates than non-Māori at 12.3 and 1.9 respectively.

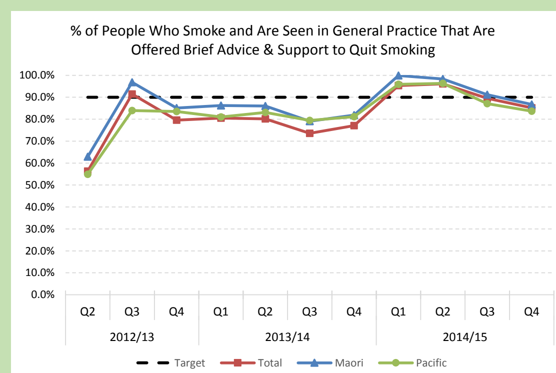
**National Health Target: Better Help for Smokers to Quit**

In Hawkes Bay we are committed to reducing smoking rates with the vision of a smokefree Aotearoa by 2025. The National Health Target: Better Help for Smokers to Quit is designed to prompt providers to give brief advice and offer quit support to current smokers. Evidence shows that brief advice is effective at prompting quit attempts and long-term quit success.

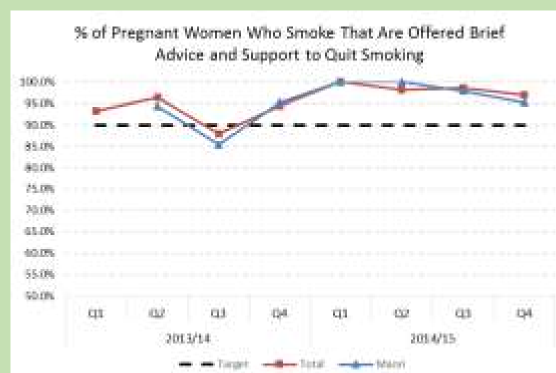
More than the targeted 95% of hospitalised patients, both Māori and total, were offered brief advice and support to quit smoking in 14/15. ABC (ask, brief advice and cessation support) is business as usual for the hospital staff.




The percentage of PHO enrolled patients who smoke that have been offered help to quit smoking by a health care practitioner in the last 15 months has increased from the baseline of 80.2%. A slight decline in performance in Q4 to 85.2% is likely attributable to balancing demand on practices during the busy winter months. This indicates that there is still work to do to ensure that performance is sustainable.




Currently, the rate of tobacco use during pregnancy in Māori women in Hawkes Bay is alarmingly high[4]. Tobacco use during pregnancy increases the risk of miscarriage, premature birth and low birth rate, as well as their children's risk of asthma and sudden unexplained death of infant. The maternity component of the health target is aimed at offering brief advice and support to quit smoking for pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer. In 2014/15 we achieved exceptional results, consistently exceeding the target of 90% for both Māori and total population. This is attributable to excellent coordination across services providing care to pregnant women.



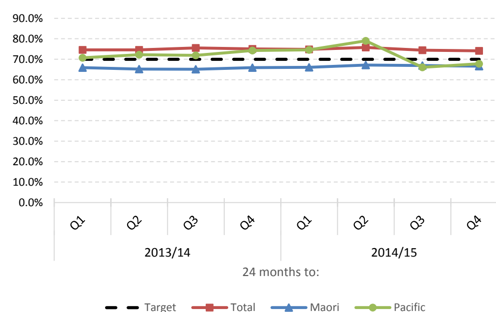

The percentage of year 10 student who have never smoked has increase from 64% in 2013 to 68% in 2014._This increase is a pleasing result, however, there is a need to accelerate the increase in order to reduce smoking, especially for young Māori women so they are tobacco free prior to becoming pregnant.

[4] Health Equity in Hawke's Bay Technical Report 2014

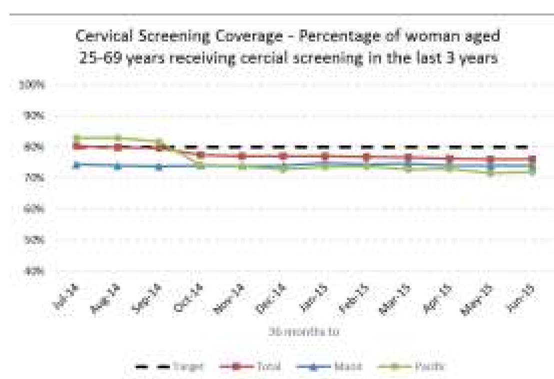
### More women are screened for cancer

Primary prevention of health includes screening those at risk and is a key strategy in effective management of long-term conditions. Screening programmes help to detect health problems early and result in better options for treatment and improved survivability. We have inequitable rates of screening so we aim to be more responsive to the needs of Māori and Pacific women in order to reduce ethnic disparities.

Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 45 and 69. Overall our rate is 74.4% which is above the national target of ≥70%. Both Māori and Pacific results are slightly below the target at 66.9% and 66.1% respectively however Māori rates have improved slightly in 2015




Screening for cervical cancer is offered every 3 years to all women between the ages of 20 and 69 years. In an attempt to reduce inequities, this is offered free for National Cervical Screening Programme priority group women i.e. Māori, Pacific and Asian women and other women aged 30-69 years who have never had a smear or have not had a smear in the past five years. Overall our rate is 76.7% which is below the target of ≥80% and while there are still inequities in results, HBDHB had the highest coverage for Māori (74.6% vs national rate of 62.6%) and the 6th highest for Pacific of 20 DHBs in the 3 years ending March 2015.




Reducing inequities continues to be an ongoing priority for the screening sector and service providers continue to take a collaborative approach to improving Māori participation in both screening programmes.

Note: Population data changed in January to use projections based on the 2013 census to calculate national and district health board (DHB) coverage for BreastScreen Aotearoa (BSA) and the National Cervical Screening Programme (NCSP). This has impacted on most DHB coverage rates, including HBDHB.

| **Prevention Services** | | | |
|---|---|---|---|
| | **2015 Actual $'m** | **2015 Plan $'m** | **2014 Actual $'m** |
| Ministry of Health | *6.4* | *6.4* | *6.4* |
| Other sources | *0.4* | *0.2* | *0.4* |
| **Income by Source** | ***6.8*** | ***6.6*** | ***6.8*** |
| *Less:* | | | |
| Personnel | *1.5* | *1.5* | *1.4* |
| Clinical supplies | *0.1* | *0.1* | *0.1* |
| Infrastructure and non clinical supplies | *0.4* | *0.4* | *0.4* |
| Payments to other providers | *8.0* | *5.0* | *7.9* |
| **Expenditure by type** | ***10.0*** | ***7.0*** | ***9.8*** |
| **Net Result** | ***(3.2)*** | ***(0.4)*** | ***(3.0)*** |

## Early Detection and Management

*Impact:* People's health issues and risk are detected early and treated to maximise wellbeing

### Statement of Service Performance Output Class 2

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

On the continuum of care these services are mostly concerned with the "at risk" population and those with health and disability conditions at all stages

For people who are at risk of illness and or injury, we undertake activities that raise awareness and recognition of risky behaviours and practices and improve the opportunity of early detection of health conditions. If people are assisted to identify risk early, and those at risk are screened to detect health conditions early, then behavioural changes and treatment interventions are often easier with less complications and greater chances of returning to a state of good health or of slowing the progression of the disease, injury or illness. Targeting environmental barriers to good health and connecting people with health services earlier is the intention because early detection of health issues or risks leads to better opportunities to influence long-term outcomes.

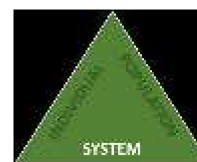
### Proportion of the population enrolled in the PHO

Across New Zealand, people are required and encouraged to enrol with a general practice that is affiliated to a Primary Health Organisation (PHO). HHB coordinates and manages the targeting of many services to those populations who are known to have a poor health status such as Māori, Pacific peoples and those living in the most deprived areas. Being enrolled in a PHO and having access to care in the right place at the right time allows for early detection and management of health issues and risks. There has been a slight overall decrease in the percentage of enrolled population in Q3 and Q4 to 95.4% (target 97%). However, there has been a consistent increase in Māori enrolled with a PHO which has been the focus. HHB continues to work closely with the DHB and general practice to promote enrolments and offer resources to facilitate the process.

Note: The reduction in Pacific people enrolled with a PHO in Q3 is likely due to the census population data being updated. This is used as the denominator to calculate the percentage of population enrolled and the greatest anomaly was in the population figures for pacific peoples.

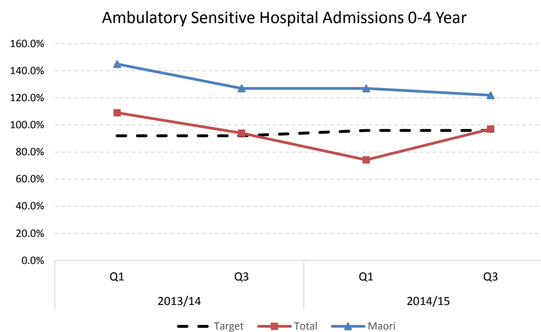
### ASH rates

With successful preventions services and provision of the right care at the right time in the right place, we would expect to see a reduction of Ambulatory sensitive hospitalisations (ASH). These are hospital admissions from causes considered to be responsive to preventative or therapeutic interventions delivered outside of a hospital setting.

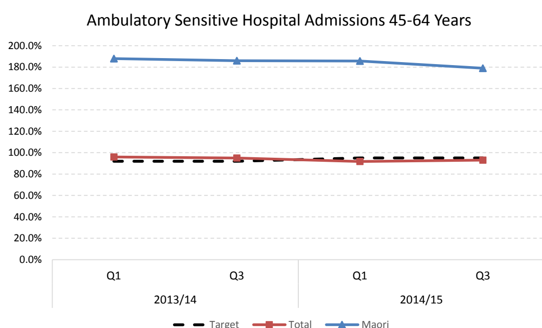


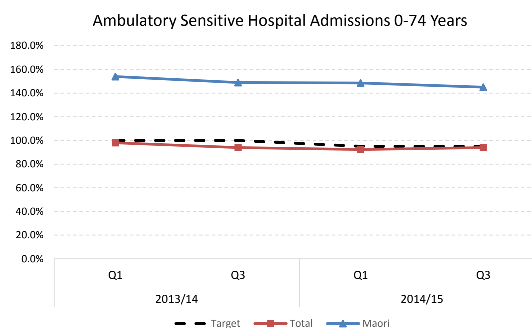

ASH rates are monitored for Māori and Total population in age groups 0-4 years, 45-64 years and 0-74 years. Rates are presented as number of hospitalisations per 100,000 DHB population as a percentage relative to the total national rate.

Rates for Māori 0-4 years continue to reduce but are still unfavourable (122% vs target of 96%) and higher compared to the total (97%). The first half or the year saw a reduction in total rates to 74.2% but this has increased to just slightly above the target in Q3. ASH rates for severe dental decay, skin conditions, respiratory and ear nose and throat infections have the largest inequity gap. We continue to focus on these areas to bring down ASH rates and reduce inequities.

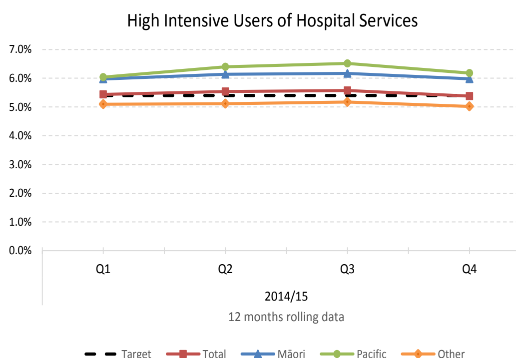



Overall, favourable results have been achieved in the 45-64 year category (93%) and the 0-74 year category (94%). The focus is on reducing inequities which are mainly evident in heart disease, skin infections, respiratory infections and diabetes.



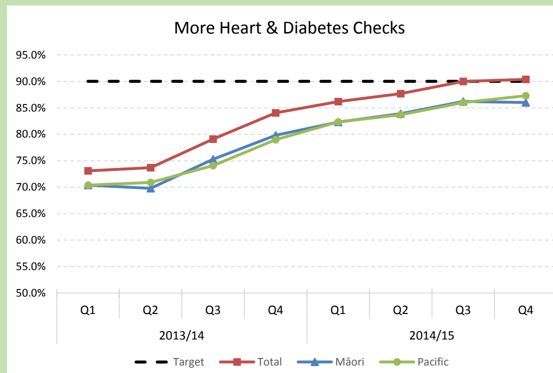



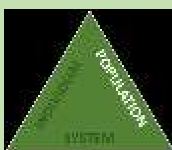

Another indicator of delivering the right care in the right place at the right time is the rate of high intensive users at ED. This has reduced this year to 5.38 (target ≤5.4). Work continues to reconnect patients with primary care, encouraging enrolment and follow up with GPs.



## National Health Target: More Heart and Diabetes Checks

The More Heart and Diabetes Checks indicator monitors the proportion of the eligible population who have had blood tests for Cardiovascular disease (CVD) risk assessment in the preceding five year period. CVD disproportionately affects Māori and is preventable with lifestyle advice and treatment for those at moderate or higher risk.



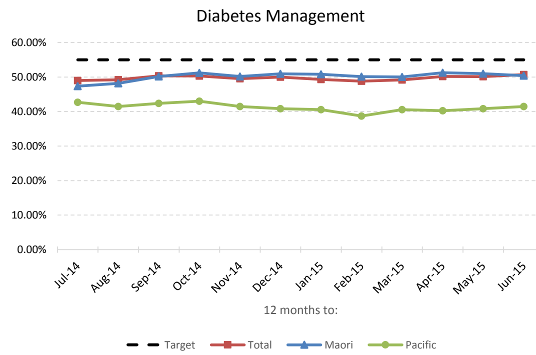



Since Q1 2013/14, the percentage of the population that have had their CVD risk assessed in the last five years has increased steadily from 73.1% to 90.4%. A commendable effort from primary care. There has been a proportionate improvement in Māori and Pacific. If performance continues to improve at the same rate, we would expect to meet the target in all ethnicities next year

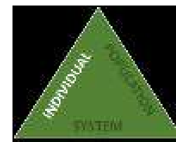
## Glycaemic Control

Good glycaemic control reduces the risk of CVD and is an indicator of long term conditions management. The number of people with good or acceptable glycaemic control remains below the target of 55% with Q4 performance reaching 50.7%.

HHB are currently in discussions with all practices to formalise their plans for next financial year – this will include the implementation of 20 quality standards as reflected in the MoH National Diabetes Work programme 2014 – 2015.

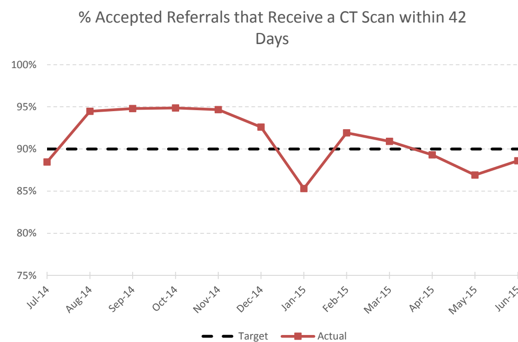



## Less Waiting for Diagnostic Services

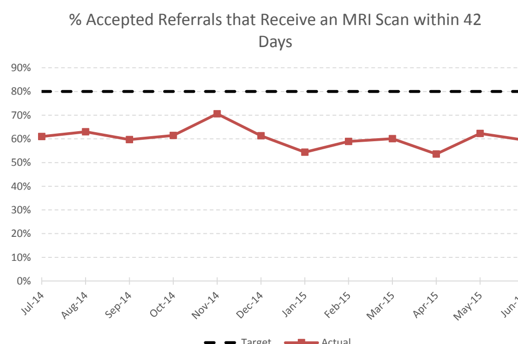



Timely access to diagnostic services is vital for early diagnose of a health condition or as part of treatment. A significant area of diagnostic support for the health sector is radiology. The growth in demand for radiology services is driven by multiple factors including the health needs of the changing population, service developments and advancements in medicine. Compliance with waiting time standards diagnosis and is crucial in the drive to support more community-based care delivery

For Computed Tomography (CT), the standard is that 90% of 'routine' referrals receive a CT scan within 42 days. For the majority of the year we have met this target, however the final Q4 result showed a slight dip in performance to 88.6%. This was due to an unexpected increase in acute and urgent referrals. Overall there was an increase in the total numbers of patients scanned in CT.

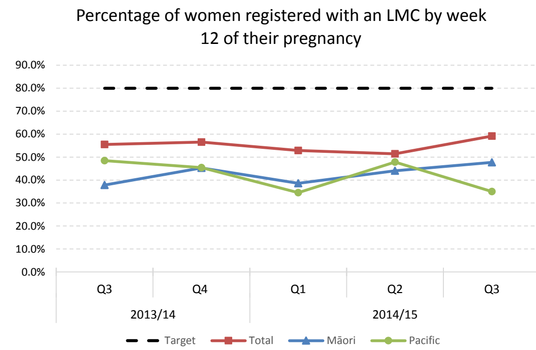


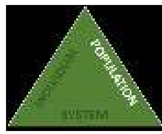

For Magnetic Resonance Imaging (MRI), at year-end, routine patients were waiting up to 12 weeks for their scans therefore the indicator is unfavourable (59.5% against target ≥80%) overall. We are participating in the National Radiology Service Improvement initiative which has led to an increase in the number of patients scanned per month however MRI demand continues to grow.



## Early Engagement with Lead Maternity Carers (LMC)

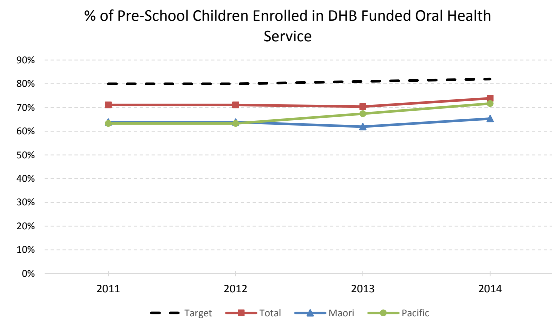
Over the last two years there has been an increased focus on how to improve the engagement with LMC's earlier for pregnant women. Early registration is paramount, especially in vulnerable women, so that vital first trimester screening and the best possible pregnancy outcomes can occur. The percentage of women registered with an LMC by week 12 has increased from 46.9% in Q2 2013/14 to 59.2% (target 80%). The overall rate for the year shows a good increase and is trending in the right direction although there has been a drop in early registration for pacific peoples.




## Oral Health

Due to the poor oral health status of Hawke's Bay children, especially Māori and Pacific, we have a focus on improving early enrolment with dental services. Those identified as needing further examination or treatments are scheduled for a recall. In the last year, 73.9% of pre-school children were enrolled in DHB funded oral health services (65.3% Māori and 71.7% Pacific). All ethnicities have improved since 2013 and should continue to improve with oral health now being included in the quadruple enrolment of babies at birth.




4% of children were not examined according to planned recall which is favourable against a target of less than 5% and an improvement on last year. The percentage of adolescents using DHB funded dental services in 2014 was 78.3% which is unfavourable against a target of ≥85% A continued effort is being undertaken to increase use of dental services by adolescents by providing a smooth transition of information from the Community Oral Health Service to dentists at Year 8 and by creating a strong continued awareness of free dental care, particularly among 17-year-olds.

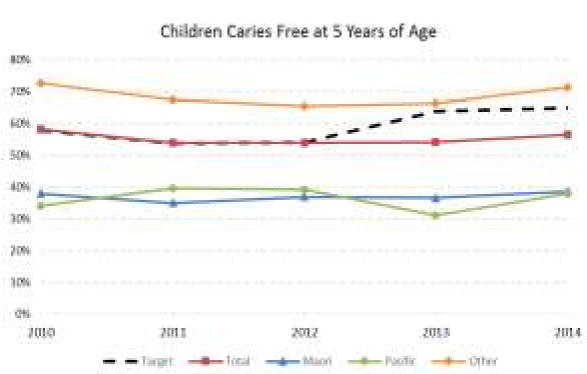
| Percentage of children not examined according to planned recall | | |
|---|---|---|
| **Baseline** | **Target** 2014 | **Actual** 2014 |
| *4.4%* | *<5%* | *4.0% (F)* |

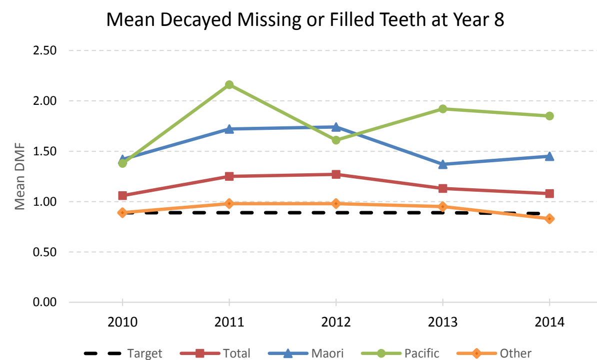
| Percentage of adolescents using DHB funded dental services | | |
|---|---|---|
| **Baseline** | **Target** 2014 | **Actual** 2014 |
| *84.5%* | *≥85%* | *78.3% (U)* |

The overall oral health status for 5 year olds has improved since last year. More children were caries free at 5 years across all ethnicities than in 2013.

Children are also checked at year 8 for decayed, missing or filled teeth (DMFT). The mean rate of DMFT has reduced from 1.13 to 1.08 in the last year although this is still unfavourable against the target rate of ≤0.88

There continues to be large inequity gaps between Māori, Pacific, and Other ethnicities. However, the data shows a downward trend across all ethnicities when compared to previous year's data.




| Early Detection and Management | | | |
|---|---|---|---|
| | **2015 Actual $'m** | **2015 Plan $'m** | **2014 Actual $'m** |
| Ministry of Health | *118.1* | *131.2* | *121.0* |
| Other District Health Boards | *1.9* | *2.6* | *2.1* |
| Other sources | *4.2* | *3.1* | *4.3* |
| **Income by Source** | ***124.2*** | ***136.9*** | ***127.4*** |
| *Less:* | | | |
| Personnel | *24.6* | *24.2* | *23.4* |
| Outsourced services | *3.8* | *3.1* | *4.6* |
| Clinical supplies | *2.9* | *2.5* | *2.8* |
| Infrastructure and non clinical supplies | *7.9* | *7.8* | *7.8* |
| Payments to other District Health Boards | *2.4* | *2.6* | *2.4* |
| Payments to other providers | *84.3* | *102.2* | *82.4* |
| **Expenditure by type** | ***125.9*** | ***142.4*** | ***123.4*** |
| **Net Result** | ***(1.7)*** | ***(5.5)*** | ***4.0*** |

## Intensive Assessment and Treatment Services

*Impact:* Complications of health conditions are minimised and illness progression is slowed down

**Statement of Service Performance Output Class 3**

Intensive Assessment and Treatment Services are delivered by a range of secondary, tertiary and quaternary providers to individuals. This Output Class includes: Mental Health services; Elective services (including outpatients, surgery, inpatient and cancer services); Acute services, (including ED, Inpatient and Intensive Care services); Maternity services; and, Assessment, Treatment and Rehabilitation (AT&R) services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

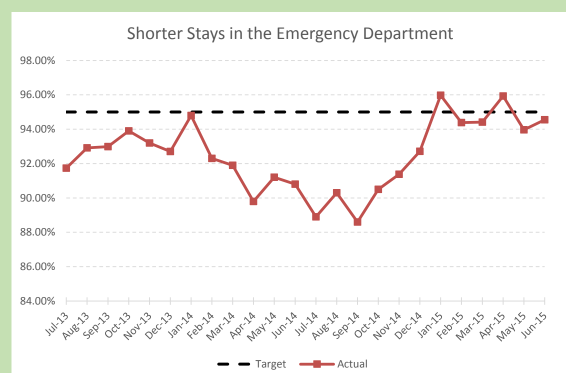
HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health, in terms of survival, and are also able to participate effectively in society and be more independent. It is important that identified disparities are also reduced as quickly as practicable.

