



# BOARD MEETING

**Date:** Wednesday, 26 October 2016

**Time:** 1.00pm

**Venue:** Te Waiora Room, DHB Administration Building,  
Corner Omaha Road and McLeod Street, Hastings

**Members:** Kevin Atkinson (Chair)  
Ngahiwi Tomoana  
Dan Druzianic  
Barbara Arnott  
Peter Dunkerley  
Helen Francis  
Diana Kirton  
Denise Eaglesome  
Jacoby Poulain  
Heather Skipworth  
Andrew Blair

**Apologies:** Jacoby Poulain

**In Attendance:** Dr Kevin Snee, Chief Executive Officer  
Members of Executive Management Team  
Members of the public and media

**Board Administrator:** Brenda Crene

## Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	<a href="#">Interests Register</a>		
4.	<a href="#">Minutes of Previous Meeting</a>		
5.	<a href="#">Matters Arising - Review of Actions</a>		
6.	<a href="#">Board Workplan</a>		
7.	<a href="#">Chair's Report - verbal</a>	-	

8.	Chief Executive Officer's Report	115	
9.	Financial Performance Report	116	
10.	Health & Safety Board Champion's Update - Helen Francis	-	
11.	Consumer Story - Kate Coley	-	
	<b>Section 2: Reports from Committee Chairs</b>		
12.	HB Clinical Council - Chris McKenna & Dr Mark Peterson	117	1.50
13.	HB Health Consumer Council - Chair, Graeme Norton	118	2.00
14.	Māori Relationship Board - Chair, Ngahiwi Tomoana	119	2.10
	<b>Section 3: Decision</b>		
15.	Annual Report 2016 - Tim Evans / Phil Lomax / Chris Lord	120	2.20
16.	Central Regions Technical Advisory Services – AGM representative - Ken Foote	121	
17.	Allied Laundry Ltd – AGM representative - Ken Foote	122	
	<b>Section 5: General Business</b>		
18.	<b>Section 6: Recommendation to Exclude</b>		2.30
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

**Public Excluded Agenda**

Item	Section 7: Agenda Items	Ref #	Time (pm)
19.	Minutes of Previous Meeting		2.30
20.	Matters Arising – Review of Actions		
21.	Board Approval of Actions exceeding limits delegated by CEO	123	
	<b>Section 8: For Information / Discussion</b>		
22.	Havelock North Gastroenteritis Outbreak Review (draft) - Kate Coley	124	2.35
23.	Urgent Care Proposal – Kevin Snee	125	2.50
	<b>Section 9: Reports from Committee Chair</b>		
24.	Finance Risk & Audit Committee – Dan Druzianic	126	3.10

**Next Meeting: 1.00 pm, Wednesday 30 November 2016**  
**Te Waioa (Boardroom), HBDHB Corporate Administration Building**

Tauwhiro Rāranga te tira He kauanuanu Ākina

## Board "Interest Register" - 22 September 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair of FRAC	
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
Helen Francis	Active	Alzheimer's Napier previously a Committee member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10
		Patron and Lifetime Member				21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropriate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropriate mitigation action is decided on.	The Chair	16.01.14

Board Meeting 26 October 2016 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair	7.12.10
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Andrew Blair	Active	Owner of Andrew Blair Consulting Limited	Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations.	Will not take part in decision relating to organisations to which he provide consultancy and advisory services.	The Chair	04.12.13
	Active	Advisor to Trustees and Management of Chelsea Hospital Trust	Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne.	Will not take part in decisions relating to services HBDHB may from time to time engage.	The Chair	24.07.14
	Active	Advisor to Hawke's Bay Orthopaedic Group Ltd	Engaged to provide advisory services to the Group	Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services.	The Chair	19.09.15
	Active	Chair of Southern Partnership Group	Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	19.09.15
	Active	Director, Breastscreen Auckland Limited	Breast screening facility.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.15
	Active	Director, St Marks Womens Health (Remuera) Limited	Womens Health facility in Auckland	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.15
	Active	Director, Board of Safer Sleep Limited	Safer Sleep is an Anaesthetic IT company which provides peri-operative safety solutions to the healthcare industry.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair and withdraw from discussions/decisions.	The Chair	22.09.16
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumaturua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14

**MINUTES OF THE BOARD MEETING  
HELD ON WEDNESDAY 28 SEPTEMBER 2016, IN THE TE WAIORA ROOM,  
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS  
AT 1.00PM**

**Present:** Kevin Atkinson (Chair)  
Andrew Blair  
Peter Dunkerley  
Diana Kirton  
Barbara Arnott  
Helen Francis  
Heather Skipworth  
Jacoby Poulain  
Denise Eaglesome

**Apologies** Ngahiwi Tomoana and Dan Druzianic

**In Attendance:** Kevin Snee (Chief Executive Officer)  
Members of the Executive Management Team  
Chris McKenna and Mark Peterson (Co-Chairs, HB Clinical Council)  
Graeme Norton (Chair, HB Health Consumer Council)

**Minutes** Brenda Crene

**KARAKIA**

Heather Skipworth opened the meeting with a Karakia.

**APOLOGIES**

Nil

**INTEREST REGISTER**

A new interest had been included on the Interest Register dated 22 September for Andrew Blair.  
No board member advised of any interest in the items on the Agenda.

**CONFIRMATION OF PREVIOUS MINUTES**

The minutes of the Board meeting held on 31 August 2016, were confirmed as a correct record of the meeting.

**Moved:** Peter Dunkerley

**Seconded:** Andrew Blair

**Carried**

**MATTERS ARISING FROM PREVIOUS MINUTES**

- Item 1: **TAW Breastfeeding**, further detail sought centred around what other DHBs were doing and where HB was benchmarked. This detail was included in the CEO's report. This review had resulted in positive recommendations to provide more support in this area. Remove action.
- Item 2: **Under 19 Mental Health Wait Target:** Detail provided and action removed.
- Item 3: **Board H&S Champion:** Met with HR 28 September, to meet prior to the October Board meeting.

- Item 4: **Fracture Clinic / Orthopaedic Dept near ED:** Options were being investigated with input from services, surgeons, Urgent Care project and the community. Ongoing.

## BOARD WORK PLAN

The Board Work Plan was noted with the Chair asking for the Executive Management Team to extend the work plan further into 2017. **ACTION**

## CHAIR'S REPORT

- The Chair advised the following retirements, with a letter being sent conveying the Board's best wishes and thanks for their extended years of devoted service.

Name	Role	Service	Years of Service	Retiring
Jennifer King	Call Centre Operator	Planning Informatics & Finance	25	4-Oct-16
Christine Stack	Registered Nurse	Women Children & Youth	25	2-Oct-16
Rayleen Hazelwood	Registered Nurse	Surgical	15	30-Sep-16
Kath Neal	ECA Operational Support Analyst	Planning Informatics & Finance	39	20-Oct-16

- A letter had been received from Meka Whaitiri ( MP Ikaroa-Rawhiti), regarding Dialysis services in Wairoa. Some concerns had been raised and it appeared numbers of those on dialysis in the Wairoa area, was growing. The COO advised delivery of services was already being reviewed. It was noted there was a significant difference between home dialysis and a Satellite Renal Unit.
- Stuart Nash had advised several constituents using home dialysis advised of a significant impact on their power accounts. Kevin Snee would see if there many be a way to assist with the power component. **ACTION.**

Following the meeting the COO advised those on Home Dialysis in Hawke's Bay included: 6 in Napier, 5 in Hastings, none in Wairoa and none in Central HB.

- Received a letter from the Minister of Health approving the HBDHB Annual Plan 2016/17, as well as the HBDHB Maori Health Plan (by separate letter).
- Received advice the National Bowel Screening Programme had been approved by Cabinet. National Bowel Screening would commence in an orderly way. HBDHB will come on stream in July 2018. Pilot screening programmes have already been tested nationally including Waitemata which would likely be reviewed by HB on how they got to their "hard to reach areas". Potentially we could see issues and the widening of inequity if not managed carefully.
- Advised that Pharmac's role had expanded in 2013 to cover the purchase of medical devices. Pharmac now has 34 national contracts for medical devices covering around 20,000 items from bandages to sutures, to orthopaedic drills and cardiac stents. These contracts will save DHB's around \$25 million over the next 5 years.

## CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report which included the Campylobacter outbreak. Performance areas were discussed including: ED; Electives (and the increased discharge targets for 16/17); and working closely with Royston. The more recent target of Faster Cancer Treatment was noted with new clinical leadership now in place which was making a difference.

Primary Care Smoking target: Dissapointment was expressed by the Board due to slow progress. There is a need for improvement in this area to at least the midway point. It appeared as though

other DHBs were buying this target through increased resources focused in this area. This is a high priority for the Healthy Populations team and PHO.

“Raising Healthy Kids” target, was questioned as to how this will be done in HB? Dr Caroline McElnay did not have specific information to hand but this would flow on from the current “B4 School Checks”. HB have good programmes in this area, however may find we have a data collection issue initially.

The detail included in the CEOs report around breastfeeding highlighted there was room for improvement in this area. Post birth support from Choices was noted as was feedback on the Baby Café. Young first time Mums need increased focus and guidance around breastfeeding, especially with support coming into the home.

It was advised and confirmed by a member that the Maternity Unit “Waioha” with its new model of care has far superior lactation/breastfeeding support than had been experienced in the past.

There was still a lot more we could do with our service(s) in HB and this was being looked at in conjunction with a review of Northland DHB services provided.

### FINANCIAL PERFORMANCE REPORT

The financial results for August showed an adverse variance of \$322 thousand resulting in a year to date adverse variance result of \$118 thousand. The direct cost impact in the month related to the Gastro event was \$379 thousand (including the cost impact due to staff illness estimated at \$216 thousand). The MoH had been approached to provide some one off funding of costs if the threshold is met. This had not been determined at the time of the meeting.

No contingency funds had been used during the month of August.

### CONSUMER STORY

Kate Coley provided an overview of a story which highlighted good outcome for the patient and his parents which highlighted speedy surgical intervention and faultless communication from all parties. The very positive letter of thanks received was shared with the services.

Separate from the Consumer Story above, focus moved to the area of **“family violence”**:

- The incidence of family violence had doubled since 2008-2014.
- Audit(s) have found we do not consistently ask the right questions of consumers. Work will be progressing in this area to ensure consistency.
- Services are available and if a person discloses “yes” they are at risk, with a process and network available to support.
- Staff need educating and they need to be sensitive and comfortable to ask the right questions. Is there a sensitivity to ethnicity? Is there a teaching on how to engage with the individual?
- In clinical practices it can be difficult – the mandate is to ask everyone but not with an audience!
- Opportunity to use our staff outside of the workplace eg with colleagues and friends.
- Questions and vigilance must also apply to “Elder Abuse”also which is very much on the rise!

## **REPORT FROM COMMITTEE CHAIRS**

### **Hawke's Bay Clinical Council**

Chris McKenna spoke to the report from the Council's meeting held on 14 September 2016 including:

- Endorsed the Quality Accounts, with significant work done.
- Prescriber registered nurses and what we are doing about it in HB was discussed and we are getting Clinical Council behind this across the sector.
- Robust and positive discussions around the gastro outbreak.

### **Hawke's Bay Health Consumer Council**

Graeme Norton Chair of Council advised the outcomes of their meeting held on 15 September 2016:

- Annual Plan – reflection of the maturing nature of Council and what they do. A draft document will be considered at the next meeting.
- Co-design groups will likely be established over the next 12 months.
- Council were keeping an eye out for integration and noting those working in silos when it is observed.
- Waikato have a view to establishing their own Consumer Council and the Chair had made himself available to the Board via video conference same day.

### **Māori Relationship Board (MRB)**

Meeting held on 14 September 2016:

Tracee provided an overview of the discussions being held with NgatiKahungunu Iwi Inc around future structure(s) to best serve Hawkes Bay into the future.

In summary:

- Want more focus on own workplan, rather than what was coming through the system.
- Look at the broader picture, need to ascertain a delivery vehicle – bringing together groups who need input from Iwi.
- Presently a MoU exists between HBDHB and Ngati Kahungunu
- The Health Inequity Report woke up leaders in the region and many now want to respond.
- If broader ie., an Intersectoral type group, it could provide input into a number of organisations.
- HBDHB to date have taken a leadership role in improving health outcomes for Maori and this appeared to be a good time as any, to look at how the relationship was working and introduce a model that progresses faster.

For example:

- Fixing housing problems will be the crucial first step as no health outcomes will result unless housing is addressed first.
- Clearly there are issues around alcohol and drug addiction.
- 92% of those in prison in HB have drug addiction or mental health issues and many of them are from Auckland. HB pick up the domiciled health costs for Auckland prisoners here in HB.
- Taking responsibility for own health eg., teach children about long term illnesses eg., asthma.

Query around HDC looking for a Maori advisory board. Aware of other organisations joining or being party to advice. Would a new organisation dilute the Maori voice coming back to the DHB table? Advised this was highly unlikely as Maori representation at HBDHB Board level was very high compared with other Boards around NZ.



## FOR DECISION

### Quality Accounts 2016

It was noted the Quality Accounts had been endorsed by Consumer and Clinical Council, MRB and the PHO Clinical Advisory Group and HBDHB's Executive Management team.

This was the fourth year the accounts had been produced, a requirement by the Health Quality and Safety Commission.

This publication, although not in final form as presented within the report, was very close to completion and was aligned with HBDHB's Annual Plan.

With little discussion the Board endorsed the Accounts through the following recommendation.

#### RECOMMENDATION

##### That the HBDHB Board:

1. Endorse the Quality Accounts
2. Endorse the Quality Accounts communications plan

##### Adopted

## UPDATE

### Health and Social Care Networks

An overview of the work progressing in this area was provided within the report. A summary of discussion follows:

- Work in progress. Definition of what constituted a network to be progressed as well as what it will be supported by HB community in co-design. This was due to EMT in several weeks following which to the COO's team for review.
- Applications would need to be in business case form defining what they would better like to achieve in their community(s).
- Consumer Council advised this needs to be consumer owned to ensure the desired outcome. Two tier makes sense.
- Advised that Practices were already a bit sceptical with HBDHB due to eg, Urgent Care, IT systems, District Nurses in the community and Pharmacy Facilitators. How do we align and support those practices. There was work going on in Wairoa and Central HB already and these areas would be easier than Napier and/or Hastings.
- How do you get the community to take ownership?
- If we could achieve this one we would have done a huge amount for all areas we have talked about. To ensure this occurs there must be complete honesty and acceptance.
- This work needs to be called something "very honest and very simple", something that a 12 year old would understand.
- We have not got what we need presently in Primary Care. Resources will be required.

The Board noted the report had been reviewed by Clinical and Consumer Council as well as MRB.

### Te Ara Whakawaiaora : Healthy Weight Strategy

This report would be provided to the October Board Meeting.

## FOR INFORMATION

### Matariki Regional Economic Development Strategy

Provided to the Board for their information, this strategy was launched by Government Ministers' on 27 July 2016, following two years of work with full regional engagement.

The Strategy's focus was not just on jobs but on career opportunities and pathways. The strategy would be in tandem with the Strategy for Social Inclusion being drafted before Christmas 2016.

There is some national funding earmarked for support the strategy.

The board were happy to adopt and were encouraged by the dedication of the HBDHB's CEO to ensure the organisations worked together and ensuring that the Maori leaders continue to be properly involved.

#### Actions:

- The work being undertaken on Social Inclusions would be brought to the Board in 2017. **ACTION.**

#### Request for Consideration:

- The Board Chair would like to see sport and recreation included in REDS.

### RESOLUTION

#### That the HBDHB Board:

1. Adopt the Regional Economic Development Strategy

**Moved:** Helen Francis

**Seconded:** Andrew Blair

**Carried**

### Final Annual Plan 2016/17 and SOI

This final Annual Plan, signed by the Minister of Health had been provided to the Board for information, with no further discussion.

## GENERAL BUSINESS

There being no further discussion, the Chair accepted a motion to move into Public Excluded.

**RESOLUTION TO EXCLUDE THE PUBLIC****RESOLUTION****That the Board****Exclude** the public from the following items:

- 20. Confirmation of Minutes of Board Meeting  
- Public Excluded
- 21. Matters Arising from the Minutes of Board Meeting - nil  
- Public Excluded
- 22. Board Approval of Actions exceeding limits delegated by CEO – nil
- 23. Taking Further Opportunities for Integration and Coherence in Primary Care

Reports and Recommendations from Committee Chairs

- 24. Finance Risk and Audit Committee Report
- 25. HB Clinical Council

**Moved: Barbara Arnott****Seconded: Heather Skipworth****Carried**

The public section of the Board Meeting closed 2.52pm with members taking a brief break.

**Signed:**


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**Chair**
**Date:**



## BOARD MEETING - MATTERS ARISING (Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	Ongoing	<b>Board Health &amp; Safety Champion:</b> Helen Francis (Board H&S Champion) and HR Manager will meet to discuss detail to be advised to the Board	Kate Coley	Oct 2016	Update from Helen Francis
2	31/8/16	<b>Fracture Clinic / Orthopaedic Dept near ED:</b> Investigating options and opportunities Progressing with verbal updates to the Board in the interim.	Sharon Mason		Ongoing.
3	28/9/16	<b>Home Dialysis:</b> Consideration of the impact on power accounts. HB Home Dialysis numbers provided by Sharon post Board meeting: 6 Napier 5 Hastings 0 Wairoa 0 Central HB.	Sharon Mason		Strategic Services are investigating options to better support those who have dialysis treatment at home.
4	28/9/16	<b>The "Social Inclusions Strategy" referred to in REDS:</b> Provide the document for inclusion on Board agenda in early 2017.	Kevin Snee	Early 2017	Included on the workplan for 2017



## HAWKE'S BAY DISTRICT HEALTH BOARD WORKPLAN

Meetings 2016	Papers and Topics	Lead(s)
24 Nov	<a href="#">HB Health Awards presentation evening</a>	
30 Nov	Consumer Story Orthopaedic Review Closure of phase one Travel Plan (quarterly update) – verbal Tobacco – Annual Update on progress against Plan Reducing Alcohol Related Harm (Final) Transform and Sustain Refresh Palliative Care in HB 2016-2016 Draft Endoscopy Project Build – Approval / Outcome Tender <b>Monitoring</b> Te Ara Whakawaiaora / Healthy Weight Strategy (revised) Te Ara Whakawaiaora / Smoking (national Indicator) HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 16 plus MoH dashboard Annual Maori Health Plan Q1 Jul-Sept 16 Transform and Sustain Strategic Dashboard Q1 Jul-Sept 16 Human Resource KPIs Q1	Kate Coley Andy Phillips Sharon Mason / Andrea Caroline / Penny Caroline / Rachel Eyre Tracee TeHuia / Kate R Tim Evans / Mary Wills Sharon Mason / Trent  Caroline McElnay Caroline McElnay Tim Evans  Tim Evans / Tracee Tim Evans Kate Coley
14 Dec	Consumer Story Orthopaedic Review – Phase 2 draft Pasifika Health Leadership Group Final External Audit Report from Oct	Kate Coley Andy Phillips Caroline McElnay Tim Evans
2017	Papers and Topics	Lead(s)
22 Feb	Consumer Story Final Developing a Person Whanau Centred Culture Orthopaedic Review – phase 3 Draft Pacifica Health Leadership Group Qtly Social Inclusions Strategy (referred to in REDS) <b>Monitoring</b> HBDHB Non-Financial Exceptions Report Q2 Oct-Dec16 plus MoH dashboard Annual Maori Health Plan Q2 Oct-Dec16 Transform and Sustain Strategic Dashboard Q2 Oct-Dec16 Human Resource KPIs Q2 Te Ara Whakawaiaora / Access (local indicator)	Kate Coley Kate Coley Andy Phillips Caroline McElnay Kevin Snee  Tim Evans  Tim Evans Tim Evans GM HR Mark Peterson

<b>29 Mar</b>	Consumer Story Pasifika Health Leadership Group HBDHB Workforce Plan – Final Health and Social Care Networks (6 monthly update) Travel Plan Update External Audit Engagement Arrangements Te Ara Whakawaiaora / Breastfeeding (national indicator) NKII MoU Relationship Review	Kate Coley Caroline McElnay GM HR Belinda Sleight Sharon Mason Tim Evans Caroline McElnay Ken Foote / Tracee
<b>26 Apr</b>	People and Culture Strategy (2016-2021) Mental Health Consolidation / Benefits Realisation (final) from Oct16 <b>Monitoring</b> Te Ara Whakawaiaora / Cardiology (national indicator)	GM HR Sharon Mason  John Gommans
<b>31 May</b>	Best Start Healthy Eating Plan (yearly review)	Caroline McElnay
<b>June</b>	Orthopaedic Review closure phase 2 Orthopaedic Review closure phase 3 Draft Equity Update Final Youth Health Strategy Final Suicide Prevention Posteventon update against 2016 Plan. Pasifika Health Leadership Group incl Dashboard (6mthly) <b>Monitoring</b> Te Ara Whakawaiaora / Oral Health (national indicator)	Andy Phillips Andy Phillips Caroline McElnay Caroline McElnay Caroline McElnay Caroline McElnay  Sharon Mason / Robin W






## **CHAIR'S REPORT**

Verbal



 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Chief Executive Officer's Report</b>	<b>115</b>
	For the attention of: <b>HBDHB Board</b>	
Document Owner:	Dr Kevin Snee, Chief Executive Officer	
Reviewed by:	Not applicable	
Month as at	20 October 2016	
Consideration:	For Information	

### Recommendations

#### That the Board

1. Note the contents of this report.

## INTRODUCTION

This month the campylobacter outbreak remains an important focus and we reflect on the stories of two people who were affected and discuss the draft internal report on the DHB's response to the outbreak. The National Inquiry into the outbreak will commence in Hastings on the 27<sup>th</sup> of October.

The Board will also receive three annual reports, our own, Central TAS and Allied Laundry.

As I write we are in the midst of RMO strike action. The hospital has coped extremely well, although as a result some elective procedures and outpatient appointments were proactively postponed. Senior Doctors, nurses and indeed many RMOs have all worked well together to ensure that a high level of services has been maintained.

**PERFORMANCE**

Measure / Indicator		Target	Month of September	Qtr to end September	Trend For Qtr
Shorter stays in ED		≥95%	92.0%	92.4%	▼
Improved access to Elective Surgery (2016/17YTD)		100%	97.7%	-	▲
	<i>Waiting list</i>	<i>Less than 3 months</i>	<i>3-4 months</i>	<i>4+ months</i>	
	<i>First Specialist Assessments (ESPI-2)</i>	2,786	383	36	
	<i>Patients given commitment to treat, but not yet treated (ESPI-5)</i>	1,073	88	29	
Faster cancer treatment*		≥85%	52.9% (September 2016)	65.3% (6m to September 2016)	▼
Increased immunisation at 8 months (3 months to end of September)		≥95%	---	95.4%	▼
Better help for smokers to quit – Primary Care		≥90%	81.3% (Quarter 4, 2015/16)	---	▲
Better help for smokers to quit – Maternity		≥90%	89.0% (Quarter 4, 2015/16)	---	▲
Raising healthy kids (New)		≥95%	-	---	
More heart diabetes checks (This indicator is no longer a Health Target)		≥90%	88.5% (Quarter 4, 2015/16)	---	▼
Financial – month (in thousands of dollars)		\$2,100	\$2,015	---	---
Financial – year to date (in thousands of dollars)		\$2,098	\$1,895	---	---

\*Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.

<i>Faster Cancer Treatment Expected Volumes v Actual</i>	<i>Target</i>	<i>Month Actual / Expected</i>	<i>Rolling 6m Actual / Expected</i>
	100%	17/19= 89.5%	124/114 = 108.8 %

Note: The Ministry of Health expectation for the number of people expected to be identified as high suspicion has been increased from 11.4 to 19 a month.

Performance this month shows a deterioration in shorter stays in ED, but in October there has been a noticeable improvement with the target being delivered over a three week period, the work to improve patient flow supported by the Francis Group getting underway and 2 of our 3 new ED SMOs starting. Our elective treatment remains below plan but has shown some improvement – obviously there will be an impact as a result of the national strike action.

Faster cancer treatment has showed a deterioration for September, however is little changed when considering the 6 month rolling average.

Immunisation at 8 months remains above target. We have no new figures for smoking and heart and diabetes checks and we will aim to post our first quarter data on the new target for healthy kids next month.

The result for the month of September is an adverse variance of \$85 thousand making a year-to-date adverse variance of \$203 thousand. This is not a cause for concern at this stage but underlines the importance of delivering our savings plans.

### **CONSUMER STORY**

In the last month two consumers have shared their experience of care in the community with us. Both live in Havelock North and were affected in different ways by the campylobacter outbreak. We will tell you about their positive experiences and highlight the excellent coordination of care between primary and secondary services.

### **ANNUAL REPORT**

The statutory deadline for sign-off of the annual report is the end of October. To meet this deadline the report is being presented to the Board on 26 October. If the auditors are prepared to provide their opinion on 26 October, the Board can sign the report and the letter of representation at the Board meeting. Otherwise the Board will be asked to approve the Chair and one other Board member to sign on their behalf, at the time the audit opinion is available.

### **CENTRAL REGION'S TECHNICAL ADVISORY SERVICES**

The Central Region's Technical Advisory Services (TAS) draft Annual Report (for year ended 30 June 2016) has been provided. Included in the cover report is a request to appoint Kevin Atkinson as HBDHB's representative to attend the TAS AGM, with myself as the alternative. The Notice of Meeting for 6 December 2016, together with the minutes of the 2014 AGM, is included in the papers.

### **ALLIED LAUNDRY SERVICES LIMITED**

Allied Laundry Services' AGM will be held on 29 November. The Chairman's report and financial statements have been provided for the year ended 30 June 2016, together with a recommendation to appoint Ken Foote as the HBDHB Shareholder Representative to attend, with Peter Kennedy appointed as alternative should Ken Foote be unable to attend. It should be noted that this has been perhaps the most significant year in Allied's history with the implementation of a very ambitious expansion project and an increase in shareholding DHBs in the business to six including: Capital Coast and Hutt Valley from 1 March 2016; joining existing DHBs Mid Central, Taranaki, Whanganui and Hawke's Bay.

### **HAVELOCK NORTH CAMPYLOBACTER OUTBREAK**


Since the request to undertake a full review of how we responded to the campylobacter outbreak was agreed at September Board, a significant amount of work has been undertaken. Rose Laloli (Central Technical Advisory Services) has been undertaking the information gathering and debriefing activities on behalf of the DHB and has spent the last three weeks working and meeting with teams that were involved in the outbreak management and gaining an understanding of the legislative requirements around drinking water monitoring. At the same time a piece of work has been undertaken to centralise all the documents, emails and texts that occurred during the period from 1 August – 26 August 2016. The report that will be discussed is still a draft working document and a final version will be presented in November for Board endorsement. In conjunction with this, we have recently met with the Government Independent Inquiry lead and are liaising with Buddle Findlay as to how we manage and support this inquiry effectively.

**URGENT CARE**

The Board will be updated on the progress to date on urgent care, whether there is an adequate proposal emerging from the consortium of local practices to proceed further or whether the DHB will have to take a different approach.

**SUMMARY**

In summary, we are making steady progress whilst we address immediate concerns and learn lessons relating to the aftermath of the campylobacter outbreak and minimise the impact of the RMO strike action.

 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Financial Performance Report, September 2016</b>	<b>116</b>
	For the attention of: <b>HBDHB Board and the Finance Risk and Audit Committee (FRAC)</b>	
Document Owner:	Tim Evans, GM Planning, Informatics & Finance	
Document Author(s):	Finance Team	
Reviewed by:	Executive Management Team	
Month:	October 2016	
Consideration:	For Information	

## RECOMMENDATION

### That the Board and FRAC

Note the contents of this report

## 1. GM Planning Informatics & Finance comments

### Financial performance

The result for the month of September is an adverse variance of \$85 thousand making a year to date adverse variance of \$203 thousand.

## 2. Resource Overview

	September				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	\$'000	\$'000	\$'000	%	\$'000	\$'000	\$'000	%		
Net Result - surplus/(deficit)	2,015	2,100	(85)	-4.0%	1,895	2,098	(203)	-9.7%	5,000	3
Contingency utilised	-	250	250	100.0%	-	750	750	100.0%	3,000	8
Quality and financial improvement	742	1,088	(346)	-31.8%	2,264	3,257	(993)	-30.5%	13,000	11
Capital spend	818	1,753	(935)	-53.3%	1,870	5,259	(3,388)	-64.4%	22,042	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,210	2,226	16	0.7%	2,191	2,195	3	0.1%	2,202	5 & 7

Update of IDF wash-up provisions adversely affected the September result, and were partly offset by lower than budgeted elective volumes and allied health vacancies.

No contingency funds have been released. Revenue banking has been excluded from the contingency above. See Section 8 – Reserves for a reconciliation of the contingency and revenue banking.

Quality and Financial Improvement (QFI) programme savings are running behind plan due to timing differences with some plans expected to deliver their savings later in the year.

Capital spend is behind plan. A number of projects have not started at the estimated times projected in the capital plan, and later than planned purchase of some large clinical equipment items going through the trial process has also impacted timing.

The FTE variance year to date reflects high patient volume in some areas, efficiencies not yet achieved, unbudgeted leave cover including long term sick leave, and cover for employees undergoing training.

Case weighted discharges have not been included again this month. The price volume schedule (payments between the funder and provider arms) is being changed, and the change affects the availability of case weighted discharge volumes. Volumes are expected to be available from the next quarter.

### 3. Financial Performance Summary

\$'000	September				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
Income	45,715	45,998	(283)	-0.6%	132,965	131,998	967	-0.7%	532,441	4
Less:										
Providing Health Services	20,618	20,791	173	0.8%	61,825	60,695	(1,130)	-1.9%	245,681	5
Funding Other Providers	19,206	19,246	40	0.2%	56,868	57,085	217	0.4%	228,008	6
Corporate Services	3,818	3,745	(73)	-1.9%	11,924	11,571	(353)	-3.0%	48,422	7
Reserves	58	116	58	50.3%	454	550	96	17.5%	5,330	8
	2,015	2,100	(85)	-4.0%	1,895	2,098	(203)	-9.7%	5,000	

Increased IDF wash-up provisions in September, were mostly offset by lower elective surgery volumes, and allied health vacancies. The income variance relates to an adjustment of PHO Performance funding from payment in arrears to payment in advance, and is offset in funding other providers.

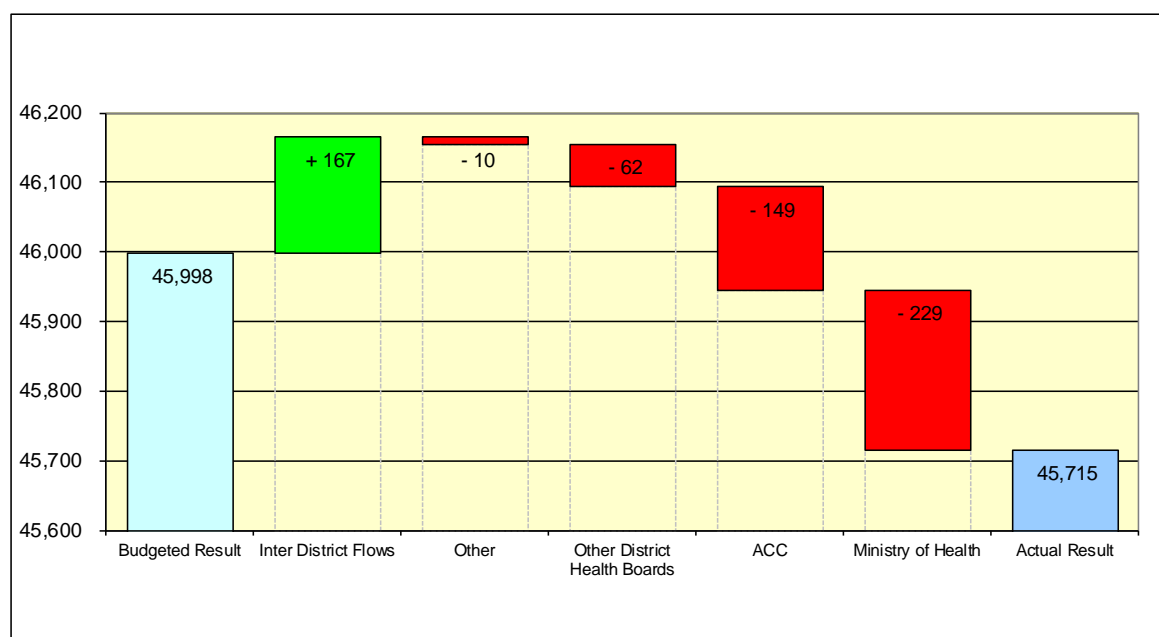


## 4. Income

*Excludes transfers between the Funder and Health Services*

\$'000	September			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Ministry of Health	43,744	43,973	(229) -0.5%	126,894	125,900	993 0.8%	507,930
Inter District Flows	796	629	167 26.5%	2,052	1,886	166 8.8%	7,545
Other District Health Boards	272	334	(62) -18.5%	882	1,001	(118) -11.8%	4,004
Financing	76	67	9 13.2%	170	228	(58) -25.5%	885
ACC	376	525	(149) -28.3%	1,416	1,511	(95) -6.3%	5,980
Other Government	19	18	1 8.4%	101	104	(3) -2.9%	444
Patient and Consumer Sourced	78	121	(43) -35.4%	266	363	(97) -26.7%	1,447
Other Income	355	332	23 6.9%	1,195	1,006	190 18.8%	4,140
Abnormals	-	0	(0) -100.0%	(10)	1	(11) -1955.2%	67
	<b>45,715</b>	<b>45,998</b>	<b>(283) -0.6%</b>	<b>132,965</b>	<b>131,998</b>	<b>967 0.7%</b>	<b>532,441</b>

### September Income



*Note the scale does not begin at zero*

#### Inter District Flows (favourable)

Includes 2015/16 IDF wash-ups.

#### Other District Health Boards (unfavourable)

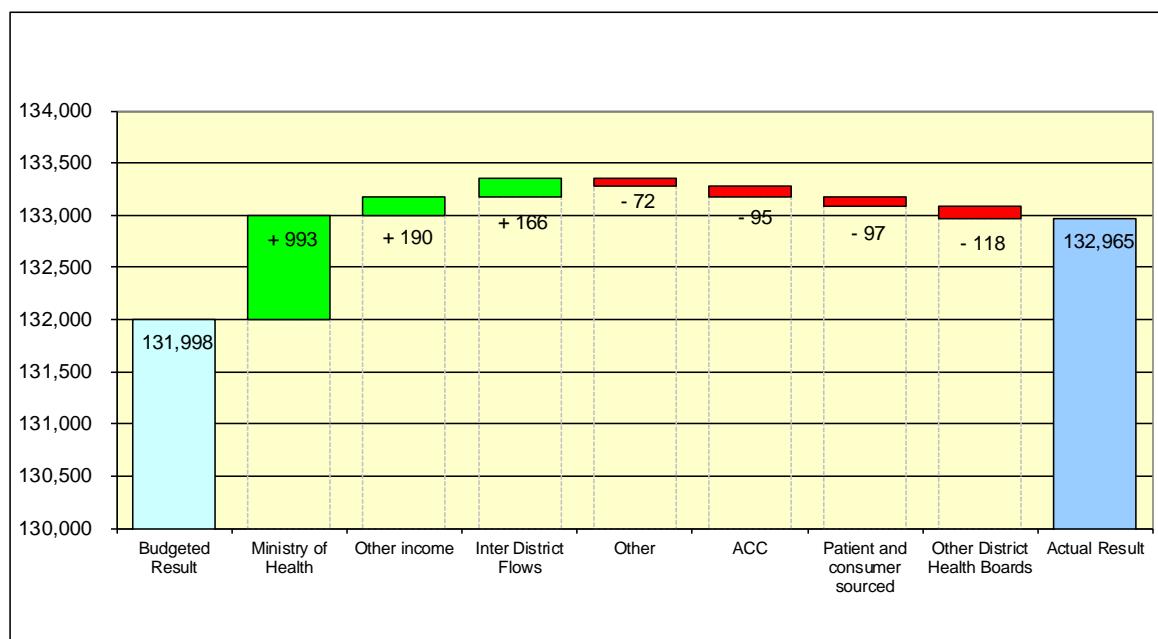
Lower than budgeted cancer drug sales to Tairawhiti DHB.