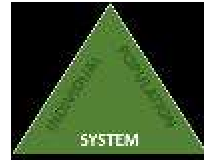
**National health Target: Shorter Stays in the Emergency Department**

Emergency Department (ED) length of stay is an important measure of the efficiency of flow of acute (urgent) patients through the hospital and home again. Shorter stays in ED mean that more people are able to access acute care when needed and they are quickly referred to the most appropriate service. Long stays in ED are linked to overcrowding which can lead to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay.

A commendable effort has seen a significant reduction in ED length of stay at HBDHB. The target of 95% was achieved in Q3 (94.9%) and Q4 (94.8%) which is a significant improvement on last year 90.6% despite the winter season bringing challenges such as staff illness and 8.2% more presentations to ED. A number of initiatives have been introduced through the Acute Inpatient Management Change Programme (AIM 24/7) both within ED and wider system to improve patient flow in the hospital which have led to shorter stays in ED. There are ongoing challenges to sustain this achievement as it requires whole system coordination



## Average Length of Stay (ALOS)



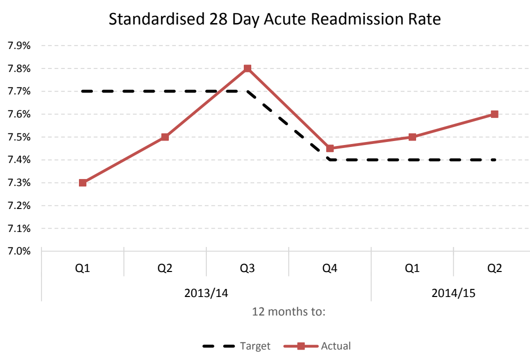

ALOS is a measure of the time spent in hospital. A shortened ALOS, while ensuring patients receive sufficient care to avoid readmission, is an indicator of good hospital productivity. Reducing the time spent in hospital also improves patient experience and reduces the risk of contracting nosocomial infections.

By delivering a more patient-centred elective service we expected to reduce the ALOS for elective inpatients. The target was set at ≤3.18 days and although we have not managed to meet the target, achieving 3.27, this is the lowest it has been in the last two years.

Acute ALOS has also reduced this year from 4.18 to 4.07 and the new target of 4.15 in Q4 was achieved. As with the Shorter Stays in the ED performance above, initiatives implemented as part of AIM24/7 have had a positive impact on productivity and patient flow

| Average Length of Stay | | | |
|---|---|---|---|
| | **Baseline** Q4 2012/13 | **Target** Q4 2014/15 | **Actual** Q4 2014/15 |
| *Elective* | *3.43* | *≤3.18 days* | *3.27 (U)* |
| *Acute* | *4.18* | *≤4.15 days* | *4.07 (F)* |

## Acute Readmission to Hospital

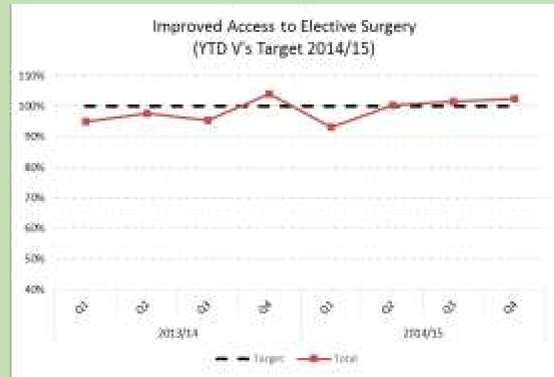



In our quest to increase hospital throughput it is important that we measure acute unplanned readmission rates. These occur when treatment, either in hospital or in the 28 days following discharge, has not been effective and a readmission is required urgently. A low rate is an indication of effective support services in the community (e.g. primary care) and hospital reliability. Our target is a rolling 12-month rate and it has increased slightly this year from 7.5% in June 2014 to 7.6% in December 2014 against a target of ≤7.5. No results were published for the period to March 2015 as the Ministry of Health are currently reviewing this measure.

We will continue to target a reduction through the *'Returning to the Community'* work stream of the AIM 24/7 Programme and monitor accordingly.

**National Health Target: Improved Access to Elective Surgery**

Elective surgery operations improve quality of life for patients suffering from significant medical conditions. They are planned and do not require immediate hospital treatment therefore, can often be delayed. Increasing elective volumes requires good collaboration between many parts of the system including outpatients, booking system, surgical procedures, treatment and delivery of care.



Many initiatives to improve productivity and throughput have been successfully implemented this year resulting in HBDHB achieving 6,154 elective surgery discharges, exceeding our target of 6,012 in 2014/15.

**Standardised Intervention Rates**

Elective services are an important part of the health care system for the treatment, diagnosis and management of health problems. Standardised intervention rates (SIR) measure a DHB's delivery of services relative to their standardised population.

For Major Joint Replacements we achieved 21.9 per 10,000 which is above the target and is an improvement from 19.6 per 10,000 in September 2013. This is a very pleasing result showing positive impact from a number of improvement programmes associated with our operating theatre productivity.

Cardiac surgery Intervention rates are below the target rate of 6.5 per 10,000 but are not significantly different from the national rate of 6.12 per 10,000. The actual result for March 2015 of 6.00 per 10,000 is a trend up from 5.6 in September 2013.

There has been a reduction in Percutaneous revascularization rates from September 2013. The Actual result for the 12 months to March 2015 is 10.8 per 10,000 which is unfavourable against the target and below the national rate. However, the actual number of discharges is similar to the last 5 years and we are ranked 8th of 20 DHBs.

Intervention rates for cataracts procedure and coronary angiography are above the target intervention rates at 52.6 and 37.1 per 10,000 respectively. Both results have increased since September 2013.

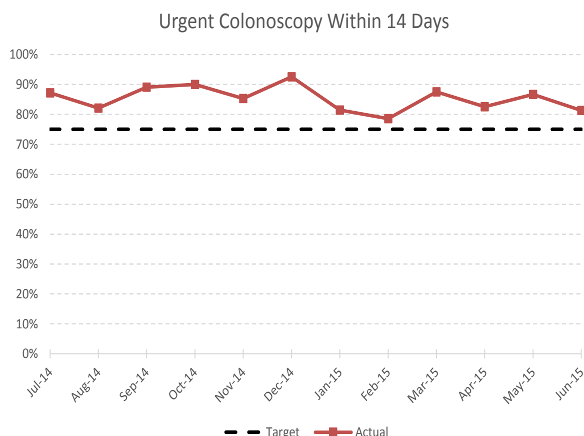
| Elective Services Standardised Intervention Rates (per 10,000 population) | | | |
|---|---|---|---|
| **Key Performance Measures** | **Baseline** September 2013 | **Actual** March 2015 | **Target 2014/15** |
| Major joint replacement | 19.6 | 21.9 (F) | ≥21.0 |
| Cataract procedures | 32.6 | 52.6 (F) | ≥27.0 |
| Cardiac procedures | 5.6 | 6.0 (U) | ≥6.5 |
| Percutaneous revascularization | 11.2 | 10.8 (U) | ≥12.5 |
| Coronary angiography services | 35.2 | 37.1 (F) | ≥34.7 |

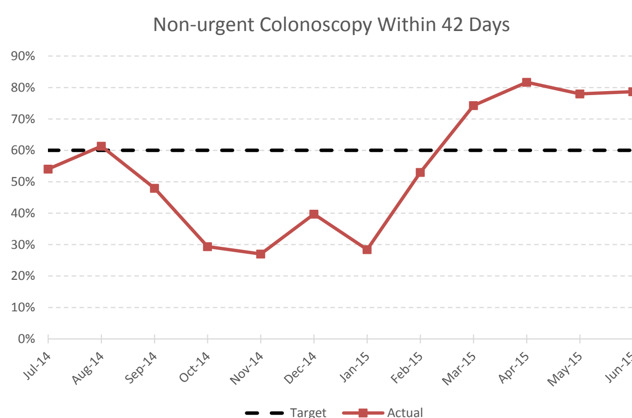
## Quicker access to diagnostics

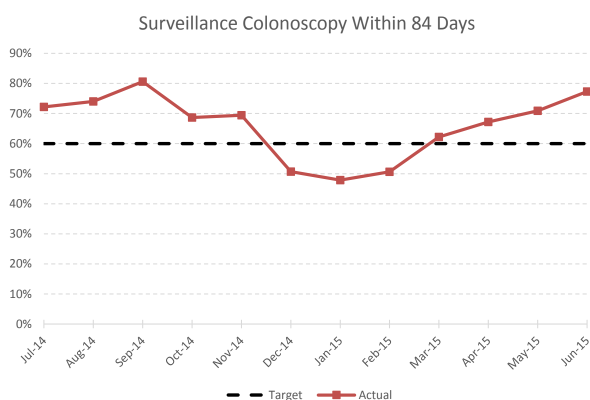
Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care, and therefore improve patient outcomes in a range of areas.

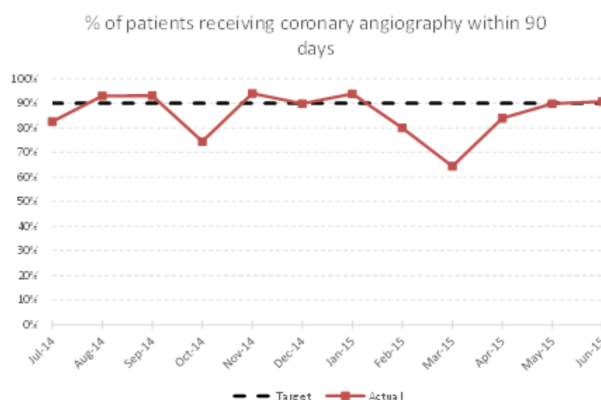
81.3% of Urgent diagnostic colonoscopys were performed within 14 days and 78.7% of routine cases performed within 42 days. These are above the targets of 75% and 60% respectively. The target for surveillance colonoscopy was also achieved with 77.3% of people waiting less than 84 days beyond planned date (target ≥60%). In Q2, a high number of urgent referrals affected wait times for routine and surveillance colonoscopys but extra sessions were carried out to reduce these waiting times by Q3.

90.7% of patients referred for elective coronary angiography received their procedure within 90 days, meeting the target of 90%. Reasons for reduced performance in Q3 was remedied in Q4.



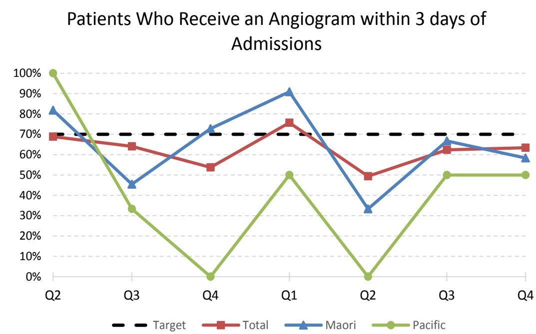




## Better Management of Long Term Conditions (LTC)

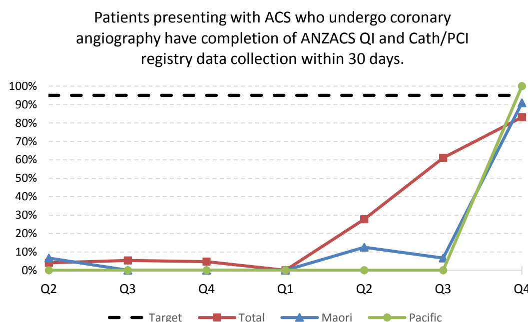
Across the Central Region there is a commitment to improved and timelier access to cardiac services. HBDHB supports the regional programme outlined in the Regional Service Plan and also works locally to:

- Improve access to cardiac diagnostics and specialist assessments
- Reduce waiting times for people requiring cardiac services
- Improve prioritisation and selection of cardiac surgical patients
- Increase cardiac surgical discharges
- Reduce variations in access across the region

In Q4 63.4% of high risk patients received an angiogram within 3 days (target 70%). For Māori we achieved 58.3%. Performance throughout the year has been inconsistent which largely reflects delays in accessing tertiary services in Wellington and provision of only twice weekly angiography services at Hawke's Bay Hospital.




All New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS QI) register collects data to inform future service provision. It allows investigation into the extent, variation and trends in Acute Coronary Syndrome (ACS) as well as inpatient cardiac investigations, medical and surgical interventions, and post-discharge rehabilitation and care. The data also provides information on whether this is equitable across age, gender, location and ethnicity after adjustment for absolute risk and comorbidity.



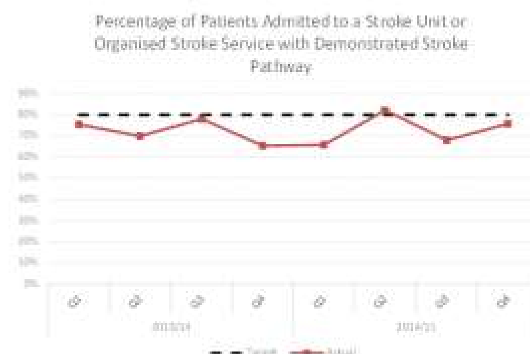

Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days. It took time to introduce a system to support data capture and data entry. In one year we have improved from 0% in Q1 to 83.1% in Q4 (90.9% for Māori). This is a great achievement and we are on track to meet the target in the coming year.

**Stroke thrombolysis and stroke pathway**

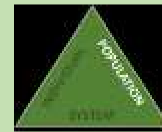
HBDHB's aim is to provide a timely, organised acute stroke service so that more patients survive stroke events and the likelihood of subsequent stroke events is reduced.

In Q4, 2.6% of eligible patients were thrombolysed against a target of 6%. The target was met in Q2 and performance has been better than last year.

Hawkes Bay Hospital continues to experience challenges during implementation of the pathway for organised stroke services. Performance has fluctuated throughout the year, achieving 75.6% in Q4 (target 80%). Targeted investigation and collaborative work with Central Region DHBs is underway to improve performance in these two areas.



**National Health Target: Shorter waits for Cancer Treatment**



HBDHB achieved 100% compliance with Radiation and Chemotherapy treatment waiting times of less than 4 weeks. Minimising waiting times ensures that people in need of intensive cancer treatment are having that need met as early as possible. Delays in cancer treatment can have negative effects such as; poorer clinical outcomes; undue stress and anxiety for patients and their families; and reduced quality of life for patients with advanced disease. Radiation oncology therapy is provided at Palmerston North hospital for Hawke's Bay district residents. As this is a regional service, maintaining this high rate relies on effective co-ordination, efficient booking and referrals and good patient relationship-management

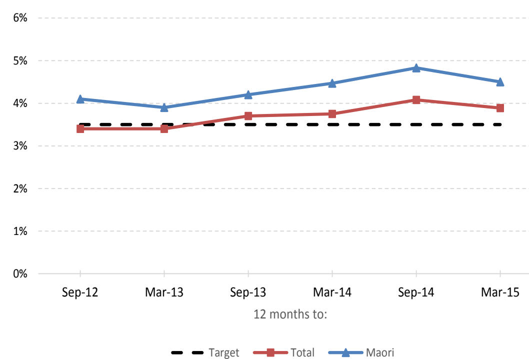
This Health Target has now been replaced with the Faster Cancer Treatment Health Target - *85% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer.* Faster Cancer Treatment was not included in the 2014/15 Statement of Performance Expectation due to it being introduced late in 2014. Performance against this measure will be reported on in next year's Annual Report.

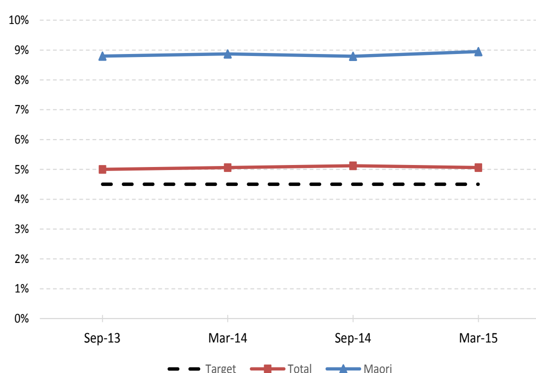
| Health Target: Shorter waits for cancer treatment - Treatment Waiting Times less than 4 weeks | | | |
|---|---|---|---|
| | **Baseline** | **Target** 2014 | **Actual** 2014 |
| *Radiation* | *100%* | *100%* | *100% (F)* |
| *Chemotherapy* | *100%* | *100%* | *100% (F)* |

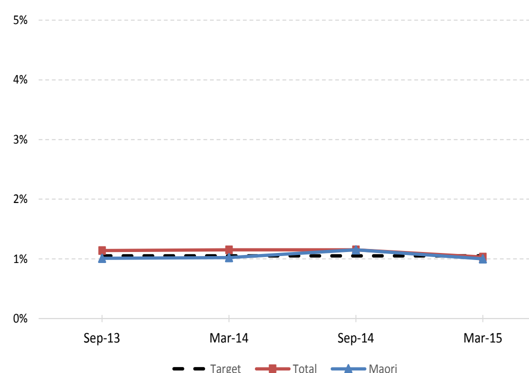
**Mental Health and Addiction Services**

Specialist mental health and addiction services are funded for people who are severely affected by mental illness or addictions. There has been a sustained year-on-year increase in the number of clients seen by Hawke's Bay Mental Health Services. Better and timelier access to a broad range of services improves people's mental health and wellbeing and contributes to better outcomes and recovery.

***Better access:*** The number of people seen has approximately doubled over the last decade with the greatest increase seen in 0-19 year olds and Māori adults. The access rate for 65+ clients for the 12 months to Mar 2015 is slightly below the target of ≥1.05% (actual 1.03%).

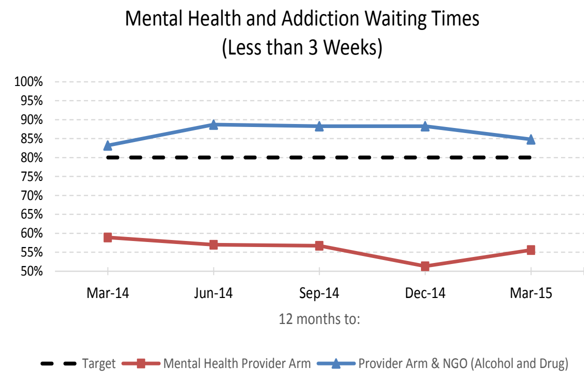


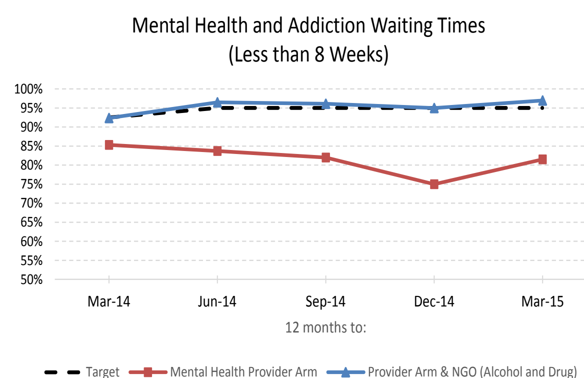
***Improved Waiting Times:*** Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. We differentiate the targets in 2 ways: firstly, between the mental health services that are delivered by our provider arm and the addiction services that are delivered by our provider and some NGO providers; and secondly, we consider results after 3 weeks of referral and again after 8 weeks of referral.

For mental health services, the waiting time expectation of 3 weeks was achieved in 55.6% of cases which is below the new target of 80%. The 8 week result was 81.5% which also fell short of the 95% Target.

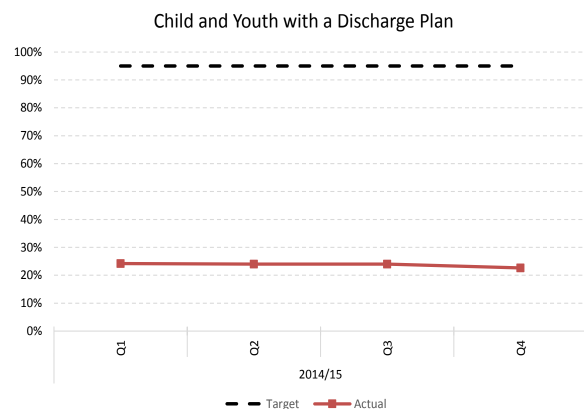



The current systems requires patients to contact the service to make an appointment that works for them. Unfortunately achievement of these targets relies on timeliness of that contact by the patient. The service is looking into solutions that meet the performance measures while still maintaining the patient centred booking approach.

For addictions services with a range of providers, the waiting times expectations have been exceeded with 84.8% of people seen within 3 weeks and 97.0% seen within 8 weeks The services maintain clear focus on referral response and turnaround time.




***Improved Discharge Planning:*** Maintaining and improving patient engagement through the use of a transition/discharge plan will ensure that services are responsive to patients needs and that people are better able to manage their own health condition. New requirements for discharge/transition planning require changes to clinical documentation which is taking time to imbed. At the end of the year, 22.7% of children and youth discharged from the community mental health and addictions services had a transition/discharge plan (target 95%)

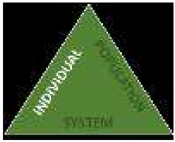



**Mental Health (Compulsory Assessment and Treatment) Act 1992**

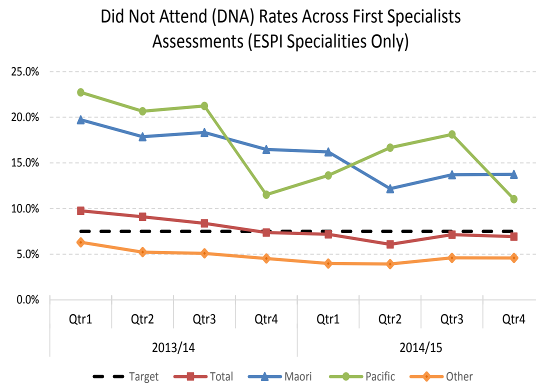
There is a disproportionately high rate of Māori placed under the s29 compulsory treatment order (CTO) and HBDHB aims to reduce this inequity. This is not a straightforward matter as all the social and health inequities which Māori experience contribute to increased use of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The total population rate in June 2015 was 85.2 per 100,000. Since the data has been available by ethnicity from the MoH in May 2015, the rate for Māori reduced from 183.4 per 100,000 to 178.4 per 100,000 in June 2015. This is a promising downward trend, however, there is still a large improvement to be made and efforts continue to address social and health inequities for Māori.

### Attendance at First Specialist Appointment

Low 'did not attend' (DNA) rates to specialist outpatient appointments are an indicator of good communication between patient, referrer and specialist services. It is a measure of the rate of scheduled first specialist appointments (FSAs) that do not proceed due to patient non-attendance. DNA rates are targeted because high rates result in significant waste and rework. Furthermore, if patients fail to attend specialist appointments, treatment will be delayed.




HBDHB's total population DNA rate has improved in the last year 7.4% to 6.9% at the end of 2014/15. The rate for Māori has also reduced by 3% but both Māori and Pacific rates remain high at 13.7% and 11.0% respectively. A programme of work is being carried out to improve patient focussed booking and ensure a consistent and measured approach to best meet the needs of FSA patients. It is anticipated that Māori and Pacific DNA rates will reduce significantly once system issues have been resolved.




| Intensive Assessment and Treatment | | | |
|---|---|---|---|
| | 2015 Actual $'m | 2015 Plan $'m | 2014 Actual $'m |
| Ministry of Health | *273.9* | *260.0* | *267.3* |
| Other District Health Boards | *4.0* | *5.3* | *4.3* |
| Other sources | *14.7* | *11.0* | *13.3* |
| **Income by Source** | ***292.6*** | ***276.3*** | ***284.9*** |
| *Less:* | | | |
| Personnel | *146.6* | *144.4* | *139.3* |
| Outsourced services | *9.4* | *7.7* | *11.3* |
| Clinical supplies | *42.2* | *37.3* | *41.0* |
| Infrastructure and non clinical supplies | *34.3* | *33.8* | *34.4* |
| Payments to other District Health Boards | *43.2* | *47.4* | *43.9* |
| Payments to other providers | *9.4* | *3.8* | *11.6* |
| **Expenditure by type** | ***285.1*** | ***274.4*** | ***281.5*** |
| **Net Result** | ***7.5*** | ***1.9*** | ***3.4*** |

## Rehabilitation and support services

Impact: People Maintain Maximum functional independence and have choices throughout life.

**Statement of Service Performance Output Class 4**

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. HBDHB provides NASC services through Options Hawke's Bay - a unit that reports to our General Manager, Integrated Care Services. Other services are provided by our Provider Arm, general practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or end-stage conditions.

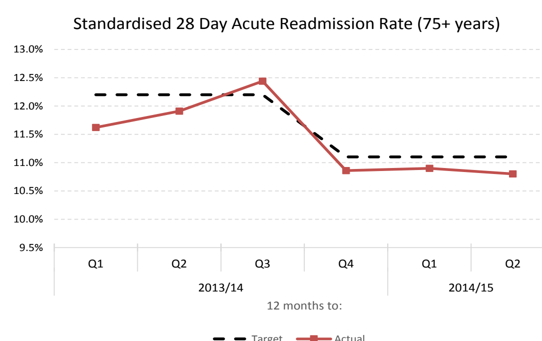
Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family or whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

**Better access to care for older people**

Age specific rate of non-urgent and semi urgent attendances at the Emergency Department are monitored for ages 75-79, 80-84 and 85+. These rates are an indicator of the services available to keep elderly safe and independent in their own homes. For both 75-79 and 80-84, the rate has reduced significantly. For 85+ year olds, the rate has increased slightly from 231.0 per 1,000 to 232.2 per 1,000.

| Age specific rate of non-urgent and semi urgent attendances at the Emergency Department (per 1,000 population) | | | |
|---|---|---|---|
| | **Previous Year** (2013/14) | **Target** (2014/15) | **Actual** (2014/15) |
| 75-79 | 164.7 | ≤164.7 | 138.0 |
| 80-84 | 222.0 | ≤222.0 | 176.1 |
| 85+ | 231.0 | ≤231.0 | 232.2 |

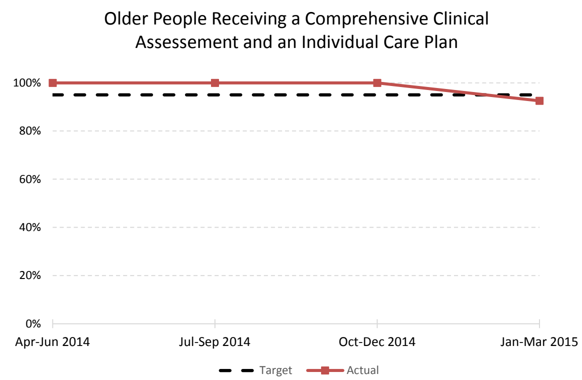
The rate of acute readmission, as discussed above in output class 3, is a measure of effective support services and treatment. Although the overall rate has increased, the rate of acute readmissions in over 75 year olds has decreased from 10.9 in the year to June 2014 to 10.8 in the year to December 2014. Reducing the readmission rate in this age group is especially important for sustainability as the over 75 population continues to grow.




NB: The Ministry of Health are currently reviewing the measure of acute readmission rates therefore no results were published for the period April 2014 to March 2015

## Better community support for older people

Delivering coordinated high quality services to older people supports New Zealanders to live longer, healthier and more independent lives. Comprehensive clinical assessments and completed care plans are an important component of keeping people safe in their own homes and maintaining their independence. From April to December 2014, 100% of the people using home support received a comprehensive clinical assessment and completed care plan. In the period from January to March 2015, this reduced to 93% however it is anticipated that performance will be back above 95% for the next reporting period.

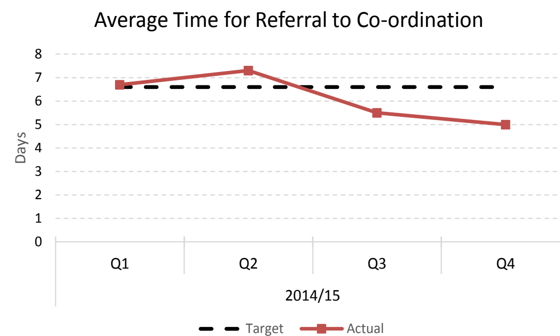



By providing better community support for elderly, we would expect that they are able to maintain independence and function in their own homes, therefore reducing rest home bed utilisation for the growing population.

## Increased capacity and efficiency in Needs Assessment and Service Coordination services

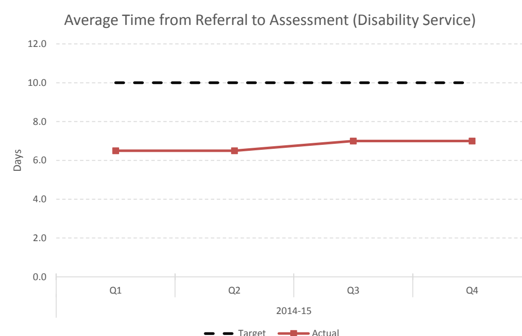
Needs Assessment and Service Coordination (NASC) services work with people who have support needs because of long-term health conditions and disabilities. NASC services determine eligibility for public funding and assist the person to define the best mix of supports based on their own strengths, resources and goals.

The elderly population of Hawke's Bay is increasing and to confirm that we are coping with the increase and providing a prompt service, we expect to reduce or maintain time from referral to co-ordination. A more appropriate and consistent support package was introduced during 2013/14 which led to reassessment of a significant number of existing clients, increasing the average time from referral to assessment to 14 days. This year, the service has worked really hard and managed to bring that time back down to 5 days (target ≤6.6 days).




As well as age-related disability, NASC services also provide disability services for people under 65 years of age. The average time from referral to assessment for this service in Q4 was 7.0 days which is favourable against the target of ≤10 days

| Number of needs assessments completed (disability service) | | |
|---|---|---|
| Previous Year (2013/14) | Target (2014/15) | Actual (2014/15) |
| 618 | ≥300 | 588 |



### More options to rest home entry

Rehabilitation services are usually enduring in nature and are delivered by a variety of health and allied health specialists in hospital, community and home settings. Funding by way of “packages of care” (POC) allows, enables and encourages the contracted provider to co-ordinate a range of treatments and or therapies according to need. This means that a service can be more tailored to the individual patient

| Number of clients funded for intensive restorative care as an alternative to rest home entry | | |
|---|---|---|
| **Baseline** (Q3 2013/14) | **Target** (2014/15) | **Actual** (2014/15) |
| 188 | ≥215 (15% increase) | 211 |

Access to restorative care has resulted in a higher number of clients being able to remain safely in their own homes. The number of clients funded for intensive restorative care has increased to 211 from the baseline of 188. This is an increase of 12%, short of the target increase of 15%.

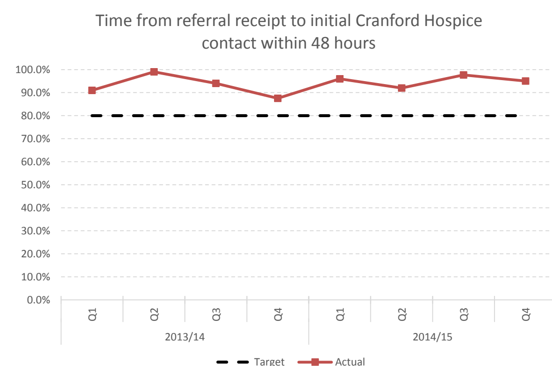
### Rest home Bed Utilisation

The proportion of rest home beds being used by over 65 year olds has reduced from 73.7% in 2013/14 to 70.9% in 2014/15. This is a reduction of 2.8% against a target of 3%

### Prompt response to Palliative referrals

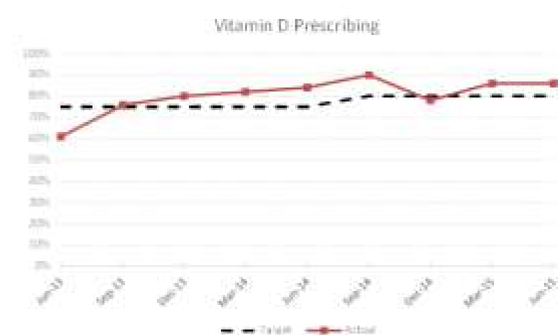
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. The service works on prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems.

Ensuring that most referrals to our district's community-based provider, Cranford Hospice, are responded to within 48 hours will improve service access, affirm that the service is responding in a timely way and show that capacity constraints are being appropriately managed. The target response standard of 48 hours was met in 95% of cases in Q4 and the target of 80% was beaten all year.




### Nutritional Support to Reduce Falls

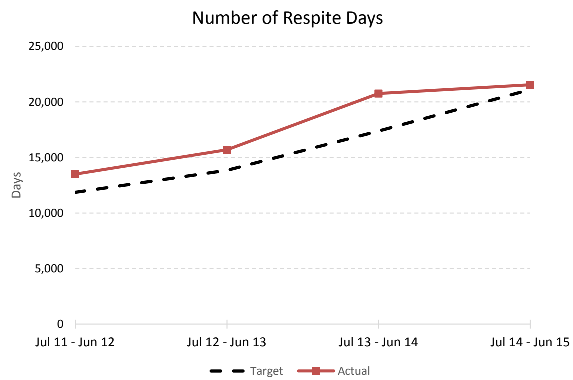
Research has shown that vitamin D deficiency is a common contributor to falls causing hospitalization amongst the elderly. Increasing vitamin D prescribing is encouraged and relies on aged care services and other primary carers to promote and monitor this practice appropriately. Supporting our primary and community partners to raise the uptake of this preventative measure meant that, by year-end coverage had reached 86.0%, which is an increase since last year and greater than the target of at least 80%.

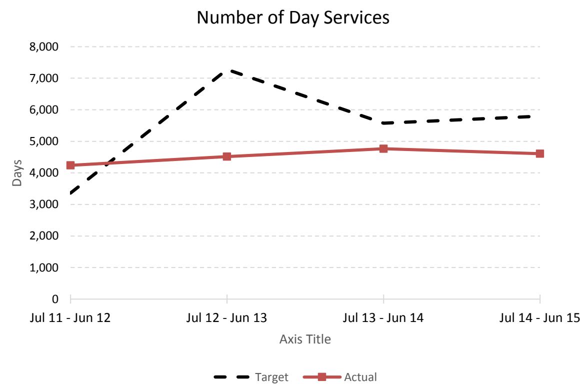


## More Respite and Day Services

Improved management and integration of services in the community along with enhanced capability, enables early intervention to maintain function so that clients remain at home for longer. We commit extra resources to increase respite and day services to give better support to people with specialised or high needs and to their carers.

Typically, the mix of respite and day services delivered will change dependent on where the need is highest. In 2014/15, we have under-delivered on targeted respite care as having respite beds available in the right area continues to be a challenge. Centre-based day care continues to increase, exceeding the target, particularly for dementia. This is consistent with the trend that has been seen since July 2011. Respite days have remained relatively static while day services have increased. We believe that this is more in line with demonstrated preferences and need.



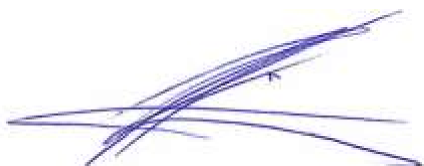

| Number of Day Services | | Number of Respite Days | |
|---|---|---|---|
| Target | Actual | Target | Actual |
| 21,117 | 21,546 | 5,798 | 4,607 |

| Rehabilitation and Support | 2015 Actual $'m | 2015 Plan $'m | 2014 Actual $'m |
|---|---|---|---|
| Ministry of Health | *70.4* | *70.6* | *64.4* |
| Other District Health Boards | *2.1* | *2.8* | *2.3* |
| Other sources | *0.1* | *0.3* | *0.4* |
| **Income by Source** | ***72.6*** | ***73.7*** | ***67.1*** |
| *Less:* | | | |
| Personnel | *6.5* | *6.4* | *6.2* |
| Clinical supplies | *0.8* | *0.7* | *0.8* |
| Infrastructure and non clinical supplies | *1.8* | *1.8* | *1.8* |
| Payments to other District Health Boards | *3.6* | *4.0* | *3.7* |
| Payments to other providers | *59.4* | *53.8* | *55.8* |
| **Expenditure by type** | ***72.1*** | ***66.7*** | ***68.3*** |
| **Net Result** | ***0.5*** | ***7.0*** | ***(1.2)*** |

# Financial Report for the year ended 30 June 2015

The board members are pleased to present the Financial Statements of Hawke's Bay District Health Board for the year ended 30 June 2015.

For and on behalf of the board members of the Board:



**Kevin Atkinson**
*Chair*

**Peter Dunkerley**
*Board Member*

28 October 2015

# 2014/15 Financial Performance

**Result**

The operating surplus for 2014/15 is $3.1 million on revenue of $496.2 million. This is in comparison to the $3.2 million surplus reported last year.

Revenue was $3.8 million ahead of plan including extra income from the Ministry of Health for additional services provided, from Mid Central DHB for oncology clinics from Tairawhiti DHB for cancer treatment pharmaceuticals, and from donations and clinical trial revenue.

**Cash flow**

The operating cash surplus of $14.9 million and $3.6 million of available cash was used to fund the $17.8 million spend on property, plant and equipment, intangible assets and investments, and to repay debt and equity of $0.6 million.

**Auditors**

The Auditor-General is required under section 15 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements and performance information presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2014/15 annual report, amount to $119,469.

**Ministerial directions**

The Minister of State Services and the Minister of Finance issued a direction under section 107 of the Crown Entities Act 2004 requiring application of the Government Rules of Sourcing from 1 February 2015. The entities affected are further directed to be guided by the Ministry of Business, Innovation and Employment on any issues arising in the application of the rules.

# Five year financial performance summary

The table below provides a comparison between the forecast financial performance measures, with actual performance achieved during the year. The table also provides a comparison with the four previous financial years.

| Performance Indicator | Target | 2015 | 2014 | 2013 | 2012 | 2011 |
|---|---|---|---|---|---|---|
| Return on net funds employed | 11.0% | 8.3% | 11.2% | 9.4% | 9.6% | 14.5% |
| Operating margin to revenue | 1.4% | 1.4% | 1.4% | 1.2% | 1.1% | 1.7% |
| Revenue to net funds employed | 5.7 | 4.5 | 5.7 | 5.5 | 5.9 | 6.5 |
| Debt to debt plus equity ratio | 47.9% | 32.7% | 46.5% | 48.2% | 49.4% | 47.2% |
| Net result before financing & abnormals | 9.4m | 9.1m | 9.5m | 8.1m | 7.5m | 10.0m |
| Net result | 3.0m | 3.1m | 3.2m | 2.1m | 2.0m | 5.3m |
| Debt servicing coverage ratio | 7.7 | 8.5 | 7.5 | 7.5 | 7.5 | 8.5 |
| Ratio of earnings to revenue | 4.6% | 4.7% | 4.8% | 4.5% | 4.3% | 4.9% |
| Average cost per paid FTE | $85,068 | $84,085 | $81,948 | $80,483 | $79,093 | $76,947 |
| Average revenue per paid FTE | $237,323 | $232,975 | $233,937 | $234,014 | $228,359 | $223,878 |

# Statement of comprehensive revenue and expense

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| | Notes | 30 June 2015 | Budget 30 June 2015 | 30 June 2014 |
|---|---|---|---|---|
| Patient care revenue | 2.6 | 489,044 | 486,915 | 478,842 |
| Interest revenue | | 1,568 | 995 | 1,246 |
| Other operating revenue | 2.7 | 5,625 | 4,535 | 6,033 |
| Total revenue | | 496,237 | 492,445 | 486,121 |
| | | | | |
| Personnel costs | 2.8 | 179,100 | 176,516 | 170,287 |
| Outsourced services | | 13,233 | 10,753 | 15,925 |
| Clinical supplies | | 42,339 | 37,099 | 40,713 |
| Infrastructure and non-clinical expenses | | 22,729 | 23,271 | 22,773 |
| Payments to other district health boards | | 50,709 | 53,992 | 50,043 |
| Payments to non-health board providers | | 159,422 | 163,716 | 157,715 |
| Other operating expenses | 2.9 | 5,743 | 4,424 | 5,229 |
| Depreciation and amortisation expense | 3.6, 3.7 | 14,062 | 13,402 | 13,992 |
| Financing costs | 2.10 | 2,289 | 2,298 | 2,634 |
| Capital charge | 2.11 | 3,740 | 3,974 | 3,664 |
| Total expenses | | 493,366 | 489,445 | 482,975 |
| | | | | |
| Share of associate surplus/(deficit) | 3.9 | 183 | - | 76 |
| | | | | |
| **Surplus/(deficit)** | | **3,054** | 3,000 | **3,222** |
| | | | | |
| **Other comprehensive revenue and expense** | | | | |
| Revaluation of land and buildings | | 37,444 | - | - |
| | | | | |
| **Total comprehensive revenue and expense** | | **40,498** | 3,000 | **3,222** |

Explanations of major variance against budget are provided in note 2.3.

District Health Boards are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2015 was underspent by $0.8 million (2014: $2.0 million). The surplus for 2015 has been transferred to the asset replacement reserve, reflecting that along with previous year surpluses it would be used for the development of the mental health intensive care unit. Consequently mental health payments in excess of funding since 1 July 2001, remains at the 30 June 2014 level of $0.3 million.

*The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.*

# Statement of changes in equity

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| | Notes | 30 June 2015 | Budget 30 June 2015 | 30 June 2014 |
|---|---|---|---|---|
| Balance at 1 July | | 49,141 | 48,922 | 46,278 |
| | | | | |
| Total comprehensive revenue and expense | | 40,498 | 3,000 | 3,222 |
| Owner transactions | | | | |
| Transfer of Chatham Island's health services to Canterbury District Health Board | 3.6 | (1,655) | - | - |
| Equity repayments to the Crown | | (357) | (357) | (359) |
| | | | | |
| **Balance at 30 June** | 4.5 | **87,627** | **51,565** | **49,141** |

Explanations of major variance against budget are provided in note 2.3.

*The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.*

# Statement of financial position

**As at 30 June 2015**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2015 | Budget 30 June 2015 | 30 June 2014 |
|---|---|---|---|---|
| **Assets** | | | | |
| *Current assets* | | | | |
| Cash and cash equivalents | 3.1 | 14,969 | 8,944 | 18,536 |
| Short term investments | 3.1 | 1,703 | 216 | 1,536 |
| Receivables and prepayments | 3.2 | 17,852 | 17,180 | 17,516 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 3.3 | 12 | 11 | 11 |
| Inventories | 3.4 | 3,881 | 3,480 | 3,713 |
| Non-current assets held for sale | 3.5 | 1,220 | 1,700 | 1,742 |
| **Total current assets** | | 39,637 | 31,531 | 43,054 |
| | | | | |
| *Non-current assets* | | | | |
| Property, plant and equipment | 3.6 | 148,232 | 122,903 | 110,044 |
| Intangible assets | 3.7 | 8,472 | 1,597 | 7,170 |
| Investment property | 3.8 | 131 | 153 | 153 |
| Investment in associate | 3.9 | 1,143 | 961 | 961 |
| Other investments | 3.10 | - | 6,516 | - |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 3.3 | 55 | 55 | 68 |
| **Total non-current assets** | | 158,033 | 132,185 | 118,396 |
| **Total assets** | | **197,670** | **163,716** | **161,450** |
| | | | | |
| **Liabilities** | | | | |
| *Current liabilities* | | | | |
| Interest-bearing loans and borrowings | 4.1 | - | - | 10,268 |
| Payables and deferred revenue | 4.2 | 30,823 | 31,476 | 35,859 |
| Employee entitlements | 4.3 | 33,872 | 31,028 | 31,109 |
| Provisions | 4.4 | 506 | - | 278 |
| **Total current liabilities** | | 65,201 | 62,504 | 77,514 |
| | | | | |
| *Non-current liabilities* | | | | |
| Interest-bearing loans and borrowings | 4.1 | 42,500 | 47,500 | 32,500 |
| Employee entitlements | 4.3 | 2,342 | 2,147 | 2,295 |
| **Total non-current liabilities** | | 44,842 | 49,647 | 34,795 |
| **Total liabilities** | | **110,043** | **112,151** | **112,309** |
| **Net assets** | | **87,627** | **51,565** | **49,141** |
| | | | | |
| **Equity** | | | | |
| Contributed capital | 4.5 | 35,572 | 37,229 | 37,584 |
| Property revaluation reserves | 4.5 | 69,188 | 31,744 | 31,744 |
| Restricted funds | 4.5 | 3,125 | 3,064 | 3,064 |
| Asset replacement reserve | 4.5 | 15,253 | 12,411 | 14,437 |
| Accumulated surpluses/(deficits) | 4.5 | (35,511) | (32,883) | (37,688) |
| **Total equity** | | **87,627** | **51,565** | **49,141** |

Explanations of major variance against budget are provided in note 2.3.