#### ACC (unfavourable)

Lower ACC elective volumes due to capacity constraints, and lower ACC rehabilitation volumes due to lower demand.

#### Ministry of Health (unfavourable)

Reversal of PHO performance funding, as the change from payment in arrears to payment in advance was not recognised last month. This variance is offset in funder expenditure.

**September YTD****Ministry Of Health** (favourable)

Funding a high cost patient and for free under thirteens.

**Other income** (favourable)

Largely unbudgeted donations and clinical trial income.

**Inter District Flows** (favourable)

Includes 2015/16 IDF wash-ups.

**ACC** (unfavourable)

Lower ACC elective volumes due to capacity constraints, and lower ACC rehabilitation volumes due to lower demand.

**Patient and Consumer Sourced** (unfavourable)

Non-resident income behind plan.

**Other District Health Boards** (unfavourable)

Lower than budgeted cancer drug sales to Tairāwhiti DHB, marginally offset by additional funding for oncology clinics by Mid Central DHB, and patient transport by Capital and Coast Health.

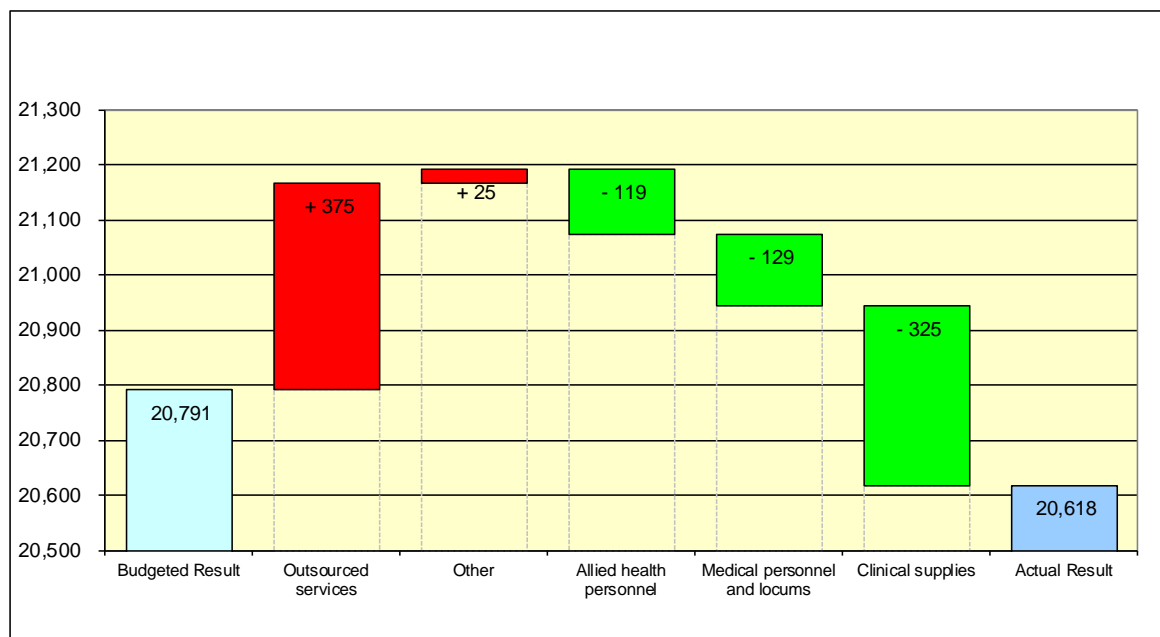
## 5. Providing Health Services

	September			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>Expenditure by type \$'000</b>							
Medical personnel and locums	4,669	4,798	129 2.7%	13,413	13,981	568 4.1%	58,566
Nursing personnel	5,931	5,987	56 0.9%	17,976	17,566	(410) -2.3%	72,813
Allied health personnel	2,714	2,833	119 4.2%	8,019	8,345	327 3.9%	33,016
Other personnel	1,805	1,793	(12) -0.7%	5,597	5,295	(302) -5.7%	21,075
Outsourced services	979	604	(375) -62.1%	2,154	2,142	(12) -0.6%	8,017
Clinical supplies	2,738	3,063	325 10.6%	9,516	8,461	(1,055) -12.5%	32,849
Infrastructure and non clinical	1,782	1,713	(69) -4.0%	5,151	4,905	(246) -5.0%	19,347
	<b>20,618</b>	<b>20,791</b>	<b>173 0.8%</b>	<b>61,825</b>	<b>60,695</b>	<b>(1,130) -1.9%</b>	<b>245,681</b>
<b>Expenditure by directorate \$'000</b>							
Acute and Medical	5,683	5,513	(169) -3.1%	16,625	15,945	(679) -4.3%	66,170
Surgical Services	4,747	4,495	(251) -5.6%	13,916	13,329	(587) -4.4%	54,085
Women Children and Youth	1,600	1,632	31 1.9%	4,973	4,818	(155) -3.2%	19,594
Older Persons & Mental Health	2,739	2,772	33 1.2%	8,228	8,208	(20) -0.2%	33,269
Rural, Oral and Community	1,939	1,830	(109) -6.0%	5,703	5,443	(260) -4.8%	21,852
Other	3,911	4,549	638 14.0%	12,381	12,952	571 4.4%	50,712
	<b>20,618</b>	<b>20,791</b>	<b>173 0.8%</b>	<b>61,825</b>	<b>60,695</b>	<b>(1,130) -1.9%</b>	<b>245,681</b>
<b>Full Time Equivalents</b>							
Medical personnel	323.5	316.8	(7) -2.1%	309	309	1 0.2%	313.8
Nursing personnel	891.3	889.1	(2) -0.2%	893	878	(15) -1.7%	891.3
Allied health personnel	439.2	460.4	21 4.6%	434	454	20 4.5%	448.5
Support personnel	128.7	130.9	2 1.6%	130	127	(3) -2.4%	127.5
Management and administration	256.0	249.8	(6) -2.5%	255	248	(7) -2.9%	245.7
	<b>2,038.8</b>	<b>2,047.0</b>	<b>8 0.4%</b>	<b>2,021</b>	<b>2,017</b>	<b>(4) -0.2%</b>	<b>2,026.8</b>

### Directorates

- Surgical Services includes a provision for outsourced elective surgery.
- Rural Oral and Community includes the Wairoa Hostel Project and training costs and cover that are budgeted for later in the year.
- Other includes phasing changes relating to the devolvement of efficiency budgets. These items balance to nil over the year.

## September Expenditure



*Note the scale does not begin at zero*

### **Outsourced Services** (unfavourable)

Outsourced elective services have been accrued to budget to provide a provision for costs to achieve elective discharge and ESPI targets later in the year.

### **Allied Health personnel** (favourable)

Vacancies

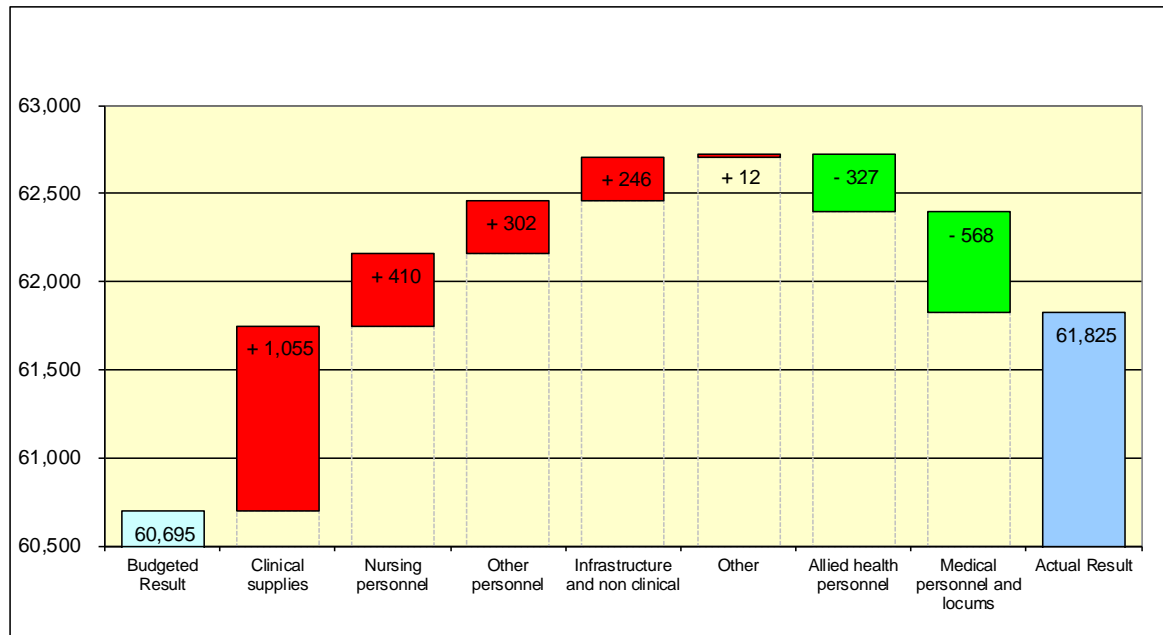
### **Medical personnel and locums** (favourable)

Locum cover for leave and vacancies is more than offset by lower medical personnel costs.

### **Clinical Supplies** (unfavourable)

Phasing changes relating to the devolvement of efficiency budgets will balance to nil over the year. In September they obscure efficiencies not yet achieved.

## September YTD Expenditure



**Clinical Supplies** (unfavourable)  
Efficiencies not yet achieved.

**Nursing Personnel** (unfavourable)  
Leave provisioning and high patients volume in July.

**Other personnel** (unfavourable)  
Payments to retiring staff, and sick, training and long service leave costs.

**Infrastructure and Non clinical** (unfavourable)  
Unachieved efficiencies, Wairoa hostel maintenance, and capital project feasibility costs.

**Allied Health personnel** (favourable)  
Vacancies

**Medical personnel and locums** (favourable)  
Includes release of a provision for allowance payments, and the reversal of continuing medical education provisions due to the retirement of a number of senior medical officers offset by additional locum costs.

## **Full time equivalents (FTE)**

FTEs are 4 unfavourable year to date including:

### **Nursing personnel** (15 FTE / 1.7% unfavourable)

- Partly driven by efficiencies not yet achieved (savings have been budgeted from the beginning of July, however the actual realisation of savings may be more gradual). High workloads in certain areas including: ED, A1 and B2 medical wards, Ata Rangi, Nga Rau Rakau, and the surgical overflow ward.

### **Support personnel** (3 FTE / 2.4% unfavourable)

- Leave cover, long term sick leave, and training, mainly impacting on orderlies and kitchen assistants.

### **Management and administration personnel** (7 FTE 2.9% unfavourable)

- High workloads in reception, health records and secretarial services. Hours related retirement payments.

mostly offset by:

### **Allied Health Personnel** (20 FTE / 4.5% favourable)

- Vacancies mainly in psychologists and social workers, community support, pharmacists and pharmacy technicians, and MRTs

## MONTHLY ELECTIVE HEALTH TARGET REPORT

### YTD To August 2016

Plan for 2016/17	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70		0	70
Non Surgical - Elective	187		0	187
Surgical - Arranged	390		307	697
Surgical - Elective	5,003	788	629	6,420
<b>TOTAL</b>	<b>5,650</b>	<b>788</b>	<b>936</b>	<b>7,374</b>

		YTD September 2016			
		Actual	Plan	Var.	% Var.
On-Site	Avastins	52	52	0	0.0%
	ENT	136	151	-15	-9.9%
	General Surgery	219	236	-17	-7.2%
	Gynaecology	175	133	42	31.6%
	Maxillo-Facial	46	49	-3	-6.1%
	Ophthalmology	225	278	-53	-19.1%
	Orthopaedics	230	235	-5	-2.1%
	Skin Lesions	46	46	0	0.0%
	Urology	125	114	11	9.6%
	Vascular	51	36	15	41.7%
	Surgical - Arranged	160	112	48	42.9%
	Non Surgical - Elective	21	49	-28	-57.1%
	Non Surgical - Arranged	6	16	-10	-62.5%
<b>On-Site</b>	<b>Total</b>	<b>1492</b>	<b>1507</b>	<b>-15</b>	<b>-1.0%</b>
Outsourced	Cardiothoracic	0	12	-12	-100.0%
	ENT	51	33	18	54.5%
	General Surgery	63	64	-1	-1.6%
	Gynaecology	8	6	2	33.3%
	Maxillo-Facial	4	14	-10	-71.4%
	Neurosurgery	0	4	-4	-100.0%
	Ophthalmology	11	8	3	37.5%
	Orthopaedics	2	20	-18	-90.0%
	Paediatric Surgery	0	2	-2	-100.0%
	Urology	20	19	1	5.3%
	Vascular	8	11	-3	-27.3%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
<b>Outsourced</b>	<b>Total</b>	<b>167</b>	<b>193</b>	<b>-26</b>	<b>-13.5%</b>
IDF Outflow	Cardiothoracic	19	19	0	0.0%
	ENT	9	12	-3	-25.0%
	General Surgery	6	12	-6	-50.0%
	Gynaecology	10	6	4	66.7%
	Maxillo-Facial	40	51	-11	-21.6%
	Neurosurgery	22	11	11	100.0%
	Ophthalmology	5	8	-3	-37.5%
	Orthopaedics	11	4	7	175.0%
	Paediatric Surgery	10	12	-2	-16.7%
	Skin Lesions	9	19	-10	-52.6%
	Urology	6	1	5	500.0%
	Vascular	2	4	-2	-50.0%
	Surgical - Arranged	43	76	-33	-43.4%
	Non Surgical - Elective	31	0	31	0.0%
	Non Surgical - Arranged	9	0	9	0.0%
<b>IDF Outflow</b>	<b>Total</b>	<b>232</b>	<b>235</b>	<b>-3</b>	<b>-1.3%</b>
<b>TOTAL</b>		<b>1891</b>	<b>1935</b>	<b>-44</b>	<b>-2.3%</b>

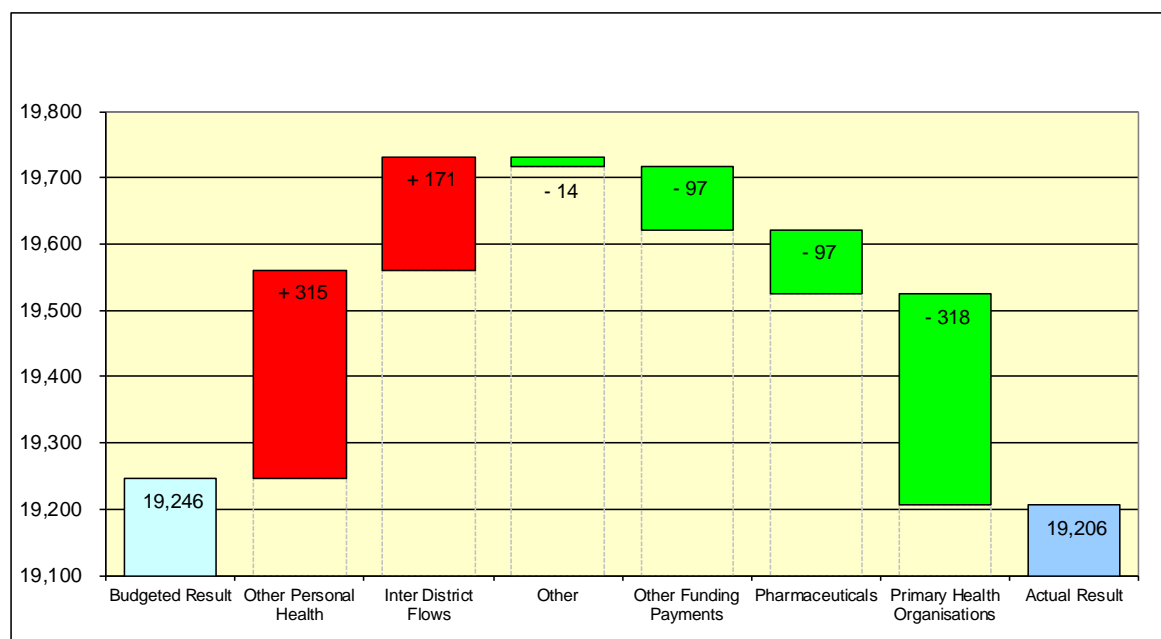
		Sep-16			
		Actual	Plan	Var.	% Var.
On-Site	Avastins	18	18	0	0.0%
	ENT	44	51	-7	-13.7%
	General Surgery	91	80	11	13.8%
	Gynaecology	60	47	13	27.7%
	Maxillo-Facial	21	16	5	31.3%
	Ophthalmology	75	98	-23	-23.5%
	Orthopaedics	57	80	-23	-28.8%
	Skin Lesions	16	16	0	0.0%
	Urology	44	38	6	15.8%
	Vascular	17	12	5	41.7%
	Surgical - Arranged	72	28	44	157.1%
	Non Surgical - Elective	5	17	-12	-70.6%
	Non Surgical - Arranged	0	5	-5	-100.0%
<b>On-Site</b>	<b>Total</b>	<b>520</b>	<b>506</b>	<b>14</b>	<b>2.8%</b>
Outsourced	Cardiothoracic	0	4	-4	-100.0%
	ENT	26	14	12	85.7%
	General Surgery	26	26	0	0.0%
	Gynaecology	2	1	1	100.0%
	Maxillo-Facial	0	8	-8	-100.0%
	Neurosurgery	0	1	-1	-100.0%
	Ophthalmology	11	3	8	266.7%
	Orthopaedics	1	10	-9	-90.0%
	Paediatric Surgery	0	1	-1	-100.0%
	Urology	5	10	-5	-50.0%
	Vascular	3	4	-1	-25.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
<b>Outsourced</b>	<b>Total</b>	<b>74</b>	<b>82</b>	<b>-8</b>	<b>-9.8%</b>
IDF Outflow	Cardiothoracic	8	7	1	14.3%
	ENT	1	5	-4	-80.0%
	General Surgery	2	4	-2	-50.0%
	Gynaecology	2	3	-1	-33.3%
	Maxillo-Facial	5	16	-11	-68.8%
	Neurosurgery	4	4	0	0.0%
	Ophthalmology	1	3	-2	-66.7%
	Orthopaedics	2	2	0	0.0%
	Paediatric Surgery	3	4	-1	-25.0%
	Skin Lesions	2	7	-5	-71.4%
	Urology	1	0	1	0.0%
	Vascular	0	2	-2	-100.0%
	Surgical - Arranged	18	28	-10	-35.7%
	Non Surgical - Elective	8	0	8	0.0%
	Non Surgical - Arranged	3	0	3	0.0%
<b>IDF Outflow</b>	<b>Total</b>	<b>60</b>	<b>85</b>	<b>-25</b>	<b>-29.4%</b>
<b>TOTAL</b>		<b>654</b>	<b>673</b>	<b>-19</b>	<b>-2.8%</b>

Please Note: This report was run on 7<sup>th</sup> September 2016. Avastins have been adjusted to plan.

## 6. Funding Other Providers

\$'000	September				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Payments to Other Providers									
Pharmaceuticals	3,710	3,807	97	2.5%	11,176	11,223	47	0.4%	43,351
Primary Health Organisations	2,787	3,106	318	10.3%	8,627	8,797	170	1.9%	35,401
Inter District Flows	3,947	3,776	(171)	-4.5%	11,523	11,329	(194)	-1.7%	45,317
Other Personal Health	2,091	1,776	(315)	-17.7%	6,001	5,433	(568)	-10.4%	22,651
Mental Health	1,154	1,148	(6)	-0.5%	3,312	3,426	115	3.3%	13,761
Health of Older People	5,139	5,159	20	0.4%	15,026	15,476	450	2.9%	61,928
Other Funding Payments	378	475	97	20.4%	1,203	1,400	196	14.0%	5,599
	19,206	19,246	40	0.2%	56,868	57,085	217	0.4%	228,008
Payments by Portfolio									
Strategic Services									
Secondary Care	4,088	3,898	(190)	-4.9%	12,247	11,694	(553)	-4.7%	46,778
Primary Care	7,933	8,164	231	2.8%	23,825	23,869	44	0.2%	94,684
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,154	1,131	(23)	-2.0%	3,312	3,392	81	2.4%	13,574
Health of Older People	5,232	5,215	(17)	-0.3%	15,246	15,627	381	2.4%	62,582
Other Health Funding	196	89	(108)	-121.5%	271	266	(5)	-1.9%	1,063
Maori Health	474	542	67	12.5%	1,430	1,600	171	10.7%	6,403
Population Health									
Women, Child and Youth	35	105	69	66.1%	224	314	90	28.7%	1,669
Population Health	94	104	10	9.6%	314	323	9	2.6%	1,255
	19,206	19,246	40	0.2%	56,868	57,085	217	0.4%	228,008

### September Expenditure



Note the scale does not begin at zero

#### Other Personal Health (unfavourable)

Includes IDF wash-up provisions for 2016/17, and higher palliative care costs.



**Inter District Flows** (unfavourable)

Includes estimated wash-up provisions for 2015/16

**Other Funding Payments** (favourable)

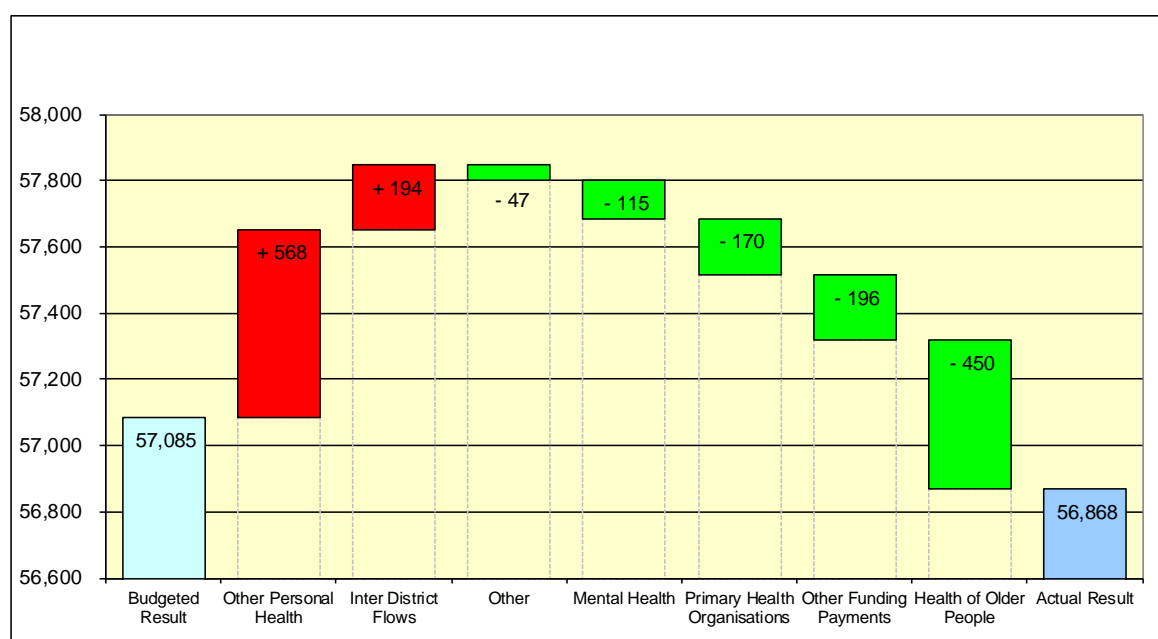
Reduced payments for Maori primary health services

**Pharmaceuticals** (favourable)

Volatile demand driven expenditure, close to budget year to date.

**Primary Health Organisations** (favourable)

Lower than budgeted costs relating to low cost access. Lower costs due to PHO performance payment being paid a month early.

**September YTD Expenditure****Other Personal Health** (unfavourable)

Includes IDF wash-up provisions for 2016/17, and higher palliative care costs.

**Inter District Flows** (unfavourable)

Includes estimated wash-up provisions for 2015/16

**Mental Health** (favourable)

Lower community residential and home based support costs earlier in the year.

**Primary Health Organisations** (favourable)

Lower than budgeted costs relating to low cost access.

**Other Funding Payments** (favourable)

Lower costs in Maori primary health

**Health of Older People** (favourable)

Lower residential care costs partly offset by higher home support.

## 7. Corporate Services

\$'000	September			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>Operating Expenditure</b>							
Personnel	1,413	1,301	(112) -8.6%	4,215	3,891	(323) -8.3%	15,136
Outsourced services	109	94	(15) -16.2%	301	282	(19) -6.8%	1,092
Clinical supplies	10	9	(1) -9.3%	39	28	(10) -36.5%	114
Infrastructure and non clinical	981	1,041	60 5.8%	3,443	3,465	22 0.6%	8,956
	2,514	2,446	(68) -2.8%	7,998	7,667	(331) -4.3%	25,298
<b>Capital servicing</b>							
Depreciation and amortisation	1,118	1,139	21 1.9%	3,409	3,414	5 0.1%	13,887
Financing	186	160	(26) -16.4%	516	490	(26) -5.3%	2,052
Capital charge	-	-	- 0.0%	-	-	- 0.0%	7,186
	1,304	1,299	(5) -0.4%	3,926	3,904	(22) -0.6%	23,125
	<b>3,818</b>	<b>3,745</b>	<b>(73) -1.9%</b>	<b>11,924</b>	<b>11,571</b>	<b>(353) -3.0%</b>	<b>48,422</b>
<b>Full Time Equivalents</b>							
Medical personnel	0.0	0.3	0 92.3%	0	0	0 65.0%	0.3
Nursing personnel	13.1	15.8	3 16.7%	12	16	4 24.9%	15.5
Allied health personnel	0.4	4.5	4 90.1%	0	4	4 90.1%	4.4
Support personnel	8.6	9.6	1 10.1%	9	10	0 2.8%	9.4
Management and administration	149.0	149.3	0 0.2%	149	148	(1) -0.5%	146.0
	<b>171.2</b>	<b>179.5</b>	<b>8 4.6%</b>	<b>171</b>	<b>178</b>	<b>8 4.3%</b>	<b>175.6</b>

Personnel costs includes restructuring, clinical trial costs (offset by income), conference costs, talent management costs, and additional staffing.

Infrastructure costs relate to professional fees, training and communications.

## 8. Reserves

\$'000	September			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>Expenditure</b>							
Contingency	(184)	16	200 1236.1%	97	97	(0) 0.0%	3,863
Transform and Sustain resource	10	64	54 83.8%	65	193	128 66.3%	593
Other	231	35	(196) -556.4%	292	260	(32) -12.3%	874
	<b>58</b>	<b>116</b>	<b>58 50.3%</b>	<b>454</b>	<b>550</b>	<b>96 17.5%</b>	<b>5,330</b>

Contingency budgets transferred to operational costs reconcile as follows:

	\$'000
Original contingency budget	3,000
Plus:	
Revenue banking	4,200
Less:	
Additional surplus agreed with MOH	-500
Feasibility studies	-600
Elective surgery delivery costs	-1,942
Melanoma and oncology treatments	-295
Remaining contingency budget (per above table)	3,863

Some transform and sustain projects are starting later than budgeted. Delays implementing new investment projects are behind the "Other" category variance.

## 9. Financial Performance by MOH Classification

\$'000	September			Year to Date			End of Year		
	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
<b>Funding</b>									
Income	44,286	44,418	(132) U	127,898	126,861	1,037 F	511,773	511,773	-
Less:									
Payments to Internal Providers	24,688	24,641	(47) U	72,685	72,505	(179) U	278,344	278,344	-
Payments to Other Providers	19,206	19,246	40 F	56,868	57,085	217 F	228,008	228,008	-
Contribution	<b>392</b>	<b>531</b>	<b>(138) U</b>	<b>(1,655)</b>	<b>(2,729)</b>	<b>1,074 F</b>	<b>5,422</b>	<b>5,422</b>	<b>-</b>
<b>Governance and Funding Admin.</b>									
Funding	262	266	(4) U	799	799	-	3,197	3,197	-
Other Income	3	3	-	8	8	-	30	30	-
Less:									
Expenditure	260	269	9 F	760	806	47 F	3,227	3,227	-
Contribution	<b>5</b>	<b>(0)</b>	<b>5 F</b>	<b>47</b>	<b>(0)</b>	<b>47 F</b>	<b>0</b>	<b>0</b>	<b>-</b>
<b>Health Provision</b>									
Funding	24,425	24,375	51 F	71,886	71,707	179 F	275,147	275,147	-
Other Income	1,426	1,578	(151) U	5,060	5,129	(69) U	20,638	20,638	-
Less:									
Expenditure	24,234	24,383	149 F	73,442	72,008	(1,434) U	296,207	296,207	-
Contribution	<b>1,618</b>	<b>1,570</b>	<b>48 F</b>	<b>3,503</b>	<b>4,827</b>	<b>(1,324) U</b>	<b>(422)</b>	<b>(422)</b>	<b>-</b>
<b>Net Result</b>	<b>2,015</b>	<b>2,100</b>	<b>(85) U</b>	<b>1,895</b>	<b>2,098</b>	<b>(203) U</b>	<b>5,000</b>	<b>5,000</b>	<b>-</b>

The table above reports the result in the classifications used by the Ministry of Health (MOH), and against the projections in the Annual Plan. Those projections differ from the budgets used elsewhere in this report as outlined in the table below.

## 10. Management Budget Movements

Changes are made to Annual Plan projections so that managers are accountable for budgets that are relevant and up-to-date. The Management budget is used for internal reporting and the annual plan is used for MOH and statutory reporting. The net result is the same in both budgets.

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2016/17 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

	September			Year to Date			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
\$'000									
<b>Funding</b>									
Income	44,418	44,273	145 F	126,861	126,980	(119) U	511,773	511,803	(30) U
Less:									
Payments to Internal Providers	24,641	24,148	(493) U	72,505	71,522	(983) U	278,344	275,461	(2,882) U
Payments to Other Providers	19,246	19,526	280 F	57,085	57,938	853 F	228,008	231,341	3,334 F
Contribution	531	599	(68) U	(2,729)	(2,480)	(249) U	5,422	5,000	422 F
<b>Governance and Funding Admin.</b>									
Funding	266	268	(2) U	799	805	(6) U	3,197	3,220	(23) U
Other Income	3	3	-	8	8	-	30	30	-
Less:									
Expenditure	269	271	2 F	806	812	6 F	3,227	3,250	23 F
Contribution	(0)	-	(0) U	(0)	-	(0) U	0	-	0 F
<b>Health Provision</b>									
Funding	24,375	23,880	495 F	71,707	70,717	989 F	275,147	272,241	2,905 F
Other Income	1,578	1,557	20 F	5,129	5,069	61 F	20,638	20,366	272 F
Less:									
Expenditure	24,383	23,936	(447) U	72,008	71,208	(801) U	296,207	292,608	(3,599) U
Contribution	1,570	1,501	68 F	4,827	4,578	249 F	(422)	(0)	(422) U
<b>Net Result</b>	<b>2,100</b>	<b>2,100</b>	<b>-</b>	<b>2,098</b>	<b>2,098</b>	<b>-</b>	<b>5,000</b>	<b>5,000</b>	<b>-</b>

## 11. Quality and Financial Improvement Programme

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Corporate	1,526,792	388,448	299,464	77%
Health Services	8,295,336	2,073,834	1,195,530	58%
Population Health	26,166	6,542	4,361	67%
Maori	148,195	37,049	24,699	67%
Health Funding	3,006,808	751,702	739,483	98%
<b>Grand Total</b>	<b>13,003,297</b>	<b>3,257,574</b>	<b>2,263,537</b>	<b>69%</b>

### Health Services

Year to date health services are achieving 58% of their savings target.

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Acute Medical	2,407,323	601,831	357,454	59%
COO	158,496	39,624	26,416	67%
FAC	793,458	198,365	48,329	24%
Lab	460,566	115,142	115,142	100%
Mental	444,579	111,145	111,145	100%
OPRS	600,850	150,212	66,175	44%
Pharm	77,638	19,410	19,410	100%
ROC	533,349	133,337	133,337	100%
Surgical	2,095,898	523,975	237,126	45%
WCY	723,180	180,795	80,996	45%
<b>Grand Total</b>	<b>8,295,336</b>	<b>2,073,834</b>	<b>1,195,530</b>	<b>58%</b>

Most of the YTD shortfall is due to timing of the savings plans. These plans are phased 1/12<sup>th</sup> mainly to avoid back-loading of savings plans into the second half of the year. Some of the savings plans will deliver higher levels of savings over the summer months as activity levels reduce.

### Corporate

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Business Intelligence	32,892	8,223	6,326	77%
CEO	159,640	39,910	39,910	100%
Contracts	14,527	3,632	-	0%
DAHST	2,142	536	536	100%
Depreciation	544,051	136,013	82,241	60%
DON	10,587	2,647	-	0%
Finance	157,152	46,038	34,768	76%
Governance	78,148	19,537	18,581	95%
Human Resources	123,967	30,992	27,230	88%
Information Services	344,360	86,090	75,041	87%
Quality	59,326	14,832	14,832	100%
<b>Grand Total</b>	<b>1,526,792</b>	<b>388,448</b>	<b>299,464</b>	<b>77%</b>

Depreciation is a timing issue with more savings coming on stream with delayed purchase dates for new equipment.

Information Services savings program is being refocused as part of the Information Services review.

## 12. Financial Position

30 June 2016	\$'000	September				Annual Budget
		Actual	Budget	Variance from budget	Movement from 30 June 2016	
	<b>Equity</b>					
102,608	Crown equity and reserves	102,608	105,733	3,125	-	105,376
(10,973)	Accumulated deficit	(9,078)	(14,170)	(5,092)	1,895	(11,268)
91,635		93,530	91,563	(1,967)	1,895	94,108
	<b>Represented by:</b>					
	<u>Current Assets</u>					
15,552	Bank	15,252	3,704	(11,548)	(300)	8,523
1,724	Bank deposits > 90 days	1,732	1,741	9	8	1,741
22,433	Prepayments and receivables	20,451	18,330	(2,121)	(1,982)	18,618
4,293	Inventory	4,251	3,982	(269)	(42)	4,044
1,220	Non current assets held for sale	1,220	1,220	-	-	-
45,222		42,906	28,977	(13,929)	(2,316)	32,927
	<u>Non Current Assets</u>					
151,944	Property, plant and equipment	150,505	159,844	9,339	(1,439)	166,159
2,037	Intangible assets	1,910	1,085	(825)	(127)	665
9,777	Investments	10,249	8,635	(1,614)	472	9,476
163,758		162,664	169,564	6,900	(1,094)	176,299
208,980	<b>Total Assets</b>	205,570	198,542	(7,029)	(3,410)	209,226
	<b>Liabilities</b>					
	<u>Current Liabilities</u>					
38,137	Payables	32,782	30,476	(2,306)	(5,356)	30,697
34,070	Employee entitlements	34,121	31,614	(2,507)	50	34,484
-	Current portion of borrowings	-	-	-	-	6,000
72,208		66,902	62,090	(4,812)	(5,305)	71,180
	<u>Non Current Liabilities</u>					
2,638	Employee entitlements	2,638	2,388	(249)	-	2,438
42,500	Term borrowing	42,500	42,500	-	-	41,500
45,138		45,138	44,888	(249)	-	43,938
117,345	<b>Total Liabilities</b>	112,040	106,979	(5,061)	(5,305)	115,118
91,635	<b>Net Assets</b>	93,530	91,563	(1,967)	1,895	94,108

The variance from budget for:

- Bank reflects lower capital spend and the higher payables and employee entitlement balances;
- Property, plant and equipment relates to slower than planned expenditure on capital projects;
- Employee entitlements – see below

## 13. Employee Entitlements

30 June 2016	\$'000	September				Annual Budget
		Actual	Budget	Variance from budget	Movement from 30 June 2016	
7,466	Salaries & wages accrued	8,607	5,513	(3,094)	1,141	6,559
482	ACC levy provisions	684	521	(163)	202	851
5,348	Continuing medical education	4,532	4,316	(217)	(816)	5,131
19,149	Accrued leave	18,722	19,606	884	(427)	20,249
4,263	Long service leave & retirement grat.	4,213	4,047	(166)	(50)	4,131
36,708	<b>Total Employee Entitlements</b>	36,758	34,002	(2,756)	50	36,922

## 14. Treasury

### Liquidity management

The surplus cash of all DHBs is managed by NZ Health Partnerships Limited (NZHPL) under a sweep arrangement facilitated by Westpac. The DHB provides forecast cash flow information to NZHPL, to allow them to invest the funds at the most advantageous rates, and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due.