*The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.*

# Statement of cash flows

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| | Notes | 30 June 2015 | Budget 30 June 2015 | 30 June 2014 |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Receipts from patient care | | 490,104 | 490,693 | 476,281 |
| Receipts from donations, bequests and clinical trials | | 578 | - | 750 |
| Other receipts | | 3,987 | - | 6,660 |
| Payments to suppliers | | (298,566) | (288,869) | (287,035) |
| Payments to employees | | (176,291) | (175,757) | (168,683) |
| Goods and services tax (net) | | (495) | - | 921 |
| Cash generated from operations | | **19,317** | **26,067** | **28,894** |
| Interest received | | 1,568 | 995 | 1,246 |
| Interest paid | | (2,252) | (2,462) | (2,375) |
| Capital charge paid | | (3,740) | (3,974) | (3,664) |
| Net cash inflow/(outflow) from operating activities | | **14,893** | **20,626** | **24,101** |
| | | | | |
| **Cash flows from investing activities** | | | | |
| Proceeds from sale of property, plant and equipment | | 58 | - | - |
| Acquisition of property, plant and equipment | | (15,576) | (21,174) | (12,551) |
| Acquisition of intangible assets | | (904) | (408) | (897) |
| Acquisition of investments | | (1,413) | (2,777) | (932) |
| Net cash inflow/(outflow) to investing activities | | **(17,835)** | **(24,359)** | **(14,380)** |
| | | | | |
| **Cash flows from financing activities** | | | | |
| Proceeds from borrowings | | 10,000 | 5,000 | - |
| Repayment of borrowings | | (10,000) | - | - |
| Repayment of finance lease liabilities | | (268) | (268) | (375) |
| Repayment of equity to the Crown | | (357) | (357) | (359) |
| Net cash inflow/(outflow) from financing activities | | **(625)** | **4,375** | **(734)** |
| | | | | |
| Net increase/(decrease) in cash and cash equivalents | | (3,567) | 642 | 8,987 |
| Add: opening cash | | 18,536 | 8,304 | 9,549 |
| **Cash and cash equivalents at end of year** | 3.1 | **14,969** | **8,946** | **18,536** |

The Cash paid to supplier's component of operating activities reflects the net Goods and Services Tax (GST) paid and received with the Inland Revenue Department. GST has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes.

Explanations of major variance against budget are provided in note 2.3.

*The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.*

# Reconciliation of surplus for the period with net cash flows from operating activities

**For the year ended 30 June 2015**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2015 | Budget 30 June 2015 | 30 June 2014 |
|---|---|---|---|---|
| **Surplus/(deficit) for the year** | | **3,054** | **3,000** | **3,222** |
| **Add back non-cash items:** | | | | |
| Share of associate surplus | | (183) | - | (76) |
| Depreciation and amortisation | | 14,062 | 13,402 | 13,992 |
| Write-down of non-current assets held for sale | | 524 | - | - |
| **Add back items classified as investing activity:** | | | | |
| Net loss/(gain) on disposal of property, plant and equipment | | 144 | - | 313 |
| Debt forgiven (Hawke's Bay Helicopter Rescue Trust) | | 10 | 12 | 10 |
| **Movement in working capital:** | | | | |
| (Increase)/decrease in receivables and prepayments | | (336) | (255) | (816) |
| (Increase)/decrease in inventories | | (167) | (53) | (247) |
| Increase/(decrease) in payables and deferred revenue | | (5,285) | 3,772 | 5,328 |
| Increase/(decrease) in employee entitlements | | 2,763 | 744 | 2,196 |
| Increase/(decrease) in provisions | | 260 | (11) | 25 |
| Net movement in working capital | | (2,765) | 4,197 | 6,486 |
| **Other movements not in working capital** | | | | |
| Increase/(decrease) in employee entitlements | | 47 | 15 | 154 |
| **Net cash inflow/(outflow) from operating activities** | | **14,893** | **20,626** | **24,101** |

*The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.*

# Notes to the financial statements

**For the year ended 30 June 2015**

In preparing the 2015 financial statements, the notes have been grouped into sections under five key categories which are considered to be the most relevant for stakeholders and other users.

- Reporting entity and basis of preparation
- Result for the year
- Resourcing the District Health Board's activities
- Financing the District Health Board's activities
- Other disclosures

Significant accounting policies have been incorporated throughout the notes to the financial statements adjacent to the disclosure to which they relate. All accounting policies are included within an outlined box. Where possible, wording has been simplified to provide clearer commentary on the financial performance of the District Health Board. The accounting policies set out below have been applied consistently to all periods presented in the financial statements.

## 1. Reporting entity and basis of preparation

### 1.1 Reporting Entity

Hawke's Bay District Health Board is a District Health Board established by the New Zealand Public Health and Disability Act 2000. The District Health Board is a crown entity as defined by the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The District Health Board is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

The Hawke's Bay District Health Board's primary objectives are the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly the District Health Board is a public benefit entity (PBE) for financial reporting purposes.

The financial statements of the Hawke's Bay District Health Board comprise the District Health Board, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited which is controlled by the six district health boards in the central region.

The financial statements for the Hawke's Bay District Health Board are for the year ended 30 June 2015, and were approved by the Board on 28 October 2015.

### 1.2 Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

#### Statement of compliance

The financial statements of the district health board have been prepared in accordance with the requirements of 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 PBE accounting standards, and comply with those standards.

The financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new 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) unless otherwise specified.

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

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. Hawke's Bay District Health Board has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Hawke's Bay District Health Board will apply these updated standards in preparing its 30 June 2016 financial statements. The district health board expects there will be minimal or no change in applying the updated accounting standards.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 2. Result for the year

### 2.1 Performance by Arm

The Hawke's Bay District Health Board's annual plan includes separate operating statements for funding, governance and funding administration and providing health services. The table below compares performance against the plan for the 2014/15 year.

| | Achieved $'millions | Plan $'millions | Variance $'millions |
|---|---|---|---|
| **Revenue** | | | |
| Funding health services | 463.0 | 464.0 | (1.0) |
| Governance and funding administration | 2.8 | 2.8 | - |
| Providing health services | 275.5 | 267.9 | 7.6 |
| Eliminations | (245.1) | (242.3) | (2.8) |
| | 496.2 | 492.4 | 3.8 |
| **Surplus/(Deficit)** | | | |
| Funding health services | 7.5 | 3.0 | 4.5 |
| Governance and funding administration | 0.1 | - | 0.1 |
| Providing health services | (4.5) | - | (4.5) |
| | 3.1 | 3.0 | 0.1 |

The funding arm surplus is $7.5 million which is $4.5 million better than plan. The variance from plan includes the elimination of $5.2 million of pharmaceutical expenditure resulting from claims by the provider arm that was not adjusted in the plan. Otherwise the result would have been $0.7 million unfavourable to plan as lower payments to other district health boards, lower pharmaceutical spend, and additional MOH income (mainly for new Well Child services), were more than offset by an increase spend on surgical inpatient services, revenue banking not drawn; higher expenditure on health of older people, and costs incurred as mental health services transition to a new model of care.

The governance and funding administration surplus is close to plan. The provider arm deficit of $4.5 million includes the $5.2 million of pharmaceutical claims as mentioned above, with the remaining $0.7 million relating to additional income from the Ministry of Health for targeted health expenditure, additional income from other district health boards relating to cancer drugs and oncology clinics, and income from donations and for clinical trials that are not budgeted for, offset mainly by locum cover for medical staff vacancies and leave.

Eliminations are transactions between funding of health services, governance and funding administration and providing of health services, which need to be eliminated when the income or deficits of these arms are consolidated.

### 2.2 Output classes

*Accounting Policy – cost allocation*

Revenue and expenditure for each output class funded or provided by the Hawke's Bay District Health Board and reported in the statement of service performance, has been derived using the allocation system outlined below.

Direct revenue and costs are allocated directly to output classes. Indirect costs are allocated to output classes using appropriate cost drivers such as volumes provided.

The purchase units that comprise an output class change over time as clinical practice and medical technology develop. Consequently while the figures prepared for each year reported in the annual report will be consistent with the figures for each year reported in its associated annual plan, they are not necessarily consistent with the annual reports and annual plans of other years.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

The Hawke's Bay District Health Board's annual plan includes projections of revenue and expenditure by output class. The table below compares performance by output class against the plan for the 2014/15 year.

| | 30 June 2015 | Budget 30 June 2015 | 30 June 2014 |
|---|---|---|---|
| **Revenue** | | | |
| Prevention services | 6.8 | 6.6 | 6.8 |
| Early detection and management | 124.2 | 136.9 | 127.4 |
| Intensive assessment and treatment | 292.6 | 276.3 | 284.9 |
| Rehabilitation and support | 72.6 | 73.7 | 67.1 |
| Total revenue | 496.2 | 493.5 | 486.2 |
| **Expenditure** | | | |
| Prevention services | 10.0 | 7.0 | 9.8 |
| Early detection and management | 125.9 | 142.4 | 123.4 |
| Intensive assessment and treatment | 285.1 | 274.4 | 281.5 |
| Rehabilitation and support | 72.1 | 66.7 | 68.3 |
| Total expenses | 493.1 | 490.5 | 483.0 |
| **Surplus/(deficit) for the year** | **3.1** | **3.0** | **3.2** |

**Comparison to 2013/14**

The comparative figures for 2013/14 have been restated to reflect changes in purchase unit alignment to output classes.

The increase in intensive assessment and treatment costs reflects the investment in transformation projects implemented by the district health board. Rehabilitation and support costs includes demographic impacts on the health of older people.

**Comparison to adjusted budget**

The budget figures have not been restated, consequently variances to budget relate mainly to changes in purchase unit alignment to output classes.

Other than realignment of purchase units, rehabilitation and support costs includes demographic impacts on the health of older people.

## 2.3 Performance against budget

*Accounting Policy*

The budget figures are those approved by the Hawke's Bay District Health Board in its annual plan. The budget figures are prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the District Health Board for the preparation of the financial statements.

The financial information contained in the statement of intent is prospective financial information in terms of PBE FRS 42 *Prospective Financial Information*. PBE FRS 42 requires the District Health Board to present a comparison of the prospective financial information with the actual financial results being reported. This requirement is met by including the budget information in the financial statements.

**Financial Performance**

Revenue for the year is $3.8 million higher than plan. This reflects:

- revenue of $0.8 million for additional services for the Ministry of Health, including the 2013/14 elective surgery wash-up of $0.7 million, $0.6 million for aged residential care and health of older people initiatives, $0.3 million for clinical training, $0.3 million for colposcopy services, $0.2 million for elective surgery in 2014/15; $0.1 million for GP practice viability, and $0.1 million funding for the sleepover settlement, and $0.6 million of other items, less a $2.1 million reduction in base funding.
- additional revenue from other DHBs of $1.5 million, including $0.8 million from Mid Central DHB for oncology clinics and $0.5 million from Tairawhiti DHB for cancer treatment pharmaceuticals;
- interest on working capital invested of $0.6 million;
- donations, bequests and clinical trial income of $0.7 million; and
- $0.2 million from a variety of other sources.

**Financial Position**

The projections for assets, liabilities and equity in the 2014/15 Annual Plan was based on forecasts prepared well before the end of the 2013/14 year. A comparison of the balances of assets, liabilities and equity with the plan will include amounts relating to the difference between the forecast 2013/14 balances and the reported 2013/14 balances. These amounts comprised increases of $9.640 million in assets, $9.421 million in liabilities and $219 thousand in equity. The comparison below excludes these items.

Higher asset balances reflect the revaluation of land and buildings, partly offset by later than planned payment for the Mental Health Inpatient Unit project. Lower liability balances reflect the delayed drawdown of $5 million of debt funding available from the Ministry of Health for the Mental Health Impatient Unit, and the payment to some home care providers of amounts outstanding and not invoiced at 30 June 2014. Higher equity balances reflect the land and building revaluation.

**Cash Flow**

Cash inflow from operating activities was $5.7 million lower than plan reflecting catch-up payments to home care providers who delayed invoicing for services during the previous year. Cash outflow to investing activities was $6.5 million lower than plan, resulting mainly from later than planned progress payments for the Mental Health Inpatient Unit (MHIU) build, although the project is on time. Cash inflow from financing activities was $5 million lower than plan as draw-down of the borrowings for the MHIU project are not yet needed.

## 2.4 Critical accounting estimates and assumptions

In preparing these financial statements, estimates and assumptions have been made concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

### Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $4.796 million (2014: $4.508 million). Refer note 4.3.

### Workplace accident self-insurance

Note 4.4a provides information about estimates and assumptions applied in determining the District Health Board's liability under the ACC Partnership Programme.

## 2.5 Critical judgements in applying accounting policies

In the process of applying Hawke's Bay District Health Board's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. Management has exercised the following critical judgements in applying accounting policies for the year ended 30 June 2015.

### Impairment of intangible assets with indefinite lives

The District Health Board has invested in the Finance, Procurement and Supply Chain (FPSC) project instigated by Health Benefits Limited (HBL), which is expected to return significant savings to the sector. Collectively the district health boards have reviewed the system designed by HBL after cost issues were raised, and have decided to complete the build within the existing budget. They have also individually endorsed the path forward to a national FPSC system. Consequently the district health boards have as a sector determined that the FPSC is not an impaired asset, as it will be completed with substantially the same scope and will contribute savings to the sector. On 30 June 2015, all the assets and liabilities of HBL transferred by Order in Council to NZ Health Partnerships Limited, a company owned collectively by the 20 district health boards.

Individually district health boards need to determine whether the FPSC system will return sufficient savings in their districts to justify their level of investment. Hawke's Bay District Health Board is of the view that sufficient savings will be made based on savings to date, and that no impairment of the asset is necessary.

The District Health Board has invested in the Regional Health Information Project (RHIP, formally CRISP) instigated by Central Region Technical Advisory Services (CTAS). RHIP is developing regional clinical systems for use by the central region district health boards. The district health boards in the central region continue to support the project, and consequently the Hawke's Bay District Health Board considers the regional clinical systems will come on-line, and that no impairment of the assets is necessary.

## 2.6 Patient care revenue

*Accounting policy*

### Ministry of Health population-based revenue

The Hawke's Bay District Health Board receives annual funding from the Ministry of Health based on Hawke's Bay's share of the national population. Revenue is recognised in the year it is received.

### Ministry of Health contract revenue

For contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service (exchange contracts), revenue is recognised as services are provided.

For other contracts (non-exchange) the total revenue receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

### Revenue from other district health boards

Inter district patient inflow revenue occurs when a patient treated within the Hawke's Bay District Health Board region is domiciled outside of Hawke's Bay, and is recognised at time of discharge. The Ministry of Health credits Hawke's Bay District Health Board with a monthly amount based on estimated patient treatment for non-Hawke's Bay residents within Hawke's Bay. An annual wash-up occurs at year end to reflect the actual non-Hawke's Bay patients treated at Hawke's Bay District Health Board.

### Other Crown entity contracted revenue

Other Crown entity contract revenue is recognised as revenue when services are provided and contract conditions have been met.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| | 30 June 2015 | 30 June 2014 |
|---|---:|---:|
| Ministry of Health population-based revenue | 431,817 | 423,438 |
| Ministry of Health contract revenue | 37,186 | 35,698 |
| Revenue from other district health boards | 12,137 | 11,613 |
| Other Crown entity contracted revenue | 6,421 | 6,375 |
| Other patient care related revenue | 1,483 | 1,718 |
| | **489,044** | **478,842** |

## 2.7 Other operating revenue

*Accounting policy*

Revenue is measured at the fair value of consideration received or receivable.

**Interest revenue**

Interest revenue is recognised using the effective interest rate method.

**Rental revenue**

Rental revenue from investment property is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

**Sale of goods**

Revenue from goods sold is recognised when Hawke's Bay District Health Board has transferred to the buyer the significant risks and rewards of ownership of the goods and the District Health Board does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

**Provision of services**

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

**Vested assets**

Where a physical asset is gifted to or acquired by the Hawke's Bay District Health Board for nil or nominal cost, the fair value of the asset received is recognised as revenue when control over the asset is obtained.

**Donated services**

The activities of the Hawke's Bay District Health Board are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the District Health Board.

| | 30 June 2015 | 30 June 2014 |
|---|---:|---:|
| Donations and bequests received | 451 | 575 |
| Rental revenue | 545 | 545 |
| Cafeteria and food sales | 967 | 1,018 |
| Other operating revenue | 3,584 | 3,860 |
| Gain on sale of property, plant and equipment | 78 | 35 |
| | **5,625** | **6,033** |

## 2.8 Personnel costs

| | 30 June 2015 | 30 June 2014 |
|---|---:|---:|
| Salaries and wages | 171,427 | 163,638 |
| Employer contributions to defined contribution plans | 4,793 | 4,301 |
| Increase/(decrease) in employee entitlements | 2,880 | 2,348 |
| | **179,100** | **170,287** |

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 2.9 Other operating expenses

*Accounting policy*

**Operating lease payments**

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Impairment of receivables (bad and doubtful debts) | 102 | 310 |
| Loss on disposal of property, plant and equipment | 222 | 313 |
| Fees to auditor for the audit of the financial statements | 119 | 115 |
| Fees to board members | 252 | 237 |
| Operating lease expenses | 3,901 | 3,761 |
| Increase/(decrease) in provisions | 626 | 492 |
| Koha | 3 | 1 |
| Write-down of non-current assets held for sale | 518 | - |
| | **5,743** | **5,229** |

## 2.10 Financing Costs

*Accounting Policy*

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

Attributed interest on finance leases are 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.

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Interest on Crown loans | 2,281 | 2,594 |
| Attributed interest on finance leases | 8 | 40 |
| | **2,289** | **2,634** |

## 2.11 Capital charge

*Accounting policy*

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

District Health Boards pay a capital charge to the Crown on their taxpayers' funds as at 30 June and 31 December each year. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2015 was 8% (2014: 8%).

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 3. Resourcing the District Health Board's activities

### 3.1 Cash and cash equivalents and short term investments

*Accounting policy*

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

Investments in bank term deposits are initially measured at the amount invested. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest rate method, less any provision for impairment.

| **Cash and cash equivalents** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Cash | 7 | 7 |
| Bank balances | 3 | 0 |
| Credit balance (Health Benefits Limited) | 13,537 | 17,001 |
| Call deposits – special funds | 436 | 644 |
| Call deposits – clinical trials | 986 | 884 |
| Cash and cash equivalents in the statement of financial position | **14,969** | **18,536** |
| Debit balance (Health Benefits Limited) | - | - |
| Cash and cash equivalents for the purposes of the cash flow statement | **14,969** | **18,536** |

| **Short term investments** | | |
|---|---|---|
| Call deposits – special funds | 1,368 | 1,161 |
| Call deposits – clinical trials | 335 | 375 |
| | **1,703** | **1,536** |

The carrying amount of term deposits with maturities less than 12 months approximate their fair value. There are no term deposits with a duration greater than 12 months. There is no impairment provision for short term investments.

*Financial assets recognised subject to restrictions*

Included in cash and cash equivalents and short term investments are unspent funds with restrictions that relate to the delivery of health services (special funds) and participation in clinical trials by the district health board. It is not practicable for the district health board to provide further detailed information about the restrictions.

| **Special funds** | | |
|---|---|---|
| Opening balance | 1,805 | 1,576 |
| Donations and bequests | 299 | 362 |
| Interest received | 70 | 37 |
| Expenditure during the year | (370) | (170) |
| | **1,804** | **1,805** |

Special funds include funding from the Ministry of Education for early childhood education purposes. Receipts in 2015 amounted to $147 thousand (2014: $46 thousand), and the balance of funds as at 30 June 2015 amounted to $372 thousand (30 June 2014: $353 thousand).

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| **Clinical Trials** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Opening balance | 1,259 | 1,274 |
| Receipts | 349 | 293 |
| Interest received | 47 | 27 |
| Expenditure during the year | (334) | (335) |
| | **1,321** | **1,259** |

**DHB Treasury Services Agreement**

The Hawke's Bay District Health Board is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHPL) and all district health boards. This agreement enables NZHPL to sweep district health board bank account balances and invest the pool of surplus funds on their behalf. The agreement also allows individual district health boards to borrow from the pool of surplus funds at the on-call interest rate earned on the pool plus an administrative margin. The maximum borrowing facility available to any district health board is the value of one month's provider arm funding plus GST. As at 30 June 2015 this limit for Hawke's Bay district health board was $20.2 million (2014: $19.4 million), and has not been utilised.

The district health boards have appointed Westpac as their preferred supplier of the banking arrangements. The district health board has undertaken as follows:

- It will not borrow any moneys during the term of the agreement from any party other than: the Ministry of Health; the surplus fund pool managed by NZHPL; or any other private sector entity with the consent of the Minister of Finance and the Minister of Health.
- It will not invest any unrestricted cash surpluses on deposit or investment with any person other the surplus fund pool managed by NZHPL.

**Credit card facility**

Hawke's Bay District Health Board has a $200 thousand BNZ Business Visa Card facility.

## 3.2 Receivables and prepayments

*Accounting policy*

Receivables and prepayments are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that Hawke's Bay District Health Board will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Ministry of Health receivables | 1,485 | 1,225 |
| Trade receivables | 1,877 | 1,803 |
| Ministry of Health accrued revenue | 5,617 | 7,650 |
| Other accrued revenue | 8,305 | 6,255 |
| Prepayments | 568 | 583 |
| | **17,852** | **17,516** |

The carrying value of trade and other receivables approximates their fair value.

The carrying value of receivables that would otherwise be past due, but not impaired, whose terms have been renegotiated is $27 thousand (2014: $19 thousand)

Receivables are shown net of impairments amounting to $139 thousand (2014: $74 thousand) recognised in the current year and arising from non-resident fees and small service charges which can be uneconomic to collect.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

As at 30 June 2015 and 2014, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

| | Gross 30 June 2015 | Impairment 30 June 2015 | Net 30 June 2015 | Gross 30 June 2014 | Impairment 30 June 2014 | Net 30 June 2014 |
|---|---|---|---|---|---|---|
| Not past due/past due<30days | 2,755 | (7) | 2,748 | 2,441 | (21) | 2,420 |
| Past due 31-60 days | 280 | (5) | 275 | 121 | (6) | 115 |
| Past due 61-90 days | 117 | (9) | 108 | 96 | (8) | 88 |
| Past due >90 days | 349 | (118) | 231 | 444 | (39) | 405 |
| | **3,501** | **(139)** | **3,362** | **3,102** | **(74)** | **3,028** |

The provision has been calculated based on expected losses for Hawke's Bay District Health Board's pools of debtors. Expected losses have been determined based on an analysis of the District Health Board's losses in previous periods to establish a collective impairment provision, and review of specific debtors. Movements in the provision for the impairment of receivables are as follows:

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Balance at beginning of year | 74 | 487 |
| Additional provisions made during the year | 102 | 272 |
| Receivables written-off during period | (37) | (685) |
| Balance at end of year | 139 | 74 |

## 3.3 Loans

*Accounting policy*
Loans are initially recognised at fair value, then at amortised cost using the effective interest rate method.

| **Loan to Hawke's Bay Helicopter Rescue Trust** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Non-current | 55 | 68 |
| Current | 12 | 11 |
| | **67** | **79** |

The fair value of loans receivable is $73 thousand (2014 $83 thousand). Fair value has been determined using contractual cash flows discounted using a rate based on market quoted Government stock at balance date plus an adequate constant credit spread totalling 3.23% ( 2014 4.33%).

## 3.4 Inventories

*Accounting Policy*

**Inventories held for distribution**

Inventories held for distribution, or consumption in the provision of services, that are not supplied on a commercial basis are measured at cost on a first in first out basis, adjusted where applicable for any loss of service potential. Where inventories are acquired through non-exchange transactions, cost is the fair value at the date of acquisition.

**Inventories held for sale**

Inventories held for sale or use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| Inventories held for distribution | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Pharmaceuticals | 738 | 783 |
| Surgical and medical supplies | 2,058 | 1,937 |
| Other supplies | 1,085 | 993 |
| | **3,881** | **3,713** |

Write-down of inventories amounted to $44 thousand (2014: $20 thousand). No reversal of previously recognised write-down was made in the current year. The amount of inventories recognised as an expense during the year ended 30 June 2015 was $39.6 million (2014: $32.3 million). No inventories were held at current replacement cost at 30 June 2015 (30 June 2014: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

## 3.5 Non-current assets held for sale

*Accounting policy*

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale, are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Land | 730 | 790 |
| Buildings | 490 | 952 |
| | **1,220** | **1,742** |

Changes and improvements to the mental health service delivery model, resulted in three properties being declared surplus in October 2013. Subsequently the three properties were transferred at their book values from property, plant and equipment to non-current assets held for sale. All three properties are expected to be sold within the next twelve months. The three properties were measured at fair value less costs to sell at 30 June 2015, resulting in a write-down of $518 thousand within other operating expenses.

## 3.6 Property, plant and equipment

*Accounting policy*

Property, plant and equipment consists of the following asset classes: land, buildings, clinical equipment, information technology, motor vehicles, and other equipment.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

**Revaluations**

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually 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.

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

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. Surplus property is carried at the book value on the date the property was declared surplus less impairment losses until it is disposed of.

#### Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the District Health Board 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 through a non-exchange transaction, it is recognised at its 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 the revaluation reserve are transferred to accumulated surpluses/(deficits).

#### Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to Hawke's Bay District Health Board 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 useful lives and associated depreciation rates have been estimated as follows:

| Class of asset | Estimated life | Depreciation rate |
|---|---|---|
| Buildings | 5 to 40 years | 2.5% to 20% |
| Clinical equipment | 2 to 32 years | 3% to 50% |
| Information technology | 3 to 10 years | 10% to 33% |
| Motor vehicles | 3 to 20 years | 5% to 33% |
| Other equipment | 3 to 30 years | 3.3% to 33% |

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

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

### Impairment of property, plant and equipment

Hawke's Bay District Health Board does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| **30 June 2015** | 1 July 2014 | | | | | | | | | 30 June 2015 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Owned assets** | Cost/ Valuation | Accumulated Depreciation | Carrying Amount | Acquisitions | Transfers (Note 1) | Revaluations (Note 2) | Disposals/ transfer/ reclassification to operating lease (Note 3) | Depreciation expense | Depreciation write back on disposal, transfer, or revaluation (Note 1,2,3) | Cost/ valuation | Accumulated Depreciation | Carrying Amount |
| Land | 5,868 | - | 5,868 | - | - | 2,432 | (170) | - | - | 8,130 | - | 8,130 |
| Buildings | 95,108 | (19,322) | 75,786 | - | 8,513 | 5,649 | (1,350) | (7,450) | 26,772 | 107,920 | - | 107,920 |
| Clinical equipment | 32,278 | (16,989) | 15,289 | - | 3,502 | - | (3,026) | (3,546) | 2,832 | 32,754 | (17,703) | 15,051 |
| Information tech. | 7,716 | (4,869) | 2,847 | - | 665 | - | (295) | (1,045) | 291 | 8,086 | (5,623) | 2,463 |
| Motor vehicles | 1,774 | (782) | 992 | - | 52 | - | (38) | (162) | 37 | 1,788 | (907) | 881 |
| Other equipment | 9,032 | (3,619) | 5,413 | - | (5,940) | - | (215) | (669) | 2,909 | 2,877 | (1,379) | 1,498 |
| | 151,776 | (45,581) | 106,195 | - | 6,792 | 8,081 | (5,094) | (12,872) | 32,841 | 161,555 | (25,612) | 135,943 |
| **Leased assets** | | | | | | | | | | | | |
| Buildings | 3,565 | (3,375) | 190 | - | - | - | (3,565) | (157) | 3,532 | - | - | - |
| Alterations | - | - | - | - | 1,347 | - | - | - | (153) | 1,347 | (153) | 1,194 |
| | 3,565 | (3,375) | 190 | - | 1,347 | - | (3,565) | (157) | 3,379 | 1,347 | (153) | 1,194 |
| **Work in Progress** | | | | | | | | | | | | |
| Buildings | 3,384 | - | 3,384 | 11,101 | (3,742) | - | - | - | - | 10,743 | - | 10,743 |
| Clinical equipment | 62 | - | 62 | 3,671 | (3,532) | - | - | - | - | 201 | - | 201 |
| Information tech. | 169 | - | 169 | 633 | (680) | - | - | - | - | 122 | - | 122 |
| Motor vehicles | - | - | - | 52 | (52) | - | - | - | - | - | - | - |
| Other equipment | 44 | - | 44 | 118 | (133) | - | - | - | - | 29 | - | 29 |
| | 3,659 | - | 3,659 | 15,575 | (8,139) | - | - | - | - | 11,095 | - | 11,095 |
| | 159,000 | (48,956) | 110,044 | 15,575 | | 8,081 | (8,659) | (13,029) | 36,220 | 173,997 | (25,765) | 148,232 |

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

**Note 1: Classification changes**

Plant to be included in the revaluation of the buildings was transferred from other equipment to buildings. The assets transferred had a cost of $6.107 million, accumulated depreciation of $2.744 million and a carrying value of $3.363 million. Alterations to leased buildings were transferred from buildings to a separate alterations category under leased assets. The assets transferred had a cost of $1.347 million, accumulated depreciation of $153 thousand, and a carrying value of $1.194 million.

**Note 2: Revaluations**

The revaluation increased land values by $2.432 million. Building values increased by $35.012 million comprising an increase in valuation of $11.756 million, the transfer of plant to buildings of $6.107 million (see above) and the write-back of depreciation of $29.363 million.

**Note 3: Transfer of Chatham Islands health services to Canterbury District Health Board**

Responsibility for the provision of health services in the Chatham Islands transferred from the Hawke's Bay District Health Board to the Canterbury District Health Board on 30 June 2015. The transfer was effected by an order in council and included the transfer of the assets in the Chatham Islands for no consideration. The effect of the transaction on Hawke's Bay District Health Board is to reduce property, plant and equipment by $1.655 million, and equity by the same amount. Land and buildings reduced by $170 thousand and $1.350 million respectively. Clinical equipment, information technology and other equipment transferred at $135 thousand comprising a cost of $205 thousand, accumulated depreciation of $137 thousand, and a $68 thousand gain on transfer.

**Valuation**

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid (MPropertyStudies BCom(VPM) ANZIV SNZPI) of Logan Stone Limited. The valuation is effective as at 30 June 2015.

*Land*

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Restrictions on the district health board's ability to sell land, would normally not impair the value of the land because it has operational use of the land for the foreseeable future, and will receive substantially the full benefits of outright ownership.

*Buildings*

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings. Depreciated replacement cost is determined using a number of significant assumptions including:

- Cost is based on replacement with modern equivalent assets, adjusted where appropriate for physical deterioration and optimisation due to over-design or surplus capacity.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

- Cost is derived from historical cost records plus other construction data including: Rawlinsons 2007 Construction handbook; Rider Levett Bucknall Costings; Maltbys (Quantity Surveyors and Construction Cost Managers) cost data and indices; Opus International Consultants (Quantity Surveyor Advice), and other data collected by Logan Stone Limited.
- In determining obsolescence and physical depreciation regard has been given to the period that the district health board expects to make use of each asset.
- The estimated remaining life has been applied in determining depreciated replacement cost, using recent asset management plans.

Non-specialised buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

The board believes that the net book value of plant and equipment is the fair value at 30 June 2015.

**Restrictions**

Hawke's Bay District Health Board does not have full title to the Crown land it occupies, but transfer is arranged if and when land is sold. The disposal of certain land may be subject to legislation such as the Reserves Act 1977 and the "offer-back" provisions of the Public Works Act 1981. The Crown may require land the District Health Board has declared surplus and wishes to sell, to be sold to it for use in the redress of Treaty of Waitangi claims. The District Health Board may also be required to assist the Crown to meet its obligations over Māori sites of significance. The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| | 1 July 2013 | | | | | | | | | | 30 June 2014 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2014** | Cost/ Valuation | Accumulated Depreciation | Carrying Amount | Acquisitions | Transfers from work in progress | Disposals | Transfers to non-current assets held for sale | Depreciation Expense | Depreciation write back on disposal | Depreciation write back on transfer | Cost/ valuation | Accumulated Depreciation | Carrying Amount |
| **Owned assets** | | | | | | | | | | | | | |
| Land | 6,658 | - | 6,658 | - | - | - | (790) | - | - | - | 5,868 | - | 5,868 |
| Buildings | 90,219 | (12,214) | 78,005 | - | 5,930 | (17) | (1,024) | (7,210) | 7 | 95 | 95,108 | (19,322) | 75,786 |
| Clinical equipment | 29,793 | (15,173) | 14,620 | - | 4,579 | (2,094) | - | (3,682) | 1,866 | - | 32,278 | (16,989) | 15,289 |
| Information tech. | 6,798 | (4,134) | 2,664 | - | 1,278 | (360) | - | (1,090) | 355 | - | 7,716 | (4,869) | 2,847 |
| Motor vehicles | 1,754 | (610) | 1,144 | - | 20 | - | - | (175) | 3 | - | 1,774 | (782) | 992 |
| Other equipment | 8,095 | (3,021) | 5,074 | - | 1,140 | (203) | - | (735) | 137 | - | 9,032 | (3,619) | 5,413 |
| | 143,317 | (35,152) | 108,165 | - | 12,947 | (2,674) | (1,814) | (12,892) | 2,368 | 95 | 151,776 | (45,581) | 106,195 |
| **Leased assets** | | | | | | | | | | | | | |
| Buildings | 3,551 | (3,136) | 415 | - | 14 | - | - | (239) | - | - | 3,565 | (3,375) | 190 |
| | 3,551 | (3,136) | 415 | - | 14 | - | - | (239) | - | - | 3,565 | (3,375) | 190 |
| **Work in Progress** | | | | | | | | | | | | | |
| Buildings | 3,264 | - | 3,264 | 5,925 | (5,786) | - | (19) | - | - | - | 3,384 | - | 3,384 |
| Clinical equipment | 322 | - | 322 | 4,328 | (4,588) | - | - | - | - | - | 62 | - | 62 |
| Information tech. | 295 | - | 295 | 1,148 | (1,274) | - | - | - | - | - | 169 | - | 169 |
| Motor vehicles | 6 | - | 6 | 14 | (20) | - | - | - | - | - | - | - | - |
| Other equipment | 201 | - | 201 | 1,136 | (1,293) | - | - | - | - | - | 44 | - | 44 |
| | 4,088 | - | 4,088 | 12,551 | (12,961) | - | (19) | - | - | - | 3,659 | - | 3,658 |
| | 150,956 | (38,288) | 112,668 | 12,551 | | (2,674) | (1,833) | (13,131) | 2,368 | 95 | 159,000 | (48,956) | 110,044 |

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 3.7 Intangible assets

*Accounting policy*

**Software acquisition and development**

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include costs of materials and services, employee costs and any directly attributable overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.

Rights in shared software developments are considered to have indefinite useful life, as the district health board has the ability and intention to review any service level agreement indefinitely. As the rights are considered to have indefinite life, the intangible asset is not amortised and is tested for impairment annually.

**Amortisation**

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the assets is available for use and ceases at the date the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangibles assets have been estimated as follows:

| Type of asset | Estimated life | Amortisation rate |
|---|---|---|
| Acquired computer software | 3 to 15 years | 6.7% to 33% |
| Developed computer software | 3 to 15 years | 6.7% to 33% |
| NZ Health Partnerships Limited – Class B Shares | Indefinite | Nil |
| Interest in CRTAS | Work in progress | Nil |

**Impairment of intangible assets**

Hawke's Bay District Health Board does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Intangible assets subsequently measured at cost that have an indefinite useful life, or are not yet available for use, are not subject to amortisation and are tested annual for impairment.

| | 1 July 2014 | | | | | | | | | 30 June 2015 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2015 Owned assets** | Cost/ Valuation | Accumulated Amortisation | Carrying Amount | Acquisitions | Transfers | Adjustments | Disposals | Amortisation Expense | Amortisation written back | Cost/ Valuation | Accumulated Amortisation | Carrying Amount |
| Software | 9,368 | (7,233) | 2,135 | - | 1,178 | 18 | (2) | (1,033) | 2 | 10,562 | (8,264) | 2,298 |
| | 9,368 | (7,233) | 2,135 | - | 1,178 | 18 | (2) | (1,033) | 2 | 10,562 | (8,264) | 2,298 |
| **Work in Progress** | | | | | | | | | | | | |
| Software | 345 | - | 345 | 904 | (1,178) | - | - | - | - | 71 | - | 71 |
| Class B Shares in NZHPL | 1,621 | - | 1,621 | 883 | - | - | - | - | - | 2,504 | - | 2,504 |
| CRTAS | 3,069 | - | 3,069 | 530 | - | - | - | - | - | 3,599 | - | 3,599 |
| | 5,035 | - | 5,035 | 2,317 | (1,178) | - | - | - | - | 6,174 | - | 6,174 |
| | 14,403 | (7,233) | 7,170 | 2,317 | - | 18 | (2) | (1,033) | 2 | 16,736 | (8,264) | 8,472 |

The shareholding in Health Benefits Limited (HBL) was reclassified from an investment to an intangible asset during the year ended 30 June 2014. HBL issued 2,504,000 Class B shares to Hawke's Bay District Health Board in December 2012, and were using the proceeds of the share issue to fund the finance, procurement and supply chain (FPSC) shared service programme it was implementing on behalf of all the district health boards. As at 30 June 2015, all of the shares (2014: 1.621 million shares) had been called at $1 per share. The shares conferred a right to use the finance, procurement and supply chain shared service and carried no voting rights. The district health board was expecting to be using the shared service from February 2016.

Collectively the district health boards reviewed the system designed by HBL after cost issues were raised, and have decided to complete the build within the existing budget. They have also individually endorsed the path forward to a national FPSC system. On 30 June 2015, all the assets and liabilities of HBL transferred by Order in Council to NZ Health Partnerships Limited, a company owned collectively by the 20 district health boards. Consequently the district health boards have as a sector determined that the FPSC is not an impaired asset, as it will be completed with substantially the same scope and will contribute savings to the sector. The Hawke's Bay District Health Board is programmed to begin using the finance, procurement and supply chain system at some point between 2017 and 2019. The intangible asset is considered to have indefinite life.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

Individually district health boards need to determine whether the FPSC system will return sufficient savings in their districts to justify their level of investment. Hawke's Bay District Health Board is of the view that sufficient savings will be made based on savings to date, and that no impairment of the asset is necessary.

The investment in Central Region's Technical Advisory Services Limited (CRTAS) relating to the Regional Health Informatics Programme (RHIP) shared service, formerly the Central Region Information Services Plan (CRISP), was reclassified from an investment to an intangible asset during the year ended 30 June 2014. The intangible asset recognised the District Health Boards right to use the shared services clinical information systems, and was considered to have indefinite life. During the year ended 30 June 2015 RHIP was reclassified into the four clinical systems and the supporting regional infrastructure it comprises, and will be amortised or depreciated when these assets are complete. The RHIP work in progress at 30 June 2015 is considered to be fit for purpose, and the district health boards in the central region continue to support the project. The Hawke's Bay District Health Board considers the carrying amount of the assets (the cost of the system build), is equivalent to the recoverable service amount using depreciated replacement cost, and consequently no impairment of the assets is necessary.

| | 1 July 2013 | | | | | | | | | 30 June 2014 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2014 Owned assets** | Cost/ Valuation | Accumulated Amortisation | Carrying Amount | Acquisitions | Transfers | Adjustments | Amortisation Expense | Amortisation written back | Impairment charges | Cost/ Valuation | Accumulated Amortisation | Carrying Amount |
| Software | 9,151 | (6,372) | 2,779 | - | 122 | 95 | (861) | - | - | 9,368 | (7,233) | 2,135 |
| | 9,151 | (6,372) | 2,779 | - | 122 | 95 | (861) | - | - | 9,368 | (7,233) | 2,135 |
| **Work in Progress** | | | | | | | | | | | | |
| Software | 201 | - | 201 | 266 | (122) | - | - | - | - | 345 | - | 345 |
| Class B Shares in NZHPL | - | - | - | 622 | 999 | - | - | - | - | 1,621 | - | 1,621 |
| RHIP | - | - | - | 9 | 3,060 | - | - | - | - | 3,069 | - | 3,069 |
| | 201 | - | 201 | 897 | 3,937 | - | - | - | - | 5,035 | - | 5,035 |
| | 9,352 | (6,372) | 2,980 | 897 | 4,059 | 95 | (861) | - | - | 14,403 | (7,233) | 7,170 |

## 3.8 Investment property

*Accounting policy*

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued will provide an assessment on the fair values of the properties. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing where the parties had each acted knowledgeably, prudently and without compulsion.

Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above).

When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to retained earnings. Any loss arising in this manner is recognised immediately in the surplus or deficit.

If an investment property becomes owner-occupied, it is reclassified as property and its fair value at the date of reclassification becomes its cost for accounting purposes of subsequent recording. When Hawke's Bay District Health Board begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Balance at beginning of year | 153 | 153 |
| Fair value adjustments | (22) | - |
| Balance at end of year | **131** | **153** |

Investment properties are valued to fair value annually as at 30 June. The valuation as at June 2015 were performed by John Reid MPropertyStudies BCom(VPM) ANZIV SNZPI of Logan Stone, who holds an annual practicing certificate and has held registration since 1985. The fair value of investment property has been determined using market based evidence. One of the properties is leased to an external party for $6 thousand per annum.

## 3.9 Investments in associates

*Accounting policy*

Investment in associate entities are accounted for using the equity method. An associate is an entity over which the district health board has significant influence, and that is neither a subsidiary nor an interest in a joint venture. The investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the district health board's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount oe investment.

If the share of deficits of an associate equals or exceeds the district health board's interest in the associate, further deficits are not recognised. After the district health board's interest is reduced to zero, additional deficits are provide for, and a liability is recognised, only to the extent that the district health board has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the district health board will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

Hawke's Bay District Health Board has an investment in one associate entity, Allied Laundry Services Limited, whose principal activity is the provision of laundry services. The interest held at 30 June 2015 was 25% and the associates balance date is 30 June. There are no significant restrictions on the ability of the associate to transfer funds to Hawke's Bay District Health Board in the form of cash dividends.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**

*in thousands of New Zealand Dollars*

| **Summarised financial information of Allied Laundry Services Limited** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| *Presented on a gross basis* | | *Restated* |
| Assets | 5,690 | 5,359 |
| Liabilities | 1,090 | 1,276 |
| Revenue | 8,003 | 7,804 |
| Surplus/(deficit) | 757 | 675 |
| Hawke's Bay District Health Board ownership interest | 25% | 25% |
| Share of ALSL's contingent liabilities incurred jointly with other investors | - | - |
| Other contracted commitments (operating leases) | 7 | 17 |

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited management accounts as at 30 June 2015, and their audited financial statements as at 30 June 2014.

The Te Matau ā Māui Health Trust (the Trust) holds all the shareholding of the Hawke's Bay Primary Health Organisation (PHO), and was included as an associate of the District Health Board last year under NZ IFRS. The Hawke's Bay District Health Board appoints four of the ten trustees to represent the general community in consultation with all of the territorial local authorities within the Hawke's Bay region. Through its association with the Trust in appointing four of the ten trustees, and its association with the Hawke's Bay PHO as the PHO's primary funder, the District Health Board has significant influence over both the Trust and the PHO.

Significant influence is the criteria for classification as an associate under NZ IFRS. Under PBE reporting standards, associates are limited to ownership interest in the form of shareholding or other formal equity structure. Consequently the Trust is no longer included in this note.

### 3.10 Other investments

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Balance at beginning of year | - | 4,663 |
| Transferred to intangible assets | - | (4,059) |
| Reclassified as an expense | - | (604) |
| | **-** | **-** |

The carrying value of the current portion of investments approximates their fair value.

## 4. Financing the District Health Board's activities

### 4.1 Borrowings and finance leases

*Accounting policy*

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method. Borrowings are classified as current liabilities unless Hawke's Bay District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date.

Finance leases transfer 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 component 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 the district health board will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the leased term and its useful life.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

| **Non-current** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Crown loans | 42,500 | 32,500 |
| | **42,500** | **32,500** |
| **Current** | | |
| Crown loans | - | 10,000 |
| Finance lease liabilities | - | 268 |
| | **-** | **10,268** |

**Crown loans**

Hawke's Bay District Health Board has a secured bank loan with the Crown. The details of terms and conditions are as follows:

| **Weighted average interest rate** | | |
|---|---|---|
| Crown loans | 4.58% | 5.36% |

| **Repayable as follows:** | | |
|---|---|---|
| Less than one year | - | 10,000 |
| One to two years | - | - |
| Two to three years | 6,000 | - |
| Three to four years | 11,500 | 6,000 |
| Four to five years | - | 11,500 |
| Later than five years | 25,000 | 15,000 |

| **Term loan facility limits:** | | |
|---|---|---|
| Crown loans | 42,500 | 42,500 |
| Surplus fund pool (New Zealand Health Partnerships Limited) refer to note 3.1 | 20,200 | 19,400 |
| | 62,700 | 61,900 |

The fair value of Crown loan borrowings is $45.117 million (2014 $44.01 million). Fair value has been determined using contractual cash flows discounted using a rate based on market quoted Government stock at balance date plus a margin for District Health Board risk ranging from 3.19% to 3.45% ( 2014 3.76% to 4.58%).