### Debt management

The term debt facility with the Ministry of Health (MOH) is for \$42.5 million, and is fully drawn. A further \$5 million relating to the disposal of the Napier site is available for the mental health build, and is likely to be drawn down in the last quarter of calendar 2016. The DHB's interest exposure is managed through a spread of maturity dates, rather than the use of derivative financial instruments, and the average cost of borrowing is currently 4.58%. No debt will become current until the 2017/18 financial year, and \$25 million is for terms longer than five years.

The drawdown of \$6.5 million in June 2012 increased the amount maturing in March 2019 to \$11.5 million. This was done to take advantage of the low interest rate applying to that maturity, but it also puts the balance for that year above the \$10 million limit set in the Treasury Management Policy.

### Foreign exchange risk management

No material transactions occurred during the month. No transactions met the criteria that would trigger the requirement to arrange foreign exchange rate cover.

## 15. Capital Expenditure

See next page.

Annual Plan as at Jun-16		Year to Date		
		Actual \$'000	Budget \$'000	Variance \$'000
	<b>Source of Funds</b>			
	<b>Operating Sources</b>			
13,878	Depreciation	3,409	3,414	5
5,000	Surplus/(Deficit)	1,793	2,098	305
6,936	Working Capital	(3,182)	32	3,214
25,814		2,021	5,544	3,523
	<b>Other Sources</b>			
-	Special funds and clinical trials	28	-	(28)
1,200	Sale of assets	-	-	-
5,000	Borrowings	-	-	-
6,200		28	-	(28)
<b>32,014</b>	<b>Total funds sourced</b>	<b>2,049</b>	<b>5,544</b>	<b>3,495</b>
	<b>Application of Funds:</b>			
	<b>Block Allocations</b>			
4,466	Facilities	370	795	426
5,062	Information Services	29	781	752
8,128	Clinical Plant & Equipment	708	1,365	657
17,656		1,107	2,942	1,836
	<b>Local Strategic</b>			
2,460	MRI	-	615	615
1,300	Renal Centralised Development	34	125	91
3,000	New Stand-alone Endoscopy Unit	259	750	490
562	New Mental Health Inpatient Unit Development	136	177	42
253	Maternity Services	117	25	(92)
1,000	Upgrade old MHIU	165	100	(65)
400	Travel Plan	12	100	88
800	Histology Upgrade	-	100	100
1,100	Fluoroscopy Unit	-	275	275
500	Theatre Eight	-	-	-
200	Education Centre Upgrade	-	50	50
11,575		723	2,317	1,594
	<b>Other</b>			
-	Special funds and clinical trials	28	-	(28)
1,000	New Technologies/Investments	-	-	-
-	Other	13	-	(13)
1,000		41	-	(41)
<b>30,231</b>	<b>Capital Spend</b>	<b>1,870</b>	<b>5,259</b>	<b>3,388</b>
	<b>Regional Strategic</b>			
1,426	RHIP (formerly CRISP)	179	285	106
1,426		179	285	106
357	Equity Repayments	-	-	-
357		-	-	-
<b>32,014</b>	<b>Total funds applied</b>	<b>2,049</b>	<b>5,544</b>	<b>3,495</b>



## 16. Rolling Cash Flow

	September			Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Actual	Forecast	Variance	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Budget	Budget	Budget
<b>Cash flows from operating activities</b>															
Cash receipts from Crown agencies	44,952	41,776	3,176	52,018	45,123	42,029	43,288	45,233	42,011	43,230	38,306	53,213	43,210	41,712	45,478
Cash receipts from donations, bequests and clinical trials	57	-	57	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(3,208)	427	(3,635)	492	432	439	428	448	455	447	455	451	426	425	427
Cash paid to suppliers	(25,427)	(26,860)	1,433	(24,932)	(28,245)	(25,817)	(25,670)	(23,015)	(25,798)	(25,452)	(24,172)	(29,745)	(27,144)	(25,118)	(27,069)
Cash paid to employees	(14,773)	(15,016)	243	(15,100)	(17,754)	(14,438)	(16,693)	(14,472)	(19,536)	(15,263)	(17,897)	(15,594)	(13,909)	(19,483)	(15,098)
<b>Cash generated from operations</b>	<b>1,601</b>	<b>327</b>	<b>1,274</b>	<b>12,478</b>	<b>(444)</b>	<b>2,213</b>	<b>1,354</b>	<b>8,194</b>	<b>(2,868)</b>	<b>2,961</b>	<b>(3,309)</b>	<b>8,325</b>	<b>2,582</b>	<b>(2,463)</b>	<b>3,738</b>
Interest received	76	67	9	66	80	72	75	68	75	73	75	73	81	80	67
Interest paid	(225)	(990)	766	(41)	(69)	(160)	(359)	(325)	(139)	(60)	(14)	(150)	(330)	(330)	(95)
Capital charge paid	-	-	-	-	-	(3,636)	-	-	-	-	-	(3,576)	-	-	-
<b>Net cash inflow/(outflow) from operating activities</b>	<b>1,452</b>	<b>(597)</b>	<b>2,048</b>	<b>12,503</b>	<b>(433)</b>	<b>(1,511)</b>	<b>1,069</b>	<b>7,937</b>	<b>(2,931)</b>	<b>2,974</b>	<b>(3,248)</b>	<b>4,672</b>	<b>2,332</b>	<b>(2,713)</b>	<b>3,709</b>
<b>Cash flows from investing activities</b>															
Proceeds from sale of property, plant and equipment	-	0	(0)	0	0	625	0	0	0	0	0	0	0	0	0
Acquisition of property, plant and equipment	(810)	(704)	(106)	(1,568)	(1,666)	(1,638)	(1,582)	(1,634)	(2,107)	(1,956)	(1,820)	(2,143)	(2,511)	(2,511)	(2,511)
Acquisition of intangible assets	(8)	(48)	40	(20)	(268)	(200)	(315)	(345)	(340)	(265)	(115)	(70)	(85)	(85)	(85)
Acquisition of investments	(179)	(285)	106	-	(652)	(301)	(8)	-	(1,075)	-	-	(284)	-	-	(285)
<b>Net cash inflow/(outflow) from investing activities</b>	<b>(997)</b>	<b>(1,037)</b>	<b>40</b>	<b>(1,588)</b>	<b>(2,586)</b>	<b>(1,514)</b>	<b>(1,905)</b>	<b>(1,979)</b>	<b>(3,522)</b>	<b>(2,221)</b>	<b>(1,935)</b>	<b>(2,497)</b>	<b>(2,595)</b>	<b>(2,595)</b>	<b>(2,880)</b>
<b>Cash flows from financing activities</b>															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	-	(357)	-	-	-
<b>Net cash inflow/(outflow) from financing activities</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(357)</b>	<b>-</b>	<b>-</b>	<b>-</b>
Net increase/(decrease) in cash or cash equivalents	455	(1,634)	2,089	10,915	(3,019)	(3,025)	(836)	5,958	(6,454)	753	(5,183)	1,817	(263)	(5,309)	829
Add: Opening cash	16,529	16,529	-	16,984	27,899	24,880	21,854	21,018	26,977	20,523	21,276	16,093	17,910	17,647	12,338
<b>Cash and cash equivalents at end of year</b>	<b>16,984</b>	<b>14,895</b>	<b>2,089</b>	<b>27,899</b>	<b>24,880</b>	<b>21,854</b>	<b>21,018</b>	<b>26,977</b>	<b>20,523</b>	<b>21,276</b>	<b>16,093</b>	<b>17,910</b>	<b>17,647</b>	<b>12,338</b>	<b>13,167</b>
<b>Cash and cash equivalents</b>															
Cash	4	7	(3)	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	13,974	11,793	2,181	24,797	21,777	18,752	17,916	24,020	17,421	18,173	12,990	14,808	14,545	9,236	10,065
Short term investments (special funds/clinical trials)	2,993	3,095	(103)	3,095	3,095	3,095	3,095	2,949	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	14	-	14	-	-	-	-	-	-	-	-	-	-	-	-
	<b>16,984</b>	<b>12,004</b>	<b>2,090</b>	<b>27,899</b>	<b>24,879</b>	<b>21,854</b>	<b>21,018</b>	<b>26,976</b>	<b>20,523</b>	<b>21,275</b>	<b>16,092</b>	<b>17,910</b>	<b>17,647</b>	<b>12,338</b>	<b>13,167</b>





## HEALTH & SAFETY BOARD CHAMPION UPDATE

Verbal






## CONSUMER STORY

Verbal Presentation

11



	<b>Hawke's Bay Clinical Council</b>	<b>117</b>
	For the attention of: <b>HBDHB Board</b>	
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs	
Reviewed by:	Not applicable	
Month:	October, 2016	
Consideration:	For Information	

#### RECOMMENDATION That the Board

Note the contents of this report; and note that **Clinical Council**:

- **Supported** holding a Palliative Care, Advanced Care and End of Life Workshop with Consumer Council on 9 November.
- **Endorsed** the establishment of a New Quality Dashboard, however further work was required.
- **Supported** a review of the Clinical Council Annual Plan 2016/17, noting the plan needs to be reviewed in conjunction with the Clinical Governance Committee Structure and Clinical Services plan etc, when finalised.
- **Note** the following papers were received and/or discussed:
  - Infection Prevention & Control Committee
  - HB Nursing Midwifery Leadership Update
  - Urgent Care Project Update
  - HB Radiology Services Committee
  - Laboratory Services Committee
  - Update on the pending RMO strike.

Council met on 12 October 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

Note there are no items included on the Board agenda that were considered by Clinical Council at this meeting.

#### The following were discussed by Council and summarised as follows:

- **Workshop planned around the Palliative Care Plan, Advanced Care and End of Life**  
Clinical Council will be joined by Consumer members for a two hour workshop on 9 November. Wide consultation is factored in to the palliative care planning process and this workshop will give both Councils an early opportunity to discuss these issues.
- **Quality Dashboard**  
Council endorsed the draft concept and principle of establishing a Quality Dashboard, however more work is required. A revised Quality Dashboard Concept Report will be provided to FRAC in December. The headings provided on the example dashboard were based on the NZ

healthcare triple aim with content focusing on a balance between primary and secondary care measures.

- ***HB Clinical Council Annual Plan 2016-17***

A draft had been prepared by the Company Secretary for review. Following some discussion there was agreement the structure of the Plan may need to be refreshed, with such a review aligned to work still progressing in the following areas:

- Clinical Governance Committee's Structure;
- Quality Dashboard; and
- Clinical Services Plan.

At Council's AGM in August there was some discussion around prioritising of the Council agenda, moving away from overview of many agenda items to a focus on those where Clinical Council input can make a difference, and having some proactive presentations around innovation.

- ***National RMO Strike Action***

7 am on 18 October to 7 am, 20 October. Council received an update on the contingency planning that was underway to ensure patient safety was maintained with all DHBs working collaboratively together.

## **Reporting Committees / Monitoring**

- ***Infection Prevention & Control Committee***

This Committee now reports to Council, providing 6 monthly updates. No areas of concern were identified.

- ***HB Nuring Midwifery Leadership Update***

Legislation for RN Prescribing came into effect on 20 September. Implementation of this is being worked through with medical colleagues to support the process.

- ***Urgent Care Project Update***

Work in progress, with a new model being planned to be in place by April 2017.


- ***HB Radiology Services Committee***

Plannning for the external review of the Radiology Service was underway with reviewers on-site later this month. The IANZ Accreditation visit had been postponed until March/April 2017.

- ***Laboratory Services Committee***

An issue was raised and a recommended process endorsed by Council around use of EasyCheck PregnancyTest kits for HB.



	<b>HB Health Consumer Council</b> <span style="float: right; font-size: 2em;">118</span>
	For the attention of: <b>HBDHB Board</b>
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	October, 2016
Consideration:	For Information

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## RECOMMENDATION

### That the Board

Review the contents of this report; and

### Note that Consumer Council:

- Approved its Annual Plan for 2016/17
- Discussed an early draft of the revised plan for Palliative Care in Hawke's Bay 2016-2026
- Held a working session with Dr Russell Wills on the workforce development project called "Working Together for Tamariki in Hawkes Bay"

Council met on 13 October 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

### The following papers were considered and discussed:

#### • **Consumer Council Annual Plan 2016/17**

The Council finalised and approved its annual plan for 2016/17 (see attached). Key objectives for the next period are

- Actively promote and participate in' co-design processes for:
      - Youth
      - Mental Health
      - Older Persons
    - Participate in the development of Health and Social Care Networks
    - Provide consumer perspective into Customer focussed Booking

To achieve these objectives and other parts of the plan members have agreed to be assigned into portfolios to enable them to focus their energies on the work ahead. Areas where there is alignment and collaboration with Clinical Council have been set out in the plan.

#### • **Palliative Care in Hawke's Bay 2016-2026**

Council held a session with senior executives of Cranford and strategic services on an early draft of the revised strategic plan for palliative care across the next 10 years. Council had reviewed an earlier draft some 18 months ago. Apart from checking whether consumer feedback of the time had been incorporated in this revised draft the overall strategy was discussed along with some suggestions for the workstreams which will inevitably follow its adoption.

Overall feedback was strongly positive eg,

- } Well written, clear and you can hear the consumer voice throughout the document
- } The original document was from a clinical perspective this one is from the patient / whanau perspective.

The role and challenges of enabling more Advanced Care Planning was also discussed. This strategic plan will go back for refining and evaluation prior to a further round of consultation.

- ***Working for Tamariki in Hawke's Bay***

Through the professional bodies there is a draft framework that describes the competencies that practitioners need to be able to work with families where there is violence, mental health and addictions. MSD are looking for a place to trial the competency framework. Through MSD, a charitable, the Lloyd Morrison Foundation and the DHB we have \$250,000 to trial the competency framework on practitioners who work with children, young people and their families in Hawke's Bay.

Following on from a session at MRB the previous day, Dr Wills led a session with Consumer Council to seek their input into "what matters" and what their views were. A wide ranging conversation followed with detailed feedback for Dr Wills. Members of Consumer Council will have an opportunity for further input at a hui being organised (with MRB and other community leaders) in November.


- ***Consumer Councils in New Zealand – National Collective***

Following a successful first meeting in late September there is a desire on the part of the 13 regions so far either with or working towards some form of consumer council to work collaboratively, share experience etc. A draft 3 year plan is being worked on. Hawke's Bay is well placed to support this initiative from our experience to date and we all have an opportunity to learn from each other.

**HAWKE'S BAY HEALTH CONSUMER COUNCIL  
ANNUAL PLAN 2016/17**

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
<b>FUNCTIONS</b>	<ul style="list-style-type: none"> <li>Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whānau Centred Care' into the Hawkes Bay health system, including input into: <ul style="list-style-type: none"> <li>Development of health service priorities</li> <li>Strategic direction</li> <li>The reduction of inequities</li> </ul> </li> <li>Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery.</li> <li>Seek to ensure that services are organised around the needs of all consumers</li> </ul>	<ul style="list-style-type: none"> <li>Identify and advise on issues that will improve clinical quality, patient safety and health literacy.</li> <li>Seek to enhance consumer experience and service integration across the sector.</li> <li>Promote equity of access/treatment</li> <li>Seek to ensure that services are responsive to individual and collective consumer needs.</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate and support the development of an appropriate Consumer Engagement Strategy for the Hawkes Bay health system</li> <li>Ensure, coordinate and enable appropriate consumer engagement within the health system <ul style="list-style-type: none"> <li>across Hawke's Bay</li> <li>within the Central region</li> <li>at National level</li> </ul> </li> <li>Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities.</li> <li>Ensure regular communication and networking with the community and relevant consumer groups.</li> <li>Link with special interest groups as required for specific issues and problems solving.</li> </ul>
<b>STRATEGIES</b>	<ul style="list-style-type: none"> <li>Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system.</li> <li>Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations.</li> <li>Review and comment on all relevant reports, papers, initiatives to the Board.</li> <li>Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these</li> <li>Consumer Council members to be allocated portfolio/areas of responsibility.</li> </ul>	<ul style="list-style-type: none"> <li>Work with Clinical Council to develop and maintain an environment that promotes and improves: <ul style="list-style-type: none"> <li>Putting patients / consumers at the centre</li> <li>Patient safety</li> <li>Consumer experience</li> <li>Clinical quality</li> <li>Health literacy</li> <li>Equity</li> </ul> </li> <li>Promote initiatives that empower communities and consumers to take more responsibility for their own health and wellness.</li> <li>Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'.</li> <li>Advocate / promote for Intersectoral action on key determinants of health.</li> </ul>	<ul style="list-style-type: none"> <li>Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making.</li> <li>Ensure good attendance and robust discussions at monthly Consumer Council meetings</li> <li>Co-ordinate consumer representation on appropriate committees and project teams: <ul style="list-style-type: none"> <li>Within Hawke's Bay</li> <li>At Central Region and National levels</li> </ul> </li> <li>Engage with HQSC programmes around consumer engagement and 'partners in care'.</li> <li>Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations.</li> <li>Provide regular updates on both the HBDHB and Health Hawke's Bay websites</li> <li>Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities</li> </ul>
<b>OBJECTIVES 2016/17</b>	<ul style="list-style-type: none"> <li>Actively promote and participate in' co-design processes for: <ul style="list-style-type: none"> <li>Youth</li> <li>Mental Health</li> <li>Older Persons</li> </ul> </li> <li>Participate in the development of Health and Social Care Networks</li> <li>Provide consumer perspective into Customer focussed Booking</li> </ul>	<ul style="list-style-type: none"> <li>Promote and assist initiatives that will improve the level of health literacy within the sector and community.</li> <li>Facilitate and promote the development of a 'person and whānau centred care' approach and culture to the delivery of health services, in partnership with the Clinical Council.</li> <li>Promote the provision of consumer feedback and 'consumer stories'.</li> <li>Monitor all 'Patient Experience' performance measures/indicators as co-sponsor of the 'patient experience Committee' within the clinical governance structure.</li> <li>Facilitate a focus on disability issues</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate and support the development and implementation of a consumer engagement strategy and principles in Hawkes Bay</li> <li>Establish a connection with Youth within the community</li> <li>Influence the establishment and then participate in regional and national Consumer Advisory Networks.</li> </ul>

Portfolios and areas of interest	HB Health Consumer Council Members:																																																																						
<p><b>AREAS OF INTEREST</b></p> <table border="0"> <tr><td>- Women's health</td><td>Sami, Olive and Leona</td></tr> <tr><td>- Child health</td><td>Sami, Malcolm and Rachel</td></tr> <tr><td>- Youth health</td><td>Malcolm, Rosemary and Jim</td></tr> <tr><td>- Older Persons health</td><td>Jenny, Heather</td></tr> <tr><td>- Chronic conditions</td><td>Rosemary, Terry, James and Rachel</td></tr> <tr><td>- Mental Health</td><td>Nicki and Terry</td></tr> <tr><td>- Alcohol and other drugs</td><td>Nicki and Rosemary</td></tr> <tr><td>- Sensory and physical disability</td><td>Sarah, Heather and Tessa</td></tr> <tr><td>- Intellectual and neurological disability</td><td>Heather and Olive</td></tr> <tr><td>- Rural health</td><td>Leona (Wairoa) and Terry (CHB), Heather, Jim,</td></tr> <tr><td>- Māori health</td><td>Tessa, Leona, Jim, James and Sami</td></tr> <tr><td>- Pacific health</td><td>Olive, Sami and Tessa</td></tr> <tr><td>- Primary health</td><td>Jenny, Rachel and Rosemary</td></tr> <tr><td>- High deprivation populations</td><td>Nicki, Jenny and Leona</td></tr> </table> <p><b>2016-17 PORTFOLIOS</b></p> <ul style="list-style-type: none"> <li>- Co-Design Youth - Malcolm, Rosemary &amp; Jim plus youth reps</li> <li>- Co-Design Mental Health - Nicki, Terry &amp; PAG</li> <li>- Co-Design Older Persons - Jenny, Heather, Rosemary</li> <li>- Health and Social Care Networks - Tessa, Rachel, Jenny, Leona, Terry</li> <li>- Customer Focussed Booking – Tessa, Sarah</li> <li>- Health Literacy – James, Leona, Olive</li> <li>- Person and Whānau Centred Care – Rosemary, Leona</li> <li>- Patient Experience Committee (of Clinical Council) – Sami, Terry</li> <li>- Disability – Sarah, Heather, Terry</li> <li>- Consumer Engagement Strategy - ALL</li> </ul> <p><b>Support:</b></p> <p><b>Operational and Minutes</b></p> <table border="0"> <tr><td>Kate Coley</td><td>(Director Quality Improvement and Patient Safety)</td></tr> <tr><td>Tracy Fricker</td><td>(Council Secretary and PA to DQIPS)</td></tr> <tr><td>Jeanette Rendle</td><td>(Consumer Engagement Manager)</td></tr> </table> <p><b>Clinical Council Liaison</b></p> <p>Debs Higgins</p> <p><b>Governance</b></p> <table border="0"> <tr><td>Ken Foote</td><td>(Company Secretary)</td></tr> <tr><td>Brenda Crene</td><td>(Board Administrator and PA to Co-Sec)</td></tr> </table> <p><b>Communications</b></p> <table border="0"> <tr><td>Anna Kirk</td><td>(Communications Manager)</td></tr> </table>	- Women's health	Sami, Olive and Leona	- Child health	Sami, Malcolm and Rachel	- Youth health	Malcolm, Rosemary and Jim	- Older Persons health	Jenny, Heather	- Chronic conditions	Rosemary, Terry, James and Rachel	- Mental Health	Nicki and Terry	- Alcohol and other drugs	Nicki and Rosemary	- Sensory and physical disability	Sarah, Heather and Tessa	- Intellectual and neurological disability	Heather and Olive	- Rural health	Leona (Wairoa) and Terry (CHB), Heather, Jim,	- Māori health	Tessa, Leona, Jim, James and Sami	- Pacific 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href="mailto:peters.jenny26@gmail.com">peters.jenny26@gmail.com</a></td></tr> <tr> <td><b>Olive Tanielu</b> HASTINGS</td><td><a href="mailto:olivetanielu@rocketmail.com">olivetanielu@rocketmail.com</a></td></tr> <tr> <td><b>Heather Robertson</b> NAPIER</td><td><a href="mailto:Heather.hb@xtra.co.nz">Heather.hb@xtra.co.nz</a></td></tr> <tr> <td><b>Leona Karauria</b> NUHAKA</td><td><a href="mailto:Info@s-a-s.co.nz">Info@s-a-s.co.nz</a></td></tr> <tr> <td><b>Rosemary Marriott</b> HASTINGS</td><td><a href="mailto:roseandterry@xtra.co.nz">roseandterry@xtra.co.nz</a></td></tr> <tr> <td><b>Terry Kingston</b> WAIPAWA</td><td><a href="mailto:terrykingston@xtra.co.nz">terrykingston@xtra.co.nz</a></td></tr> <tr> <td><b>Tessa Robin</b> NAPIER</td><td><a href="mailto:tessa.robin@tkh.org.nz">tessa.robin@tkh.org.nz</a></td></tr> <tr> <td><b>Malcolm Dixon</b> HAVELOCK NORTH</td><td><a href="mailto:dixonmj24@icloud.com">dixonmj24@icloud.com</a></td></tr> <tr> <td><b>Rachel Ritchie</b> HAVELOCK NORTH</td><td><a href="mailto:andyrach@xtra.co.nz">andyrach@xtra.co.nz</a></td></tr> <tr> <td><b>Sarah Hansen</b> HASTINGS</td><td><a href="mailto:hansennorsemen@xtra.co.nz">hansennorsemen@xtra.co.nz</a></td></tr> <tr> <td><b>Samitioata (Sami) McIntosh</b> HASTINGS</td><td><a href="mailto:smkoko@live.com">smkoko@live.com</a></td></tr> </table>	<b>Graeme Norton (Chair)</b> HASTINGS	<a href="mailto:graeme.norton@clear.net.nz">graeme.norton@clear.net.nz</a>	<b>Nicki Lishman</b> (MSD Rep) WESTSHORE	<a href="mailto:nicki.lishman004@msd.govt.nz">nicki.lishman004@msd.govt.nz</a>	<b>Jim Henry</b> NAPIER	<a href="mailto:jimbhenry@hotmail.co.nz">jimbhenry@hotmail.co.nz</a>	<b>Jim Morunga</b> NAPIER	<a href="mailto:jim.morunga@tkh.org.nz">jim.morunga@tkh.org.nz</a>	<b>Jenny Peters</b> NAPIER	<a href="mailto:peters.jenny26@gmail.com">peters.jenny26@gmail.com</a>	<b>Olive Tanielu</b> HASTINGS	<a href="mailto:olivetanielu@rocketmail.com">olivetanielu@rocketmail.com</a>	<b>Heather Robertson</b> NAPIER	<a href="mailto:Heather.hb@xtra.co.nz">Heather.hb@xtra.co.nz</a>	<b>Leona Karauria</b> NUHAKA	<a href="mailto:Info@s-a-s.co.nz">Info@s-a-s.co.nz</a>	<b>Rosemary Marriott</b> HASTINGS	<a href="mailto:roseandterry@xtra.co.nz">roseandterry@xtra.co.nz</a>	<b>Terry Kingston</b> WAIPAWA	<a href="mailto:terrykingston@xtra.co.nz">terrykingston@xtra.co.nz</a>	<b>Tessa Robin</b> NAPIER	<a href="mailto:tessa.robin@tkh.org.nz">tessa.robin@tkh.org.nz</a>	<b>Malcolm Dixon</b> HAVELOCK NORTH	<a href="mailto:dixonmj24@icloud.com">dixonmj24@icloud.com</a>	<b>Rachel Ritchie</b> HAVELOCK NORTH	<a href="mailto:andyrach@xtra.co.nz">andyrach@xtra.co.nz</a>	<b>Sarah Hansen</b> HASTINGS	<a href="mailto:hansennorsemen@xtra.co.nz">hansennorsemen@xtra.co.nz</a>	<b>Samitioata (Sami) McIntosh</b> HASTINGS	<a href="mailto:smkoko@live.com">smkoko@live.com</a>
- Women's health	Sami, Olive and Leona																																																																						
- Child health	Sami, Malcolm and Rachel																																																																						
- Youth health	Malcolm, Rosemary and Jim																																																																						
- Older Persons health	Jenny, Heather																																																																						
- Chronic conditions	Rosemary, Terry, James and Rachel																																																																						
- Mental Health	Nicki and Terry																																																																						
- Alcohol and other drugs	Nicki and Rosemary																																																																						
- Sensory and physical disability	Sarah, Heather and Tessa																																																																						
- Intellectual and neurological disability	Heather and Olive																																																																						
- Rural health	Leona (Wairoa) and Terry (CHB), Heather, Jim,																																																																						
- Māori health	Tessa, Leona, Jim, James and Sami																																																																						
- Pacific health	Olive, Sami and Tessa																																																																						
- Primary health	Jenny, Rachel and Rosemary																																																																						
- High deprivation populations	Nicki, Jenny and Leona																																																																						
Kate Coley	(Director Quality Improvement and Patient Safety)																																																																						
Tracy Fricker	(Council Secretary and PA to DQIPS)																																																																						
Jeanette Rendle	(Consumer Engagement Manager)																																																																						
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Anna Kirk	(Communications Manager)																																																																						
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 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Māori Relationship Board (MRB)</b>	<b>119</b>
	For the attention of: <b>HBDHB Board</b>	
Document Owner:	Heather Skipworth (Chair)	
Reviewed by:	Not applicable	
Month:	October, 2016	
Consideration:	For Information	

## RECOMMENDATION

### That the Board

Review the contents of this report; and

**Note that MRB**, pending MRBs feedback and advice:

- **Supported** the Co-Designing Relationship Centred Practice (RCP) Framework
- **Supported** the Complementary Therapies Policy

MRB met on 12 October 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

### The following papers were considered:

- ***Co-Designing Relationship Centred Practice Presentation***

Dr Andy Phillips (Chief Allied Health Professions Officer HBDHB) and Anne McLeod (Allied Health Educator HBDHB) presented the Co-Designing Relationship Centred Practice (RCP) framework for discussion and to get MRB's feedback.

MRB provided the following feedback for consideration:

- Consider what experiences whānau have had with the health services in the past
- Involve the whānau and community in the design of the framework
- There is concern the DHB will start to tell Māori how the Mihimihi process works whereas Māori should be instructing the DHB. Consider using a whānau member to manage the cultural aspect so the clinician can focus on the clinical aspect
- Examine the current system and identify the areas that are seen as discriminative
- Identify the activities that happen before the patient is admitted and after discharge
- Identify other projects that connect or overlap and work in partnership
- Consider while the framework has seven steps, in Māoridom there may be 700 steps and the beginning may not necessarily start at step one
- This approach could not only be implemented across long term conditions and disability sectors, but eventually across the entire health sector.

- ***Complementary Therapies Policy***

Dr Andy Phillips (Chief Allied Health Professions Officer HBDHB) also presented the Complementary Therapies Policy for discussion and to obtain MRB's feedback.

MRB provided the following feedback for consideration:

- The registration process is great but would like consideration for registration to be reviewed on an annual basis
- A lot of maintenance work will be required and this extra work could potentially fall onto the manager of that facility. This is where there is a risk around some people getting through before others.
- Ensure the process remains flexible and informed
- Look at patient feedback on complementary therapies
- There are some very strong Māori organisations who would disagree with Rongoa defined as Complementary and Alternative Medicines. Fitting Rongoa inside the policy would have wider ramifications so thinking needs to be more laterally around Māori concepts of Rongoa in a Tikanga sense. In addition, Rongoa has its own standard of practice and is dealt with separately.
- The term 'Practitioner' has a specific meaning in the medical world. Consider removing practitioner and using just 'Therapist'.

**Other discussions included:**

- ***Mahi Tahi: Working Together For Tamariki In Hawke's Bay***

Dr Russell Wills (Community Paediatrician HBDHB) presented the Oranga Tamariki – Investing in Hawke's Bay Children, Mahi Tahi mo ngā Tamariki – One Workforce for Children Terms of Reference (TOR) to obtain MRB's feedback. Particularly about which agencies should be involved from the onset and outset, get assistance to write the TOR and get MRB's guidance on how to progress this further.

While the paper needs a lot of work, MRB acknowledged Dr Wills for his efforts to date and the work achieved whilst the Child Commissioner. Moreover, his desire and passion to help our Tamariki and the courage to start the ball rolling.

MRB provided the following feedback for consideration:

- In relation to the sentence 'Tamariki of parents with mental illness, addictions and in violent relationships ("vulnerable children")', violence is the issue not the relationship. There is a tone of victim blaming and stigmatisation of Māori instead of aspiring them. The Māori Women's Welfare League (MWWL) have a crisis intervention team and Dr Wills offered to meet with the group
- 'Vulnerable children' should be defined first before we can decide on how to address the issues and determine what the outcomes will look like
- Whānau and community involvement throughout the entire project was echoed by the MRB members. The issues are in the communities and this is also where you will find the solutions. It is for these reasons that communities need to be involved in the development and implementation stages but also to provide advice to the clinicians. Gangs and solo parents should also be included in the development. To be able to respond appropriately to these issues, Dr Wills was encouraged to engage with these communities..
- The proposal is too clinically focused and driven. Māori need to be involved in the scoping and development. Also, having Māori lead as opposed to clinicians telling Māori what works for them as well as to advocate for our most vulnerable children and whānau. Consumer Council, Māori and community representation should be included on the governance group, management team structure and stakeholder map

- Strategically placing Māori in key lead roles will be imperative to the implementation and effectiveness of this project. To understand the complexities and make-up of our vulnerable children and whānau, you have to be understanding of an indigenous world view
- Perform a Peer Review of the TOR and a HEAT to identify gaps, triggers and evaluate the effectiveness of the project
- Examine the current problematic system and identify the areas that are discriminative instead of looking at Māori being the issue in the system
- Clearly demonstrate the connectivity between training that staff will receive and what the outcome of this training will be for the target group. Also, with the training at least three years away, identify the activities over this period
- Recognise and include what Māori are currently doing in the sector that are contributing in some way to vulnerable whānau - i.e. marae, Te Kōhanga Reo, MWWL and Kura Kaupapa
- Consider the Pae Ora methodology and the relativity of this approach
- Ensure this work is connected to Social Inclusion and other projects

A workshop will be held to discuss the project further. MRB will use their networks in the community to shoulder tap whānau that can contribute to the project development.

The Co-Designing Relationship Centred Practice framework contained a lot of great information that overlapped with the above paper and could be incorporated. With this in mind, I suggested Dr Phillips also attend the meeting with Dr Wills (Community Paediatrician) and Patrick LeGeyt (Programme Manager Māori Health).

#### • **Te Matatini 2017**


Te Matatini 2017 will be the largest event in Hawke's Bay to date and sounds out of this world. The event will be live streamed by Māori Television and is estimated to attract 35,000 visitors to the Kahungunu region including 48 Kapa Haka teams consisting of 2000 performers from New Zealand and Australia. More teams than ever before. The event is smokefree, drug and alcohol free, sugar free, free of deep fried food, and zero waste.

The Iwi has been working closely with the 'Hauora Team'; Shari Tidswell (Team Leader/ Population Health Advisor), Maree Rohleder (Team Leader/ Health Protection Officer) and Tracee Te Huia (GM Māori Health). The Team will provide health messages and a one-on-one interactive stall to engage with the audience to promote health. In addition, the Team are working with different marae to develop health and safety plans, including the development and implementation of contingency plans. The innovative approach by the 'Hauora Team' was acknowledged.

The Iwi are also working with the Hawke's Bay Regional and District councils and also local fresh produce suppliers John Bostock and Hawke's Bay Fisheries to supply organic food and seafood to local marae. MRB were heartened by the collaboration across the sector.





 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Annual Report 2016</b>	<b>120</b>
	For the attention of: <b>Finance Risk &amp; Audit Committee, and HBDHB Board</b>	
Document Owner:	Tim Evans, General Manager - Planning, Informatics and Finance	
Document Author(s):	Phil Lomax, Financial Accountant Chris Lord, Publications Advisor	
Reviewed by:	Executive Management Team	
Month:	October, 2016	
Consideration:	Decision	

#### RECOMMENDATION

**That the Finance Risk and Audit Committee recommend the HBDHB Board:**

1. **Approve** and sign the Annual Report 2016; or
2. **Approve** the Chair and one other Board member to sign on behalf.

#### BACKGROUND

The statutory deadline for sign-off of the annual report is the end of October. To meet this deadline the report was presented to EMT on Tuesday 18 October, for Board consideration on 26 October (through the FRAC Committee).

Audit New Zealand and internal audit are doing additional audit work to gain assurance that the performance information the DHB receives from the PHO is accurate. If the work is successful, the qualification of the service performance information in the annual report will only relate to the comparative data for 2014/15. This additional work should be complete by the board meeting date, and is not expected to have any effect on the annual report other than the auditors opinion.