**Security and Terms**

The loan facility is provided by the Ministry of Health. The Ministry of Health term liabilities are secured by a negative pledge. Without the Ministry of Health's prior written consent Hawke's Bay District Health Board cannot perform the following actions:

- create any security over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of its business as presently conducted;
- dispose of any of its assets except disposals in the ordinary course of business or disposals for full value; or
- provide or accept services other than for proper value and on reasonable commercial terms.

The Government of New Zealand does not guarantee term loans.

**Finance Lease Liabilities**

The lease of the Central Hawke's Bay Health Centre expired in February 2015, and is likely to be extended for the first of the three six year periods of the right of renewal. The new lease does not meet the criteria for a finance lease and has been reclassified as an operating lease.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**

*in thousands of New Zealand Dollars*

## 4.2 Payables and deferred revenue

*Accounting policy*

Payables and deferred revenue are recorded at their face value.

| **Payables and deferred revenue under exchange transactions** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Trade payables | 4,814 | 4,908 |
| Income in advance relating to contracts with specific performance obligations | 2,228 | 1,729 |
| Other non-trade payables and accrued expenses | 21,020 | 25,712 |
| | 28,062 | 32,349 |
| **Payables and deferred revenue under non exchange transactions** | | |
| ACC levy payable | 864 | 832 |
| Goods and services tax | 1,897 | 2,678 |
| | 2,761 | 3,510 |
| **Total payables and deferred revenue** | **30,823** | **35,859** |

Payables and deferred revenue are non-interest bearing and are normally settled on the 20th of the following month or on 7-day terms, therefore the carrying value of payables and deferred revenue approximates their fair value.

## 4.3 Employee entitlements

*Accounting policy*

**Short-term employee entitlements**

Employee entitlements 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 based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave and continuing medical education leave earned, but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

The 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 on balance date, to the extent that it will be used by staff to cover those future absences.

The liability and an expense are recognised for bonuses where it is 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 entitlements 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 long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on: likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlement information; and the present value of the estimated future cash flows.

**Superannuation schemes**

**Defined contribution schemes**

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

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

**Defined benefit schemes**

The Hawke's Bay District Health Board makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in note 5.5.

| **Non-current liabilities** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Long service leave | 2,194 | 2,143 |
| Retirement gratuities | 148 | 152 |
| | **2,342** | **2,295** |
| **Current liabilities** | | |
| Accrued salaries and wages | 7,919 | 6,556 |
| Annual leave | 19,125 | 18,265 |
| Sick leave | 257 | 288 |
| Continuing medical education leave and expenses | 4,375 | 4,075 |
| Sabbatical leave | 576 | 514 |
| Long service leave | 1,463 | 1,278 |
| Retirement gratuities | 157 | 133 |
| | **33,872** | **31,109** |

**Key assumptions in measuring employee entitlements**

The present value of sick leave, sabbatical leave, long service leave, and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis by external independent actuarial valuer, Paul Dalebroux BSc(Hons), FIA, FNZSA. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any change 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, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 2.93% in year one to 5.50% after 30 years. The salary inflation factor is the district health board's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $212 thousand higher/lower. If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $167 thousand higher/lower.

## 4.4 Provisions (ACC Partnership Programme)

*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 an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a 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 included in financing costs.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**

*in thousands of New Zealand Dollars*

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Balance at beginning of year | 278 | 253 |
| Additional provisions made | 626 | 542 |
| Amounts used | (398) | (517) |
| Unused amounts reversed | - | - |
| Balance at end of year | **506** | **278** |

All provisions are classified as current.

### a. ACC Accredited Employers Programme

The Hawke's Bay District Health Board belongs to the ACC Accredited Employers Programme's full self-cover plan, whereby the District Health Board accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme, the District Health Board is liable for all claims costs for a period of five years after the end of the cover period in which the injury occurred. At the end of the five-year period, the District Health Board pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

*Liability valuation*

The liability for the ACC Accredited Employers Programme is measured at the present value of anticipated future payments to be made in respect of the employee injuries and claims up to the reporting date using actuarial techniques. Consideration is given to expected future wage and salary levels, and experience of employee claims and injuries. Expected future payments are discounted using market yields at balance date on government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Exposures arising from the programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies;
- induction training on health and safety;
- actively managing workplace injuries to ensure that employees return to work as soon as practical;
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

Hawke's Bay District Health Board has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the district health board will carry the total cost of claims up to $1.4 million for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceed the stop loss limit, the district health board will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

The district health board is nor exposed to any significant concentrations of insurance risk, as work-related injuries are generally the result of an isolated event involving an individual employee.

An independent actuarial valuer, Peter Davies B.Bus.Sc, FIA, FNZSA, AIAA has calculated the district health board's liability, and the valuation is effective 30 June 2015. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

In the valuer's opinion, there are insufficient long-term claims to be able to carry out any meaningful discounting. Accordingly all liabilities have been taken at their face value.

Any changes in liability valuation assumptions will not have a material effect on the financial statements.

### b. Other provisions

There are no provisions for site restoration or onerous contracts as at 30 June 2015 (30 June 2014: Nil).

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 4.5 Equity

| | Crown Equity | Property Revaluation Reserves | Restricted Funds | Asset Replace Reserve | Accumulated Deficit | Total Equity |
|---|---|---|---|---|---|---|
| Balance at 1 July 2014 | 37,584 | 31,744 | 3,064 | 14,437 | (37,688) | 49,141 |
| Surplus/(deficit) for the year | - | - | - | - | 3,054 | 3,054 |
| Transfers between reserves | - | - | 61 | 816 | (877) | - |
| Transfer to Canterbury DHB | (1,655) | - | - | - | - | (1,655) |
| Repayment to the Crown | (357) | - | - | - | - | (357) |
| Revaluation of land and buildings | - | 37,444 | - | - | - | 37,444 |
| **Balance at 30 June 2015** | **35,572** | **69,188** | **3,125** | **15,253** | **(35,511)** | **87,627** |

| | Crown Equity | Property Revaluation Reserves | Restricted Funds | Asset Replace Reserve | Accumulated Deficit | Total Equity |
|---|---|---|---|---|---|---|
| Balance at 1 July 2013 | 37,943 | 31,744 | 2,850 | 12,411 | (38,670) | 46,278 |
| Surplus/(deficit) for the year | - | - | - | - | 3,222 | 3,222 |
| Transfers between reserves | - | - | 214 | 2,026 | (2,240) | - |
| Repayment to the Crown | (359) | - | - | - | - | (359) |
| **Balance at 30 June 2014** | **37,584** | **31,744** | **3,064** | **14,437** | **(37,688)** | **49,141** |

### Asset Replacement Reserves

The asset replacement reserve includes cash proceeds from the sale of the Napier Hill site of $7.850 million, and underspends relating to mental health funding from the Ministry of Health of $0.816 million (prior years: $6.587 million). These funds have been reserved for the development of the mental health intensive care unit.

### Property Revaluation Reserves

These reserves relate to the revaluation of land and buildings to fair value. Where land and buildings are reclassified as investment property, the cumulative increase in the fair value of the land and buildings at the date of reclassification in excess of any previous impairment losses is included in the revaluation reserve. The revaluation reserve consists of amounts relating to:

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Land | 7,842 | 5,410 |
| Buildings | 61,346 | 26,334 |
| | **69,188** | **31,744** |

### Restricted Funds

Restricted funds represent the unspent portion of donations, bequests and clinical trial revenue that is subject to restrictions. The restrictions generally specify how the donations, bequests and clinical trial revenue are required to be spent in providing specified deliverables.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 5. Other disclosures

### 5.1 Taxes

*Accounting policy*

**Goods and services tax**

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

The net amount of GST recoverable from, or payable to, the Inland Revenue Department 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.

GST relating to revenue from the Crown is recognised when the income is accrued in accordance with section 9(7) of the Goods and Services Tax Act 1985.

Commitments and contingencies are disclosed exclusive of GST.

**Income tax**

Hawke's Bay District Health Board is a public authority and consequently is exempt from the payment of income tax under section CB3 of the Income Tax Act 2007.

### 5.2 Capital commitments and operating leases

| **Capital commitments** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Property, plant and equipment | | |
| Buildings | 6,833 | 11,830 |
| Clinical equipment | 457 | - |
| Plant | 13 | - |
| Information technology | 5 | - |
| Intangible assets | | |
| Software | 3 | - |
| NZ Health Partnerships Limited – Class B shares | - | 883 |
| Regional Health Information Project (RHIP) | 2,309 | 2,776 |
| | 9,620 | 15,489 |

Capital commitments include orders issued for property, plant and equipment, and future agreed contributions to NZ Health Partnerships Limited and RHIP.

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

| **Non-cancellable commitments – operating leases** | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Not more than one year | 1,994 | 2,299 |
| One to five years | 5,797 | 5,470 |
| Later than five years | 3,556 | 4,520 |
| | **11,347** | **12,289** |

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

Hawke's Bay District Health Board leases a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The main property leases are listed below.

- The Napier Health Centre lease was extended from the December 2011 expiry date for a further twelve years ending December 2023, with a right of renewal for a further two periods of six years each, and an escalation clause allowing for increases in line with the inflation rate.
- The lease of the administration building at 100 McLeod Street was renewed in January 2013, for the first of four right of renewal periods of three years each. The lease is reviewed to market every two years.
- The lease of the store building on Omahu Road was renewed in December 2014, for the first of three right of renewal periods of two years each, with a review to market on each renewal date.
- The Central Hawke's Bay Health Centre lease expired in February 2015. Negotiations for a new lease are ongoing.

## 5.3 Financial instruments

### a. Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

**Financial Assets**

| Loans and receivables | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Cash and cash equivalents | 14,969 | 18,536 |
| Short term investments | 1,703 | 1,536 |
| Loans | 67 | 83 |
| Trade and other receivables | 17,852 | 17,516 |
| | **34,591** | **37,671** |

**Financial Liabilities**

| Financial liabilities measured at amortised cost | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Secured bank loans (Ministry of Health) | 42,500 | 42,500 |
| Finance lease liabilities | - | 268 |
| Trade and other payables | 30,823 | 35,859 |
| | **73,323** | **78,627** |

### b. Fair value hierarchy disclosures

The Hawke's Bay District Health Board recognises no financial instruments at fair value in the statement of financial position.

### c. Financial instrument risks

The Hawke's Bay District Health Board's activities expose it to a variety of financial instrument rate risks, including market risk, credit risk and liquidity risk. The District Health Board 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 any transactions that are speculative in nature to be entered into.

**Market risk**

*Fair value interest rate risk*

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. The Hawke's Bay District Health Board's exposure to fair value interest rate risk is to Ministry of Health borrowings and bank deposits which were at fixed rates of interest at balance date.

*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. Investments and borrowings issued at variable interest rates expose the Hawke's Bay District Health Board to cash flow interest rate risk.

The Hawke's Bay District Health Board's investment policy requires a spread of investment maturity dates to limit exposure to short-term interest rate movements. The District Health Board currently has no variable interest rate investments.

The Hawke's Bay District Health Board's borrowing policy requires a spread of interest rate re-pricing dates on borrowings to limit the exposure to short-term interest rate movements.

In respect of income-earning financial assets and interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance sheet date and the periods in which they re-price. The re-pricing gap is the net value of financial instruments which will cease to be at fixed interest rates in each period after the balance sheet date.

| 30 June 2015 | Effective Interest Rates | Total | 6 months or less | 6-12 months | 1-2 years | 2-5 years | > 5 years |
|---|---|---|---|---|---|---|---|
| Cash and cash equivalents | | | | | | | |
| Cash | - | 7 | 7 | | | | |
| Bank balances | - | 3 | 3 | | | | |
| Credit balance (HBL) | 4.19% | 13,537 | 13,537 | - | - | - | - |
| Short term deposits | 2.76% | 1,422 | 1,422 | - | - | - | - |
| Short term investments | 3.27% | 1,703 | 1,703 | - | - | - | - |
| Secured bank loans: | | | | | | | |
| NZD fixed rate loans | 4.58% | (42,500) | - | - | - | (17,500) | (25,000) |
| Repricing gap | | **(25,828)** | **16,672** | **-** | **-** | **(17,500)** | **(25,000)** |

During the year $10 million of borrowings matured and was re-borrowed to April 2025 at an interest rate of 3.40%.

| 30 June 2014 | Effective Interest Rates | Total | 6 months or less | 6-12 months | 1-2 years | 2-5 years | > 5 years |
|---|---|---|---|---|---|---|---|
| Cash and cash equivalents | | | | | | | |
| Cash | - | 7 | 7 | | | | |
| Credit balance (HBL) | 4.55% | 17,001 | 17,001 | - | - | - | - |
| Short term deposits | 2.73% | 1,528 | 1,528 | - | - | - | - |
| Secured bank loans: | 4.26% | 1.536 | 1,321 | 215 | - | - | - |
| NZD fixed rate loans | 5.36% | (42,500) | - | (10,000) | - | (17,500) | (15,000) |
| Finance lease liabilities | 8.40% | (268) | - | (268) | - | - | - |
| Repricing gap | | **(22,696)** | **19,857** | **(10,053)** | **-** | **(17,500)** | **(15,000)** |

*Currency risk*

Currency risk is the risk that the fair value or future cash flows on a financial instrument will fluctuate because of changes in foreign exchange rates. Hawke's Bay District Health Board is exposed to currency risk on sales and purchases that are denominated in a currency other than the NZD. The currencies giving rise to this risk are primarily U.S. Dollars and Euro.

Hawke's Bay District Health Board hedges all capital asset purchase orders greater than $100,000 denominated in foreign currencies. The District Health Board uses forward exchange contracts to hedge its foreign currency risk. Usually the forward exchange contracts have maturities of less than one year after balance sheet date. Where necessary, the forward exchange contracts are rolled over at maturity or the contract is completed and the funds held in a foreign currency account at the District Health Board's bankers. The District Health Board does not hold any other monetary assets and liabilities in currencies other than NZD.

*Sensitivity analysis*

The effect of a general increase of one percentage point in the value of NZD against other foreign currencies would reduce earnings dependent on how New Zealand based suppliers reflect the increase through the prices they charge. Direct import of goods from overseas is restricted to major capital investment, with no major items planned for 2015/16.

**Credit risk**

Credit risk is the risk that a third party will default on its obligations to Hawke's Bay District Health Board, causing it to incur a loss.

Financial instruments, which potentially subject the District Health Board to concentrations of risk consist principally of cash, short-term deposits and accounts receivable. The District Health Board places its cash with Health Benefits Limited, a low risk and high quality entity due to its status as a Crown Entity which among other activities, invests surplus cash on behalf of the district health boards.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 96% (30 June 2014: 96%) of the District Health Board's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

At the balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

*Sensitivity analysis*

At 30 June 2015, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2015/16, as most of the District Health Board's term debt is at fixed rates, and only the net interest from cash holdings would be affected.

*Credit quality of financial assets*

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) and counterparties without credit rating are mainly made up of receivables from the Crown and entities related to the Crown.

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| **Counterparties with credit ratings** | | |
| **Cash, cash equivalents and investments** | | |
| AA- | 3,135 | 3,071 |
| *Total cash and cash equivalents* | 3,135 | 3,071 |

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**

*in thousands of New Zealand Dollars*

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| **Counterparties without credit ratings** | | |
| **Cash and cash equivalents** | | |
| NZ Health Partnerships Ltd – no defaults in the past | 13,537 | 17,001 |
| **Receivables and prepayments** | | |
| Receivables and prepayments with no defaults in the past | 17,825 | 17,497 |
| Receivables and prepayments with defaults in the past | 27 | 19 |
| Total Receivables and prepayments | 17,852 | 17,516 |
| **Loans** | | |
| Hawke's Bay Helicopter Rescue Trust - no defaults in the past | 67 | 83 |

**Liquidity risk**

Liquidity risk is the risk that the Hawke's Bay District Health Board 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 an adequate amount of committed credit facilities and the ability to close out market positions. The District Health Board aims to maintain flexibility in funding by keeping committed credit lines available. In meeting its liquidity requirements the Hawke's Bay District Health Board maintains a target level of investments that must mature within specified time frames.

**Contractual maturity analysis of financial liabilities**

The table below analyses the Hawke's Bay District Health Board's financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate on the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows and include interest payments.

| **30 June 2015** | **Carrying amount** | **Contractual cash flows** | **6 months or less** | **6-12 months** | **1-2 years** | **2-5 years** | **> 5 years** |
|---|---|---|---|---|---|---|---|
| Payables and deferred revenue | 30,823 | 30,823 | 30,823 | - | - | - | - |
| Secured loans (Ministry of Health) | 42,500 | 53,399 | 981 | 970 | 1,945 | 21,752 | 27,751 |
| | **73,323** | **84,222** | **31,804** | **970** | **1,945** | **21,752** | **27,751** |

| **30 June 2014** | **Carrying amount** | **Contractual cash flows** | **6 months or less** | **6-12 months** | **1-2 years** | **2-5 years** | **> 5 years** |
|---|---|---|---|---|---|---|---|
| Payables and deferred revenue | 35,859 | 35,859 | 35,859 | - | - | - | - |
| Secured loans (Ministry of Health) | 42,500 | 52,203 | 1,147 | 10,989 | 1,609 | 21,573 | 16,885 |
| Finance lease liabilities | 268 | 285 | 215 | 70 | - | - | - |
| | **78,627** | **88,347** | **37,221** | **11,059** | **1,609** | **21,573** | **16,885** |

**Forecasted transactions**

Hawke's Bay District Health Board does not hedge forecasted transactions.

## 5.4 Contingent assets

The Hawke's Bay District Health Board had a guarantee from Honeywell that energy efficiency and conservation measures managed by Honeywell would result in significant savings within a four year time period. Savings were not achieved as quickly or to the extent expected and as a result payments were received from Honeywell between 2009 and 2014 for periods up to 30 November 2012. Final payment was received from Honeywell during the year. There are no contingent assets at 30 June 2015.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 5.5 Contingent liabilities

**Lawsuits against the District Health Board**

Hawke's Bay District Health Board has exposure to contingent losses in respect of employment disputes and consumer grievances. It is uncertain whether the liabilities, if any, will fall on the District Health Board or some other party. An assessment of the financial effect of the disputes and grievances cannot be made. The District Health Board was exposed to the same type of contingent losses last year, and no assessment of the financial effect could be made.

**Superannuation schemes**

The District Health Board is a participating employer in the National Provident Fund Defined Benefit Plan Contributors Scheme (the scheme) which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the District Health Board could be responsible for any deficit of the scheme. Similarly, if a number of employers ceased to participate in the scheme, the District Health Board could be responsible for and increased share of any deficit.

As at March 2015, the scheme had a past service surplus of $20.9 million (11.4% of the liabilities) exclusive of employer superannuation contribution tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology are consistent with the requirements of PBE IPSAS 25 *Employee Benefits.* The actuary to the scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report the actuary recommended employer contributions remain suspended.

## 5.6 Related party transactions

Hawke's Bay District Health Board 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 and/or client/recipient relationship, on terms and conditions no more or less favourable than those that it is reasonable to expect Hawke's Bay District Health Board 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 compensation**

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| **Board Members** | | |
| Remuneration | 274 | 274 |
| *Full time equivalent members* | *1.3* | *1.3* |
| **Executive management team** | | |
| Remuneration | 2,670 | 2,548 |
| *Full time equivalent members* | *9.3* | *9.3* |
| **Total key management personnel remuneration** | **2,944** | **2,822** |
| ***Total full time equivalent personnel*** | ***10.6*** | ***10.6*** |

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.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in thousands of New Zealand Dollars*

## 5.7 Remuneration

**Remuneration – Board members**

The total value of remuneration paid or payable to each Board member during the year was:

| | 30 June 2015 | | 30 June 2014 | |
|---|---|---|---|---|
| | Board | Committees | Board | Committees |
| Kevin Atkinson *Chair* | 42,000 | 2,500 | 42,000 | 2,750 |
| Ngahiwi Tomoana *Deputy Chair (appointed member)* | 25,500 | 2,188 | 25,500 | 1,250 |
| Barbara Arnott *(appointed member)* | 20,400 | 2,250 | 20,400 | 3,500 |
| David Barry *(retired November 2013)* | - | - | 8,500 | 1,250 |
| Andrew Blair *(appointed October 2013)* | 20,400 | 2,500 | 11,900 | 1,250 |
| David Davidson *(retired November 2013)* | - | - | 8,500 | 250 |
| Dan Druzianic *(appointed member/elected October 2013)* | 20,400 | 3,120 | 20,400 | 3,684 |
| Peter Dunkerley | 20,400 | 2,500 | 20,400 | 4,000 |
| Denise Eaglesome *(appointed member)* | 20,400 | 750 | 20,400 | 1,000 |
| Helen Francis | 20,400 | 1,500 | 20,400 | 1,500 |
| Diana Kirton | 20,400 | 1,250 | 20,400 | 750 |
| Jacoby Poulain *(elected October 2013)* | 20,400 | 2,500 | 11,900 | 1,000 |
| Heather Skipworth *(elected October 2013)* | 20,400 | 2,063 | 11,900 | 500 |
| Kirsten Wise *(retired November 2013)* | - | - | 8,500 | 1,000 |
| | 251,100 | 23,121 | 251,100 | 23,684 |

Payments for committee meetings include the Finance, Risk and Audit Committee (FRAC), and Māori Relationship Board. Payments were also made to Barbara Arnott as chair of the Community and Public Health Advisory Committee for attendance at the Pacifika Health Leadership Group and reporting back to the board.

Directors fees of $11,250 were paid to ex-board member David Ritchie (2014: $7,500) as one of the District Health Board's representatives on the Board of Allied Laundry Services Limited. Andrew Blair was not able to attend a Board meeting and FRAC committee meeting during the year as he was representing the Board in the Chatham Islands at the time the meeting was held.

**Remuneration – Committee members who are not board members or employees**

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Mabel Aiolupotea | - | 750 |
| Lynlee Aitcheson | - | 750 |
| Heather Campbell | - | 250 |
| Iakopo Faafuata | - | 500 |
| Tevita Fakaosi | - | 750 |
| Patricia Giddens | - | 750 |
| Tatiana Greening | - | 4,650 |
| Leslie Hokianga | - | 500 |
| Patrick Legeyt | - | 500 |
| George Mackey | - | 750 |
| Graeme Norton | - | 250 |

| | 30 June 2015 | 30 June 2014 |
|---|---|---|
| Kerri Nuku | - | 1000 |
| Eileen Page | - | 250 |
| Diana Peterson | - | 250 |
| Na Raihania | - | 750 |
| Caren Rangi | - | 750 |
| Desma Ratima | - | 750 |
| Joan Sye | - | 250 |
| Panu TeWhaiti | - | 750 |
| Diane Walsh | - | 250 |
| Evangelene Wong | - | 750 |
| | | |

The restructure and realignment of the statutory advisory committees last year has resulted in no payments during the year to statutory committee members other than Board members. Consumer input is now sought through the non-statutory Consumer Council, Māori Relationship Board and the Pacifika Health Leadership Group.

# Notes to the financial statements (continued)

**For the year ended 30 June 2015**
*in New Zealand Dollars*

**Employee Remuneration**

The number of employees whose income was in the specified band are as follows:

| | 30 June 2015 | 30 June 2014 | | 30 June 2015 | 30 June 2014 |
|---|---|---|---|---|---|
| 100,000-109,999 | 47 | 22 | 290,000-299,999 | 2 | 6 |
| 110,000-119,999 | 27 | 28 | 300,000-309,999 | 2 | 4 |
| 120,000-129,999 | 19 | 18 | 310,000-319,999 | 7 | 5 |
| 130,000-139,999 | 19 | 8 | 320,000-329,999 | 4 | 4 |
| 140,000-149,999 | 8 | 4 | 330,000-339,999 | 1 | 2 |
| 150,000-159,999 | 12 | 6 | 340,000-349,999 | - | 2 |
| 160,000-169,999 | 5 | 5 | 350,000-359,999 | 2 | 2 |
| 170,000-179,999 | 10 | 7 | 360,000-369,999 | 1 | - |
| 180,000-189,999 | 9 | 7 | 370,000-379,999 | 1 | 3 |
| 190,000-199,999 | 7 | 11 | 380,000-389,999 | - | 1 |
| 200,000-209,999 | 9 | 9 | 390,000-399,999 | - | - |
| 210,000-219,999 | 9 | 8 | 400,000-409,999 | 1 | - |
| 220,000-229,999 | 11 | 12 | 410,000-419,999 | - | - |
| 230,000-239,999 | 6 | 11 | 420,000-429,999 | - | - |
| 240,000-249,999 | 8 | 8 | 430,000-439,999 | - | 1 |
| 250,000-259,999 | 6 | 11 | 440,000-449,999 | - | - |
| 260,000-269,999 | 3 | 5 | 450,000-459,999 | - | - |
| 270,000-279,999 | 1 | 9 | 460,000-469,999 | - | - |
| 280,000-289,999 | 7 | 5 | 470,000-479,999 | 1 | 1 |

During the year, four (30 June 2014: 11) employees received compensation and other benefits in relation to cessation totalling $53,851 (30 June 2014: $173,041).

**Compensations**

No loans are made to board members, and no short-term employee, post-employment, termination, or other long-term benefits are paid to executive officers other than their annual salary, which may or may not include performance payments, employer contributions to superannuation schemes and the payment of professional fees.

The Hawke's Bay District Health Board has taken out Directors' and Officers' Liability and Professional Indemnity Insurance cover during the financial year in respect of the liability or costs of Board members and employees.

## 5.8. Capital management

Hawke's Bay District Health Board's capital is its equity, which comprises Crown equity, reserves, restricted funds and accumulated surpluses/(deficits). The district health board is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. The district health board manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes, while remaining a going concern.

## 5.9. Events after balance date

There are no significant events after balance date.

# Appendix one: Technical Results Report

**Key for technical results report**

| | |
|---|---|
| **Baseline** | Latest available data for planning purpose |
| **Target 2014/15** | Target 2014/15 |
| **Actual to date** | Actual to date |
| **F (Favourable)** | Actual to date is favourable to target<br>(above or within 0.5% of target) |
| **U (Unfavourable)** | Actual to date is unfavourable to target |

## OUTPUT CLASS 1: PREVENTION SERVICES

## Population and Individual Dimensions

| **Health Target: Better help for smokers to quit -** Percentage of hospitalised smokers offered advice to quit | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 99.5%<br>October – December 2012 | ≥95% | 99.2% (F) - July to September 2013 |
| | | | 98.6% (F) – October to December 2013 |
| | | | 98.2% (F) – January to March 2014 |
| | | | 97.7% (F) - April to June 2014 |
| 2014/15 | 98.6%<br>October – December 2013 | ≥95% | 97.5% (F) – July to September 2014 |
| | | | 98.2% (F) – October to December 2014 |
| | | | 98.3% (F) – January to March 2015 |
| | | | 97.8% (F) – April to June 2015 |

| **Health Target: Better help for smokers to quit -** Percentage of PHO enrolled smokers offered advice to quit | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Ministry of Health | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 56.3%<br>October – December 2012<br>(Source: DHBNZ) | ≥90% | 80.5% (U) - 12 months to September 2013 |
| | | | 80.2% (U) – 12 months to December 2013 |
| | | | 73.5% (U) - 12 months to March 2014 |
| | | | 77.0% (U) - 12 months to June 2014 |
| 2014/15 | 80.2%<br>October – December 2013<br>(Source: DHBNZ) | ≥90% | 95.3% (F) – July to September 2014 |
| | | | 96.1% (F) – October to December 2014 |
| | | | 89.5% (F) – January to March 2015 |
| | | | 85.2% (U) – April to June 2015 |

| **Health Target: Better help for smokers to quit -** % of pregnant women offered advice and support to quit | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Ministry of Health | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | ≥90% | 93.2% (F) - 12 months to September 2013 |
| | | | 96.3% (F) - 12 months to December 2013 |
| | | | 87.9% (U) - 12 months to March 2014 |
| | | | 94.5% (F) - 12 months to June 2014 |
| 2014/15 | New | ≥90% | 100% (F) - July to September 2014 |
| | | | 98.1% (F) – October to December 2014 |
| | | | 98.6% (F) – January to March 2015 |
| | | | 96.9% (F) - April to June 2015 |

| Rate of Year 10 Student who have never smoked | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 64%<br>2013 | ≥64% | 68.11% (F) January to December 2014 |

| **Health Target: Increased immunisation -** Percentage of 8 month who complete their primary course of immunisations | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | 91.8%<br>3 months to December 2012 | ≥90% | 92.0% (F) – 3 months to September2013 |
| | | | 94.7% (F) – 3 months to December 2013 |
| | | | 93.7% (F) – 3 months to March 2014 |
| | | | 93.8% (F) - 3 months to June 2014 |
| 2014/15 | 94.7%<br>3 months to December 2013 | ≥95% | 94.3% (U) – 3 months to September 2014 |
| | | | 96.0% (F) – 3 months to December 2014 |
| | | | 95.1% (F) – 3 months to March 2015 |
| | | | 95.5% (F) - 3 months to June 2015 |
| **MAORI** | | | |
| 2013/14 | 90.3%<br>3 months to December 2012 | ≥90% | 92.2% (F) – 3 months to September2013 |
| | | | 96.4% (F) – 3 months to December 2013 |
| | | | 91.6% (F) – 3 months to March 2014 |
| | | | 92.7% (F) - 3 months to June 2014 |
| 2014/15 | 96.4%<br>3 months to December 2013 | ≥95% | 95.1% (F) – 3 months to September2014 |
| | | | 95.9% (F) – 3 months to December 2014 |
| | | | 95.8% (F) – 3 months to March 2015 |
| | | | 95.2% (F) - 3 months to June 2015 |

| **Health Target: Increased immunisation -** Percentage of 2 year olds fully immunised: | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | 94.9%<br>3 months to December 2012 | ≥95% | 93.8% (U) – 3 months to September2013 |
| | | | 95.5% (F) – 3 months to December 2013 |
| | | | 92.3% (U) – 3 months to March 2014 |
| | | | 94.6% (F) - 3 months to June 2014 |
| 2014/15 | 95.5%<br>3 months to December 2013 | ≥95% | 95.7% (F) – 3 months to September2014 |
| | | | 94.0% (U) – 3 months to December 2014 |
| | | | 94.3% (U) – 3 months to March 2015 |
| | | | 96.6% (F) - 3 months to June 2015 |
| **MAORI** | | | |
| 2013/14 | 97.2%<br>3 months to December 2012 | ≥95% | 96.0% (F) – 3 months to September2013 |
| | | | 97.7% (F) – 3 months to December 2013 |
| | | | 95.6% (F) – 3 months to March 2014 |
| | | | 94.5% (F) - 3 months to June 2014 |
| 2014/15 | 97.7%<br>3 months to December 2012 | ≥95% | 97.1% (F) – 3 months to September2014 |
| | | | 95.0% (F) – 3 months to December 2014 |
| | | | 96.7% (F) – 3 months to March 2015 |
| | | | 97.4% (F) - 3 months to June 2015 |

| Rheumatic fever hospitalisations rate per 100,000 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 0%<br>3 months to December 2012 | ≤5% | 1.2% (F) - July to September 2012 |
| | | | 0.0% (F) – October to December 2012 |
| | | | 0.0% (F) – January to March 2013 |
| | | | 0.0% (F) - April to June 2013 |
| 2014/15* | 2.6%<br>July 2012 to June 2013 | ≤2.6% | *(see note below)* |
| | | | *(see note below)* |

*Due to the low numbers the Ministry have not released a rate for Hawke's Bay. During the financial year 2014/15 the Ministry classify Hawke's Bays First episode rheumatic fever hospitalization numbers as <4 cases.

| Percentage of high needs 65 years olds and over influenza immunisation rate | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 66.5%<br>January to December 2012 | ≥75% | 69.0% (U) - January to December 2013 |
| 2014/15 | 68.3%<br>January to December 2013 | ≥70% | 67.9% (U) - January to December 2014 |

# POPULATION BASED SCREENING SERVICES

| Percentage of women aged 50-69 years receiving breast screening in the last 2 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Breast Screen Coast to Coast | **Baseline** | **Target** | **Actual to Date** |
| **OVERALL RATE** | | | |
| 2013/14 | 73.6%<br>24 months to November 2012 | ≥70% | 75.7% (F) - 24 months to 30 April 2014 |
| 2014/15 | 74.0%<br>24 months to October 2013 | ≥70% | 74.4% (F) - 24 months to 31 March 2015 |
| **MAORI** | | | |
| 2013/14 | 62.7%<br>24 months to November 2012 | ≥70% | 65.6% (U) - 24 months to 30 April 2014 |
| 2014/15 | 65.8%<br>24 months to October 2013 | ≥70% | 66.9% (U) - 24 months to 31 March 2015 |
| **PACIFIC** | | | |
| 2013/14 | 70.1%<br>24 months to November 2012 | ≥70% | 73.8% (F) - 24 months to 30 April 2014 |
| 2014/15 | 73.1%<br>24 months to October 2013 | ≥70% | 66.1% (U) - 24 months to 31 March 2015 |

| Percentage of women aged 25-69 years receiving cervical screening in the last 3 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Breast Screen Coast to Coast | **Baseline** | **Target** | **Actual to Date** |
| **OVERALL RATE** | | | |
| 2013/14 | 81.2%<br>36 months to 30 September 2012 | ≥80% | 80.7% (F) - 36 months to 31 March 2014 |
| 2014/15 | 82.2%<br>36 months to 31 October 2013 | ≥80% | 76.7% (U) - 36 months to 31 March 2015 |
| **MAORI** | | | |
| 2013/14 | 72.6%<br>36 months to 30 September 2012 | ≥80% | 74.2% (U) - 36 months to 31 March 2014 |
| 2014/15 | 74.1%<br>36 months to 31 October 2013 | ≥80% | 74.6% (U) - 36 months to 31 March 2015 |

| PACIFIC | | | |
|---|---|---|---|
| 2013/14 | 82.7%<br>36 months to 30 September 2012 | ≥80% | 83.9% (F) - 36 months to 31 March 2014 |
| 2014/15 | 84.2%<br>36 months to 31 October 2013 | ≥80% | 72.6% (U) - 36 months to 31 March 2015 |

| Rate of SUDI deaths per 1,000 live births | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 2.1 per 1,000 live births<br>2010 Calendar Year | ≤0.5 | 1.77 (U) 2011 Calendar Year |

| Infants are exclusively or fully breastfed | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **Breastfeeding: Plunket Data** | | | |
| **At 6 Weeks:** | | | |
| 2013/14 | New | New | - |
| 2014/15<br>At 6 weeks: TOTAL: | 67.2%<br>12 months to 30 June 2013 | ≥68% | 69% (F) - July 2014 to June 2015 |
| 2014/15<br>At 6 weeks: MĀORI | 58.0%<br>12 months to 30 June 2013 | ≥68% | 62% (U) - July 2014 to June 2015 |
| **At 3 Months:** | | | |
| 2013/14 | New | New | - |
| 2014/15<br>At 3 months: TOTAL: | 52.8%<br>12 months to 30 June 2013 | ≥54% | 54% (F) - July 2014 to June 2015 |
| 2014/15<br>At 3 months: MĀORI: | 37.0%<br>12 months to 30 June 2013 | ≥54% | 42% (U) - July 2014 to June 2015 |
| **Tamariki Ora Data*** | | | |
| **At 6 Weeks:** | | | |
| 2013/14 | New | New | - |
| At 6 weeks: TOTAL: | 58.8%<br>January to 30 June 2014 | ≥68% | 56% (U) – July 2014 to June 2015 |
| At 6 weeks: MĀORI | 56.9%<br>January to 30 June 2014 | ≥68% | 51% (U) – July 2014 to June 2015 |
| **At 3 Months:** | | | |
| 2013/14 | New | New | - |
| 2014/15<br>At 3 months: TOTAL: | 32.8%<br>January to 30 June 2014 | ≥54% | 36% (U) – July 2014 to June 2015 |
| 2014/15<br>At 3 months: MĀORI: | 33.1%<br>January to 30 June 2014 | ≥54% | 33% (U) – July 2014 to June 2015 |

*The SOI only referenced Plunket data. Since then we have been able to obtain Tamariki Ora data and have included it in the governance reporting for 2014/15 and therefore decided to include it in our Annual Report.

| Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed) | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **Plunket Data** | | | |
| 2013/14 | New | New | - |
| At 6 months: TOTAL: | 57.5%<br>12 months to 30 June 2013 | ≥59% | 59% (F) - July 2014 to June 2015 |
| At 6 Months: MĀORI | 48.0% | ≥59% | 49% (U) - July 2014 to June 2015 |

| | 12 months to 30 June 2013 | | |
|---|---|---|---|
| **Tamariki Ora Data:*** | | | |
| 2013/14 | New | New | - |
| At 6 months: TOTAL: | 45.5% January to 30 June 2014 | ≥59% | 45% (U) - July 2014 to June 2015 |
| At 6 months: MAORI: | 43.5% January to 30 June 2014 | ≥59% | 42% (U) - July 2014 to June 2015 |

*The SOI only referenced Plunket data. Since then we have been able to obtain Tamariki Ora data and have included it in the governance reporting for 2014/15 and have decided to include it in our Annual Report.

| **Rate of pregnancy under 17 years of age** | | | |
|---|---|---|---|
| **Financial Year** Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 10.3% 12 months to 30 June 2013 | ≤10.3% | 5.7% (F) July 2014 to June 2015 |

## OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

| Proportion of the population enrolled in the PHO | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 96.9%<br>April 2014 | ≥97% | 97.1% (F) - July to September 2014 |
| | | | 97.3% (F) – October to December 2014 |
| | | | 95.5% (U) – January to March 2015 |
| | | | 95.4% (U) - April to June 2015 |
| **MĀORI:** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 93.1%<br>April 2014 | ≥97% | 93.8% (U) - July to September 2014 |
| | | | 94.7% (U) – October to December 2014 |
| | | | 95.0% (U) – January to March 2015 |
| | | | 95.4% (U) - April to June 2015 |

| Percentage of Women booked with an LMC by week 12 of their pregnancy | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 46.9%<br>October 2013 to December 2013 | ≥80% | 56.5% (U) – April to June 2014 |
| | | | 52.9% (U) – July to September 2014 |
| | | | 51.4% (U) – October to December 2014 |
| | | | 59.2% (U) – January to March 2015 |
| **MĀORI:** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 37.8%<br>October 2013 to December 2013 | ≥80% | 45.3% (U) – April to June 2014 |
| | | | 38.6% (U) – July to September 2014 |
| | | | 44.1% (U) – October to December 2014 |
| | | | 47.7% (U) – January to March 2015 |

| Rate of high intensive users of hospital Emergency Department as a proportion of Total ED visits | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 5.4%<br>October to December 2013 | ≤5.4% | 5.44% (U) - July to September 2014 |
| | | | 5.53% (U) – October to December 2014 |
| | | | 5.57% (U) – January to March 2015 |
| | | | 5.38% (F) - April to June 2015 |
| **MĀORI:** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 6.1%<br>October to December 2013 | ≤5.4% | 5.97% (U) - July to September 2014 |
| | | | 6.14% (U) – October to December 2014 |
| | | | 6.17% (U) – January to March 2015 |
| | | | 5.98% (U) - April to June 2015 |

| Health Target: More heart and diabetes checks:<br>% of the eligible population will have had their cardiovascular disease risk assessed in the last 5 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2013/14 | 57.5%<br>As at 30th June 2012 | ≥90% | 73.1% (U) - July to September 2013 |
| | | | 73.7% (U) – October to December 2013 |
| | | | 79.1% (U) – January to March 2014 |
| | | | 84.1% (U) - April to June 2014 |
| 2014/15 | 73.7%<br>October to December 2013 | ≥90% | 86.2% (U) - July to September 2014 |
| | | | 87.7% (U) – October to December 2014 |
| | | | 90.0% (F) – January to March 2015 |
| | | | 90.4% (F) - April to June 2015 |
| **MAORI** | | | |
| 2013/14 | 59.5%<br>As at 30th June 2012 | ≥90% | 70.4% (U) - July to September 2013 |
| | | | 69.8% (U) – October to December 2013 |
| | | | 75.3% (U) – January to March 2014 |
| | | | 79.8% (U) - April to June 2014 |
| 2014/15 | 69.8%<br>October to December 2013 | ≥90% | 82.3% (U) - July to September 2014 |
| | | | 83.9% (U) – October to December 2014 |
| | | | 86.2% (U) – January to March 2015 |
| | | | 86.0% (U) - April to June 2015 |
| **PACIFIC** | | | |
| 2013/14 | 59.4%<br>As at 30th June 2011 | ≥90% | 70.4% (U) - July to September 2013 |
| | | | 70.9% (U) – October to December 2013 |
| | | | 74.1% (U) – January to March 2014 |
| | | | 79.0% (U) - April to June 2014 |
| 2014/15 | 70.9%<br>October to December 2013 | ≥90% | 82.3% (U) - July to September 2014 |
| | | | 83.7% (U) – October to December 2014 |
| | | | 86.0% (U) – January to March 2015 |
| | | | 87.3% (U) - April to June 2015 |

| Percentage of eligible preschool enrolments in DHB-funded oral health services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2013/14 | 71.1%<br>2012 calendar year | ≥81% | 70.4% (U) - 2013 calendar year |
| 2014/15 | 70.4%<br>2013 calendar year | ≥82% | 73.9% (U) - 2014 calendar year |
| **MAORI:** | | | |
| 2013/14 | 63.8%<br>2012 calendar year | ≥81% | 61.9% (U) - 2013 calendar year |
| 2014/15 | 61.9%<br>2013calendar year | ≥82% | 65.3% (U) - 2014 calendar year |
| **PACIFIC:** | | | |
| 2013/14 | 63.3%<br>2012 calendar year | ≥81% | 67.4% (U) - 2013 calendar year |
| 2014/15 | 67.4%<br>2013 calendar year | ≥82% | 71.7% (U) - 2014 calendar year |

| Percentage of enrolled preschool and primary school children not examined according to planned recall | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 4%<br>2012 calendar year | <5% | 4.2% (F) - 2013 calendar year |
| 2014/15 | 4.4%<br>2013 calendar year | <5% | 4.0% (F) - 2014 calendar year |

| Percentage of adolescents using DHB-funded dental services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 84.5%<br>2012 calendar year | ≥85% | 78.3% (U) – 2014 calendar year |

| Percentage of children without decay at 5 years of age | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 54.2% | ≥65% | 56.5% (U) – 2014 calendar year |

| Mean 'decayed, missing or filled teeth' score at year 8 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 1.13*<br>2013 calendar year | <0.88 | 1.08 (U) – 2014 calendar year |

*The baseline was 1.27 (2012 calendar year) in the Annual plan, this has been updated in the Annual Report for 2013.

| More heart and diabetes checks - Better management of long-term conditions: Proportion of diabetic patients with good or acceptable glycaemic control | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2013/14 | NEW* | ≥80% | 54.1% (U) – July 2013 to September 2013 |
| | | | 54.0% (U) – July 2013 to December 2013 |
| | | | 52.5% (U) – July 2013 to March 2014 |
| | | | 51.7% (U) - July 2013 to June 2014 |
| 2014/15 | 54.3%<br>July to December 2013 | ≥55% | 50.3% (U) – October 2013 to September 2014 |
| | | | 50.0% (U) – January 2013 to December 2014 |
| | | | 49.2% (U) – April 2014 to March 2015 |
| | | | 50.7% (U) - July 2014 to June 2015 |
| **MAORI:** | | | |
| 2013/14 | NEW* | ≥80% | 50.5% (U) – July 2013 to September 2013 |
| | | | 49.0% (U) – July 2013 to December 2013 |
| | | | 49.3% (U) – July 2013 to March 2014 |
| | | | 50.2% (U) - July 2013 to June 2014 |
| 2014/15 | No baseline | ≥55% | 50.2% (U) – October 2013 to September 2014 |
| | | | 50.9% (U) – January 2013 to December 2014 |
| | | | 50.0% (U) – April 2014 to March 2015 |
| | | | 50.4% (U) - July 2014 to June 2015 |
| **PACIFIC:** | | | |
| 2013/14 | NEW* | ≥80% | 45.8% (U) – July 2013 to September 2013 |
| | | | 43.0% (U) – July 2013 to December 2013 |
| | | | 45.3% (U) – July 2013 to March 2014 |
| | | | 45.4% (U) - July 2013 to June 2014 |
| 2014/15 | No baseline | ≥55% | 42.4% (U) – October 2013 to September 2014 |
| | | | 40.9% (U) – January 2013 to December 2014 |
| | | | 40.5% (U) – April 2014 to March 2015 |
| | | | 41.5% (U) - July 2014 to June 2015 |