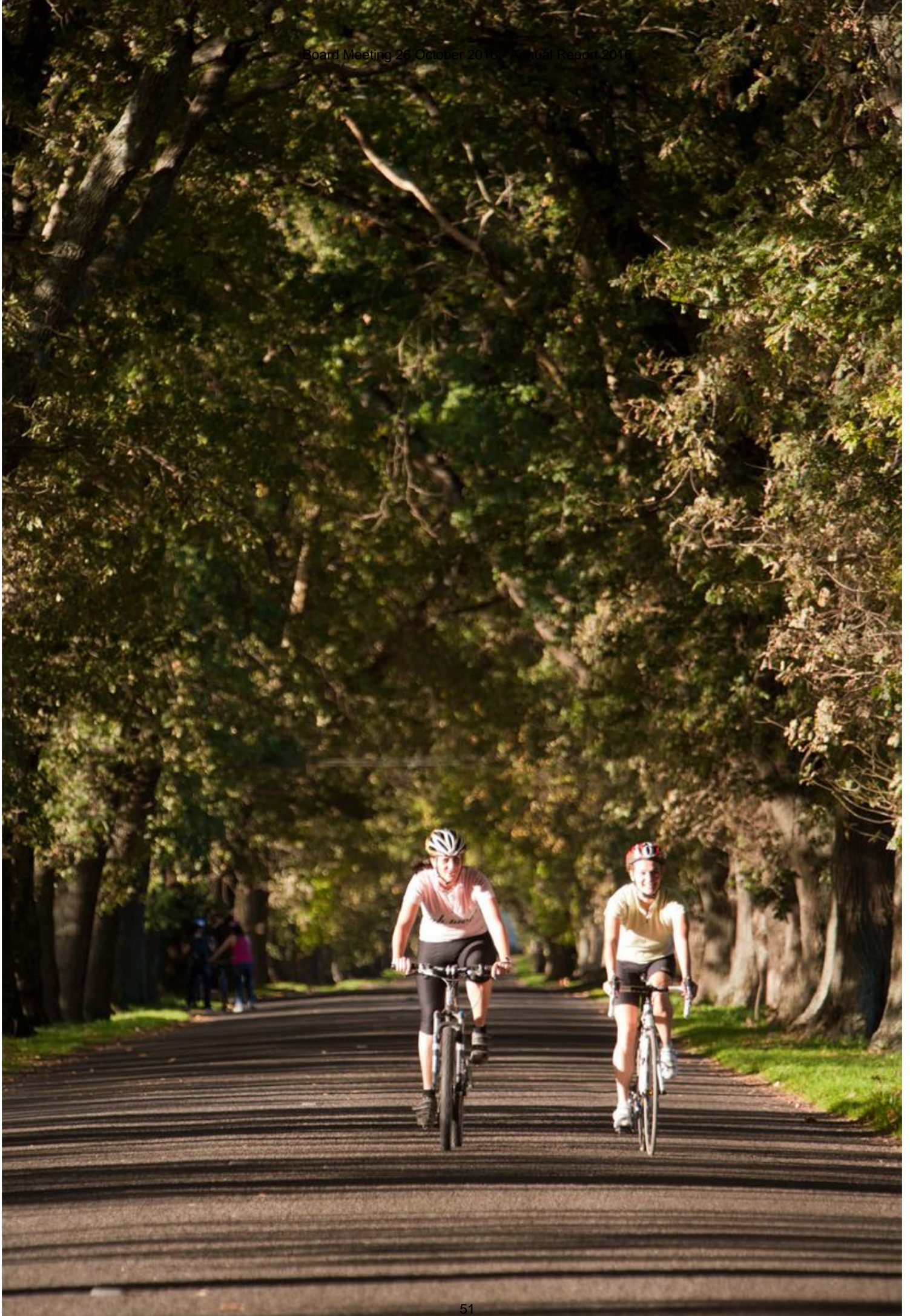
The message from the Chair and CEO is not included in the attachment, but is expected to be included for the board meeting. The letter of representation from the board to the auditors is also expected to be available for the board meeting.

If the auditors are prepared to provide their opinion on 26 October, the Board can sign the report and the letter of representation at the board meeting. Otherwise the board will be asked to approve the Chair and one other board member to sign on their behalf, at the time the audit opinion is available.

#### ATTACHMENTS

2015/16 Annual Report









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## ACRONYMS USED IN THIS REPORT

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

## Message from the Chair and Chief Executive

TO BE FINALISED – Anna Kirk



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**Kevin Snee**  
Chief Executive



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**Kevin Atkinson**  
Chair

## Organisation profile

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

### PUBLIC HOSPITAL AND HEALTH FACILITIES

**Hawke's Bay Fallen Soldiers' Memorial Hospital**  
**Omaha 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



## Hawke's Bay DHB vision, values and structure

### *Te hauora o te Matau-ā-Māui: Healthy Hawke's Bay*

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



**1 HE KAUANUANU RESPECT**  
Showing **respect** for each other, our staff, patients and consumers. This means I actively seek to understand what matters to you.

**1 RĀRANGA TE TIRA PARTNERSHIP**  
Working together in **partnership** across the community. This means I will work with you and your whānau on what matters to you.

**1 ĀKINA IMPROVEMENT**  
Continuous **improvement** in everything we do. This means that I actively seek to improve my service.

**1 TAUWHIRO CARE**  
Delivering high quality **care** to patients and consumers. This means I show empathy and treat you with care, compassion and dignity.



## 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

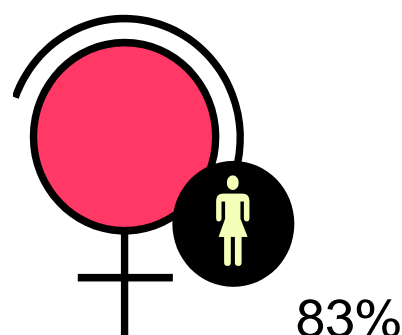
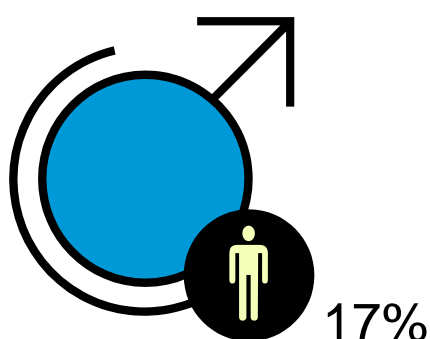
*Chief Executive Dr Kevin Snee*

**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 **2710** people, a number of whom are multi-jobbed; with **2982** positions held throughout the organisation. Of these **2982** positions:



### WORKFORCE PROFILE – by age bands

<25	4.7%
25 - 35	16.2%
35 - 45	19.5%
45 - 55	29.5%
55 - 64	23.3%
65+	6.8%

### WORKFORCE PROFILE – by occupational group

Medical staff	9.4%
Nursing staff	50.4%
Allied Health staff	18.6%
Non-clinical support staff	6.3%
Management & admin staff	15.3%

### WORKFORCE PROFILE – by ethnicity

NZ European	64.2%
NZ Māori	12.5%
Pacific Island	1.2%
British & Irish	7.1%
Other ethnicities	21.6%
Not known	2.4%

### EMPLOYEE STATUS

Casual	13%	
Full time	36%	
Part time	51%	

## 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:

- 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

### **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 newsletter to all staff, annual Hawke's Bay health sector awards and the annual people publication. Our Transformational Leadership and Basics Management programmes have continued to develop our Managers and Clinical Leaders across the health sector and have been very well received.

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 co-design in service planning, project development and strategy to ensure the consumer voice is heard.

Our new service directorate partnerships support medical, nursing and allied health leaders to lead and drive clinical quality and improve patient safety.

The DHB runs an annual Talent Management programme to identify high performing and high potential individuals 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 continuing to make changes to our policies and procedures to reflect the new Health and Safety legislation.

HBDHB promotes and provides opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via Health and Safety Representatives 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.

A Healthy Workplace group has been established to bring together a range of healthy workplace activities (including Healthy Eating Policy, Active Transport, Healthy @ Work activities, Smokefree and Occupational Health). This group is leading activity which support staff by promoting health, including healthy eating, physical activity, healthy sleep and Smokefree.

**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 25.9 percent.

As at the end of the 2015/16 year the target of 14.30 percent of staff identifying as Māori was not reached although there had been a slight improvement on the previous year:

30 June 2016 = 12.47 percent Māori

30 June 2015 = 12.27 percent Māori

	Positions filled	% of Total
NZ & European	2248	75.39%
Māori	372	12.47%
Pacific Islands	35	1.18%
Other	255	8.55%
Not known	72	2.41%
<b>Total</b>	<b>2982</b>	

June 2016 breakdown

- Support staff (29.26%) and Management & Admin staff (15.97%) exceed the DHB target.
- Medical (3.21%), Nursing (10.77%) and Allied Health staff (13.20%) are below the target. Nursing has been the primary focus for recruitment and has increased from 9.3% to 10.8% in the last two years.

# 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 Hawke's Bay District Health Board (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 Chief Executive Officer (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.

## Advisory Committees

A DHB is required to establish three statutory advisory committees: Community and Public Health Advisory Committee; Disability Support Advisory Committee; Hospital Advisory Committee but may establish other committees for a particular purpose. The Board may assign defined levels of authority to them. Advisory committees operate under terms of reference and may advise the Board on issues which have been referred to them. Committees may meet collectively as required to discuss the Annual Plan and other Strategic issues.

Whilst HBDHB has established the three Statutory Advisory Committees, they no longer routinely meet.

The other two Board Committees (Finance Risk and Audit Committee and Māori Relationship Board) do however meet on a regular basis.

**Finance Risk and Audit Committee:**

The purpose of the Finance Risk and Audit Committee (FRAC) is to advise and assist the HBDHB to meet governance responsibilities relating to finance, risk, safety and quality management, audit and compliance.

**Māori Relationship Board (MRB):**

The purpose of the Māori Relationship Board (MRB) is to maximise the relationship between the HBDHB and Ngāti Kahungunu Iwi Inc. (NKII), to benefit the Māori population within the Kahungunu rohe principally by identifying and removing health inequities and instituting processes that support Māori centric models of health care.

**Other components of HBDHB's governance structures include:**

- The Hawke's Bay Clinical Council
- Hawke's Bay Health Consumer Council; and the
- Pasifika Health Leadership Group

The Board now obtains stakeholder and community input and advice directly and indirectly through these structures.

**Note:**

- The Hawke's Bay Clinical Council and Hawke's Bay Health Consumer Council are management committees, reporting through the CEOs of HBDHB and Health HB Ltd.
- The Pasifika Health Leadership Group is a sub-committee of the Community and Public Health Advisory Committee

## 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

Director, Hawke's Bay Rugby Football Union

Trustee Te Matau ā Māui Health Trust

### **NGAHIWI TOMOANA - Deputy Chair**

#### **Meetings attended 10 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 10 of 11**

Trustee of the Hawke's Bay Air Ambulance Trust

Daughter, Commercial Manager Food for Health Benefits Limited (to 24 February 2016)

### **PETER DUNKERLEY**

#### **Meetings attended 11 of 11**

Trustee – Hawke's Bay Rescue Helicopter Trust

### **HELEN FRANCIS**

#### **Meetings attended 8 of 11**

Patron and Lifetime member of Alzheimer's Society Napier

Employee of Hastings Health Centre

Trustee Hawke's Bay Power Consumers' Trust

Trustee of HB Medical Research Foundation

### **DIANA KIRTON**

#### **Meetings attended 11 of 11**

Brother is a surgeon for HBDHB

Practicum Manager – EIT School of Health and Sport Science

Trustee Hawke's Bay Power Consumers' Trust

Son is a GP in Wairoa

Daughter-in-law is a Paediatric Registrar at HBDHB

Daughter-in-law at Starship Hospital undertaking Paediatrics Training (14 Dec 2015 to 30 Mar 2016)

### **DAN DRUZIANIC**

#### **Meetings attended 9 of 11**

Director Markhams Hawke's Bay Limited

Director of Hawke's Bay Rugby Football Union (HBRFU)

**DENISE EAGLESOME**

**Meetings attended 9 of 11**

Deputy Mayor of Wairoa District Council

Trustee Te Matau ā Māui Health Trust

Co-ordinator of health contract with Wairoa Rugby

**ANDREW BLAIR**

**Meetings attended 10 of 11**

Chairman of Cancer Control New Zealand (until 8 August 2015)

Owner of Andrew Blair Consulting Limited

Advisor to Chelsea Hospital Trust

Advisor to Hawke's Bay Orthopaedic Group Ltd (from 19 September 2015)

Chair of Southern Partnership Group (from 19 September 2015)

Director of Breastscreen Auckland Limited (from 17 December 2015)

Director St Marks Women's Health (Remuera) Limited (from 17 December 2015)

**JACOBY POULAIN**

**Meetings attended 11 of 11**

Board Member of Eastern Institute of Technology

Councillor Hastings District Council

**HEATHER SKIPWORTH**

**Meetings attended 9 of 11**

Mother is a Kaumatua – Kaupapa Māori HBDHB

Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB



## **Membership of Advisory Committees – statutory**

### **DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)**

### **COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC); and HOSPITAL ADVISORY COMMITTEE (HAC)**

No DSAC, CPHAC and HAC meetings were held and all the above named Statutory Committees are made up of Board members. 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**

## **FINANCE RISK AND AUDIT COMMITTEE (FRAC)**

Number of FRAC Meetings held 11

**Dan Druzianic - Chairperson**

**Meetings attended 10 of 11**

Refer Board interests disclosed

**Kevin Atkinson**

**Meetings attended 11 of 11**

Refer Board interests disclosed

**Barbara Arnott**

**Meetings attended 10 of 11**

Refer Board interests disclosed

**Peter Dunkerley**

**Meetings attended 11 of 11**

Refer Board interests disclosed

**Andrew Blair**

**Meetings attended 10 of 11**

Refer Board interests disclosed

**Jacoby Poulain**

**Meetings attended 10 of 11**

## **MĀORI RELATIONSHIP BOARD (MRB)**

Number of MRB and Annual Planning Meetings held 10.

### **Ngahiwi Tomoana – Chairperson**

**Meetings attended 6 of 10**

Refer Board interests disclosed

### **Denise Eaglesome**

**Meetings attended 5 of 10**

Refer Board interests disclosed

### **Helen Francis**

**Meetings attended 6 of 10**

Refer Board interests disclosed

### **Diana Kirton**

**Meetings attended 8 of 10**

Refer Board interests disclosed

### **Heather Skipworth**

**Meetings attended 7 of 10**

Refer Board interests disclosed

### **Tatiana Cowan-Greening**

**Meetings attended 6 of 10**

Ngāti Kahungunu Iwi Inc representative

Trustee, Te Matau ā Māui Health Trust

Husband is Manager of Te Kupenga Hauora

### **Kerri Nuku**

**Meetings attended 6 of 10**

Ngāti Kahungunu Iwi Inc representative

Kaiwhakahaere New Zealand Nurses Association

Trustee of Maunga Haruru Tangitu Trust

### **Des Ratima**

**Meetings attended 8 of 10**

Representative of Ahuriri District Health (Wai 692)

Chairperson, Ahuriri District Health Trust

Chairperson, Te Whanantahi Charitable Trust

Deputy Chair, Māori Wardens NZ Maori Council

Chair Kaupapa Māori Committee

Chair Takatimu Māori District Council

Chair Whakatu Kohanga Reo

**Trish Giddens**

**Meetings attended 9 of 10**

Ngāti Kahungunu Iwi Inc representative

Trustee, HB Air Ambulance Trust

Assistant Director Rotary District 9930

Manager, Taruna College

Member of the Lotteries Board

**Na Raihania**

**Meetings attended 10 of 10**

Ngāti Kahungunu Iwi Inc representative

Wife employed at Te Taiwhenua o Heretaunga

Member Tairāwhiti DHB Māori Relationship Board

**George Mackey**

**Meetings attended 6 of 10**

Ngāti Kahungunu Iwi Inc representative

Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB

Wife employed at Te Timatanga Ararau Trust holding several contracts with HBDHB

Employee of Te Puni Kokiri (from 19 June 2014)

**Lynlee Aitcheson** [married name] **Lynlee Aitcheson-Johnson** (from 14 May 2016)

**Meetings attended 7 of 10**

Ngāti Kahungunu Iwi Inc representative

Chair of Māori Party, Heretaunga Branch

Chair of Te Whare Whānau Purotu Inc. Māori Women's Refuge (from 22 December 2015)

**Ana Apatu**

**Meetings attended 8 of 9**

Ngāti Kahungunu Iwi Inc representative

CEO of U-Turn Trust – a member of Takitimu Ora Whanau Collective (since August 2015)

Chairperson of Directions (from August 2015)

Member of the Heart Foundation (from August 2015)

Deputy Chair Health Promotion Forum (from August 2015)

## 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 2016, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

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**Kevin Atkinson**  
*Chair*

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**Dan Druzianic**  
*Board Member*

xx October 2016

## **AUDITORS REPORT – to be supplied**

# Statement of Service Performance 2015/16

This section outlines Hawke's Bay District Health Board's achievement against the 2015/16 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 throughout the document to indicate whether or not the forecast performance target has been achieved.

## 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 good 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.

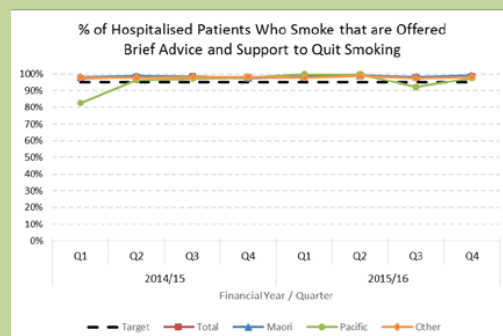


### National Health Target: Better Help for Smokers to Quit

In Hawkes Bay we are committed to reducing smoking rates with the vision of a Smokefree Aotearoa by 2025. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care. 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.

### Hospitalised smokers are offered advice to quit

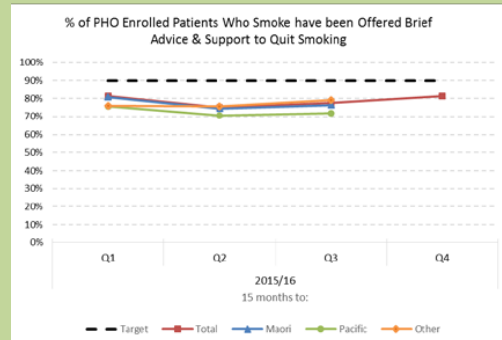
In Q4, 98.6% of hospitalised patients were offered brief advice and support to quit smoking in 15/16. The target of 95% has been consistently achieved for Māori and Total population for at least two years. ABC (ask, brief advice and cessation support) is business as usual for the hospital staff.





### Smokers are offered advice to quit when seen in General Practice

In Q4, of the current smokers that are registered with a GP practice, 81.3% were offered advice to quit in the last year. Performance has sat below the target of 90% in the last year as the practices are unable to sustain the level of activity required to follow up those who do not present to the GP at least once a year. In very low cost access (VLCA) practices, there are high volumes of patients registered who do not have up to date contact details and therefore cannot be contacted to offer support for becoming smokefree. Initiatives to improve performance in this area over the coming year include a Stoptober campaign, alternative forms of contact such as text messaging, and the use of independent nurses to support practices.



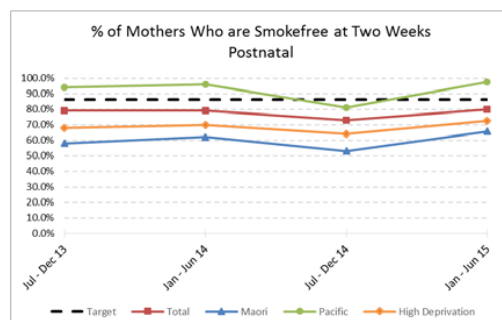
### Pregnant women are offered advice and support to quit

Of pregnant women who smoke, 89% were offered advice and support to quit in Q4. This result was lower for Māori at 81%. The latest data from 2014/15 showed that 43% of pregnant Māori women giving birth in Hawke's Bay were smokers<sup>1</sup>. This rate is alarmingly high. 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.



### Smokefree Māori women at two weeks postnatal

As well as offering advice and support during pregnancy, we also monitor smoking rates of the mother at two weeks postnatal. In Q4, 65.6% of Māori women who gave birth were smokefree at two weeks postnatal. Although this is an improvement on the baseline of 58%, it is still below the target of 86% and reducing smoking rates amongst Māori women must remain a key health equity target. HBDHB in collaboration with Choices Heretaunga have successfully implemented the Increasing Smokefree Pregnancy Programme (ISPP) which incentivises mothers and whānau members to be smokefree.



<sup>1</sup> Health Equity in Hawke's Bay Update 2016

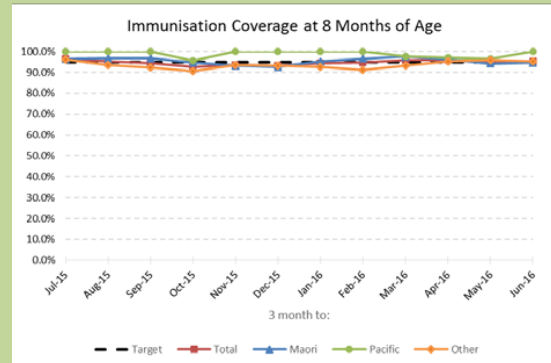


### National Health Target: Increased Immunisation

The Increased Immunisation Health Target aims to prevent the outbreak of vaccine preventable disease through improved immunisation coverage.

#### Eight month olds have received their complete primary course of immunisations

Hawke's Bay DHB is one of only six DHBs to have achieved over 95% coverage of eight month olds in Q4. Māori, Pacific and total population rates have fluctuated throughout the year.

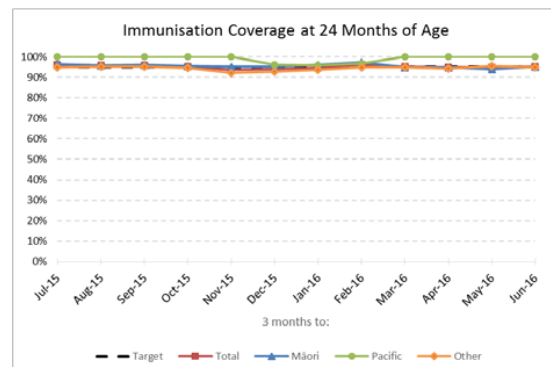


#### Children are fully immunised at 2 years of age

95% immunisation coverage in 2 year olds was achieved in Māori, Pacific and total population. There was a short period of time where the total population rate dropped to 94% but this was quickly recovered.

#### Children are fully immunised by 5 years of age

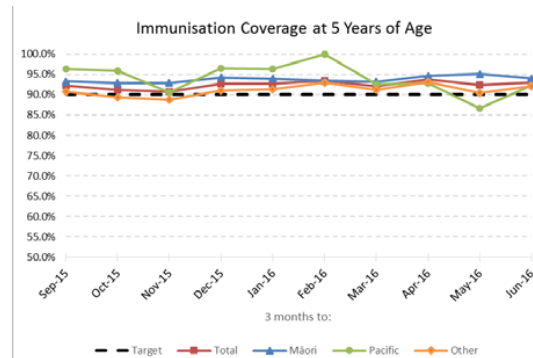
At the end of 2015/16, 93% of children were fully immunised by 5 years of age. Favourable results were achieved throughout the year.



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.

#### Girls receive all three HPV immunisations

Human Papillomavirus (HPV) immunisation is a primary preventative intervention to help reduce the incidence of cancer. In June 2016, 68.4% of eligible girls had received all three doses of the HPV immunisation. This is above the national target of 65%. Māori girls had a higher rate of immunisation at 87.8%. This is a pleasing result for a new indicator and we expect to see this performance increase in the coming year as we strive for the new target of 70%.



#### Vulnerable elderly receive an influenza vaccine

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. Data for this period is unavailable but the DHB and Health Hawke's Bay Immunisation teams are working alongside Māori providers to improve their capability through education and support with authorised vaccines and cold chain protocols.

### Rheumatic Fever - Reduced rate of first time hospitalisations for Rheumatic Fever

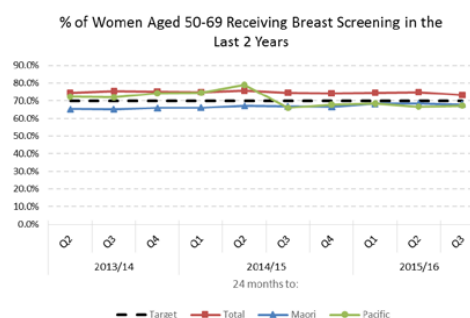
Hawke's Bay has high rates of Rheumatic Fever, a preventable diseases that has serious consequences. Ongoing implementation and review of the Rheumatic Fever Prevention Plan is proving to be effective as rates continue to decline in Hawkes Bay. The latest results show that the first time hospitalisation rate for rheumatic fever in 2015/16 was 1.88 per 100,000, better than the target rate of  $\leq 1.9$  per 100,000. Rheumatic fever prevention programmes such as 'Say Ahh' continue to be effective at preventing new cases of rheumatic fever.

### 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.

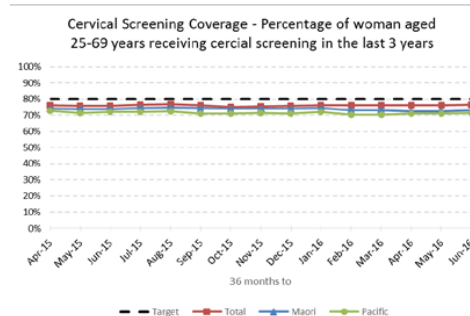
#### Women aged 50-69 years received breast screening in the last 2 years

Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 50 and 69. Overall our rate at the end of Q3 was 73.4% which is above the national target of  $\geq 70\%$ . Both Māori and Pacific results are slightly below the target at 67.9% and 67.2% respectively. Māori and Pacific rates have improved slightly over the past year.



#### Women aged 25 to 69 years receive cervical screening in the last 3 years

Screening for cervical cancer is offered every three years to all women between the ages of 25 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 76.6% which is below the target of  $\geq 80\%$  for all ethnicities. The DHB Population Screening, Health Hawke's Bay and Māori providers are working together to promote a mobile visit to the Cook Island Community Centre and offering support services to priority women.



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.

### Reduced rate of Sudden Unexplained Death of Infant in HB

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 1.77 per 1,000 live births in 2011 to 1.16 per 1,000. This is a good result but it is still higher than the target of  $< 0.5$  per 1,000 live births and rate for Māori is higher than the total population rate. In 2016/17 there will continue to be a focus on eliminating the inequity by continuing to target at risk populations through allocation of ongoing sustainable funding to the programme.

## 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  $\geq 75\%$ ) and 3 months (Target 60%) as well as receiving breast milk either exclusively, fully or partially at 6 months (Target 65%).

We are unable to compare breastfeeding rates with the baseline set in the Annual Plan as the data source has changed from Plunket only data to Tamariki Ora and Plunket combined data.

Increasing breastfeeding rates requires excellent coordination of breastfeeding activities across the Hawke's Bay health sector and community. Work continues on the development of a model of service provision that effectively supports Māori in particular, to sustain Breastfeeding. This is a joint approach between Māori Health and Women, Children and Youth teams.

Key Performance Measures	Infants are exclusively of fully breastfed at 6 weeks		Infants are exclusively of fully breastfed at 3 months		Infants are receiving breast milk at 6 months of age	
	Target	Actual 2015/16	Target	Actual 2015/16	Target	Actual 2015/16
Māori	$\geq 75\%$	67% (U)	$\geq 60\%$	39% (U)	$\geq 65\%$	48% (U)
Total		73% (U)		53% (U)		58% (U)

## Sexual Health Services

Of those accessing CPO funded sexual health services for an initial consultation in Q3, 43.8% were Māori. The goal is for more than 50% to be Māori as they are the target population. Although teenage pregnancy rates have been dropping due to improved access to contraception and sexual health services, three year averages show that Māori teenage conception rates are four times that of non-Māori 13 to 17 year olds<sup>2</sup>.

Prevention Services			
\$'millions	2015/16 Actual	2015/16 Budget	2014/15 Actual
Ministry of Health	6.5	10.0	6.4
Other sources	0.2	0.1	0.4
<b>Income by Source</b>	<b>6.7</b>	<b>10.1</b>	<b>6.8</b>
Less:			
Personnel costs	1.4	1.4	1.5
Clinical supplies	0.1	0.1	0.1
Infrastructure and non-clinical supplies	0.3	0.3	0.4
Payments to other providers	8.4	8.3	8.0
<b>Expenditure by type</b>	<b>10.2</b>	<b>10.1</b>	<b>10.0</b>
<b>Net Result</b>	<b>(3.5)</b>	<b>-</b>	<b>(3.2)</b>

<sup>2</sup> Health Equity in Hawke's Bay Update 2016 – Teenage conception rate per 1000 population (births and terminations) by ethnicity

## 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

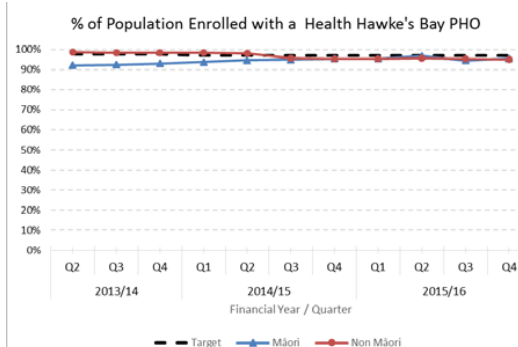
Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, 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 will 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

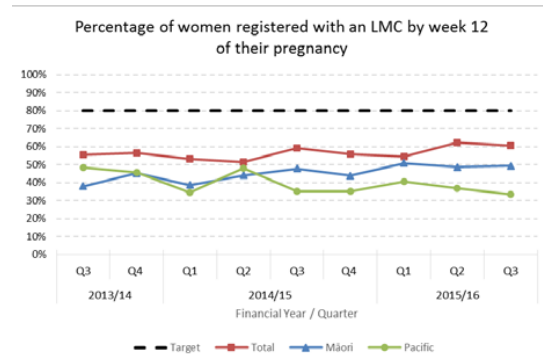
Across New Zealand, people are required and encouraged to enrol with a general practice that is affiliated to a Primary Health Organisation (PHO). Health Hawke's Bay coordinates and manages the targeting of many services to those populations who are known to have a poor health status such as Māori, Pacific 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. 95.9% of people are enrolled with the PHO which is just below the target of 97%. There has been a steady increase in Māori enrolled with the PHO, reaching 95.6% in Q4. Health Hawke's Bay continues to work closely with Hawke's Bay DHB and general practice to promote enrolments and offer resources to facilitate the process.



## Early Engagement with Lead Maternity Carers (LMC)

### Women booked with an LMC by week 12 of their pregnancy

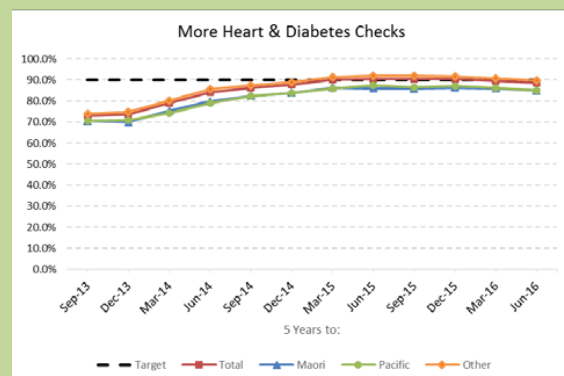
Promoting engagement with LMC's earlier in pregnancy continues to be a focus. Early registration is paramount, especially in vulnerable women, so that vital first trimester screening and the best possible pregnancy outcomes can occur. The percentage of women registered with an LMC by week 12 has increased from the baseline 51.4% in Q2 2014/15 to 60.6% (target 80%). The overall rate for the year shows a good increase in Māori. However, there is an inequity gap as 49% of Māori and 33% of Pacific pregnant women registered by 12 weeks.



### National Health Target: More Heart and Diabetes Checks

#### People have had a Cardiovascular Disease Risk Assessment in the last 5 years

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.

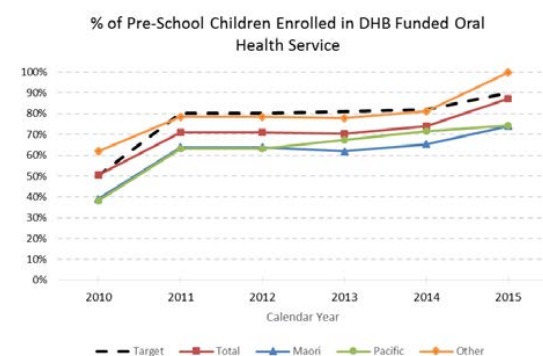


Since Q1 2013/14, the percentage of the population that have had their CVD risk assessed in the last five years has increased steadily from 73.1% and has sat around the target of  $\geq 90\%$  with a slight decline to 88.5% in Q4. A similar profile has occurred for all ethnicities but with persistent inequities. This indicator has been removed as a Health target for 2016/17 but Health Hawkes Bay will continue to put emphasis into this indicator through System Level Measures framework.

## Oral Health

### Pre-school enrolments with oral health services

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, 87.1% of pre-school children were enrolled in DHB funded oral health services (74.1% Māori and 74.2% Pacific). All ethnicities have improved remarkably since 2014 due to the quadruple enrolment initiative which involved babies being enrolled with oral health services at birth.





## Children and youth attending oral health services

3.7% 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 (4.0%).

The percentage of adolescents using DHB funded dental services in 2015 was 75.9% which is unfavourable against a target of  $\geq 85\%$ . 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

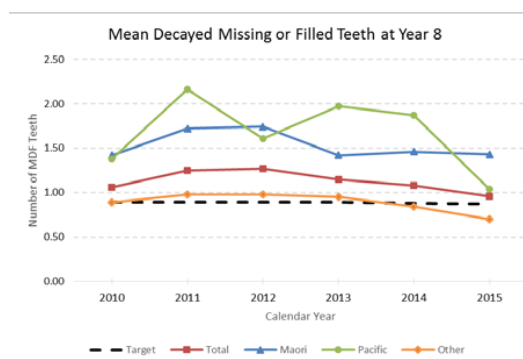
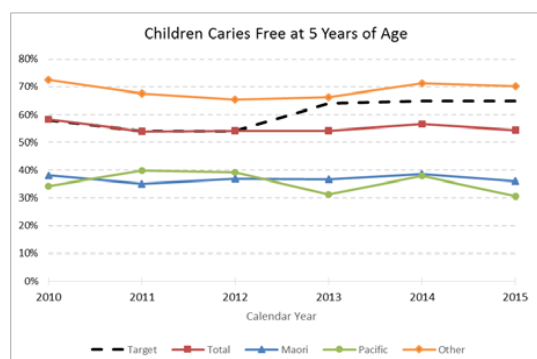
Percentage of children not examined according to planned recall		
Baseline 2014	Target 2015	Actual 2015
4.0%	<5%	3.7% (F)

Percentage of adolescents using DHB funded dental services		
Baseline 2013	Target 2015	Actual 2015
84.5%	$\geq 85\%$	75.9% (U)

## Children without decay

54.4% of five year olds were caries free in 2015 which is unfavourable against a target of  $\geq 66\%$ .

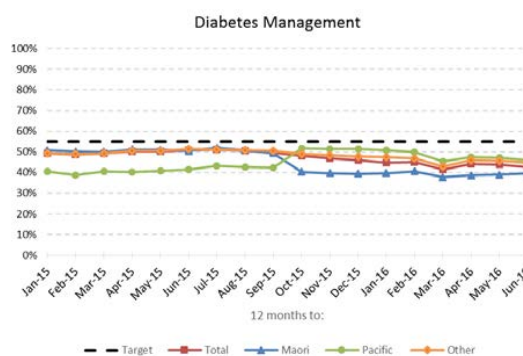
Children are also checked at year 8 for decayed, missing or filled teeth (DMFT). The mean rate of DMFT has reduced from 1.08 to 0.96 in the last year however Māori have remained at 1.43. At both 5 years and year 8 there are large inequity gaps between Māori, Pacific, and Other ethnicities which need to be eliminated. This is the aim of a project that is underway to improve access to oral health services for Māori tamariki.



## Management of Diabetes

### People with good 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 dropping to 42.8%. A consumer-led governance group is being established and an integrated work plan developed to progress initiatives to improve diabetes management in the population.

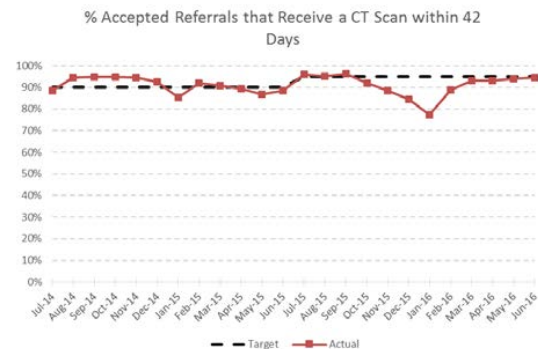


## Less Waiting for Diagnostic Services

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 is crucial in the drive to support more community-based care delivery

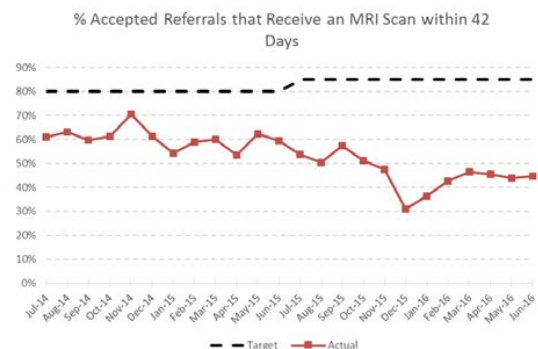
### Computed Tomography

For Computed Tomography (CT), the target is that 95% of 'routine' referrals receive a CT scan within 42 days. In Q4, 94.6% of referrals met the target which is an increase from the baseline of 92.6%



### Magnetic Resonance Imaging

For Magnetic Resonance Imaging (MRI), at year-end, 44.7% of referrals waited less than 42 days to receive their MRI. Internally, the radiology department is undergoing a review to ensure the most efficient use of resources.



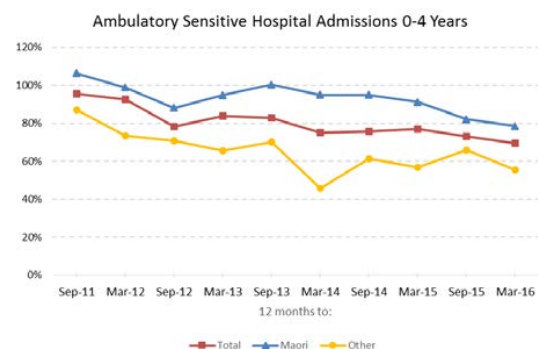
### Ambulatory sensitive hospitalisations

With successful prevention 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, and 45-64 years. Rates are presented as number of hospitalisations per 100,000 DHB population as a percentage relative to the total national rate.

#### 0-4 year olds

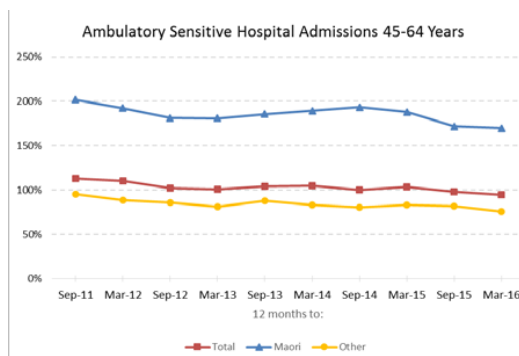
Rates for Māori 0-4 years continue to reduce but are still higher when compared with the total population. In March 16, the Māori rate was 79% compared to total population (70%). The downward trend is promising but more needs to be done to keep children out of hospital and eliminate the inequity. The conditions that have the highest ASH rates are severe dental decay, skin conditions, respiratory and ear nose and throat infections. We continue to focus on these areas to bring down ASH rates and reduce inequities.





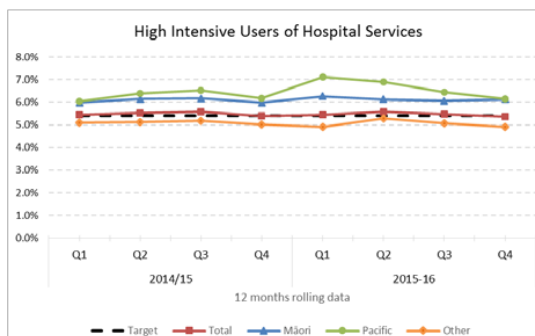
### 45-64 years

Like the 0-4 age group, the ASH rates for 45-65 years are decreasing but there is a large inequity observed between Māori and non-Māori. In March 2016, the total population rate was 94% and the Māori rate was 170%. Our focus remains on reducing inequities which are mainly evident in heart disease, skin infections, respiratory infections and diabetes.



### High intensive users of hospital services

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 5.4%, meeting the target of ≤5.4%. Māori and Pacific rates remain above the target. ED and primary care are working on a pilot programme to reduce high intensive users of ED through re-engagement with General Practice and the development of integrated care plans.



### B4 School Checks

At the end of 2015/16, 107% of the eligible population had received a B4 school check. The purpose of the B4 School Check is to promote health and wellbeing in 4-year-olds, and to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school. We have a consistently high performing service achieving equitable coverage in this area.

Early Detection and Management			
\$'millions	2015/16 Actual	2015/16 Budget	2014/15 Actual
Ministry of Health	90.6	92.7	118.1
Other District Health Boards	2.8	2.8	1.9
Other sources	3.4	3.4	4.2
<b>Income by Source</b>	<b>96.8</b>	<b>98.9</b>	<b>124.2</b>
Less:			
Personnel costs	5.5	5.6	24.6
Outsourced services	0.1	-	3.8
Clinical supplies	0.5	0.5	2.9
Infrastructure and non-clinical supplies	1.5	1.4	7.9
Payment to other District Health Boards	2.5	2.5	2.4
Payments to other providers	87.5	88.3	84.3
<b>Expenditure by type</b>	<b>97.6</b>	<b>98.3</b>	<b>125.9</b>
<b>Net Result</b>	<b>(0.8)</b>	<b>0.6</b>	<b>(1.7)</b>

## 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.



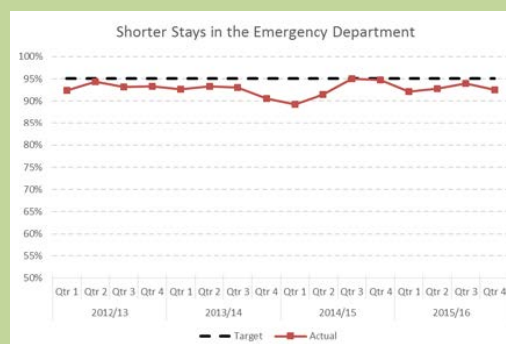
### National health Target: Shorter Stays in the Emergency Department

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.

#### People presenting at ED wait less than six hours

In 2015/16, the percentage of people waiting less than six hours in ED fluctuated between 92.1% and 93.9% (target 95%).

ED front of house has undergone some renovations which have just been completed and should result in improved processes and flow with new designs and increased treatment areas.



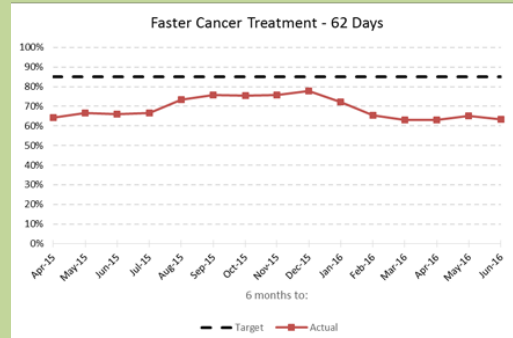


### Faster Cancer Treatment (FCT)

FCT takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. The target aims to reduce the time from referral to treatment for those with a high suspicion of cancer.

In Q4 2015/16, 62.5% of people referred with a high suspicion of cancer received their first cancer treatment within 62 days (Target 85%). There has been an increased focus on identifying the patient group for the target which has increased the volumes for the target. The key period from referral to diagnosis remains a significant barrier to achieving the 62 day target as well as access to diagnostics.

The Faster Cancer Treatment team are working with improved processes to identify patients on the cancer pathway and we expect to see improvement in the coming year.

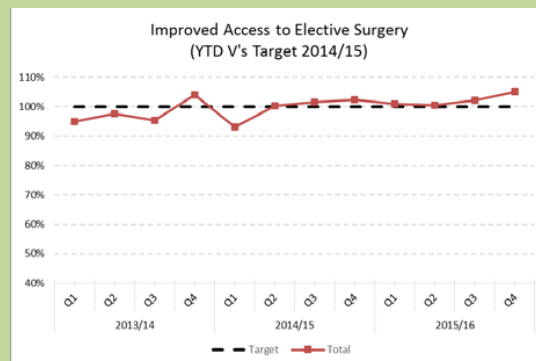


### National Health Target: Improved Access to Elective Surgery

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.

#### More people have access to Surgery

Many initiatives to improve productivity and throughput have been successfully implemented this year resulting in HBDHB achieving 7,469 elective surgery discharges, exceeding our target of 7,109. There were 1,315 more elective surgeries carried out in 15/16 than in 14/15.



### 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 19.2 per 10,000 which is below the target and a reduction from 21.3 per 10,000 in December 2014. In 2015/16 there were 95 more major joint replacement surgeries than in 2014/15. This is not reflected in the SIR results due to the time frame of reporting and a spike in volumes in June 14.

Cardiac surgery intervention rates are below the target rate of 6.5 per 10,000 reaching 6.3 per 10,000, an improvement from 5.7 in December 2014.

There has been an increase in percutaneous revascularization rates from December 2014. The Actual result for the 12 months to March 2016 is 13.3 per 10,000 which is favourable against the target.

Intervention rates for cataracts procedure and coronary angiography are above the target intervention rates at 49.6 and 37.3 per 10,000 respectively.

Elective Services Standardised Intervention Rates (per 10,000 population)			
Key Performance Measures	Baseline December 2014	Actual March 2016	Target 2015/16
Major joint replacement	21.3	19.2 (U)	≥21.0
Cataract procedures	52.1	49.6 (F)	≥27.0
Cardiac procedures	5.7	6.3 (U)	≥6.5
Percutaneous revascularization	10.9	13.3 (F)	≥12.5
Coronary angiography services	36.2	37.3 (F)	≥34.7

### 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 ≤1.59 days and although we have not quite managed to meet the target, we have reduced the ALOS from 1.74 to 1.61.

Acute ALOS has also reduced this year from 2.79 to 2.47 and the new target of 2.79 in Q4 was achieved. We will continue to focus on work to improve patient flow through the hospital to ensure good hospital productivity.

Average Length of Stay			
	Baseline September 2014	Target 2015/16	Actual March 2016
Elective	1.74	≤1.59 days	1.61 (U)
Acute	2.79	≤2.79 days	2.47 (F)

## Acute Readmission to Hospital

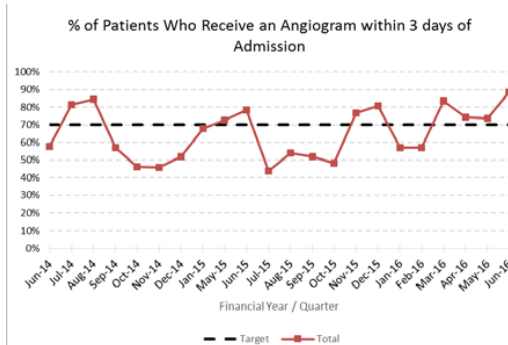
In our quest to increase hospital throughput it is important that we measure acute unplanned readmission rates. These occur when treatment, either in hospital or in the 28 days following discharge, has not been effective and a readmission is required urgently. A low rate is an indication of effective support services in the community (e.g. primary care) and hospital reliability. Unfortunately, no results were published for the period April 2014 to March 2015 as the Ministry of Health are currently reviewing this measure. We will continue to target a reduction in readmission rates through better integration with primary and community services.

## 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:

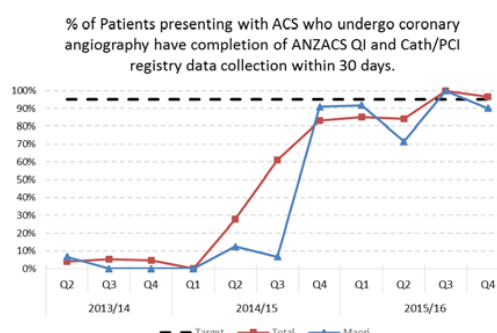
- Improve access to cardiac diagnostics and specialist assessments
- Reduce waiting times for people requiring cardiac services
- Improve prioritisation and selection of cardiac surgical patients
- Increase cardiac surgical discharges
- Reduce variations in access across the region

In Q4, 77.6% of high risk patients received an angiogram within 3 days (target 70%). For Māori we achieved 84.6%. 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. However, overall this is a commendable achievement with a significant improvement in performance on last year.



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. Near the end of 2014/15 we introduced a more robust system to support data capture and data entry. In Q4 we achieved 96.6% against a target of ≥95%. We fell just short of the target in Q4 with our Māori population, achieving 90%.

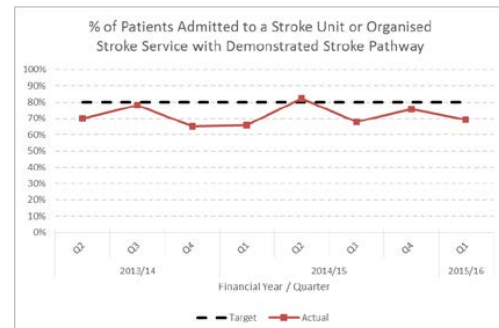
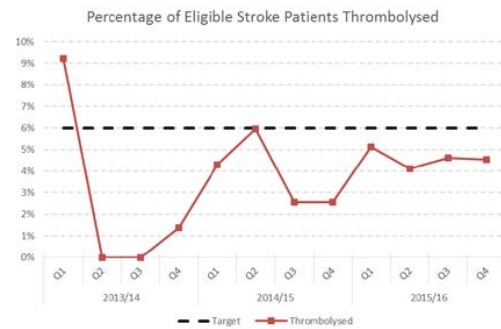


### Stroke thrombolysis and stroke pathway

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, 4.5% of eligible patients were thrombolysed against a target of 6%. Although the target has not been met this year, performance has been consistently better than last year.

In 2015/16 Hawkes Bay Hospital has managed to overcome a number of challenges which arose during implementation of the pathway for organised stroke services. The percentage of patients admitted to the demonstrated stroke pathway has increased to 90.9% in Q4 which is favourable against the target of  $\geq 80\%$ .

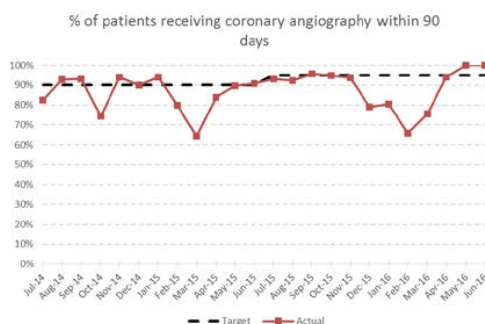
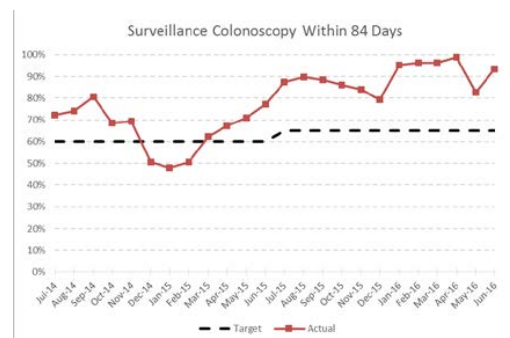
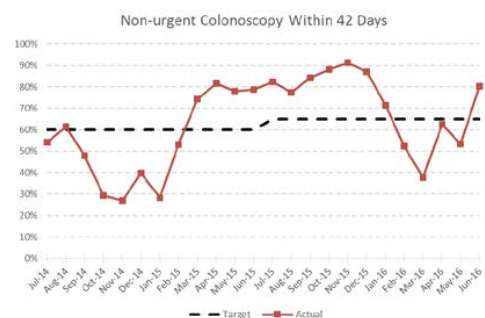
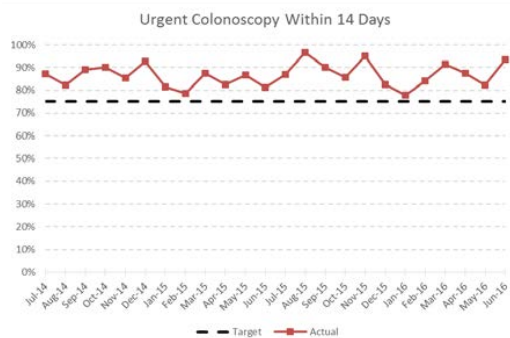


### Quicker access to diagnostics

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.

In June 2016, 93.5% of Urgent diagnostic colonoscopies were performed within 14 days and 80.4% of routine cases performed within 42 days. These are above the targets of 75% and 65% respectively. The target for surveillance colonoscopy was also achieved with 93.5% of people waiting less than 84 days beyond planned date (target  $\geq 65\%$ ).

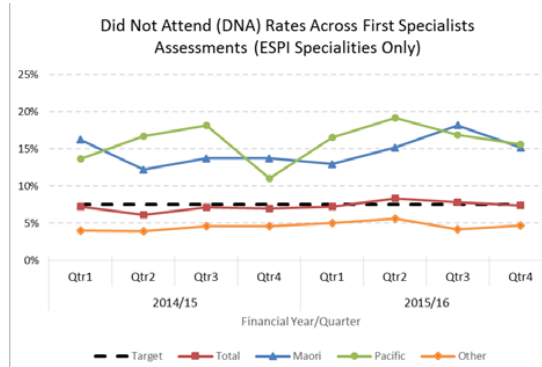
The percentage of patients receiving coronary angiography within 90 days has fluctuated throughout the year. We ended the year achieving 100%.



### 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. High rates also indicate unnecessary delays in treatment and could, in some cases, be avoided by a more customer focused booking system and improved patient experience.

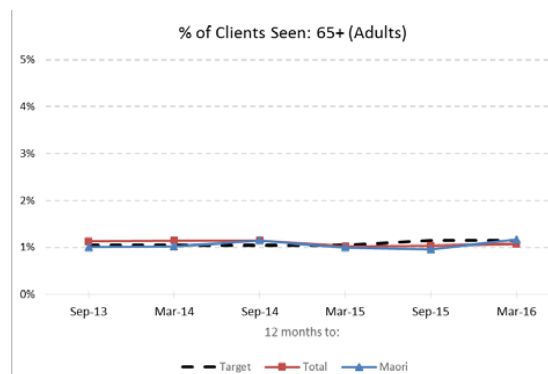
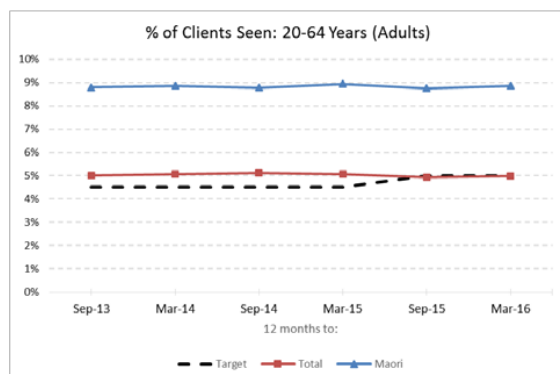
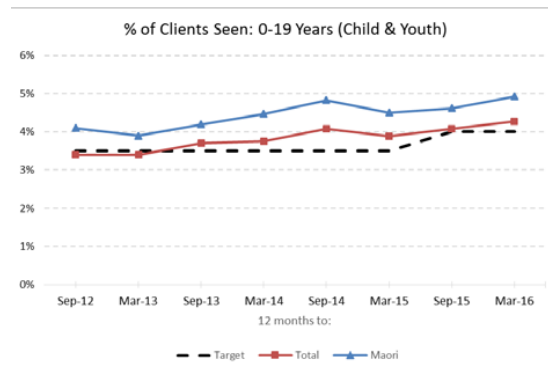
The overall DNA rate is 7.4% which is favourable against the target. However, the Māori DNA rate is 15.2% indicating a significant inequity gap. The customer focussed booking project has developed better DNA reporting and have launched a new initiative focussing on the three specialties with the highest DNA rates.



### 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.

**Improved access to services:** The proportion of children and youth (aged 0-19 years) seen by mental health and addiction services in Hawke's Bay has increased steadily over the past four years with the proportion of adults and older adults remaining constant. In the year ending March 2016, 4.28% of 0-19 year old (target  $\geq 4\%$ ), 4.98% of 20-64 year olds (target  $\geq 5\%$ ) and 1.09% of 65+ year olds (target  $\geq 1\%$ ).

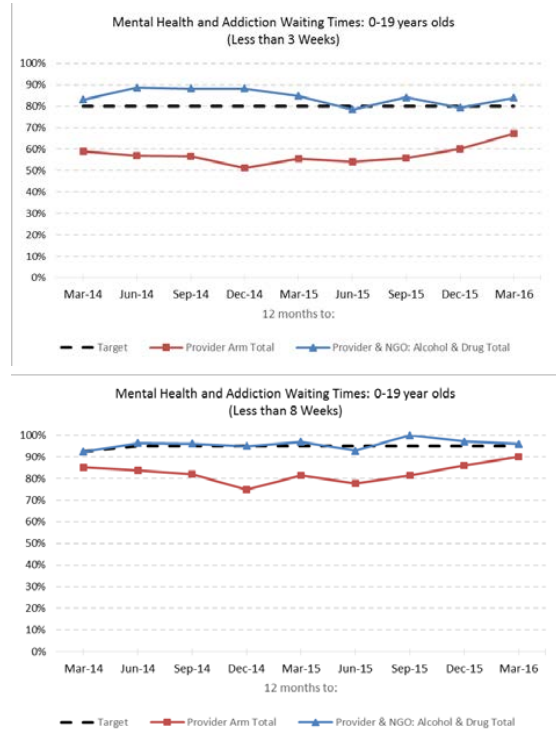




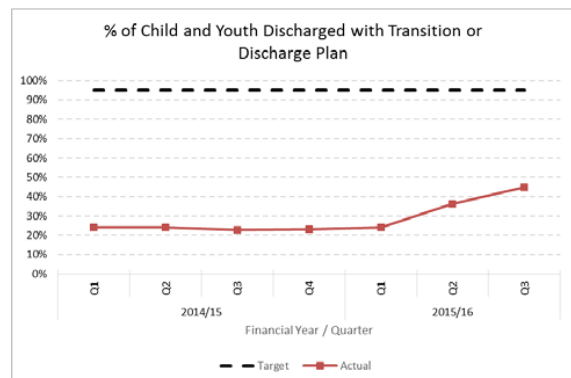
**Improved Waiting Times:** Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. We differentiate the targets in 2 ways: firstly, between the mental health services that are delivered by our provider arm and the addiction services 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 67.4% of cases and the 8 week result was 90.2%. Both of these results are below the targets of 80% and 95% respectively however, considerable efforts have resulted in improved performance and we anticipate this trend will continue.

For addictions services with a range of providers, the waiting times expectations have been exceeded with 84.0% of people seen within 3 weeks and 96.0% 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. Improving discharge planning has been a real focus over the past six months which is reflected in the improved performance. The end of year result of 44.83% for the 12 months to March 2016, it will take a while for our current performance to be fully reflected in the data.



### 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. In Q4, The rate of s29 orders per 100,000 Māori was 97.3 which is higher than the target of ≤80 per 100,000. 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. We have put in place new services to provide early interventions for people with mental health problems and as alternatives to hospitalisation. These include; Home based Treatment; NGO provided recovery orientated short term day programmes; resilience focussed community group programmes; and later this year the Harekeke acute day programme based in Nga Rau Rakau. We are also carrying out an audit of cases locally to see if any of these factors particularly stand out as contributing towards the inequity.



<b>Intensive Assessment and Treatment</b>			
<i>\$'millions</i>	<b>2015/16 Actual</b>	<b>2015/16 Budget</b>	<b>2014/15 Actual</b>
Ministry of Health	322.1	313.8	273.9
Other District Health Boards	5.7	5.7	4.0
Other sources	10.0	9.5	14.7
<b>Income by Source</b>	<b>337.8</b>	<b>329.0</b>	<b>292.6</b>
Less:			
Personnel costs	174.1	175.1	146.6
Outsourced services	14.9	10.6	9.4
Clinical supplies	43.2	42.1	42.2
Infrastructure and non-clinical supplies	42.4	38.3	34.3
Payment to other District Health Boards	45.7	45.8	43.2
Payments to other providers	11.9	14.2	9.4
<b>Expenditure by type</b>	<b>332.2</b>	<b>326.1</b>	<b>285.1</b>
<b>Net Result</b>	<b>5.6</b>	<b>2.9</b>	<b>7.5</b>

## 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 75-79 the rate has increased slightly from 139.5 per 1,000 to 153.3 per 100. For both 80-84 and 85+ year olds, the rate has decreased. This data will continue to be used to assess community services.

Age specific rate of non-urgent and semi urgent attendances at the Emergency Department (per 1,000 population)			
	Baseline Dec 2014	Target (2015/16)	Actual (2015/16)
75-79	139.5	≤139.5	153.3
80-84	183.1	≤183.1	178.1
85+	254	≤231.0	221.8

The rate of acute readmission, as discussed above in output class 3, is a measure of effective support services and treatment. Reducing the readmission rate in this age group is especially important for sustainability as the over 75 population continues to grow. As in output class 3, no results were published for the period April 2014 to March 2015 as the Ministry of Health are currently reviewing this measure.

#### 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. 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. Comprehensive clinical assessments and completed care plans are an important component of keeping people safe in their own homes and maintaining their independence. In 2015/16, 100% of the people using home support received a comprehensive clinical assessment and completed care plan.

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

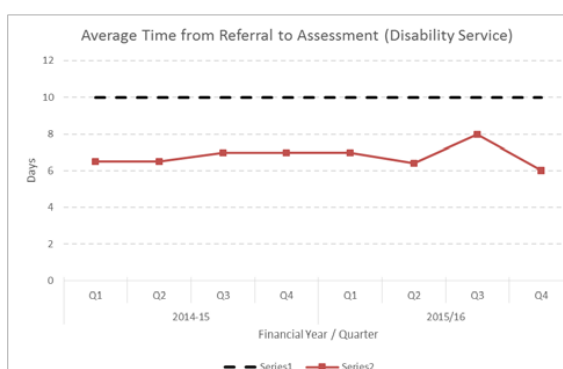
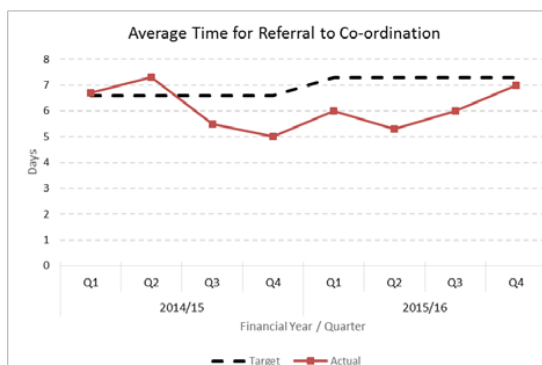
Needs Assessment and Service Coordination (NASC) services work with people who have support needs because of long-term health conditions and disabilities. NASC services determine eligibility for public funding and assist the person to define the best mix of supports based on their own strengths, resources 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. The average time from referral to assessment in Q4 was 7.0 days against a target of  $\leq 7.3$  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 6.0 days which is favourable against the target of  $\leq 10$  days.

Number of needs assessments completed (disability service)		
Previous Year (2012/13)	Target (2015/16)	Actual (2015/16)
618	$\geq 600$	508

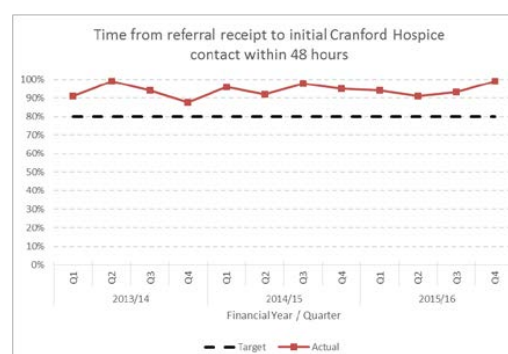
The number of needs assessments completed is lower than the target of  $\geq 600$ . This is likely due to a lower number of 3 yearly assessments being due.



### 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 99% of cases in Q4 and the target of 80% was exceeded all year.



### More Day Services

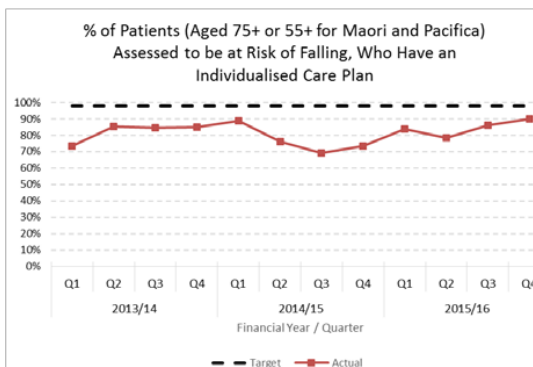
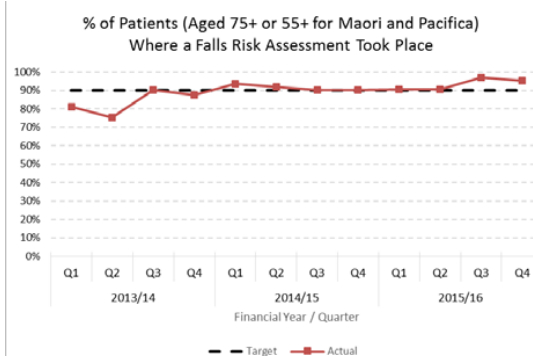
Improved management and integration of services in the community along with enhanced capability, enables early intervention to maintain function so that clients remain at home for longer. We commit extra resources to increase day services to give better support to people with specialised or high needs and to their carers. The number of day services increased over the past year but fell just short of the target.

Number of Day Services	
Target	Actual
21,791	21,546

## Reducing harm from falls

Reducing harm from falls is one of our priority Quality and Safety Markers. Our stand up for falls campaign started in April 2015 which has been successful at increasing awareness. In Q4, a falls risk assessment was completed for 95.2% of elderly patients which is above the target of 90%.

If assessed to be at risk of falling, a patient needs an individualised care plan to minimise the risk. There has been steady improvement in the percentage of at risk patients who have a care plan. Now that falls risk assessments are being completed routinely, the Falls working group and Clinical Nurse Managers can now focus on ensuring all of those at risk have an individualised care plan. We ended the year below the target at 90% but hope to see this continue to increase over the coming year.



Rehabilitation and Support			
\$millions	2015/16 Actual	2015/16 Budget	2014/15 Actual
Ministry of Health	72.6	69.1	70.4
Other District Health Boards	3.0	3.0	2.1
Other sources	0.2	0.3	0.1
<b>Income by Source</b>	<b>75.8</b>	<b>72.4</b>	<b>72.6</b>
Less:			
Personnel costs	6.3	6.3	6.5
Outsourced services	0.1	0.1	0.8
Clinical supplies	0.7	0.7	-
Infrastructure and non-clinical supplies	1.8	1.7	1.8
Payment to other District Health Boards	3.9	3.9	3.6
Payments to other providers	59.9	59.2	59.4
<b>Expenditure by type</b>	<b>72.7</b>	<b>71.9</b>	<b>72.1</b>
<b>Net Result</b>	<b>3.1</b>	<b>0.5</b>	<b>0.5</b>

## Financial Report for the year ended 30 June 2016



The board members are pleased to present the Financial Statements of HBDHB for the year ended 30 June 2016.

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

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**Kevin Atkinson**  
*Chair*

26 October 2016

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**Dan Druzianic**  
*Board Member*

## 2015/16 Financial Performance

### Result

The operating surplus for 2015/16 is \$4.4 million on revenue of \$517.1 million. This is in comparison to the \$3.1 million surplus reported last year.

Revenue was \$6.7 million ahead of plan including \$3.0 million of funding for the increased capital charge relating to the 2014/15 revaluation of land and buildings, and extra income from the Ministry of Health for additional services provided.

### Cash flow

The operating cash surplus of \$20.4 million was used to fund the \$19.4 million spend on property, plant and equipment, intangible assets and investments, repay equity of \$0.4 million, and increase cash holdings by \$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 2015/16 annual report, amount to \$122,608.

### Ministerial directions

The Minister of State Services and the Minister of Finance issued a direction under section 107 of the Crown Entities Act 2004, that tier 2 agencies (including the DHB) must give effect to, or have regard to requirements for the implementation of the New Zealand Business Number (NZBN).