*in 2013/14 this measure was accumulative over a year. In 2014/15 the time period was changed to cover a rolling 12 months

| Percentage of accepted referrals for Computed Tomography (CT) who received their scans within 42 days | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 88%<br>July - December 2013 | ≥90% | 94.8% (F) September 2014 |
| | | | 92.6% (F) December 2014 |
| | | | 90.9% (F) March 2015 |
| | | | 88.6% (U) June 2015 |

| Percentage of accepted referrals for MRI scans who receive their scans within 6 weeks | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 54.1%<br>October - December 2013 | ≥80% | 59.7% (U) September 2014 |
| | | | 61.3% (U) December 2014 |
| | | | 60.1% (U) March 2015 |
| | | | 59.5% (U) June 2015 |

| Ambulatory sensitive hospitalisation rate 0-74 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 96%<br>Year end Dec 2013 | ≤95% | 92.4% (F) 12 months to September 2014 |
| | | | 94.0% (F) 12 months to March 2015 |
| **MĀORI** | | | |
| 2013/14 | New | New | - |
| 2014/15 | No baseline available | ≤95% | 149% (U) 12 months to September 2014 |
| | | | 145.0% (U) 12 months to March 2015 |

| Ambulatory sensitive hospitalisation rate 0-4 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 97%<br>Year end Dec 2013 | ≤96% | 74.2% (F) 12 months to September 2014 |
| | | | 97.0% (U) 12 months to March 2015 |
| **MĀORI** | | | |
| 2013/14 | New | New | - |
| 2014/15 | No baseline available | ≤96% | 127.0% (U) 12 months to September 2014 |
| | | | 122.0% (U) 12 months to March 2015 |

| Ambulatory sensitive hospitalisation rate 45-64 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 96%<br>Year end Dec 2013 | ≤95% | 91.8% (F) 12 months to September 2014 |
| | | | 93.0% (F) 12 months to March 2015 |
| **MĀORI** | | | |
| 2013/14 | New | New | - |
| 2014/15 | No baseline available | ≤95% | 185.7% (U) 12 months to September 2014 |
| | | | 179.0% (U) 12 months to March 2015 |

## OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

**Health Target: Shorter stays in Emergency Departments - Percentage of patients admitted, discharged or transferred from an emergency department within 6 hours**

| Financial Year | Baseline | Target | Actual to Date |
|---|---|---|---|
| 2013/14 | 94.3%<br>October to December 2012 | ≥95% | 92.6% (U) - July to September 2013 |
| | | | 93.3% (U) – October to December 2013 |
| | | | 93.0% (U) – January to March 2014 |
| | | | 90.6% (U) - April to June 2014 |
| 2014/15 | 93.3%<br>October to December 2013 | ≥95% | 89.2% (U) - July to September 2014 |
| | | | 91.5% (U) – October to December 2014 |
| | | | 94.9% (F) – January to March 2015 |
| | | | 94.8% (F) - April to June 2015 |

**Health Target: Shorter waits for cancer treatment – Radiation Oncology treatment waiting times less than 4 weeks**

| Financial Year | Baseline | Target | Actual to Date |
|---|---|---|---|
| 2013/14 | 100%<br>October to December 2012 | 100% | 100% (F) - July to September 2013 |
| | | | 100% (F) – October to December 2013 |
| | | | 100% (F) – January to March 2014 |
| | | | 100% (F) - April to June 2014 |
| 2014/15 | 100%<br>October to December 2013 | 100% | 100% (F) - July to September 2014 |
| | | | 100% (F) – October to December 2014 |
| | | | 100% (F) – January to March 2015 |
| | | | 100% (F) - April to June 2015 |

**Health Target: Shorter waits for cancer treatment – Chemotherapy treatment waiting times less than 4 weeks**

| Financial Year | Baseline | Target | Actual to Date |
|---|---|---|---|
| 2013/14 | 100%<br>October to December 2012 | 100% | 100% (F) - July to September 2013 |
| | | | 100% (F) – October to December 2013 |
| | | | 100% (F) – January to March 2014 |
| | | | 100% (F) - April to June 2014 |
| 2014/15 | 100%<br>October to December 2013 | 100% | 100% (F) - July to September 2014 |
| | | | 100% (F) – October to December 2014 |
| | | | 100% (F) – January to March 2015 |
| | | | 100% (F) - April to June 2015 |

**Health target: Improved access to elective surgery (discharges)**[5]

| **Financial Year**<br>Please note data is subject to change over time | Baseline | Target | Actual to Date |
|---|---|---|---|
| **NUMBER OF ELECTIVE DISCHARGES (VOLUMES)**(Source: Ministry of Health) | | | |
| 2013/14 | 5,729<br>2012/2013 | ≥5,866 | 6,103 (F) - July 2013 to June 2014 |
| 2014/15 | 5,866<br>2013/2014 | ≥6,012 | 6,154 (F) - July 2014 to June 2015 |

[5] Health Target Elective Discharges is all elective surgery excluding inpatient dental treatment and cardiology inpatient services

| Acute coronary syndrome | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **PERCENTAGE OF HIGH RISK PATIENTS RECEIVING AN ANGIOGRAM WITHIN 3 DAYS** | | | |
| **TOTAL** | | | |
| 2014/15 | 68.3%<br>October to December 2013 | ≥70% | 75.7% (F) - July to September 2014 |
| | | | 49.3% (U) – October to December 2014 |
| | | | 62.3% (U) – January to March 2015 |
| | | | 63.4% (U) - April to June 2015 |
| **MAORI** | | | |
| 2014/15 | 81.8%<br>January to March 2014 | ≥70% | 90.9% (F) - July to September 2014 |
| | | | 33.3% (U) – October to December 2014 |
| | | | 66.7% (U) – January to March 2015 |
| | | | 58.3% (U) - April to June 2015 |
| **PERCENTAGE OF ANGIOGRAPHY PATIENTS WHOSE DATA SI RECORDED ON NATIONAL DATABASES** | | | |
| 2014/15 | 68.3%<br>October to December 2013 | ≥95% | 0% (U) - July to September 2014 |
| | | | 27.8% (U) – October to December 2014 |
| | | | 61.1% (U) – January to March 2015 |
| | | | 83.1% (U) - April to June 2015 |
| **MAORI** | | | |
| 2014/15 | 6.7%<br>January to March 2014 | ≥95% | 0% (U) - July to September 2014 |
| | | | 12.5% (U) – October to December 2014 |
| | | | 6.7% (U) – January to March 2015 |
| | | | 90.9% (U) - April to June 2015 |

| STROKE – Percentage of potentially eligible patients who are thrombolysed | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 0%<br>October to December 2013 | ≥6% | 4.3% (U) - July to September 2014 |
| | | | 6.0% (F) – October to December 2014 |
| | | | 2.6% (U) – January to March 2015 |
| | | | 2.6% (U) - April to June 2015 |

| STROKE – Percentage of patients admitted to the demonstrated stroke pathway | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 78%<br>October to December 2013 | ≥80% | 65.7% (U) - July to September 2014 |
| | | | 82.1% (F) – October to December 2014 |
| | | | 67.9% (U) – January to March 2015 |
| | | | 75.6% (U) - April to June 2015 |

| Standardised intervention rates for surgery (per 10,000 population) | | | |
|---|---|---|---|
| **Financial Year** Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **Major joint replacement** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 19.6<br>12 months to September 2013 | ≥21.0 | 23.3 (F) – July 2013 to June 2014<br>22.5 (F) – October 2013 to September 2014<br>21.3 (F) – January 2014 to December 2014<br>21.9 (F) - April 2014 to March 2015 |
| **Cataract procedures** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 32.6<br>12 months to September 2013 | ≥27.0 | 52.7 (F) – July 2013 to June 2014<br>54.3 (F) – October 2013 to September 2014<br>52.1 (F) – January 2014 to December 2014<br>52.6 (F) - April 2014 to March 2015 |
| **Cardiac surgery** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 5.6<br>12 months to September 2013 | ≥6.5 | 5.49 (U) – July 2013 to June 2014<br>6.0 (U) – October 2013 to September 2014<br>5.7 (U) – January 2014 to December 2014<br>6.0 (U) - April 2014 to March 2015 |
| **Percutaneous revascularisation** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 11.2<br>12 months to September 2013 | ≥12.5 | 10.88 (U) – July 2013 to June 2014<br>11.1 (U) – October 2013 to September 2014<br>10.9 (U) – January 2014 to December 2014<br>10.8 (U) - April 2014 to March 2015 |
| **Coronary angiography** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 35.2<br>12 months to September 2013 | ≥34.7 | 35.55 (F) – July 2013 to June 2014<br>35.5 (F) – October 2013 to September 2014<br>36.2 (F) – January 2014 to December 2014<br>37.1 (F) - April 2014 to March 2015 |

| Elective inpatient ALOS | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 3.49 days<br>January to December 2012 | ≤3.21 days | 3.4 (U) - April to June 2013<br>3.4 (U) – July to September 2013<br>3.3 (U) – October to December 2013<br>3.4 (U) – January to March 2014 |
| 2014/15 | 3.43 days | ≤3.18 days | 3.38 (U) – July 2013 to June 2014<br>3.41 (U) – October 2013 to September 2014<br>3.36 (U) – January 2014 to December 2014<br>3.27 (U) - April 2014 to March 2015 |

| Acute inpatient ALOS | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 4.18 | ≤4.15 days | 4.17 (U) – July 2013 to June 2014<br>4.15 (F) – October 2013 to September 2014<br>4.12 (F) – January 2014 to December 2014<br>4.07 (F) - April 2014 to March 2015 |

| Acute readmissions to hospital | | | |
|---|---|---|---|
| Financial Year | Baseline | Target | Actual to Date |
| 2013/14 | New | New | - |
| 2014/15 | 7.4% | ≤7.5% | 7.5% (F) – July 2013 to June 2014 |
| | | | 7.5% (F) – October 2013 to September 2014 |
| | | | 7.6% (U) – January 2014 to December 2014 |
| | | | * |

*the Ministry of Health are currently reviewing this measure, no results were published for the period April 2014 to March 2015

| Percentage of coronary angiography completed within 90 days | | | |
|---|---|---|---|
| Financial Year | Baseline | Target | Actual to Date |
| 2013/14 | New | New | - |
| 2014/15 | New | ≥90% | 93.1% (F) - September 2014 |
| | | | 89.8% (F) –December 2014 |
| | | | 64.4% (U) – March 2015 |
| | | | 90.7% (F) - June 2015 |

| Diagnostic Colonoscopy : Percentage of urgent cases performed within 14 days | | | |
|---|---|---|---|
| Financial Year | Baseline | Target | Actual to Date |
| 2013/14 | New | New | - |
| 2014/15 | 63.0% October to December 2013 | ≥75% | 89.1% (F) - September 2014 |
| | | | 92.6% (F) –December 2014 |
| | | | 87.5% (F) – March 2015 |
| | | | 81.3% (F) - June 2015 |

| Diagnostic Colonoscopy : Percentage of diagnostic cases performed within 42 days | | | |
|---|---|---|---|
| Financial Year | Baseline | Target | Actual to Date |
| 2013/14 | New | New | - |
| 2014/15 | 51.4% October to December 2013 | ≥60% | 48.0% (U) - September 2014 |
| | | | 39.7% (U) –December 2014 |
| | | | 74.3% (F) – March 2015 |
| | | | 78.7% (F) - June 2015 |

| Surveillance Colonoscopy : Percentage waiting less than 84 days beyond planned date | | | |
|---|---|---|---|
| Financial Year | Baseline | Target | Actual to Date |
| 2013/14 | New | New | - |
| 2014/15 | 64.3% October to December 2013 | ≥60% | 80.6% (F) - September 2014 |
| | | | 50.7% (U) –December 2014 |
| | | | 62.2% (F) – March 2015 |
| | | | 77.3% (F) - June 2015 |

| Did not attend (DNA) rate across first specialist assessments[6] | | | |
|---|---|---|---|
| Financial Year Please note data is subject to change over time | Baseline | Target | Actual to Date |
| TOTAL | | | |
| 2013/14 | 8.8% October to December 2012 | ≤7.5% | 9.8% (U) - July to September 2013 |
| | | | 9.1% (U) – October to December 2013 |

[6] ESPI specialties only

| | | | |
|---|---|---|---|
| | | | 8.4% (U) – January to March 2014 |
| | | | 7.4% (F) - April to June 2014 |
| 2014/15 | 9.1% October to December 2013 | ≤7.5% | 7.2% (F) - July to September 2014 |
| | | | 6.1% (F) – October to December 2014 |
| | | | 7.2% (F) – January to March 2015 |
| | | | 6.9% (F) - April to June 2015 |
| **MAORI** | | | |
| 2013/14 | 18.5% October to December 2012 | ≤7.5% | 19.7% (U) - July to September 2013 |
| | | | 17.9% (U) – October to December 2013 |
| | | | 18.3% (U) – January to March 2014 |
| | | | 16.5% (U) - April to June 2014 |
| 2014/15 | 17.9% October to December 2013 | ≤7.5% | 16.2% (U) - July to September 2014 |
| | | | 12.2% (U) – October to December 2014 |
| | | | 13.7% (U) – January to March 2015 |
| | | | 13.7% (U) - April to June 2015 |

| **Better Access to Mental Health and Addiction Services: Proportion of the population seen by mental health and addiction services** | | | |
|---|---|---|---|
| **Financial Year** Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **Child and Youth (0-19)** | | | |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 3.68% | ≥3.5% | 4.08% (F) – October 2013 to September 2014 |
| | | | 3.89% (F) - April 2014 to March 2015 |
| **MAORI** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 4.20% | ≥3.5% | 4.83% (F) – October 2013 to September 2014 |
| | | | 4.50% (F) - April 2014 to March 2015 |
| **Adult (20-64)** | | | |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 5.04% | ≥4.5% | 5.12% (F) – October 2013 to September 2014 |
| | | | 5.06% (F) - April 2014 to March 2015 |
| **MAORI** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 8.87% | ≥4.5% | 8.79% (F) – October 2013 to September 2014 |
| | | | 8.95% (F) - April 2014 to March 2015 |
| **Older Adult (65+)** | | | |
| **TOTAL** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 1.05% | ≥1.05% | 1.15% (F) – October 2013 to September 2014 |
| | | | 1.03% (U)* - April 2014 to March 2015 |
| **MAORI** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 1.02% | ≥1.05% | 1.15% (F) – October 2013 to September 2014 |
| | | | 1.00% (U) - April 2014 to March 2015 |

*because the target is a low number favourable is calculated within 0.5% of the target, which is 1.044. Therefore the result is classed as unfavourable.

| Shorter waits for non-urgent drug and alcohol services* | | | |
|---|---|---|---|
| **Financial Year** Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **PERCENTAGE OF PEOPLE SEEN WITHIN 3 WEEKS OF REFERRAL** | | | |
| **MENTAL HEALTH PROVIDER ARM** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 56.9% 12 months to September 2013 | ≥80% | 57.0% (U) - July 2013 to June 2014 |
| | | | 56.7% (U) - October 2013 to September 2014 |
| | | | 51.3% (U) – January 2014 to December 2014 |
| | | | 55.6% (U) - April 2014 to March 2015 |
| **ADDICTIONS (PROVIDER ARM AND NGO)** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 73.5% 12 months to September 2013 | ≥80% | 88.7% (F) - July 2013 to June 2014 |
| | | | 88.3% (F) - October 2013 to September 2014 |
| | | | 88.3% (F) – January 2014 to December 2014 |
| | | | 84.8% (F) - April 2014 to March 2015 |
| **PERCENTAGE OF PEOPLE SEEN WITHIN 8 WEEKS OF REFERRAL** | | | |
| **MENTAL HEALTH PROVIDER ARM** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 85.4% 12 months to September 2013 | ≥95% | 83.7% (U) - July 2013 to June 2014 |
| | | | 82.0% (U) - October 2013 to September 2014 |
| | | | 75.0% (U) – January 2014 to December 2014 |
| | | | 81.5% (U) - April 2014 to March 2015 |
| **ADDICTIONS (PROVIDER ARM AND NGO)** | | | |
| 2013/14 | New | New | - |
| 2014/15 | 92.0% 12 months to September 2013 | ≥95% | 96.5% (F) - July 2013 to June 2014 |
| | | | 96.1% (F) - October 2013 to September 2014 |
| | | | 95.0% (F) – January 2014 to December 2014 |
| | | | 97.0% (F) - April 2014 to March 2015 |

*Previously we were required to report on the total result for all age groups, in 2014/145 this was changed to only report on the age group of 0-19.

| Improving mental health services using discharge planning – Percentage of children and youth with a transition (discharge) plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | New | ≥95% | 24.17% (U) - July to September 2014 |
| | | | 23.99% (U) – October to December 2014 |
| | | | 23.99% (U) – January to March 2015 |
| | | | 22.66% (U) - April to June 2015 |

| More equitable use of Mental Health Act: Section 29 community treatment orders – Rate of section 29 orders per 100,000 population | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | New | Reduce the rate* | 74.4 (U) - July to September 2014 |
| | | | 82.0 (U) – October to December 2014 |
| | | | 85.8 (U) – January to March 2015 |
| | | | 85.2 (U) - April to June 2015 |

*there was no baseline data so we used quarter 1 results as a baseline for the rest of the year to determine Favourable or Unfavorable results

# OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

| Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital emergency department (per 1,000 population) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 75-79 Years | | | |
| 2013/14 | New | New | - |
| 2014/15 | 164.7<br>July 2012 to June 2013 | ≤164.7 | 125.7 (F) - July to September 2014 |
| | | | 139.2 (F) – October to December 2014 |
| | | | 127.2 (F) – January to March 2015 |
| | | | 138.0 (F) - April to June 2015 |
| 80-84 Years | | | |
| 2013/14 | New | New | - |
| 2014/15 | 222.0<br>July 2012 to June 2013 | ≤222.0 | 172.7 (F) - July to September 2014 |
| | | | 183.1 (F) – October to December 2014 |
| | | | 161.4 (F) – January to March 2015 |
| | | | 176.1 (F) - April to June 2015 |
| 85+ Years | | | |
| 2013/14 | New | New | - |
| 2014/15 | 231.0<br>July 2012 to June 2013 | ≤231.0 | 244.8 (U) - July to September 2014 |
| | | | 254.8 (U) – October to December 2014 |
| | | | 230.8 (F) – January to March 2015 |
| | | | 232.2 (U) - April to June 2015 |

| Acute readmissions to hospital 75 Years | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2014/15 | 11.1% | ≤11.1% | 10.9% (F) – July 2013 to June 2014 |
| | | | 10.9% (F) – October 2013 to September 2014 |
| | | | 10.8% (F) – January 2014 to December 2014 |
| | | | * |

* the Ministry of Health are currently reviewing this measure, no results were published for the period April 2014 to March 2015

| Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| *2013/14* | *93.8%<br>October to December 2012* | *≥95%* | 95.8% (F) – July to September 2013 |
| | | | 94.4% (U) – October to December 2013 |
| | | | 97.0% (F) – January to March 2014 |
| | | | 100% (F) – April to June 2014 |
| 2014/15 | 94.4%<br>January to March 2014 | ≥95% | 100% (F) April to June 2014* |
| | | | 100% (F) July to September 2014 |
| | | | 100% (F) October to December 2014 |
| | | | 93% (U) January to March 2015 |

*The Ministry changed the reporting period for the start of the 2014/15. For 2013/14 reporting was on the quarter that has just finished, this was changed to a quarter in arrears. As a consequence in the 2013/14 Q4 and the 2014/15 Q1 results are reported as the same.

| Percentage reduction in rest home bed utilisation 65+ | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | New | ≥3% | 2.8% |

| Average time from assessment to coordination (65 years and over) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 6.6 Days | ≤6.6 Days* | 6.7 days (U) - July to September 2014 |
| | | | 7.3 days (U) - October to December 2014 |
| | | | 5.5 days (F) - January to March 2015 |
| | | | 5.0 days (F) - April to June 2015 |

*The SOI stated the target as greater or equal to 6.6 however this was incorrect and the target is less than equal to 6.6.

| Number of needs assessments completed (Disability Services) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 415<br>2011/12 | ≥300 | 618 (F) July 2013 to June 2014 |
| 2014/15 | 415<br>2012/13 | ≥300 | 558 (F) July 2014 to June 2015 |

| Average time from referral to assessment (Disability Services) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 4 days<br>October - December 2012 | ≤13 days | 2 days (F) - July to September 2013 |
| | | | 3 days (F) - October to December 2013 |
| | | | 2.5 days (F) - January to March 2014 |
| | | | 2 days (F) - April to June 2014 |
| 2014/15 | 4 days<br>October - December 2012 | ≤10days | 6.5 days (F) - July to September 2014 |
| | | | 6.5 days (F) - October to December 2014 |
| | | | 7.0 days (F) - January to March 2015 |
| | | | 7.0 days (F) - April to June 2015 |

| Percentage increase in number of clients funded for intensive restorative care as an alternative to rest home entry | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | New | New | - |
| 2014/15 | 188<br>January to March 2014 | ≥15% | 28% (F) - July to September 2014 |
| | | | 23% (F) - October to December 2014 |
| | | | 10% (U) - January to March 2015 |
| | | | 12% (U) - April to June 2015 |

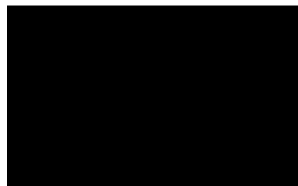
| Time from referral receipt to initial Cranford Hospice contact within 48 hours | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 92.0%<br>October to December 2012 | ≥80% | 91.0% (F) - July to September 2013 |
| | | | 99.0% (F) – October to December 2013 |
| | | | 94.0% (F) – January to March 2014 |
| | | | 87.5% (F) - April to June 2014 |
| 2014/15 | 99%<br>October to December 2013 | ≥80% | 96.0% (F) – July to September 2014 |
| | | | 92.0% (F) - October to December 2014 |
| | | | 97.7% (F) – January to March 2015 |
| | | | 95.0% (F) – April to June 2015 |

| Vitamin D prescribing | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 61.0%<br>Sep 2012 | ≥75% | 75.8% (U) - July to September 2013 |
| | | | 80.0% (U) – October to December 2013 |
| | | | 82.0% (U) – January to March 2014 |
| | | | 84.0% (U) - April to June 2014 |

| 2014/15 | 80%<br>October to December 2013 | ≥80% | 90.0% (F) – July to September 2014<br>78.0% (U) - October to December 2014<br>86.0% (F) - January to March 2015<br>86.0% (F) - April to June 2015 |
|---|---|---|---|

| Number of respite days | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 4,242<br>July 2011 June 2012 | ≥5,577 | 4,765(U) - July 2013 to June 2014 |
| 2014/15 | 4,242<br>July 2011 June 2012 | ≥5,798 | 4,607 (U) – July 2014 to June 2015 |

| Number of day services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2013/14 | 13,510<br>2011/12 | ≥17,374 | 20,754 (F) - July 2013 to June 2014 |
| 2014/15 | 13,510<br>2011/12 | ≥21,117 | 21,546 (F) – July 204 to June 2015 |



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