## 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	2016	2015	2014	2013	2012
Return on net funds employed	9.2%	11.9%	8.3%	11.2%	9.4%	9.6%
Operating margin to revenue	1.6%	2.2%	1.4%	1.4%	1.2%	1.1%
Revenue to net funds employed	4.7	4.7	4.5	5.7	5.5	5.9
Debt to debt plus equity ratio	33.0%	31.7%	32.7%	46.5%	48.2%	49.4%
Net result before financing & abnormals	10.0m	13.2m	9.1m	9.5m	8.1m	7.5m
Net result	4.0m	4.4m	3.1m	3.2m	2.1m	2.0m
Debt servicing coverage ratio	10.1	9.9	8.5	7.5	7.5	7.5
Ratio of earnings to revenue	4.7%	5.2%	4.7%	4.8%	4.5%	4.3%
Average cost per paid FTE	\$87,437	\$86,563	\$84,085	\$81,948	\$80,483	\$79,093
Average revenue per paid FTE	\$236,851	\$238,939	\$232,975	\$233,937	\$234,014	\$228,359

# Statement of comprehensive revenue and expense

For the year ended 30 June 2016

in thousands of New Zealand Dollars

	Notes	30 June 2016	Budget 30 June 2016	30 June 2015
Patient care revenue	2.6	510,496	505,247	489,044
Interest revenue		1,419	1,008	1,568
Other operating revenue	2.7	5,149	4,159	5,625
Total revenue		517,064	510,414	496,237
Personnel costs	2.8	187,322	188,426	179,100
Outsourced services		15,116	10,654	13,233
Clinical supplies		40,766	39,794	42,339
Infrastructure and non-clinical expenses		22,228	20,849	22,729
Payments to other DHBs		52,097	52,182	50,709
Payments to non-health board providers		167,759	170,012	159,422
Other operating expenses	2.9	4,962	4,623	5,743
Depreciation and amortisation expense	3.6, 3.7	13,695	13,872	14,062
Financing costs	2.10	2,018	1,957	2,289
Capital charge	2.11	6,783	4,055	3,740
Total expenses		512,746	506,424	493,366
Share of associate surplus/(deficit)	3.9	48	-	183
<b>Surplus/(deficit)</b>		<b>4,366</b>	<b>3,990</b>	<b>3,054</b>
<b>Other comprehensive revenue and expense</b>				
Revaluation of land and buildings		-	-	37,444
<b>Total comprehensive revenue and expense</b>		<b>4,366</b>	<b>3,990</b>	<b>40,498</b>

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

DHBs 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 2016 was overspent by \$0.4 million (2015: underspent \$0.8 million). Mental health payments in excess of funding since 1 July 2001 is \$0.7 million (30 June 2015: \$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 2016**

*in thousands of New Zealand Dollars*

	Notes	30 June 2016	Budget 30 June 2016	30 June 2015
Balance at 1 July		87,627	93,017	49,141
Total comprehensive revenue and expense		4,366	3,990	40,498
Owner transactions				
Transfer of Chatham Island's health services to Canterbury DHB	3.6	-	-	(1,655)
Equity repayments to the Crown		(356)	(357)	(357)
<b>Balance at 30 June</b>	4.5	<b>91,637</b>	<b>96,650</b>	<b>87,627</b>

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 2016

in thousands of New Zealand Dollars

	Notes	30 June 2016	Budget 30 June 2016	30 June 2015
<b>Assets</b>				
<i>Current assets</i>				
Cash and cash equivalents	3.1	15,537	12,085	14,969
Short term investments	3.1	1,739	1,563	1,703
Receivables and prepayments	3.2	22,421	18,133	17,852
Loans (Hawke's Bay Helicopter Rescue Trust)	3.3	13	13	12
Inventories	3.4	4,293	3,845	3,881
Non-current assets held for sale	3.5	1,220	-	1,220
<b>Total current assets</b>		<b>45,223</b>	<b>35,639</b>	<b>39,637</b>
<i>Non-current assets</i>				
Property, plant and equipment	3.6	151,796	165,876	148,232
Intangible assets	3.7	10,743	4,721	8,472
Investment property	3.8	131	140	131
Investment in associate	3.9	1,045	6,805	1,143
Loans (Hawke's Bay Helicopter Rescue Trust)	3.3	42	42	55
<b>Total non-current assets</b>		<b>163,758</b>	<b>177,584</b>	<b>158,033</b>
<b>Total assets</b>		<b>208,981</b>	<b>213,223</b>	<b>197,670</b>
<b>Liabilities</b>				
<i>Current liabilities</i>				
Payables and deferred revenue	4.2	38,318	33,982	30,823
Employee entitlements	4.3	33,588	32,660	33,872
Provisions	4.4	300	-	506
<b>Total current liabilities</b>		<b>72,206</b>	<b>66,642</b>	<b>65,201</b>
<i>Non-current liabilities</i>				
Interest-bearing loans and borrowings	4.1	42,500	47,500	42,500
Employee entitlements	4.3	2,638	2,431	2,342
<b>Total non-current liabilities</b>		<b>45,138</b>	<b>49,931</b>	<b>44,842</b>
<b>Total liabilities</b>		<b>117,344</b>	<b>116,573</b>	<b>110,043</b>
<b>Net assets</b>		<b>91,637</b>	<b>96,650</b>	<b>87,627</b>
<b>Equity</b>				
Contributed capital	4.5	35,216	36,871	35,572
Property revaluation reserves	4.5	67,392	72,976	69,188
Restricted funds	4.5	3,013	-	3,125
Asset replacement reserve	4.5	-	-	15,253
Accumulated surpluses/(deficits)	4.5	(13,984)	(13,197)	(35,511)
<b>Total equity</b>		<b>91,637</b>	<b>96,650</b>	<b>87,627</b>

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 2016

in thousands of New Zealand Dollars

	Notes	30 June 2016	Budget 30 June 2016	30 June 2015
<b>Cash flows from operating activities</b>				
Receipts from patient care		508,871	509,033	490,104
Receipts from donations, bequests and clinical trials		510	-	578
Other receipts		2,351	-	3,987
Payments to suppliers		(297,889)	(290,079)	(298,566)
Payments to employees		(187,513)	(188,334)	(176,291)
Goods and services tax (net)		1,258	-	(495)
Cash generated from operations		<b>27,588</b>	<b>30,620</b>	<b>19,317</b>
Interest received		1,419	1,068	1,568
Interest paid		(1,855)	(2,089)	(2,252)
Capital charge paid		(6,783)	(4,055)	(3,740)
Net cash inflow/(outflow) from operating activities		<b>20,369</b>	<b>25,544</b>	<b>14,893</b>
<b>Cash flows from investing activities</b>				
Proceeds from sale of property, plant and equipment		123	1,275	58
Acquisition of property, plant and equipment		(16,733)	(23,923)	(15,576)
Acquisition of intangible assets		(395)	(1,500)	(904)
Acquisition of investments		(2,440)	(1,379)	(1,413)
Net cash inflow/(outflow) to investing activities		<b>(19,445)</b>	<b>(25,527)</b>	<b>(17,835)</b>
<b>Cash flows from financing activities</b>				
Proceeds from borrowings		-	5,000	10,000
Repayment of borrowings		-	-	(10,000)
Repayment of finance lease liabilities		-	-	(268)
Repayment of equity to the Crown		(356)	(2,022)	(357)
Net cash inflow/(outflow) from financing activities		<b>(356)</b>	<b>2,978</b>	<b>(625)</b>
Net increase/(decrease) in cash and cash equivalents		568	2,995	(3,567)
Add: opening cash		14,969	9,090	18,536
<b>Cash and cash equivalents at end of year</b>	3.1	<b>15,537</b>	<b>12,085</b>	<b>14,969</b>

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 2016

in thousands of New Zealand Dollars

	Notes	30 June 2016	Budget 30 June 2016	30 June 2015
<b>Surplus/(deficit) for the year</b>		<b>4,366</b>	<b>3,990</b>	<b>3,054</b>
<b>Add back non-cash items:</b>				
Share of associate surplus		(48)	-	(183)
Depreciation and amortisation		13,695	13,872	14,062
Write-down of non-current assets held for sale		-	-	524
<b>Add back items classified as investing activity:</b>				
Net loss/(gain) on disposal of property, plant and equipment		23	-	144
Debt forgiven (Hawke's Bay Helicopter Rescue Trust)		13	12	10
<b>Movement in working capital:</b>				
(Increase)/decrease in receivables and prepayments		(4,571)	(359)	(336)
(Increase)/decrease in inventories		(412)	(77)	(167)
Increase/(decrease) in payables and deferred revenue		7,495	8,014	(5,285)
Increase/(decrease) in employee entitlements		(281)	21	2,763
Increase/(decrease) in provisions		(206)	-	260
Net movement in working capital		2,025	7,599	(2,765)
<b>Other movements not in working capital</b>				
Increase/(decrease) in employee entitlements		295	71	47
<b>Net cash inflow/(outflow) from operating activities</b>		<b>20,369</b>	<b>25,544</b>	<b>14,893</b>

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 2016

In preparing the 2016 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 DHB's activities
- Financing the DHB'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 DHB. 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

HBDHB is a DHB established by the New Zealand Public Health and Disability Act 2000. The DHB is a crown entity as defined by the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

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

The financial statements of HBDHB comprise the DHB, its 19% 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 DHB's in the central region.

The financial statements for HBDHB are for the year ended 30 June 2016, and were approved by the Board on 26 October 2016.

#### 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 DHB 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.

##### 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 July 2015, the External Reporting Board issued 2015 Omnibus Amendments to PBE Standards for reporting periods beginning on or after 1 January 2016. HBDHB will apply the updated standards in preparing its 30 June 2017 financial statements. The DHB expects there will be minimal or no change in applying the updated standards.

# Notes to the financial statements (continued)

**For the year ended 30 June 2016**  
in thousands of New Zealand Dollars

## 2. Result for the year

### 2.1 Performance by Arm

HBDHB'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 2015/16 year.

	Achieved \$'millions	Plan \$'millions	Variance \$'millions
<b>Revenue</b>			
Funding health services	495.8	489.5	6.3
Governance and funding administration	3.2	3.2	-
Providing health services	285.0	281.1	3.9
Eliminations	(266.8)	(263.4)	(3.4)
	517.2	510.4	6.8
<b>Surplus/(Deficit)</b>			
Funding health services	4.6	4.0	0.6
Governance and funding administration	0.4	-	0.4
Providing health services	(0.6)	-	(0.6)
	4.4	4.0	0.4

*Note: Providing health services includes \$4.5 million of claims for pharmaceutical expenditure through sector services (MOH) that are ultimately paid for from the funding health services category. These claims are eliminated in the financial statements, but are included in the above table to provide a more useful comparison.*

Funding health services includes \$3.0 of revenue to offset the additional capital charge arising from land and building revaluations in 2014/15, and additional MOH funding for additional services provided. The funding arm surplus is \$4.6 million which is \$0.6 million better than plan. The variance from plan results from slower than planned implementation of: medicine use reviews by pharmacies; lower access payments by the PHO; and new investment expenditure by the DHB.

The governance and funding administration surplus relates to vacancies and lower than planned consultancy costs.

Providing health services revenue includes the \$3.0 million of capital charge funding, with the remainder from donations and bequests, clinical trials income and sundry income. The deficit of \$0.6 million includes additional costs for medical vacancy and leave cover, and outsourcing costs to meet elective surgery targets, partly offset by lower ACC levies.

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 HBDHB 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 2016**  
in thousands of New Zealand Dollars

HBDHB'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 2015/16 year.

	30 June 2016	Budget 30 June 2016	30 June 2015
<b>Revenue</b>			
Prevention services	6.7	10.1	6.8
Early detection and management	96.8	98.9	124.2
Intensive assessment and treatment	337.8	329.0	292.6
Rehabilitation and support	75.8	72.4	72.6
Total revenue	517.1	510.4	496.2
<b>Expenditure</b>			
Prevention services	10.2	10.1	10.0
Early detection and management	97.6	98.3	125.9
Intensive assessment and treatment	332.2	326.1	285.1
Rehabilitation and support	72.7	71.9	72.1
Total expenses	512.7	506.4	493.1
<b>Surplus/(deficit) for the year</b>	<b>4.4</b>	<b>4.0</b>	<b>3.1</b>

### Comparison to 2014/15

The increase in intensive assessment and treatment reflects medical vacancy and leave costs, outsourcing of some elective surgery to meet health targets, and the investment in transformation projects. Rehabilitation and support costs includes demographic impacts on the health of older people. The comparison includes reclassifications between early detection and management and intensive assessment and treatment.

### Comparison to budget

The increase in intensive assessment and treatment reflects the same medical, outsourcing and investment factors mentioned above. 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 HBDHB 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 DHB 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 DHB 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 \$6.7 million higher than plan. This reflects:

## Notes to the financial statements (continued)

### For the year ended 30 June 2016

*in thousands of New Zealand Dollars*

- additional funding of \$3.5 million from MOH, including \$3.0 million to compensate for additional capital charges resulting from land and building revaluations in June 2015, and the remainder for palliative assessment care coordination and cancer nurse coordinator funding.
- sundry income of \$1.1 million including \$0.5 million from donations, bequests and clinical trials;
- reduced ACC levies of \$1 million due mainly to the removal of the residual claims levy; and
- interest on working capital invested of \$0.4 million;

partly offset by:

- reduced revenue from Tairāwhiti DHB of \$1.0 million, due to lower sales of cancer treatment pharmaceuticals;
- increased costs for Hawke's Bay patients treated by other district health boards;
- reduced revenue of \$0.6 million from ACC as the DHB prioritised elective surgery targets over ACC volumes earlier in the year.

### Financial Position

The projections in the 2015/16 Annual Plan was based on forecasts prepared well before the end of the 2014/15 year. A comparison of the actual balances with the plan would include amounts reflecting differences between the forecast and reported 2014/15 balances. These amounts comprised increases of \$9.4 million in assets, \$5.8 million in liabilities and \$3.6 thousand in equity, and explain most of the variances from budget.

### Cash Flow

Cash from operating activities was \$5.2 million lower than plan reflecting higher amounts owed by MOH at balance date. The \$6.1 million lower cash investments related to the Mental Health Inpatient Unit (MHIU) build, and long lead times for radiology equipment. Lower financing inflows of \$3.3 million resulted from the postponement of \$5.0 million of borrowing until October 2016, and the non-cash transfer of the Chatham Islands health services to Canterbury DHB.

## 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 \$5.225 million (2015: \$4.796 million). Refer note 4.3.

### Workplace accident self-insurance

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

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

### 2.5 Critical judgements in applying accounting policies

In the process of applying HBDHB'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 2016.

#### Impairment of intangible assets with indefinite lives

The DHB has invested in the National Oracle Solution (NOS) facilitated by New Zealand Health Partnerships Limited, a company collectively owned by the 20 DHBs, to provide a finance, procurement and supply chain (FPSC) system and return significant procurement savings to the sector. The investment is considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. The fund established by NZHPL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to maintain the FPSC assets standard of performance or service potential indefinitely. The DHB is expecting to be using the new system at some point between 2017 and 2019.

The DHBs have determined that NOS will be completed with substantially the same scope as originally designed and will contribute savings to the sector. HBDHB is of the view that sufficient savings will be made in Hawke's Bay based on savings to date, and that no impairment of the asset is necessary.

The DHB 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 DHBs. The DHBs in the central region continue to support the project, and consequently HBDHB 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

HBDHB 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 DHBs

Inter district patient inflow revenue occurs when a patient treated within HBDHB region is domiciled outside of Hawke's Bay, and is recognised at time of discharge. The Ministry of Health credits HBDHB 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 HBDHB.

##### 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 2016**  
in thousands of New Zealand Dollars

	30 June 2016	30 June 2015
Ministry of Health population-based revenue	467,815	431,817
Ministry of Health contract revenue	23,980	37,186
Revenue from other DHBs	11,455	12,137
Other Crown entity contracted revenue	5,933	6,421
Other patient care related revenue	1,313	1,483
	<b>510,496</b>	<b>489,044</b>

### 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 HBDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB 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 HBDHB 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 HBDHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB.

	30 June 2016	30 June 2015
Donations and bequests received	333	451
Rental revenue	576	545
Cafeteria and food sales	965	967
Other operating revenue	3,239	3,584
Gain on sale of property, plant and equipment	36	78
	<b>5,149</b>	<b>5,625</b>

### 2.8 Personnel costs

	30 June 2016	30 June 2015
Salaries and wages	182,031	171,427
Employer contributions to defined contribution plans	5,279	4,793
Increase/(decrease) in employee entitlements	12	2,880
	<b>187,322</b>	<b>179,100</b>

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**  
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 2016	30 June 2015
Impairment of receivables (bad and doubtful debts)	132	102
Loss on disposal of property, plant and equipment	27	222
Fees to auditor for the audit of the financial statements	123	119
Fees to board members	275	252
Operating lease expenses	4,160	3,901
Increase/(decrease) in provisions	243	626
Koha	2	3
Write-down of non-current assets held for sale	-	518
	<b>4,962</b>	<b>5,743</b>

### 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 2016	30 June 2015
Interest on Crown loans	2,018	2,281
Attributed interest on finance leases	-	8
	<b>2,018</b>	<b>2,289</b>

### 2.11 Capital charge

#### Accounting policy

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

DHBs 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 2016 was 8% (2015: 8%).

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**  
in thousands of New Zealand Dollars

### 3. Resourcing the DHB'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.

<b>Cash and cash equivalents</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
Cash	4	7
Bank balances	35	3
Credit balance (NZ Health Partnerships Limited)	14,223	13,537
Call deposits – special funds	423	436
Call deposits – clinical trials	852	986
<b>Cash and cash equivalents</b>	<b>15,537</b>	<b>14,969</b>

##### **Short term investments**

Term deposits – special funds	1,397	1,368
Term deposits – clinical trials	342	335
	<b>1,739</b>	<b>1,703</b>

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 DHB. The delivery of health services is usually restricted by specialty, location or patient type.

##### **Special funds**

Opening balance	1,804	1,805
Donations and bequests	233	299
Interest received	61	70
Expenditure during the year	(278)	(370)
	<b>1,820</b>	<b>1,804</b>

Special funds include funding from the Ministry of Education for early childhood education purposes. Receipts in 2016 amounted to \$165 thousand (2015: \$147 thousand), and the balance of funds as at 30 June 2016 amounted to \$358 thousand (30 June 2015: \$372 thousand).

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**  
in thousands of New Zealand Dollars

<b>Clinical Trials</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
Opening balance	1,321	1,259
Receipts	312	349
Interest received	32	47
Expenditure during the year	(472)	(334)
	<b>1,193</b>	<b>1,321</b>

### DHB Treasury Services Agreement

HBDHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHPL) and all DHBs. This agreement enables NZHPL to sweep DHB bank account balances and invest the pool of surplus funds on their behalf. The agreement also allows individual DHBs 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 DHB is the value of one month's provider arm funding plus GST. As at 30 June 2016 this limit for HBDHB was \$24.9 million (2015: \$20.2 million), and has not been utilised.

The DHBs have appointed Westpac as their preferred supplier of the banking arrangements. The DHB 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

HBDHB 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 HBDHB 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.

	<b>30 June 2016</b>	<b>30 June 2015</b>
Ministry of Health receivables	3,423	1,485
Trade receivables	2,111	1,877
Ministry of Health accrued revenue	6,489	5,617
Other accrued revenue	9,842	8,305
Prepayments	556	568
	<b>22,421</b>	<b>17,852</b>

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 \$33 thousand (2015: \$27 thousand)

Receivables are shown net of impairments amounting to \$216 thousand (2015: \$139 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 2016**  
in thousands of New Zealand Dollars

As at 30 June 2016 and 2015, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

	<b>Gross</b> <b>30 June 2016</b>	<b>Impairment</b> <b>30 June 2016</b>	<b>Net</b> <b>30 June 2016</b>	<b>Gross</b> <b>30 June 2015</b>	<b>Impairment</b> <b>30 June 2015</b>	<b>Net</b> <b>30 June 2015</b>
Not past due/past due<30days	3,426	(43)	3,383	2,755	(7)	2,748
Past due 31-60 days	256	(4)	252	280	(5)	275
Past due 61-90 days	1,045	(13)	1,032	117	(9)	108
Past due >90 days	1,023	(156)	867	349	(118)	231
	<b>5,750</b>	<b>(216)</b>	<b>5,534</b>	<b>3,501</b>	<b>(139)</b>	<b>3,362</b>

The provision has been calculated based on expected losses for HBDHB's pools of debtors. Expected losses have been determined based on an analysis of the DHB'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:

	<b>30 June 2016</b>	<b>30 June 2015</b>
Balance at beginning of year	139	74
Additional provisions made during the year	141	102
Receivables written-off during period	(65)	(37)
Balance at end of year	<b>215</b>	<b>139</b>

### 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

	<b>30 June 2016</b>	<b>30 June 2015</b>
Non-current	42	55
Current	13	12
	<b>55</b>	<b>67</b>

The fair value of loans receivable is \$60 thousand (2015 \$73 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 2.14% (2015 3.23%).

### 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 2016**  
in thousands of New Zealand Dollars

<b>Inventories held for distribution</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
Pharmaceuticals	775	738
Surgical and medical supplies	2,432	2,058
Other supplies	1,086	1,085
	<b>4,293</b>	<b>3,881</b>

Write-down of inventories amounted to \$28 thousand (2015: \$44 thousand). No reversal of previously recognised write-downs was made in the current year. The amount of inventories recognised as an expense during the year ended 30 June 2016 was \$34.2 million (2015: \$39.6 million). No inventories were held at current replacement cost at 30 June 2016 (30 June 2015: 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.

	<b>30 June 2016</b>	<b>30 June 2015</b>
Land	730	730
Buildings	490	490
	<b>1,220</b>	<b>1,220</b>

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. The properties were expected to be sold prior to 30 June 2016, however the disposal process through the Treaty of Waitangi protection mechanism took longer than anticipated. All three properties are now expected to be sold within the next twelve months. At 30 June 2015 the three properties were measured at fair value less costs to sell, 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

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

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.

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 DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired 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 HBDHB 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	2 to 50 years	2% to 50%
Clinical equipment	2 to 20 years	5% to 50%
Information technology	3 to 10 years	10% to 33%
Motor vehicles	8.5 to 20 years	5% to 12%
Other equipment	10 to 30 years	3.3% to 10%

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

HBDHB 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 2016**

*in thousands of New Zealand Dollars*

30 June 2016	1 July 2015			Acquisitions	Transfers from work in progress	Reclassifications between classes of assets	Disposals	Depreciation expense	Depreciation write back on disposal	30 June 2016		
	Cost/Valuation	Accumulated Depreciation	Carrying Amount							Cost/valuation	Accumulated Depreciation	Carrying Amount
<b>Owned assets</b>												
Land	8,130	-	8,130	-	-	-	-	-	-	8,130	-	8,130
Buildings	107,920	-	107,920	-	19,656	-	-	(7,521)	-	127,576	(7,521)	120,055
Clinical equipment	32,754	(17,703)	15,051	-	2,454	-	(1,904)	(3,695)	1,765	33,304	(19,633)	13,671
Information tech.	8,086	(5,623)	2,463	-	681	-	(1,543)	(1,226)	1,542	7,224	(5,307)	1,917
Motor vehicles	1,788	(907)	881	-	28	-	(9)	(164)	8	1,807	(1,063)	744
Other equipment	2,877	(1,379)	1,498	-	533	-	(300)	(315)	257	3,110	(1,437)	1,673
	161,555	(25,612)	135,943	-	23,352	-	(3,756)	(12,921)	3,572	181,151	(34,961)	146,190
<b>Leased assets</b>												
Alterations	1,347	(153)	1,194	-	87	-	-	(64)	-	1,434	(217)	1,217
	1,347	(153)	1,194	-	87	-	-	(64)	-	1,434	(217)	1,217
<b>Work in Progress</b>												
Buildings	10,743	-	10,743	13,056	(19,743)	-	-	-	-	4,056	-	4,056
Clinical equipment	201	-	201	2,441	(2,441)	-	-	-	-	201	-	201
Information tech.	122	-	122	633	(681)	-	-	-	-	74	-	74
Motor vehicles	-	-	-	28	(28)	-	-	-	-	-	-	-
Other equipment	29	-	29	575	(546)	-	-	-	-	58	-	58
	11,095	-	11,095	16,733	(23,439)	-	-	-	-	4,389	-	4,389
	173,997	(25,765)	148,232	16,733		-	(3,756)	(12,985)	3,572	186,974	(35,178)	151,796



## Notes to the financial statements (continued)

### For the year ended 30 June 2016

*in thousands of New Zealand Dollars*

#### 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 DHB'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.
- 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 DHB 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

HBDHB 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 DHB has declared surplus and wishes to sell, to be sold to it for use in the redress of Treaty of Waitangi claims. The DHB 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 2016**

*in thousands of New Zealand Dollars*

30 June 2015	1 July 2014			Acquisitions	Transfers	Revaluations	Disposals/ transfer/ reclassification to operating lease	Depreciation expense	Depreciation write back on disposal, transfer, or revaluation	30 June 2015		
	Cost/ Valuation	Accumulated Depreciation	Carrying Amount							Cost/ valuation	Accumulated Depreciation	Carrying Amount
<b>Owned assets</b>					(Note 1)	(Note 2)	(Note 3)					
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
<b>Leased assets</b>												
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
<b>Work in Progress</b>												
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 2016

*in thousands of New Zealand Dollars*

#### **Note 1: Classification changes**

Plant to be included in the revaluation of 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 HBDHB 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 HBDHB 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 \$250 thousand, accumulated depreciation of \$137 thousand, and a \$38 thousand gain on transfer.

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*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 DHB 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:

<b>Type of asset</b>	<b>Estimated life</b>	<b>Amortisation rate</b>
Acquired computer software	1.5 to 15 years	6.7% to 67%
Developed computer software	3 to 15 years	6.7% to 33%
FPSC rights	Indefinite	Nil
RHIP assets	Work in progress	Nil

##### **Impairment of intangible assets**

HBDHB 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 2016

*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 2015									30 June 2016		
<b>30 June 2016</b>	Cost/ Valuation	Accumulated Amortisation	Carrying Amount	Acquisitions	Transfers	Adjustments	Disposals	Amortisation Expense	Amortisation written back	Cost/ Valuation	Accumulated Amortisation	Carrying Amount
<b>Owned assets</b>												
Software	10,562	(8,264)	2,298	-	450	-	(13)	(710)	11	10,999	(8,963)	2,036
	10,562	(8,264)	2,298	-	450	-	(13)	(710)	11	10,999	(8,963)	2,036
<b>Work in Progress</b>												
Software	71	-	71	396	(450)	-	-	-	-	17	-	17
FPSC rights	2,504	-	2,504	-	-	-	-	-	-	2,504	-	2,504
RHIP assets	3,599	-	3,599	1,900	-	687	-	-	-	6,186	-	6,186
	6,174	-	6,174	2,296	(450)	687	-	-	-	8,707	-	8,707
	16,736	(8,264)	8,472	2,296	-	687	(13)	(710)	11	19,706	(8,963)	10,743

The FPSC rights represent the DHB's right to access, under a service agreement, shared finance, procurement and supply chain (FPSC) systems using assets funded by the DHBs. The intangible asset is recognised at the cost of capital invested by the DHB in the National Oracle Solution (NOS), a national initiative facilitated by New Zealand Health Partnerships Limited (NZHPL), whereby all 20 DHBs will move to shared systems model for the provision of FPSC systems. NZHPL is a company owned collectively by the 20 DHBs with equal voting rights, and has taken over a number of national initiatives previously facilitated by Health Benefits Limited (HBL).

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. The fund established by NZHPL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to maintain the FPSC assets standard of performance or service potential indefinitely. The DHB is expecting to be using the new system from 2019.

## Notes to the financial statements (continued)

### For the year ended 30 June 2016

*in thousands of New Zealand Dollars*

The RHIP assets are the DHB's share of the assets comprising the Regional Health Informatics Programme (RHIP) facilitated by Central Region's Technical Advisory Services Limited (CRTAS). The intangible asset recognises the DHB's right to use the RHIP clinical information systems, and its ownership of a proportion of the systems assets. 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 2016 is considered to be fit for purpose, and the DHBs in the central region continue to support the project. HBDHB 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 2014									30 June 2015		
<b>30 June 2015</b>	Cost/ Valuation	Accumulated Amortisation	Carrying Amount	Acquisitions	Transfers	Adjustments	Disposals	Amortisation Expense	Amortisation written back	Cost/ Valuation	Accumulated Amortisation	Carrying Amount
<b>Owned assets</b>												
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
<b>Work in Progress</b>												
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

# Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

## 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 HBDHB 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 2016	30 June 2015
Balance at beginning of year	131	153
Fair value adjustments	-	(22)
Balance at end of year	131	131

No revaluation was completed for investment properties as at 30 June 2016 due to the minimal value of the properties. The properties were last revalued as at 30 June 2015 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 the investment properties was determined using market based evidence. One of the properties is leased to an external party for \$11 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 DHB 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 DHB's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount of the investment.

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

HBDHB has an investment in one associate entity, Allied Laundry Services Limited (ALSL), whose principal activity is the provision of laundry services. The interest held at 30 June 2016 was 19% (30 June 2015: 25%). ALSL issued 400,000 bonus shares to each of the existing shareholders, taking their shareholdings to 1,150,000 each, and Capital and Coast DHB (CCDHB) and Hutt Valley DHB (HVDHB) were each issued 1,150,000 shares for \$1 per share in cash. The CCDHB shares are fully paid, and the HVDHB shares are paid to \$300,000, with the remainder to be paid over the next three years. The associates balance date is 30 June. There are no significant restrictions on the ability of the associate to transfer funds to HBDHB in the form of cash dividends.

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

<b>Summarised financial information of Allied Laundry Services Limited</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
<i>Presented on a gross basis</i>		
Assets	10,418	5,690
Liabilities	4,419	1,090
Revenue	9,239	8,003
Surplus/(deficit)	354	757
HBDHB ownership interest	19%	25%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Other contracted commitments (operating leases)	-	7

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 draft financial statements as at 30 June 2016, and their audited financial statements as at 30 June 2015.

### 4. Financing the DHB'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 HBDHB 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 DHB 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.

<b>Non-current</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
Crown loans	42,500	42,500
	<b>42,500</b>	<b>42,500</b>

##### **Crown loans**

HBDHB 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%	4.58%
-------------	-------	-------

The Ministry of Health has signalled an intent to convert all current DHB debt held by the Ministry into equity in October 2017. If the Ministry of Health proceeds with that intent, the capital structure of the DHBs will change significantly, as will the nature and timing of their current term liabilities.



## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

<b>Repayable as follows:</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
Less than one year	-	-
One to two years	6,000	-
Two to three years	11,500	6,000
Three to four years	-	11,500
Four to five years	10,000	-
Later than five years	15,000	25,000

<b>Term loan facility limits:</b>		
Crown loans	42,500	42,500
Surplus fund pool (New Zealand Health Partnerships Limited) refer to note 3.1	24,900	20,200
	67,400	62,700

The fair value of Crown loan borrowings is \$46.803 million (2015 \$45.117 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 DHB risk ranging from 2.10% to 2.35% (2015 3.19% to 3.45%).

### 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 HBDHB 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 was extended for the first of the three six year periods of the right of renewal. The new lease did not meet the criteria for a finance lease and was reclassified as an operating lease.

# Notes to the financial statements (continued)

For the year ended 30 June 2016

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 2016	30 June 2015
Trade payables	6,308	4,814
Income in advance relating to contracts with specific performance obligations	2,933	2,228
Other non-trade payables and accrued expenses	25,327	21,020
	34,568	28,062
Payables and deferred revenue under non exchange transactions		
ACC levy payable	482	864
Goods and services tax	3,268	1,897
	3,750	2,761
<b>Total payables and deferred revenue</b>	<b>38,318</b>	<b>30,823</b>

Payables and deferred revenue are non-interest bearing and are normally settled on the 20<sup>th</sup> 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 2016

in thousands of New Zealand Dollars

## Defined benefit schemes

HBDHB 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.

<b>Non-current liabilities</b>	<b>30 June 2016</b>	<b>30 June 2015</b>
Long service leave	2,497	2,194
Retirement gratuities	141	148
	<b>2,638</b>	<b>2,342</b>
<b>Current liabilities</b>		
Accrued salaries and wages	7,465	7,919
Annual leave	18,807	19,125
Sick leave	342	257
Continuing medical education leave and expenses	4,729	4,375
Sabbatical leave	619	576
Long service leave	1,470	1,463
Retirement gratuities	156	157
	<b>33,588</b>	<b>33,872</b>

## 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 2.12% in year one to 4.75% after 39 years. The salary inflation factor is the DHB'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 \$228 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 \$195 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 2016**

*in thousands of New Zealand Dollars*

	30 June 2016	30 June 2015
Balance at beginning of year	506	278
Additional provisions made	243	626
Amounts used	(449)	(398)
Unused amounts reversed	-	-
Balance at end of year	300	506

All provisions are classified as current.

### a. ACC Accredited Employers Programme

HBDHB belongs to the ACC Accredited Employers Programme's full self-cover plan, whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme, the DHB 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 DHB 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.

HBDHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will carry the total cost of claims up to \$1.5 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 DHB will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

The DHB is not 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 DHB's liability, and the valuation is effective 30 June 2016. 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 2016 (30 June 2015: Nil).

## Notes to the financial statements (continued)

For the year ended 30 June 2016

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 2015	35,572	69,188	3,125	15,253	(35,511)	87,627
Surplus/(deficit) for the year	-	-	-	-	4,366	4,366
Transfers between reserves	-	-	(112)	(15,253)	15,365	-
Repayment to the Crown	(356)	-	-	-	-	(356)
Revaluation of land and buildings	-	(1,796)	-	-	1,796	-
<b>Balance at 30 June 2016</b>	<b>35,216</b>	<b>67,392</b>	<b>3,013</b>	<b>-</b>	<b>(13,984)</b>	<b>91,637</b>

	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
<b>Balance at 30 June 2015</b>	<b>35,572</b>	<b>69,188</b>	<b>3,125</b>	<b>15,253</b>	<b>(35,511)</b>	<b>87,627</b>

#### Asset Replacement Reserves

The asset replacement reserve included 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 \$7.403 million. These funds were reserved for the development of the mental health intensive care unit, and with the completion of Nga Rau Rakau in February 2016, were transferred to accumulated deficit.

#### Property Revaluation Reserves

These reserves result from the revaluation of land and buildings to fair value. Recreation of the revaluation history of land and buildings in 2015/16 has allowed the transfer of \$1.795 million from revaluation reserves to accumulated deficits relating to assets disposed of prior to 30 June 2015. The revaluation reserve consists of amounts as follows:

	30 June 2016	30 June 2015
Land	7,060	7,842
Buildings	60,332	61,346
	<b>67,392</b>	<b>69,188</b>

#### 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 2016**

*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

HBDHB 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 2016	30 June 2015
Property, plant and equipment		
Buildings	1,148	6,833
Clinical equipment	451	457
Plant	7	13
Information technology	56	5
Intangible assets		
Software	12	3
Regional Health Information Project (RHIP)	1,539	2,309
	3,213	9,620

Capital commitments include orders issued for property, plant and equipment, and future agreed contributions to 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 2016	30 June 2015
Not more than one year	2,730	1,994
One to five years	7,524	5,797
Later than five years	3,682	3,556
	13,936	11,347

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

HBDHB 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 Omaha 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 was renewed from July 2015, for four years, with a right of renewal for a further three periods of four years each.

### 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 2016	30 June 2015
Cash and cash equivalents	15,537	14,969
Short term investments	1,739	1,703
Loans	55	67
Trade and other receivables	22,421	17,852
	<b>39,752</b>	<b>34,591</b>

##### Financial Liabilities

Financial liabilities measured at amortised cost

Secured bank loans (Ministry of Health)	42,500	42,500
Trade and other payables	38,318	30,823
	<b>80,818</b>	<b>73,323</b>

#### b. Fair value hierarchy disclosures

HBDHB recognises no financial instruments at fair value in the statement of financial position.

#### c. Financial instrument risks

HBDHB's activities expose it to a variety of financial instrument rate risks, including market risk, credit risk and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow 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. HBDHB'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.

## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

### 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 HBDHB to cash flow interest rate risk.

HBDHB's investment policy requires a spread of investment maturity dates to limit exposure to short-term interest rate movements. The DHB currently has no variable interest rate investments.

HBDHB'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.

<b>30 June 2016</b>	<b>Effective Interest Rates</b>	<b>Total</b>	<b>6 months or less</b>	<b>6-12 months</b>	<b>1-2 years</b>	<b>2-5 years</b>	<b>&gt; 5 years</b>
Cash and cash equivalents							
Cash	-	4	4				
Bank balances	-	35	35				
Credit balance (HBL)	3.93%	14,223	14,223	-	-	-	-
Short term deposits	1.29%	1,275	1,275	-	-	-	-
Short term investments	3.27%	1,739	1,739	-	-	-	-
Secured bank loans:							
NZD fixed rate loans	4.58%	(42,500)	-	-	(6,000)	(21,500)	(15,000)
Repricing gap		<b>(25,224)</b>	<b>17,276</b>	<b>-</b>	<b>(6,000)</b>	<b>(21,500)</b>	<b>(15,000)</b>

During the year ended 30 June 2015, \$10 million of borrowings matured and was re-borrowed to April 2025 at an interest rate of 3.40%.

<b>30 June 2015</b>	<b>Effective Interest Rates</b>	<b>Total</b>	<b>6 months or less</b>	<b>6-12 months</b>	<b>1-2 years</b>	<b>2-5 years</b>	<b>&gt; 5 years</b>
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		<b>(25,828)</b>	<b>16,672</b>	<b>-</b>	<b>-</b>	<b>(17,500)</b>	<b>(25,000)</b>

### 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. HBDHB 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.



## Notes to the financial statements (continued)

**For the year ended 30 June 2016**

*in thousands of New Zealand Dollars*

HBDHB hedges all capital asset purchase orders greater than \$100,000 denominated in foreign currencies. The DHB 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 DHB's bankers. The DHB 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, usually with the price fixed in NZD.

### **Credit risk**

Credit risk is the risk that a third party will default on its obligations to HBDHB, causing it to incur a loss.

Financial instruments, which potentially subject the DHB to concentrations of risk consist principally of cash, short-term deposits and accounts receivable. The DHB 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 DHBs.

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 2015: 96%) of the DHB'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 2016, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2016/17, as most of the DHB's term debt is at fixed rates, and only the net interest from cash holdings would be affected.

### *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 2016	30 June 2015
<b>Counterparties with credit ratings</b>		
<b>Cash, cash equivalents and investments</b>		
AA-	3,053	3,135
<i>Total cash and cash equivalents</i>	3,053	3,135

## Notes to the financial statements (continued)

For the year ended 30 June 2016

in thousands of New Zealand Dollars

	30 June 2016	30 June 2015
<b>Counterparties without credit ratings</b>		
<b>Cash and cash equivalents</b>		
NZ Health Partnerships Limited – no defaults in the past	14,223	13,537
<b>Receivables and prepayments</b>		
Receivables and prepayments with no defaults in the past	22,388	17,825
Receivables and prepayments with defaults in the past	33	27
Total Receivables and prepayments	22,421	17,852
<b>Loans</b>		
Hawke's Bay Helicopter Rescue Trust - no defaults in the past	55	67

### Liquidity risk

Liquidity risk is the risk that HBDHB 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 DHB aims to maintain flexibility in funding by keeping committed credit lines available. In meeting its liquidity requirements HBDHB maintains a target level of investments that must mature within specified time frames.

### Contractual maturity analysis of financial liabilities

The table below analyses HBDHB'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 2016	Carrying amount	Contractual cash flows	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
Payables and deferred revenue	38,318	38,318	38,318	-	-	-	-
Secured loans (Ministry of Health)	42,500	51,047	6,964	767	1,547	25,055	16,714
	<b>80,818</b>	<b>89,365</b>	<b>45,282</b>	<b>767</b>	<b>1,547</b>	<b>25,055</b>	<b>16,714</b>

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
	<b>73,323</b>	<b>84,222</b>	<b>31,804</b>	<b>970</b>	<b>1,945</b>	<b>21,752</b>	<b>27,751</b>

### Forecasted transactions

HBDHB does not hedge forecasted transactions.

## 5.4 Contingent assets

There are no contingent assets at 30 June 2016.

# Notes to the financial statements (continued)

For the year ended 30 June 2016

in thousands of New Zealand Dollars

## 5.5 Contingent liabilities

### Lawsuits against the DHB

HBDHB 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 DHB or some other party. An assessment of the financial effect of the disputes and grievances cannot be made. The DHB was exposed to the same type of contingent losses last year, and no assessment of the financial effect could be made.

### Superannuation schemes

The DHB 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 DHB could be responsible for any deficit of the scheme. Similarly, if a number of employers cease to have employees participating in the scheme, the DHB could be responsible for an increased share of any deficit.

As at March 2016, the scheme had a past service surplus of \$11.7 million (7.4% of the liabilities). This amount is 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

HBDHB 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 HBDHB 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 2016	30 June 2015
<b>Board Members</b>		
Remuneration	275	274
<i>Full time equivalent members</i>	1.3	1.3
<b>Executive management team</b>		
Remuneration	2,864	2,670
<i>Full time equivalent members</i>	10.6	9.3
<b>Total key management personnel remuneration</b>	<b>3,139</b>	<b>2,944</b>
<b>Total full time equivalent personnel</b>	<b>11.9</b>	<b>10.6</b>

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 2016**

*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 2016		30 June 2015	
	Board	Committees	Board	Committees
Kevin Atkinson <i>Chair</i>	42,000	2,500	42,000	2,500
Ngahiwi Tomoana <i>Deputy Chair (appointed member)</i>	25,500	1,438	25,500	2,188
Barbara Arnott <i>(appointed member)</i>	20,400	3,250	20,400	2,250
Andrew Blair <i>(appointed member)</i>	20,400	2,500	20,400	2,500
Dan Druzianic	20,400	3,120	20,400	3,120
Peter Dunkerley	20,400	2,562	20,400	2,500
Denise Eaglesome <i>(appointed member)</i>	20,400	1,000	20,400	750
Helen Francis	20,400	1,000	20,400	1,500
Diana Kirton	20,400	1,750	20,400	1,250
Jacoby Poulain	20,400	2,500	20,400	2,500
Heather Skipworth	20,400	1,813	20,400	2,063
	251,100	23,433	251,100	23,121

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 Pacifica Health Leadership Group and reporting back to the board.

Directors fees of \$10,000 were paid to ex-board member David Ritchie (2014: \$11,250) as one of the DHB's representatives on the Board of Allied Laundry Services Limited (ALSL). David ceased to be a director of ALSL when the board of that company was restructured to accommodate Capital and Coast Health DHB and Hutt Valley DHB (see note 3.9).

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

There are no statutory committee members other than Board members. Consumer input is now sought through the non-statutory Consumer Council, Māori Relationship Board and the Pacifica Health Leadership Group.

# Notes to the financial statements (continued)

For the year ended 30 June 2016

in New Zealand Dollars

## Employee Remuneration

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

	30 June 2016	30 June 2015		30 June 2016	30 June 2015
100,000-109,999	55	47	300,000-309,999	6	2
110,000-119,999	29	27	310,000-319,999	5	7
120,000-129,999	21	19	320,000-329,999	3	4
130,000-139,999	16	19	330,000-339,999	1	1
140,000-149,999	8	8	340,000-349,999	2	-
150,000-159,999	15	12	350,000-359,999	1	2
160,000-169,999	9	5	360,000-369,999	2	1
170,000-179,999	12	10	370,000-379,999	1	1
180,000-189,999	10	9	380,000-389,999	1	-
190,000-199,999	9	7	390,000-399,999	-	-
200,000-209,999	8	9	400,000-409,999	1	1
210,000-219,999	9	9	410,000-419,999	-	-
220,000-229,999	6	11	420,000-429,999	1	-
230,000-239,999	7	6	430,000-439,999	-	-
240,000-249,999	5	8	440,000-449,999	-	-
250,000-259,999	8	6	450,000-459,999	-	-
260,000-269,999	6	3	460,000-469,999	-	-
270,000-279,999	9	1	470,000-479,999	-	1
280,000-289,999	-	7	480,000-489,999	1	-
290,000-299,999	6	2	490,000-500,000	-	-

During the year, ten (30 June 2015: 4) employees received compensation and other benefits in relation to cessation totalling \$144,923 (30 June 2015: \$53,851).

## 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.

HBDHB 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

HBDHB's capital is its equity, which comprises Crown equity, reserves, restricted funds and accumulated surpluses/(deficits). The DHB 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 DHB 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

<b>Baseline</b>	Latest available data for planning purpose
<b>Target 2015/16</b>	Target 2015/16
<b>Actual to date</b>	Actual to date
<b>F (Favourable)</b>	Actual to date is favourable to target (above or within 0.5% of target)
<b>U (Unfavourable)</b>	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
2014/15	98.6% 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
2015/16	98.2% October – December 2014	≥95%	98.1% (F) – July to September 2015
			99.1% (F) – October to December 2015
			97.8% (F) – January to March 2016
			98.6% (F) – April to June 2016

Health Target: Better help for smokers to quit - Percentage of PHO enrolled smokers offered advice to quit			
Financial Year Source: Ministry of Health	Baseline	Target	Actual to Date
2014/15	80.2% October – December 2013 (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
2015/16	96.0% October – December 2014 (Source: DHBNZ)	≥90%	81.2% (U) – July to September 2015
			75.0% (U) – October to December 2015
			77.6% (U) – January to March 2016
			81.3% (U) – April to June 2016

Health Target: Better help for smokers to quit - % of pregnant women offered advice and support to quit			
Financial Year Source: Ministry of Health	Baseline	Target	Actual to Date
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
2015/16	98.1% October – December 2014	≥90%	90.3% (F) – July to September 2015
			96.5% (F) – October to December 2015
			88.6% (U) – January to March 2016
			89.0% (U) – April to June 2016

Percent of pregnant Māori women that are smokefree at 2 weeks postnatal			
Financial Year	Baseline	Target	Actual to Date
2014/15	New	New	-
2015/16	58% July to December 2013	≥86%	65.6% (U) January to June 2015

Health Target: Increased immunisation - Percentage of 8 month who complete their primary course of immunisations			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2014/15	94.7% 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
2015/16	96.0% 3 months to December 2014	≥95%	94.5% (F) – July to September 2015
			93.3% (U) – October to December 2015
			98.5% (F) – January to March 2016
			95.2% (F) – April to June 2016
MAORI			
2014/15	96.4% 3 months to December 2013	≥95%	95.1% (F) – 3 months to September 2014
			95.9% (F) – 3 months to December 2014
			95.8% (F) – 3 months to March 2015
			95.2% (F) - 3 months to June 2015
2015/16	95.9% 3 months to December 2014	≥95%	96.7% (F) – July to September 2015
			92.6% (U) – October to December 2015
			97.7% (F) – January to March 2016
			94.6% (F) – April to June 2016

Increased immunisation - Percentage of 2 year olds fully immunised:			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2014/15	95.5% 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
2015/16	94.0% 3 months to December 2014	≥95%	95.7% (F) – July to September 2015
			93.9% (U) – October to December 2015
			95.1% (F) – January to March 2016
			95.2% (F) – April to June 2016
MAORI			
2014/15	97.7% 3 months to December 2013	≥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
2015/16	95.0% 3 months to December 2014	≥95%	95.9% (F) – July to September 2015
			95.1% (F) – October to December 2015
			94.8% (F) – January to March 2016
			95.1% (F) – April to June 2016

Increased immunisation - Percentage of 4 year olds fully immunised by age 5:			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2014/15	New	New	-
2015/16	90.6% 3 months to December 2014	≥90%	92.2% (F) – July to September 2015
			92.7% (F) – October to December 2015
			92.2% (F) – January to March 2016
			93.0% (F) – April to June 2016
MAORI			
2014/15	New	New	-
2015/16	New	≥90%	93.3% (F) – July to September 2015
			94.2% (F) – October to December 2015
			93.2% (F) – January to March 2016
			94.0% (F) – April to June 2016

Increased immunisation - Percentage of girls what have received HPV dose three			
Financial Year	Baseline	Target	Actual to Date
<b>TOTAL</b>			
2014/15	New	New	-
2015/16	New	≥65%	68.4% (F) 2002 – June 2016
<b>MAORI</b>			
2014/15	New	New	-
2015/16	New	≥65%	87.8% (F) 2002 – June 2016

Rheumatic fever hospitalisations rate per 100,000			
Financial Year	Baseline	Target	Actual to Date
2014/15	4.0 per 100,000 July 2012 – June 2013	≤2.6	0.63 per 100,000 July 2014 – June 2015
2015/16	2.6 per 100,000 July 2013 – June 2014	≤1.9	1.88 per 100,000 July 2015 – June 2016

Percentage of high needs 65 years olds and over influenza immunisation rate			
Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
2014/15	68.3% January to December 2013	≥70%	67.9% (U) - January to December 2014
2015/16	67.9% - January to December 2014	≥75%	Data no longer available from PHO

## POPULATION BASED SCREENING SERVICES

Percentage of women aged 50-69 years receiving breast screening in the last 2 years			
Financial Year	Baseline	Target	Actual to Date
Source: Breast Screen Coast to Coast			
<b>OVERALL RATE</b>			
2014/15	74.0% 24 months to October 2013	≥70%	74.4% (F) - 24 months to 31 March 2015
2015/16	75.8% 24 months to October 2014	≥70%	73.4% (F) - 24 months to 31 March 2016
<b>MAORI</b>			
2014/15	65.8% 24 months to October 2013	≥70%	66.9% (U) - 24 months to 31 March 2015



2015/16	62.7% 24 months to October 2014	≥70%	67.9% (U) - 24 months to 31 March 2016
<b>PACIFIC</b>			
2014/15	73.1% 24 months to October 2013	≥70%	66.1% (U) - 24 months to 31 March 2015
2015/16	79.0% 24 months to October 2014	≥70%	67.2% (U) - 24 months to 31 March 2016

**Percentage of women aged 25-69 years receiving cervical screening in the last 3 years**

Financial Year	Baseline	Target	Actual to Date
Source: Breast Screen Coast to Coast			
<b>OVERALL RATE</b>			
2014/15	82.2% 36 months to 31 October 2013	≥80%	76.7% (U) - 36 months to 31 March 2015
2015/16	76.9% 36 months to 31 December 2014	≥80%	76.6% (U) - 36 months to 31 June 2016
<b>MAORI</b>			
2014/15	74.1% 36 months to 31 October 2013	≥80%	74.6% (U) - 36 months to 31 March 2015
2015/16	73.8% 36 months to 31 December 2014	≥80%	73.2% (U) - 36 months to 31 June 2016
<b>PACIFIC</b>			
2014/15	84.2% 36 months to 31 October 2013	≥80%	72.6% (U) - 36 months to 31 March 2015
2015/16	72.8% 36 months to 31 December 2014	≥80%	71.4% (U) - 36 months to 31 June 2016

**Rate of SUDI deaths per 1,000 live births**

Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
2014/15	2.1 per 1,000 live births 2010 Calendar Year	≤0.5	1.77 (U) 2011 Calendar Year
2015/16	1.77 per 1,000 live births 2011 Calendar Year	≤0.5	1.16 (U) 2010-2014 (five year annualised)

**Infants are exclusively or fully breastfed**

Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
<b>At 6 Weeks Total:</b>			
2014/15	New	New	-
2015/16	New	≥75%	73% (U) - December 2015 to June 2015
<b>At 6 Weeks Maori:</b>			
2014/15	New	New	-
2015/16	58% New	≥75%	67% (U) - December 2015 to June 2015
<b>At 3 Months Total</b>			
2014/15	New	New	-
2015/16	52% 6 months to June 2015	≥60%	53% (U) - June 2015 to December 2015

<b>At 3 Months Maori:</b>			
2014/15	New	New	-
2015/16	New	≥60%	39% (U) - June 2015 to December 2015

<b>Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)</b>			
Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
<b>AT 6 Month Total</b>			
2014/15	New	New	-
2015/16	New	≥65%	58% (U) – June to December 2015
<b>AT 6 Months Maori</b>			
2014/15	New	New	-
2015/16	New	≥65%	48% (U) – June to December 2015

\*The SPE only referenced Plunket data. Since then we have been able to obtain joint Tamariki Ora and Plunket data and have included it in the governance reporting for 2015/16 and have decided to include it in our Annual Report. As a result the baseline set in the Annual Plan is no longer relevant and has been removed from this table.

<b>Percentage of youth accessing CPO sexual health service who are Maori</b>			
Financial Year	Baseline	Target	Actual to Date
2014/15	New	New	-
2015/16	New	≥50%	43.8% (U) January 2016 – March 2016

**OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES**

Proportion of the population enrolled in the PHO			
Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
TOTAL:			
2014/15	96.9% 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
2015/16	97.3% December 2014	≥97%	95.6% (U) - July to September 2015
			96.0% (U) – October to December 2015
			95.2% (U) – January to March 2016
			95.9% (U) - April to June 2016
MĀORI:			
2014/15	93.1% 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
2015/16	94.7% December 2014	≥97%	95.9% (U) - July to September 2015
			97.2% (U) – October to December 2015
			97.8% (U) – January to March 2016
			95.6% (U) - April to June 2016

Percentage of Women booked with an LMC by week 12 of their pregnancy			
Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
TOTAL:			
2014/15	46.9% October 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
2015/16	51.4% October to December 2014	≥80%	56.8% (U) – April to June 2015
			54.5% (U) – July to September 2015
			62.1% (U) – October to December 2015
			60.6% (U) – January to March 2016
MĀORI:			
2014/15	37.8% October 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
2015/16	44.1% October to December 2014	≥80%	43.9% (U) – April to June 2015
			50.7% (U) – July to September 2015
			48.5% (U) – October to December 2015
			49.2% (U) – January to March 2016

<b>Rate of high intensive users of hospital Emergency Department as a proportion of Total ED visits</b>			
<b>Financial Year</b>	<b>Baseline</b>	<b>Target</b>	<b>Actual to Date</b>
Source: DHB Shared Services			
<b>TOTAL:</b>			
2014/15	5.4% October to December 2013	≤5.4%	5.4% (U) - July to September 2014
			5.5% (U) – October to December 2014
			5.6% (U) – January to March 2015
			5.4% (F) - April to June 2015
2015/16	5.5% October to December 2014	≤5.4%	5.4% (U) - July to September 2015
			5.6% (U) – October to December 2015

			5.5% (U) – January to March 2016
			5.4% (F) - April to June 2016
<b>MĀORI:</b>			
2014/15	6.1% October to December 2013	≤5.4%	6.0% (U) - July to September 2014
			6.1% (U) – October to December 2014
			6.2% (U) – January to March 2015
			6.0% (U) - April to June 2015
2015/16	6.1% October to December 2014	≤5.4%	6.3% (U) - July to September 2015
			6.1% (U) – October to December 2015
			6.1% (U) – January to March 2016
			6.1% (U) - April to June 2016

Health Target: More heart and diabetes checks:			
% of the eligible population will have had their cardiovascular disease risk assessed in the last 5 years			
Financial Year	Baseline	Target	Actual to Date
Source: DHB Shared Services			
TOTAL:			
2014/15	73.7% 5 years to December 2013	≥90%	86.2% (U) - 5 years to September 2014
			87.7% (U) – 5 years to December 2014
			90.0% (F) – 5 years to March 2015
			90.4% (F) - 5 years to June 2015
2015/16	87.7% 5 years to December 2014	≥90%	90.3% (F) – 5 years to September 2015
			90.3% (F) – 5 years to December 2015
			89.6% (U) – 5 years to March 2016
			88.5% (U) – 5 years to June 2016
MAORI			
2014/15	69.8% 5 years to December 2013	≥90%	82.3% (U) - 5 years to September 2014
			83.9% (U) – 5 years to December 2014
			86.2% (U) – 5 years to March 2015
			86.0% (U) - 5 years to June 2015
2015/16	83.98% 5 years to December 2014	≥90%	85.8% (U) – 5 years to September 2015
			86.3% (U) – 5 years to December 2015
			86.0% (U) – 5 years to March 2016
			84.9% (U) – 5 years to June 2016
PACIFIC			
2014/15	70.9% 5 years to December 2013	≥90%	82.3% (U) - 5 years to September 2014
			83.7% (U) – 5 years to December 2014
			86.0% (U) – 5 years to March 2015
			87.3% (U) - 5 years to June 2015
2015/16	83.7% 5 years to December 2014	≥90%	86.5% (U) – 5 years to September 2015
			87.0% (U) – 5 years to December 2015
			86.3% (U) – 5 years to March 2016
			84.9% (U) – 5 years to June 2016

<b>Percentage of eligible preschool enrolments in DHB-funded oral health services</b>			
Financial Year	Baseline	Target	Actual to Date
<b>TOTAL:</b>			
2014/15	70.4% 2013 calendar year	≥82%	73.9% (U) - 2014 calendar year
2015/16	73.9% 2014 calendar year	≥90%	87.1% (U) - 2015 calendar year
<b>MĀORI:</b>			
2014/15	61.9% 2013calendar year	≥82%	65.3% (U) - 2014 calendar year
2015/16	65.3%	≥90%	74.1% (U) - 2015 calendar year

	2014 calendar year		
<b>PACIFIC:</b>			
2014/15	67.4% 2013 calendar year	≥82%	71.7% (U) - 2014 calendar year
2015/16	71.7% 2014 calendar year	≥90%	74.2% (U) - 2015 calendar year

Percentage of enrolled preschool and primary school children not examined according to planned recall			
Financial Year	Baseline	Target	Actual to Date
2014/15	4.4% 2013 calendar year	<5%	4.0% (F) - 2014 calendar year
2015/16	4.0% 2014 calendar year	<5%	3.7% (F) - 2015 calendar year

Percentage of adolescents using DHB-funded dental services			
Financial Year	Baseline	Target	Actual to Date
2014/15	81.0% 2012 calendar year	≥85%	78.3% (U) – 2014 calendar year
2015/16	84.5% 2013 calendar year	≥85%	75.9% (U) – 2015 calendar year

Percentage of children without decay at 5 years of age			
Financial Year	Baseline	Target	Actual to Date
2014/15	54.2% 2013 calendar year	≥65%	56.5% (U) – 2014 calendar year
2015/16	56.5% 2014 calendar year	≥66%	54.4% (U) – 2015 calendar year

Mean 'decayed, missing or filled teeth' score at year 8			
Financial Year	Baseline	Target	Actual to Date
2014/15	1.13 2013 calendar year	<0.88	1.08 (U) – 2014 calendar year
2015/16	1.08 2014 calendar year	<0.87	0.96 (U) – 2015 calendar year

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:			
2014/15	54.3% 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
2015/16	49.2% April 2014 to March 2015	≥55%	49.7% (U) – July to September 2015
			42.9% (U) – October to December 2015
			42.6% (U) – January to March 2016
			42.8% (U) – April to June 2016
MAORI:			
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
2015/16	50.0% – April 2014 to March 2015	≥55%	49.4% (U) – July to September 2015
			41.4% (U) – October to December 2015
			41.4% (U) – January to March 2016
			39.8% (U) – April to June 2016
PACIFIC:			

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
2015/16	40.9% – January 2013 to December 2014	≥55%	42.4% (U) – July to September 2015
			37.8% (U) – October to December 2015
			36.4% (U) – January to March 2016
			46.1% (U) – April to June 2016

Percentage of accepted referrals for Computed Tomography (CT) who received their scans within 42 days			
Financial Year	Baseline	Target	Actual to Date
<b>TOTAL</b>			
2014/15	88% December 2013	≥90%	94.8% (F) September 2014
			92.6% (F) December 2014
			90.9% (F) March 2015
			88.6% (U) June 2015
2015/16	92.6% December 2014	≥95%	96.4% (F) September 2015
			84.4% (F) December 2015
			93.2% (F) March 2016
			94.6% (U) June 2016

Percentage of accepted referrals for MRI scans who receive their scans within 6 weeks			
Financial Year	Baseline	Target	Actual to Date
<b>TOTAL</b>			
2014/15	54.1% December 2013	≥80%	59.7% (U) September 2014
			61.3% (U) December 2014
			60.1% (U) March 2015
			59.5% (U) June 2015
2015/16	61.3% December 2014	≥85%	57.5% (U) September 2015
			31.0 % (U) December 2015
			46.5% (U) March 2016
			44.7% (U) June 2016

Ambulatory sensitive hospitalisation rate 0-4			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2014/15	New	New	-
2015/16	New	NA	73% - 12 months to September 2015
			70% -12 months to March 2016
MĀORI			
2014/15	New	New	-
2015/16	New	NA	82% - 12 months to September 2015
			79% - 12 months to March 2016

Ambulatory sensitive hospitalisation rate 45-64			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2014/15	New	New	-
2015/16	New	NA	98% - 12 months to September 2015
			94% -12 months to March 2016
MĀORI			
2014/15	New	New	-
2015/16	New	NA	172% - 12 months to September 2015
			170% - 12 months to March 2016

Percentage of 4 year olds that receive a B4 School Check			
Financial Year	Baseline	Target	Actual to Date
<b>TOTAL</b>			
2014/15	New	New	-
2015/16	81% April 2015	≥90%	107% (F) July 2015 to June 2016
<b>MĀORI</b>			
2014/15	New	New	-
2015/16	New	≥90%	101% (F) July 2015 to June 2016

### 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
2014/15	93.3% 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
2015/16	91.5% - October to December 2014	≥95%	92.1% (U) - July to September 2015
			92.7% (U) - October to December 2015
			93.9% (U) - January to March 2016
			92.5% (U) - April to June 2016

Health Target: Faster Cancer Treatment - Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.			
Financial Year	Baseline	Target	Actual to Date
2014/15	New	New	-
2015/16	61.5% October to December 2014	85%	75.9% (U) - April to September 2015
			78.0% (U) - July to December 2015
			63.2% (U) - October 2015 to March 2016
			62.5% (U) - January to June 2016

Health target: Improved access to elective surgery (discharges) <sup>3</sup>			
Financial Year	Baseline	Target	Actual to Date
Please note data is subject to change over time			
NUMBER OF ELECTIVE DISCHARGES (VOLUMES)(Source: Ministry of Health)			
2014/15	5,866 2012/13	≥6,012	6,154 (F) - July 2014 to June 2015
2015/16	6,103 2013/2014	≥7,109	7,469 (F) - July 2015 to June 2016

<sup>3</sup> 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% October to December 2013	≥70%	75.7% (F) - July to September 2014
			50.7% (U) – October to December 2014
			62.3% (U) – January to March 2015
			63.4% (U) - April to June 2015
2015/16	50.7% October to December 2014	≥70%	50.7% (U) - July to September 2015
			68.7% (U) – October to December 2015
			71.1% (F) – January to March 2016
			77.6% (F) - April to June 2016
MAORI			
2014/15	81.8% 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
2015/16	33.3% October to December 2014	≥70%	38.5% (U)- July to September 2015
			60.0% (U)– October to December 2015
			80% (F) – January to March 2016
			84.6% (F) - April to June 2016
PERCENTAGE OF ANGIOGRAPHY PATIENTS WHOSE DATA SI RECORDED ON NATIONAL DATABASES			
2014/15	68.3% October to December 2013	≥95%	0% (U) - July to September 2014
			12.3% (U) – October to December 2014
			61.1% (U) – January to March 2015
			83.1% (U) - April to June 2015
2015/16	12.3% October to December 2014	≥95%	85.1% (U) - July to September 2015
			84.1% (U) – October to December 2015
			100% (F) – January to March 2016
			96.6% (U) - April to June 2016
MAORI			
2014/15	6.7% 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
2015/16	12.5% October to December 2014	≥95%	91.7% (U) - July to September 2015
			71.4% (U) – October to December 2015
			100.0% (F) – January to March 2016
			90.0% (U) - April to June 2015

<b>STROKE – Percentage of potentially eligible patients who are thrombolysed</b>			
<b>Financial Year</b>	<b>Baseline</b>	<b>Target</b>	<b>Actual to Date</b>
Please note data is subject to change over time			
2014/15	0% 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
2015/16	6.0% October to December 2014	≥6%	5.1% (U) - July to September 2015
			4.1% (U) – October to December 2015
			4.6% (U) – January to March 2016



			4.5% (U) - April to June 2016
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**STROKE – Percentage of patients admitted to the demonstrated stroke pathway**

Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
2014/15	78% 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
2015/16	82.1% October to December 2014	≥80%	69.2% (U) - July to September 2015
			69.9% (F) – October to December 2015
			84.6% (F) – January to March 2016
			90.9% (F) - April to June 2016

**Standardised intervention rates for surgery (per 10,000 population)**

Financial Year	Baseline	Target	Actual to Date
Please note data is subject to change over time			
Major joint replacement			
2014/15	19.6 12 months to September 2013	≥21.0	23.3 (F) – July 2013 to June 2014
			22.5 (F) – October 2013 to September 2014
			21.3 (F) – January 2014 to December 2014
			21.9 (F) - April 2014 to March 2015
2015/16	21.3 12 months to December 2014	≥21.0	16.9 (U) – July 2013 to June 2015
			17.6 (U) – October 2013 to September 2015
			19.4 (U) – January 2014 to December 2015
			19.2 (U) - April 2014 to March 2016
Cataract procedures			
2014/15	32.6 12 months to September 2013	≥27.0	52.7 (F) – July 2013 to June 2014
			54.3 (F) – October 2013 to September 2014
			52.1 (F) – January 2014 to December 2014
			52.6 (F) - April 2014 to March 2015
2015/16	52.1 12 months to December 2014	≥27.0	50.2 (F) – July 2013 to June 2015
			51.2 (F) – October 2013 to September 2015
			47.0 (F) – January 2014 to December 2015
			49.6 (F) - April 2014 to March 2016
Cardiac surgery			
2014/15	5.6 12 months to September 2013	≥6.5	5.49 (U) – July 2013 to June 2014
			6.0 (U) – October 2013 to September 2014
			5.7 (U) – January 2014 to December 2014
			6.0 (U) - April 2014 to March 2015
2015/16	5.7 12 months to December 2014	≥6.5	5.9 (U) – July 2013 to June 2015
			6.3 (U) – October 2013 to September 2015
			6.8 (F) – January 2014 to December 2015
			6.3 (U) - April 2014 to March 2016
Percutaneous revascularisation			
2014/15	11.2 12 months to September 2013	≥12.5	10.88 (U) – July 2013 to June 2014
			11.1 (U) – October 2013 to September 2014
			10.9 (U) – January 2014 to December 2014
			10.8 (U) - April 2014 to March 2015
2015/16	10.9 12 months to December 2014	≥12.5	11.7 (U) – July 2013 to June 2015
			12.4 (U) – October 2013 to September 2015
			12.8 (F) – January 2014 to December 2015
			13.3 (F) - April 2014 to March 2016

Coronary angiography			
2014/15	35.2 12 months to September 2013	≥34.7	35.55 (F) – July 2013 to June 2014
			35.5 (F) – October 2013 to September 2014
			36.2 (F) – January 2014 to December 2014
			37.1 (F) – April 2014 to March 2015
2015/16	36.2 12 months to December 2014	≥34.7	39.0 (F) – July 2013 to June 2015
			39.5 (F) – October 2013 to September 2015
			38.6 (F) – January 2014 to December 2015
			37.3 (F) – April 2014 to March 2016

Elective inpatient ALOS			
Financial Year	Baseline	Target	Actual to Date
2014/15	3.43 days	≤3.18 days	3.38 (U) – July 2013 to June 2014
			3.41 (U) – October 2013 to September 2014
			3.36 (U) – January 2014 to December 2014
			3.27 (U) – April 2014 to March 2015
2015/16	1.74 days 12 months to September 2014	≤1.59 days	1.67 (U) – July 2014 to June 2015
			1.65 (U) – October 2014 to September 2015
			1.66 (U) – January 2015 to December 2016
			1.61 (U) – April 2015 to March 2016

Acute inpatient ALOS			
Financial Year	Baseline	Target	Actual to Date
2014/15	4.18	≤4.15 days	4.17 (U) – July 2013 to June 2014
			4.15 (F) – October 2013 to September 2014
			4.12 (F) – January 2014 to December 2014
			4.07 (F) – April 2014 to March 2015
2015/16	2.79 12 months to September 2014	≤2.79 days	2.62 (F) – July 2014 to June 2015
			2.57 (F) – October 2014 to September 2015
			2.55 (F) – January 2015 to December 2016
			2.47 (F) – April 2015 to March 2016

Acute readmissions to hospital			
Financial Year	Baseline	Target	Actual to Date
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
			*
2015/16	7.6%	Reduce	NA
			NA
			NA
			NA

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

For 2015/16 the DHB was supplied results by the Ministry however the DHB was not measured against the data as the measure is still under development.

Percentage of coronary angiography completed within 90 days			
Financial Year	Baseline	Target	Actual to Date
2014/15	New	≥90%	93.1% (F) – September 2014
			89.8% (F) – December 2014
			64.4% (U) – March 2015
			90.7% (F) – June 2015
2015/16	89.8% – December 2014	≥95%	95.8% (F) – September 2015

			78.9% (U) –December 2015
			75.6% (U) – March 2016
			100% (F) - June 2016

**Diagnostic Colonoscopy : Percentage of urgent cases performed within 14 days**

Financial Year	Baseline	Target	Actual to Date
2014/15	63.0% December 2013	≥75%	89.1% (F) - September 2014
			92.6% (F) –December 2014
			87.5% (F) – March 2015
			81.3% (F) - June 2015
2015/16	92.6% December 2014	≥75%	90.0% (F) - September 2015
			82.4% (F) –December 2015
			91.3% (F) – March 2016
			93.5% (F) - June 2016

**Diagnostic Colonoscopy : Percentage of diagnostic cases performed within 42 days**

Financial Year	Baseline	Target	Actual to Date
2014/15	51.4% December 2013	≥60%	48.0% (U) - September 2014
			39.7% (U) –December 2014
			74.3% (F) – March 2015
			78.7% (F) - June 2015
2015/16	39.7% December 2014	≥65%	84.1% (F) - September 2015
			87.1% (F) –December 2015
			37.6% (U) – March 2016
			80.4% (F) - June 2016

**Surveillance Colonoscopy : Percentage waiting less than 84 days beyond planned date**

Financial Year	Baseline	Target	Actual to Date
2014/15	64.3% December 2013	≥60%	80.6% (F) - September 2014
			50.7% (U) –December 2014
			62.2% (F) – March 2015
			77.3% (F) - June 2015
2015/16	50.7% December 2014	≥65%	88.5% (F) - September 2015
			79.3% (U) –December 2015
			96.3% (F) – March 2015
			93.5% (F) - June 2015

**Did not attend (DNA) rate across first specialist assessments<sup>4</sup>**

Financial Year	Baseline	Target	Actual to Date
Please note data is subject to change over time			
<b>TOTAL</b>			
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
2015/16	7.2% October to December 2014	≤7.5%	6.8% (F) - July to September 2014
			8.1% (U) – October to December 2014
			7.8% (U) – January to March 2015
			7.4% (F) - April to June 2015

<sup>4</sup> ESPI specialties only

<b>MAORI</b>			
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
2015/16	12.2% October to December 2014	≤7.5%	11.6% (U) - July to September 2015
			14.9% (U) – October to December 2015
			18.2% (U) – January to March 2016
			15.2% (U) - April to June 2016

Better Access to Mental Health and Addiction Services: Proportion of the population seen by mental health and addiction services			
Financial Year	Baseline	Target	Actual to Date
Please note data is subject to change over time			
Child and Youth (0-19)			
TOTAL			
2014/15	3.68% October 2012 to September 2013	≥3.5%	4.08% (F) – October 2013 to September 2014 3.89% (F) - April 2014 to March 2015
2015/16	4.1% October 2013 to September 2014	≥4.0%	4.07% (F) – October 2014 to September 2015 4.28% (F) - April 2015 to March 2016
MAORI			
2014/15	4.20% October 2012 to September 2013	≥3.5%	4.83% (F) – October 2013 to September 2014 4.50% (F) - April 2014 to March 2015
2015/16	4.83% October 2013 to September 2014	≥4.0%	4.62% (F) – October 2014 to September 2015 4.93% (F) - April 2015 to March 2016
Adult (20-64)			
TOTAL			
2014/15	5.04% October 2012 to September 2013	≥4.5%	5.12% (F) – October 2013 to September 2014 5.06% (F) - April 2014 to March 2015
2015/16	5.1% October 2013 to September 2014	≥5.0%	4.94% (F) – October 2014 to September 2015 4.98% (F) - April 2015 to March 2016
MAORI			
2014/15	8.87% October 2012 to September 2013	≥4.5%	8.79% (F) – October 2013 to September 2014 8.95% (F) - April 2014 to March 2015
2015/16	8.79% October 2013 to September 2014	≥5.0%	8.75% (F) – October 2014 to September 2015 8.87% (F) - April 2015 to March 2016
Older Adult (65+)			
TOTAL			
2014/15	1.05% October 2012 to September 2013	≥1.05%	1.15% (F) – October 2013 to September 2014 1.03% (U) - April 2014 to March 2015
2015/16	1.15% October 2013 to September 2014	≥1.15%	1.04% (U) – October 2014 to September 2015 1.09% (U) - April 2015 to March 2016
MAORI			
2014/15	1.02%		1.15% (F) – October 2013 to September 2014

	October 2012 to September 2013	≥1.05%	1.00% (U) - April 2014 to March 2015
2015/16	1.15% October 2013 to September 2014	≥1.15%	0.96% (U) – October 2014 to September 2015 1.17% (F) - April 2015 to March 2016

**Shorter waits for non-urgent mental health and addiction services for 0-19 year olds**

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			
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
2015/16	56.7% 12 months to September 2014	≥80%	54.2% (U) - July 2014 to June 2015
			55.8% (U) - October 2014 to September 2015
			60.1% (U) – January 2015 to December 2015
			67.4% (U) - April 2015 to March 2016
ADDICTIONS (PROVIDER ARM AND NGO)			
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
2015/16	88.3% 12 months to September 2014	≥80%	78.6% (U) - July 2014 to June 2015
			84.2% (F) - October 2014 to September 2015
			79.4% (U) – January 2015 to December 2015
			84.0% (U) - April 2015 to March 2016
PERCENTAGE OF PEOPLE SEEN WITHIN 8 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
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
2015/16	82.0% 12 months to September 2014	≥95%	77.6% (U) - July 2014 to June 2015
			81.5% (U) - October 2014 to September 2015
			86.0% (U) – January 2015 to December 2015
			90.2% (U) - April 2015 to March 2016
ADDICTIONS (PROVIDER ARM AND NGO)			
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
2015/16	96.1% 12 months to September 2014	≥95%	92.9% (F) - July 2014 to June 2015
			100.0% (F) - October 2014 to September 2015
			97.1% (F) – January 2015 to December 2015
			96.0% (F) - April 2015 to March 2016

**Improving mental health services using discharge planning – Percentage of children and youth with a transition (discharge) plan**

Financial Year	Baseline	Target	Actual to Date
2014/15			24.17% (U) - July 2013 to June 2014

	New	≥95%	23.99% (U) – October 2013 to September 2014
			23.99% (U) – January 2014 to December 2014
			22.66% (U) - April 2014 to March 2015
			22.95% (U) - July to June 2015
2015/16	24% January 2014 to December 2014	≥95%	24.16% (U) – October 2014 to September 2015
			36.17% (U) – January 2015 to December 2015
			44.83% (U) – April 2015 to March 2016

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
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
2015/16	81.5 October to December 2014	≤80	91.1 (U) - July to September 2015
			97.0 (U) – October to December 2015
			100.7 (U) – January to March 2016
			97.3 (U) - April to June 2016

## 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			
2014/15	164.7 July 2012 to June 2013	≤164.7	125.7 (F) - July to September 2014
			139.5 (F) – October to December 2014
			127.2 (F) – January to March 2015
			138.0 (F) - April to June 2015
2015/16	139.5 January 2014 to December 2014	≤139.5	186.7 (U) - October 2014 to September 2015
			160.0 (U) – January 2015 to December 2015
			146.7 (U) – April 2015 to March 2016
			153.3 (U) - July 2015 to June 2016
80-84 Years			
2014/15	222.0 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
2015/16	183.1 October to December 2014	≤183.1	166.9 (F) - October 2014 to September 2015
			175.5 (F) – January 2015 to December 2015
			180.5 (F) – April 2015 to March 2016
			178.1 (F) - July 2015 to June 2016
85+ Years			
2014/15	231.0 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
2015/16	254 October to December 2014	≤231.0	231.5 (U) - October 2014 to September 2015
			233.9 (U) – January 2015 to December 2015
			221.3 (F) – April 2015 to March 2016
			221.8 (F) - July 2015 to June 2016

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
			*
2015/16	7.6% 12 months to September 2014	<10%	NA
			NA
			NA
			NA

\*the Ministry of Health are currently reviewing this measure. 2015/16 the DHB was supplied results by the Ministry however the DHB was not measured against the target as the measure is still under development.

Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
Financial Year	Baseline	Target	Actual to Date
2014/15	94.4% 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
2015/16	100% October to December 2014	≥95%	100% (F) April to June 2015
			100% (F) July to September 2015
			100% (F) October to December 2015
			100% (F) January to March 2016

Average time from assessment to coordination (65 years and over)			
Financial Year	Baseline	Target	Actual to Date
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
2015/16	7.3 Days October to December 2014	≤7.3 Days	6.0 days (U) - July to September 2015
			5.3 days (U) - October to December 2015
			6.0 days (F) - January to March 2016
			7.0 days (F) - April to June 2016

Number of needs assessments completed (Disability Services)			
Financial Year	Baseline	Target	Actual to Date
2014/15	415 2011/12	≥300	618 (F) July 2013 to June 2014
2015/16	618 2013/14	≥600	508 (U) July 2015 to June 2016

Average time from referral to assessment (Disability Services)			
Financial Year	Baseline	Target	Actual to Date
2014/15	4 days 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

2015/16	6.5 days October - December 2014	≤10days	7.0 days (F) - July to September 2015
			6.4 days (F) - October to December 2015
			8.0 days (F) - January to March 2016
			6.0 days (F) - April to June 2016

Time from referral receipt to initial Cranford Hospice contact within 48 hours			
Financial Year	Baseline	Target	Actual to Date
2014/15	99% 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
2015/16	92.0% October to December 2014	≥80%	94.0% (F) – July to September 2015
			91.0% (F) - October to December 2015
			93.0% (F) – January to March 2016
			99.0% (F) – April to June 2016

Number of day services			
Financial Year	Baseline	Target	Actual to Date
2014/15	13,510 2011/12	≥17,374	20,754 (F) - July 2013 to June 2014
2015/16	20,754 July 2013 to June 2014	≥21,791	21,546 (U) – July 2015 to June 2016

Percentage of older patients given a falls risk assessment			
Financial Year	Baseline	Target	Actual to Date
2014/15	New	New	-
2015/16	91.8% October to December 2014	≥90%	90.5% (F) – July to September 2015
			90.5% (F) - October to December 2015
			97.1% (F) – January to March 2016
			95.2% (F) – April to June 2016


Percentage of older patients assessed as at risk of falling receive an individualised care plan			
Financial Year	Baseline	Target	Actual to Date
2014/15	New	New	-
2015/16	76.0% October to December 2014	≥98%	83.8% (U) – July to September 2015
			78.4% (U) - October to December 2015
			86.3% (U) – January to March 2016
			90.2% (U) – April to June 2016





HAWKE'S BAY DISTRICT HEALTH BOARD  
PRIVATE BAG 9014  
HASTINGS 4156



 <p><b>HAWKE'S BAY</b> District Health Board Whakawāteatia</p>	<p><b>Central Regions Technical Advisory Services Ltd</b></p> <p style="text-align: right; font-size: 2em;"><b>121</b></p>
	<p>For the attention of: <b>HBDHB Board</b></p>
Document Owner:	Ken Foote, Company Secretary
Approved by:	Executive Management
Month:	October, 2016
Consideration:	For Decision

#### RECOMMENDATION

##### That the Board

Note the draft Annual Report for TAS for the year ended 30 June 2016.

Appoint Kevin Atkinson as the HBDHB representative to attend the TAS Annual General Meeting to be held Tuesday 6 December 2016, with Kevin Snee appointed as his Alternate.

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#### ATTACHMENTS

- A Notice of Meeting
- B Minutes of 2014 AGM
- C Draft Annual Report 2015/16

#### ANNUAL REPORT

An extract from the letter received from the TAS CEO includes:

*"The draft report includes the approved financial statements, along with the Independent Auditor's Report which will be signed once the Annual Report is approved by the TAS Board at its 26 October meeting. The final version will then be sent out to you both electronically and in hard copy. We anticipate few changes, if any."*

#### AGM REPRESENTATIVE

As the Chair of HBDHB, it is recommended that Kevin Atkinson be appointed to represent HBDHB at the TAS AGM. Should Kevin for any reason be unable to attend, it is also recommended that Kevin Snee be appointed as his Alternate.



# Notice of Annual General Meeting

Tuesday 6 December 2016  
at 3:30pm

**Notice is hereby given that the Annual General Meeting of Shareholders of Central Region's Technical Advisory Services Ltd will be held on 6 December 2016.**

**Venue: TAS Boardroom, Level 3, New Zealand Language Centre House, 186 Willis St, Wellington**

1. Apologies
2. Minutes - *To review and accept the minutes of the AGM held 7 December 2015*
3. Directors' report on the year ended 30 June 2016 - *To receive the report*
4. Financial Statements and Report - *To receive, consider and adopt the Company's financial statements for the year ended 30 June 2016, along with the Independent Auditor's Report*
5. Auditors - *To record the continuance of KPMG as the Company's auditors for the 2016/17 financial year*
6. General - *Any other business*

*Shareholders attending the Annual General Meeting are invited to join the Board and TAS' CE and Senior Leadership Team for light refreshments following the meeting*



*Minutes of  
Annual General Meeting of Shareholders  
of  
Central Region's Technical Advisory Services Limited*

Held on 7 December 2015 commencing at 1.30pm at the Capital and Coast District Health Board Boardroom, Level 11, Grace Neill Block, Wellington Hospital

**Present:**

**Directors:**

Dr Jan White (Chair), Murray Bain, Deryck Shaw, Murray Georgel, Wendy McPhail

**Shareholder Representatives:**

Judith Aitken (Capital and Coast District Health Board), Dot McKinnon (Whanganui District Health Board), Kevin Atkinson (Hawkes Bay District Health Board), Kathryn Cook (MidCentral District Health Board), Dr Derek Milne (Wairarapa District Health Board), Wayne Guppy (Hutt Valley District Health Board)

**Also in Attendance:**

Dr Kevin Snee (Chief Executive, Hawke's Bay District Health Board), Phil Sunderland (Deputy Board Chair), Sally Webb (Chair of RGG), Julie Patterson (Chief Executive, Wanganui District Health Board)

Graham Smith (TAS Chief Executive), Lucy Haberfield (Manager, Business Support Services), Gail Holman (Minute Secretary)

**1. Apologies:**

Dr Virginia Hope, Chair, Capital and Coast District Health Board,

**2. Minutes:**

**Resolved:** That the minutes of the Annual General Meeting held on 1 December 2014 be accepted as a true and accurate record of that meeting.

Carried: all

**3. Financial Statements and Reports:**

**Resolved:** That the Company's financial statements for the year ending 30 June 2015, together with the Auditor's report and the Directors' Annual Report, be received and adopted.

Carried: all

**4. Auditors:**

Resolved: That the appointment of KPMG as the Company's auditors be approved and recorded.

Carried: all

**5. General:**

No other business was recorded.

The meeting closed at 1.45 pm.

DRAFT



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## Annual Report 2015/16







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## Chair's Report

I am pleased to present the annual report for the 2015/16 year for the Central Region's Technical Advisory Services (TAS).

During the year TAS has continued to make progress to becoming a respected professional services organisation delivering high quality management services to District Health Boards (DHBs) and other health sector organisations. With our focus on value to the sector, it has been pleasing to see the delivery of significant service and programme outcomes this year that will improve the performance of the health system.

Organisational capability has continued to improve and this has seen active involvement in strategic areas supported by strong technical analytical skills. The systems, structures and processes that were in the early stages of development last year are now well embedded with a marked improvement in organisational efficiency and effectiveness as a result.

We are encouraged by the ongoing investment and commitment by our customers to the services we are providing. TAS is now well positioned to deliver greater value to the sector through its continued development of leadership, strategy and business intelligence capability.

I would like to thank and recognise the staff of TAS for their continued professionalism and drive to further improve services. Their commitment to excellence and to the development of new opportunities has been much appreciated by the Board.

My thanks to the Board for their continued input and support during the year. I look forward to working with members to further develop the organisation in the period ahead.

**Dr Jan White, Chair**

*The systems, structures and processes that were in their early stages of development last year are now well embedded and the Board has seen a marked improvement in TAS' efficiency and effectiveness over these past two years.*





# Chief Executive's Report

2015/16 saw the TAS team take great strides in building the organisation to deliver high quality management services to the DHBs and Ministry of Health.

Our key focus this year has been to ensure our customers are getting the best return from their investment in our services while also exploring ways in which we can add further value to the sector.

We asked a broad range of stakeholders to rate our service and over 90% of our customers rated us as delivering a high professional standard of advice and support. We also enjoy a high level of advocacy with 80% of our customers saying they would recommend TAS to a colleague or other organisation.

A range of new initiatives that are adding value to the sector are in progress. In particular;

- We have extended our role in workforce strategy development in support of the newly formed Workforce Strategy Group.
- We successfully implemented a permanent service to provide interRAI education and support. This year saw over 960 new assessors and over 240 managers trained, with 677 facilities having at least one nurse competent. We are supporting the interRAI NZ governance structures and providing the sector with reporting and analytics.
- A significant milestone was achieved in the Regional Health Informatics Programme with the Clinical Portal solutions going live and taken up by the first of Central Region DHBs.
- We also made good progress in establishing the infrastructure around core business intelligence functions through the development of the Information Services Strategy.

Our new website was launched with a newly created modern visual identity. The website more comprehensively tells the story of TAS and reflects who we are as an organisation.

Looking towards the future, we aim to remain on course with our strategic plan and ensure understanding, alignment and support of our purpose and strategic direction with shareholders, stakeholders and customers.

The key planks of our future are:

- Actively pursuing new areas of value
- Further evolving our professional service culture
- Focusing internally on continuous process improvement
- Continuing to develop our people capability with a focus on leadership and specific technical skillsets

I want to take this opportunity to thank the Board for their support through this journey, customers and stakeholders for their continued belief in us and TAS staff for their commitment to TAS and to the sector.

A handwritten signature in black ink, appearing to read 'G Smith', written over a light blue circular background.

**Graham Smith, Chief Executive**

*We are now progressing a number of new initiatives that will deliver new value to the sector.*



## About TAS

*TAS provides ideas, expertise and programme management to support the health sector to achieve healthcare targets, and improve the services provided.*

Central Region's Technical Advisory Services Limited (TAS) is a multi-parent subsidiary of the six District Health Boards (DHBs) of the Central Region: Capital & Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui and Hawke's Bay. TAS was set up by the Central Region DHBs in June 2001 as a joint venture company under equal joint ownership. DHB Shared Services (DHBSS) integrated with TAS in 2011 creating a combined national and regional service offering. TAS now provides support and services not only to its six shareholders but also to all 20 DHBs, managing on average 30 national and regional work programmes on their behalf. TAS also works collaboratively with other health service providers, including the Ministry of Health.

### Organisational Purpose

We see the role of TAS as bringing information and insight to the health sector, and helping customers develop national and regional strategies that will address their priorities. From there, we will need to facilitate turning the thinking into actionable pieces of work delivering real change and improved health system outcomes.

We are continuously exploring ways in which we can add further value for our customers and use our capabilities for maximum effectiveness.

*We see the role of TAS as bringing information and insight to the health sector, and helping customers develop national and regional strategies that will address their priorities.  
We are continuously exploring ways in which we can add further value for our customers and use our capabilities for maximum effectiveness.*

# TAS Vision and Mission

**VISION** *“A respected professional services organisation delivering high quality management services to New Zealand DHBs and other health sector organisations.”*

**MISSION** *“To successfully partner the health system through providing expert resources and knowledge in a highly connected and collaborative way to facilitate better health and wellbeing outcomes for all New Zealanders.”*

## Key Priorities

The three key pillars of our supporting framework are the strategic priorities of doing what we do well, building our reputation and delivering new value.



## Key Strategic Priorities

### Do what we do well

Our first priority has been to ensure the programmes and services of today are operating well and have sufficient support and management to deliver the expected outcomes for our customers. These programmes and expected deliverables are detailed in the National and Regional Plans and related Service Level Agreements (SLAs) with DHBs. Changes to the organisational structures have been progressively made to prepare us to deliver on this priority and are well along the way to being embedded.

### Build our reputation

Building on our service delivery, we planned to better understand how we are performing in order to prioritise improvement (and communicate our successes). The immediate requirement was to implement a value based measurement framework to monitor our delivery performance and to establish a unified brand and company identity. We have successfully implemented a Balanced Scorecard measurement and monitoring tool. We have also asked customers and stakeholders for their views of our performance and are using this valuable feedback in the evolution of our services. In our first customer satisfaction survey 91% of customers believe TAS services and advice are of a high standard.

### Deliver New Value

We are now in a position to explore a range of new areas, using the capabilities we have developed, to add value to the health sector, as well as evolve those already in progress. Currently in progress:

- interRAI phase two integration
- Pharmacy strategy development
- Workforce information strategy development
- Health of Older People strategy development

Future value:

- Business intelligence and analytics
- Health informatics



### Translating Strategy into Action

In order to translate strategy into action, TAS has developed a strategic framework built on four perspectives: value, customer, internal business processes and learning and growth. These four dimensions are used to ensure that there is a balance in TAS' strategic initiatives.

This framework also underpins business planning and helps create alignment across the organisation. The framework is based on connecting the dots where all efforts and initiatives undertaken by TAS should eventually lead to an increased value in the eyes of shareholders, stakeholders and customers.

#### Value



To ensure best return from current investment through improved efficiency and effectiveness of services. Explore areas that will create new value for stakeholders.

#### Customer



To ensure clients experience an integrated company wide approach to stakeholder management, and key stakeholders and clients are aware and advocate for our services.

#### Internal Business Processes



To ensure internal processes are (as appropriate) standardised, repeatable and reliable. Our service delivery and operating processes are measured and tracked.

#### Learning and Growth



To ensure we grow our leadership capability at all levels and enable leaders to work effectively across the organisation. Capability and performance of the organisation improves.

# Highlights

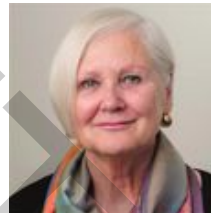
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## Board of Directors

*TAS has an independent board of directors. The Board comprises an independent chair, two independent directors and two representative directors, one of whom represents the Central Region and the other who represents the 20 DHBs. The Board reports to the Regional Governance Group (RGG).*



### **Dr Jan White - Chair**

A medical doctor by training, Jan has worked in medical and general management for over 20 years in both Australia and New Zealand. She has held a number of senior posts including six years as Chief

Executive of the Waikato District Health Board and seven years as Chief Executive of the Accident Compensation Corporation (ACC). She is also on the Boards of PHARMAC and Worksafe New Zealand.



### **Murray Bain**

Murray is an experienced company director who is currently Chair of the Open Polytechnic, Chair of Top Energy, Deputy Chair of TSB Bank and a Director of TSB Group Capital. In the past, he has held CEO roles

in the Foundation for Research Science and Technology and the Ministry of Science and Innovation and, prior to that, senior management positions in IT, finance and banking in the Trust Bank Group and roles as Chief Operating Officer in ACC and Assistant Governor in the Reserve Bank of New Zealand.



### **Deryck Shaw**

Deryck is Chair of Lakes District Health Board and Deputy Chair of New Zealand Māori Arts and Crafts Institute. He is a former member of the Waikato District Health Board, Chair of Waiariki Institute of

Technology and Board Member of Institutes of Technology Polytechnics New Zealand. He is a Chartered Member of the NZ Institute of Directors and has a 30-year career as the Director of Strategic Planning consultancy firm, APR Consultants Ltd.



### **Murray Georgel**

Murray was MidCentral DHB's Chief Executive from 1999 to May 2015. He has gained considerable management and leadership experience across a wide range of industries in both the public

and private sectors, including primary production, tourism, pharmaceuticals and social services. Murray has had, and maintains, governance roles in health-related organisations as well as community and privately owned entities.



### **Wendy McPhail**

Wendy has over 20 years senior management experience most recently as CEO for the New Zealand owned Office Products Depot Co-operative. She has extensive technology, strategy and

change management expertise. Wendy was the former Deputy Chair of the Auckland Museum Trust Board and holds community and private governance roles.



# Board of Directors

## Directors' Interests

The following information was included in the Board's interests register over the period 1 July 2015 to 30 June 2016.

### Dr Jan White - Chair

- Member of PHARMAC Board
- Member of Worksafe New Zealand Board

### Murray Bain

- Chair of Top Energy
- Director of Powerco NZ
- Deputy Chair of TSB Bank
- Director TSB Group Capital Ltd
- Director TSB Group Investments Ltd
- Chair of Open Polytechnic NZ
- Shareholder and Director of Oryx Technologies Ltd
- Shareholder and Director of M I Bain & Associates Ltd

### Murray Georgel

- Director and shareholder, NV Enterprises Ltd
- Director and shareholder, Xenos Ltd
- BCC Limited Director
- Manawatu Investment Group Limited Director
- MIG Nominee No 1 Limited Director
- Palmerston North Airport Limited Trustee
- Sir Patrick Higgins Charitable Trust
- Son working for Deloitte

### Deryck Shaw

- Member of the DHB Executive
- Chair of Lakes DHB
- Deputy Chair of NZ Māori Arts and Crafts Institute
- Owner and Director of APR Consultants Ltd
- Majority owner and Director of Principal Holdings Ltd
- Co-owner and Director of APR Group
- Partner, Shaw Property Partnership
- Board member of Waikato Bay of Plenty Football
- Committee member Bay of Plenty Branch NZ Institute of Directors
- Chair of NZ Walking Association Inc
- Trustee of Rotorua Bike Festival Trust
- National Executive Member of NZ Football
- President NZ Football Board
- Board member- NZ Health Partnership Limited
- Director, Great Value Accommodation Ltd

### Wendy McPhail

- Advisory Board member to the Marketing Company
- Principal Consultant and Director, Wendy McPhail Consulting Ltd

## The Work We Do

*We are a compact organisation with a broad range of roles and functions, working independently and cross-functionally to optimise resource allocation and knowledge sharing; key elements in being cost-effective and providing the best service possible.*



### Audit and Assurance

Consisting of expert lead auditors, specialist contractors and support staff providing objective audit and assurance services to private and public health sector organisations in the central North Island and the South Island.

### Community Pharmacy Services

Working with DHBs and the wider health sector to implement the new Community Pharmacy Services Agreement. This is all about keeping patients at the centre of their own health care and recognising the key role pharmacists have in delivering better health outcomes.

### Regional Health Informatics

Working with the health sector to develop systems that ensure the right information gets to healthcare professionals at the right time, so they can deliver the most appropriate care for patients. TAS has been contracted to support the development of a suite of regional solutions that will centralise the acquisition, storage, retrieval and use of patient information across the Central Region's six DHBs.

### Health of Older People

Working collaboratively with DHBs, the Ministry of Health, and the wider health sector to improve the delivery of health and disability services to older New Zealanders through a joint programme of work.

### interRAI

interRAI<sup>TM1</sup> refers to both the international organisation responsible for developing comprehensive clinical assessment systems, and the suite of clinical assessment tools available. The tools are standardised assessments designed to work together to form an integrated health information system. interRAI tools all share a common language; that is, they refer to the same clinical concepts in the same way across different tools. Using common measures enables clinicians and providers in different care settings to improve continuity of care, and to integrate the care and support needed for each individual.

The Ministry of Health appointed TAS as the national provider of interRAI Services.

### Planning and Collaboration

Partnering with the health sector to provide planning services to support the development of regional and national plans that not only enhance the effectiveness of collaboration among key executive groups, but also enable them to deliver on key work programmes and projects.

The team also plays an important role in identifying value-adding opportunities through analysis and assessment of programmes and activities.

### Strategic Workforce Services

Providing employment relations and intelligence services to help maintain the current and future staffing needs of the health sector. The team also provides programmes and services to ensure staff are healthy and well and are providing safe and professional healthcare experiences for patients.

### Business Support Services

Supporting all areas of the business by providing Human Resources, IT and Desktop Support, Finance, Project Management, Communications and Planning support. The team also works alongside senior management and staff throughout the organisation, providing advice, tools, processes and systems to enable the organisation to achieve its business goals, and to help staff develop and grow.

<sup>1</sup> For ease of reading, we have removed the 'TM' symbol when referring to interRAI in the remainder of this report, however it is noted that interRAI<sup>TM</sup> is a registered trademark and appropriate use of the term applies.



# A Year in Review

## Audit and Assurance

The Audit and Assurance team deliver a range of audit services, namely Provider Audits, Internal Audits and Certification Audits.

### Provider Audits

TAS provides a contract based audit service for the DHBs in the Central Region and the South Island. The audit approach is holistic and systems based which is aimed to obtain a full picture of the organisation. An equivalent of 65 audits for the Central Region and 40 audits for the South Island were undertaken in 2015/16.

### Internal Audit for DHBs

Internal Audit delivered assurance to the six DHBs in the Central Region based on individual internal audit plans. A number of integrated reviews across DHBs were also completed. Internal Audit has been focused on delivering value over and above historic compliance reviews. The six plans in total consisted of approximately 40 reviews ranging from clinical governance, risk management, outpatient management through to three-dimensional fraud review, investigations, security and health and safety.

The Audit team also supported Health Share Ltd. with IT audits across the Midland Region.

### Certification Audit Programme

Over the year, the programme grew significantly to include clients in all areas in which TAS is designated to audit under the Ministry of Health, including Aged Residential Care facilities, Mental Health providers, Private Hospitals and DHBs. TAS also became a Retirement Villages Association Accredited Audit Agency, of which there were previously only two in New Zealand. Feedback from clients audited under this programme has been positive. TAS' ability to conduct combined audits which helps to reduce the audit impact for providers, has also been acknowledged by the sector. The programme continues to grow with marketing as a major focus for the next financial year.

### TAS' key achievements:

- Approved to join a security panel to provide Certification and Assurance to Government agencies by the Department of Internal Affairs.
- Approved by the Ministry of Business, Innovation and Employment as a Tier 2 provider for Audit and a Tier 3 provider for Assurance.
- Certification audit programme continues to meet all requirements with no non-conformities over the previous audits: significant achievement validating the high calibre of the programme.

*The Audit and Assurance team deliver a range of audit services, namely Provider Audits, Internal Audits and Certification Audits.*

# A Year in Review

## Community Pharmacy Services

The Community Pharmacy Services Programme (the CPS Programme) implements and manages the current Community Pharmacy Services Agreement (CPSA) between nearly 1,000 community pharmacies and 20 DHBs.

Introduced on 1 July 2012, the Community Pharmacy Services Agreement (CPSA), which was initially phased over three years, gave community pharmacists an increased opportunity to put their expert clinical skills to good use through the provision of patient-centric services. In 2015, following consultation with the pharmacy sector, the current CPSA was extended for up to two years to enable the next contract to be developed. This provided time to evaluate the outcomes of the current contract, and ensure key government strategies, such as the new Pharmacy Action Plan, were developed as they will underpin the next pharmacy contract.

The purpose of the CPS Programme is to:

1. Support, monitor and evaluate the implementation of the current CPSA; and
2. Support the design, development and implementation of the future contract.

### TAS' key achievements:

#### CPSA

- Maintained responsibility for the financial management of the CPSA funding envelope (\$376.9M 2014/15; and \$380.9M 2015/16) including managing transition payments to all community pharmacies, implementing interim payment mechanisms and agreeing on the annual end of year adjustment process.
- Developed a quality report for a key patient-centric service delivered through the contract, called Community Pharmacy Anti-coagulation Management Service (or CPAMS).
- Developed and implemented the contract extension (2015/17), including providing DHB staff with resources, analytics and training to support the implementation of the contract extension.

- Supported all DHBs to manage contractual breaches; including managing the outcomes of a mediation process on behalf of the two DHBs who went through the disputes resolution process.
- Supported DHBs and other key stakeholders to develop an interim solution to the pharmaceutical margins model throughout 2015/16, which was introduced in August 2016 through a Voluntary Variation to the CPSA.
- Undertook an independent evaluation of the current CPSA by Sapere.

#### Strategic Direction

- Provided input into the development of government strategies including the NZ Health Strategy and the Pharmacy Action Plan. Supported DHBs to ensure the new service delivery and contracting model provides a vehicle, where appropriate, to implement the NZ Health Strategy, the Pharmacy Action Plan and other relevant government strategies.
- Undertook a review of the Programme Governance Structure to ensure it is fit for purpose to continue to deliver the current CPSA while supporting DHBs to develop the next contract.
- Coordinated and facilitated two national stakeholder forums, which included a presentation from the Minister of Health, the Hon Dr Jonathan Coleman and Director General at the Ministry of Health, Chai Chua.
- Supported DHBs in coordinating and facilitating 20 local stakeholder forums to inform the strategic direction for pharmacist services in the community.
- Supported DHBs in the development of the design of the new service delivery and contracting model, which will continue into 2016/17.

*The Community Pharmacy Services Programme (the CPS Programme) implements and manages the current Community Pharmacy Services Agreement (CPSA) between nearly 1,000 community pharmacies and 20 DHBs.*

# A Year in Review

## Regional Health Informatics

Regional Health Informatics is about building organisational and technology capability to deliver the right information, to the right people, through a range of information channels, in order to deliver better health outcomes for all New Zealanders.

A critical first step in this journey is developing the Central Region's first fully integrated Patient Information Management Solution and electronic health record.

This will provide, in the first instance, a single consistent view of key patient data across the region's hospitals, and over time be made available to Primary Health service providers and the patients themselves.

Key functionality includes a clinical portal for key clinical information, a radiology information system and imaging repository plus a patient administration system.

The long term benefits of regional health informatics are, among others:

- Improving the quality and timeliness of information to inform real time clinical decision making.
- Improving the patient experience by being able to keep them better informed as they move through the health service continuum from primary to tertiary and end of life care.
- Providing tools and information that enable individuals, families and communities to pro-actively manage their health, lifestyle, preventative actions and long term conditions.
- Enabling greater efficiency and cost savings in service delivery by reducing the amount of manual intervention required in the extraction, manipulation, application and reporting of health data.
- Creating an 'intelligent network' with the aggregation of operation and client data to gain greater insights into demand, usage, performance and trend patterns.

### TAS' key achievements:

- Completed Regional Solution build and integration for Clinical Portal and Radiology Information System. The WebPAS application build is near completion and on track for completion October 2016.
- Transitioned Whanganui DHB, the first of the six regional DHBs, across onto the Regional Clinical Portal to be followed with Radiology Information system before the end of 2016.
- Agreed regional service management approach with CCDHB to take a lead both in the provision of a regional service desk and accountability of the ongoing service management functionality. The system will evolve as the additional DHBs on-board onto the solution .

*Regional Health Informatics is about building organisational and technology capability to deliver the right information, to the right people, through a range of information channels in order to deliver better health outcomes for all New Zealanders.*



# A Year in Review

## Health of Older People (HoP)

The Health of Older People programme supports close collaboration with DHBs, the aged residential care sector, home and community support providers and Ministry of Health. Consumer engagement is critical to successful planning and prioritisation.

The HOP team provides the 20 DHBs with a common platform and system-wide focus across the service continuum, to support their continued performance improvement activity. The national aged care demand and supply model and the quarterly bed and utilisation survey and reporting to stakeholders provide planning and decision-making support to all stakeholders and will be a focus for further improvement in 2016/17.

### TAS' key achievements:

- Completed the Aged Residential Care Contracts (ARCC) on time with agreement reached on key issues as reflected in the variations to the Agreements. The sector accepted that the ARRC agreements should be amended so that all residents assessed as requiring long-term residential care, including private payers, are covered by the Agreement.
- Facilitated two Leaders' forums informing further strategy development as we continue engagement on an integrated medicines management approach for national consideration.
- Ensured the passing of responsibility for in-between travel, undertaken by support workers providing services to clients in the community, was both seamless and supported by sufficient funding.
- Supported a review of models of care and funding models across aged care which commenced April 2016. This will be a key focus for 2016/17.
- Provided input into the development of both the NZ Health Strategy and the draft NZ Health of Older People Strategy.
- Provided input into the national palliative care review and the design for secure dementia facilities.
- Facilitated the bed and occupancy reporting framework for aged care which is now experiencing 97% response rates from providers each quarter supporting sound planning and decision-making.
- Updated the National Demand Model for Aged Care with latest census data and data from the ARC reporting framework built in, to provide a demand and supply model for aged care projected through until 2031/32.
- Represented the 20 DHBs and provided expertise into the planning for regularisation of the majority of home and community support workforce.
- Maintained on-going support for, and facilitation of, national sector forums, including secretariat services.

*The Health of Older People programme supports close collaboration with DHBs, the aged residential care sector, home and community support providers and Ministry of Health. Consumer engagement is critical to successful planning and prioritisation.*





# A Year in Review

## interRAI

TAS is funded to deliver all aspects of interRAI Services across four key business areas:

- Education and Support
- Reporting and Analytics
- Governance
- Software Services

This was a foundation year for interRAI Services as a business unit within TAS and also the interRAI New Zealand Governance Board. Alongside establishing a business unit, there were some significant achievements and highlights.

### TAS' key achievements

#### Governance

- Established the interRAI New Zealand Governance Board, who have provided leadership and oversight to the development of interRAI in New Zealand.
- Published a three year rolling strategic plan, interRAI New Zealand – Future Direction.
- Developed a full visual and online identity, brand and a broad range of communications across New Zealand, and commenced a programme of positive engagement with interRAI stakeholders in New Zealand, and internationally.
- Made a significant contribution to the inaugural World interRAI conference 2016 in Toronto. Our achievements in New Zealand were recognised by winning the Collaborative Effort, Innovation Award.

#### Data Analysis and Reporting

- Established the National interRAI Data Analysis and Reporting Centre
- Published interRAI data access protocols
- Developed a suite of interRAI reports to DHBs and aged care providers. The suite of reports is expected to expand over time.
- Published the first interRAI Data Analysis Annual report.

#### Education and support

- Trained 960 registered nurses in aged residential care to use the Long Term Care Facilities assessment tool.
- Trained and supported 241 aged residential care facility managers to use interRAI data reports for service delivery and improvement.
- Supported three DHBs to pilot the interRAI Palliative Care tool

#### Software Services

- Upgraded interRAI software
- Fully tested interRAI data security

*The vision for interRAI Services is to continuously improve health outcomes for New Zealanders as they age, and improve the effectiveness and efficiency of our health system by guiding and leading the use of interRAI instruments and the dissemination and use of interRAI information.*



# A Year in Review

## Planning and Collaboration

The Planning and Collaboration Service facilitates strategic planning on behalf of DHBs and stakeholders and delivers knowledge, insight, project management and support services to our customers across a number of projects and programmes of work.

### Regional Services

Regional Services' plans were prepared collaboratively across the Central Region DHBs with input from clinicians, managers, and consumer representatives. TAS provided support in the form of project management and coordination, administration, network engagement, maintenance, and analytics.

### TAS' key Achievements

- Supported the Cardiac Network to successfully implement the Accelerated Chest Pain Pathways with primary care. The Central Region Cardiac Expected Clinical Guidelines were completed ready to be endorsed nationally.
- Supported the development of the Central Region Workforce Plan 2015-2020 using the data and information from the national adult Mental Health and Addiction (MHA) stocktake.
- Supported the regional Orthopaedics, Ophthalmology and Otorhinolaryngology clinical networks that have developed 17 clinical pathways and one patient pathway.
- Completed an evaluation of the Elective Services Productivity and Workforce Programme which has been accepted by the Ministry of Health. The focus of this programme was managing the capacity and demand for elective services to enable patients to receive their First Specialist Assessment (FSA) and treatment within target waiting times.
- Supported the regional leads in developing a Mental Health and Addiction Regional Leadership group (MHARL). Models of care for residential alcohol and other drug (AOD) and youth acute response were developed.
- Supported the DHBs in achieving set patient admission targets and exceeding the thrombolysis target. An electronic decision support tool for the clinical management of Transient Ischaemic Attacks (TIAs) was implemented in the region.
- Supported the region's sonography workforce by successfully carrying out an overseas recruitment initiative. Additional appointments were made to the sonography workforce as a result of this initiative.
- Lead the development of the formal working group and project governance structure for Well Child Tamariki Ora including planning, quality improvement training and support. Provided support for the Plan Do Study Act Quality Improvement Cycles across all DHB working groups.
- Provided secretariat and administrative support to a number of regional working groups including the Regional Health Informatics Steering Group.

*The Planning and Collaboration Service facilitates strategic planning on behalf of DHBs and stakeholders and delivers knowledge, insight, project management and support services for our customers across a number of projects and programmes of work.*

# A Year in Review

## Planning and Collaboration

### National Services

The Planning and Collaboration team helps customers develop national plans that enhance the effectiveness of collaboration and enables them to deliver on work programmes and projects. TAS ensures that there is a common platform for improvements across the DHBs' operating systems and plays a role in identifying opportunities to add value to the sector through analysis, assessments and recommendations on various programmes of work.

### TAS' key achievements

- Managed the Combined Dental Agreement (CDA) contract review process on behalf of the 20 DHBs. The CDA ensures that New Zealand's children and adolescents with special dental needs can receive free primary dental care and treatment.
- Coordinated Official Information Requests (OIA) for the 20 DHBs which increased by 18% over the year.
- Established the National Primary Care Integration Programme which aims to create strategic forums that enable the sector to discuss and deliberate on key issues, challenges and the future direction of primary care.
- Strengthened services to PHO Services Agreement Protocol (PSAAP) and the Independent Chair by providing increased coordination and policy briefings to the DHB representatives and preparation of papers on behalf of the DHBs.
- Provided advice, planning and support to a number of national executive groups including the General Managers' Planning and Funding network and Chief Information Officers' network.
- Worked with a lead group of Chief Operating Officers and Chief Financial Officers to review the focus and content of the Hospital Quality and Productivity (HQ&P) Programme, including engaging with key agencies such as the Treasury.

*Planning and Collaboration helps customers develop national plans that enhance the effectiveness of collaboration and enables them to deliver on work programmes and projects.*



# A Year in Review

## Strategic Workforce Services

The Strategic Workforce Services (SWS) team has three key programmes which all contribute to the successful delivery of workforce and employment relations services to the DHBs

- Workforce Information and Projects,
- Employment Relations (ER); and
- Safe Staffing Health Workplaces (SSHW)

### Workforce Information and Projects

The workforce represents the DHBs' single largest investment, accounting for 60% to 70% of provider-arm expenditure. Effective national workforce and employment relations activity supports DHBs to engage with their workforces and fosters improvements in service delivery, quality and responsiveness.

2015/16 saw the DHBs recognise the need for a stronger workforce focus. This resulted in the establishment of a dedicated national workforce team within SWS and investment in a workforce information visualisation tool. A dedicated governance structure was also established to ensure strategic focus and priority were given to workforce development. The Workforce Strategy Group has representatives from the DHB Executive and professional lead groups, together with the Ministry of Health as the DHBs strategic partner.

### Employment Relations (ER)

The ER Programme is responsible for the development and regular review of the ER Strategy for the 20 DHBs and ensuring the delivery of the employment relations programmes and associated workforce activities. It manages and delivers the National and Regional Collective Bargaining Programme for the 20 DHBs. The Employment Relations Strategy Group (ERSG) provides governance oversight to ER strategy development and the ER work programme. The strategy is underpinned by accurate workforce information and analysis and supported by operational projects as required.

There is a strong emphasis on strategy development as a core function of the team. This covers all aspects from DHB workforce strategy to organisational design, performance, human resources and industrial relations.

Workforce and ER strategy development and maintenance requires strong relationships with DHBs including second tier management and clinical leader groups. DHBs seek to implement a strategy of greater flexibility in the workforce and this has created a number of industrial relations challenges through the year. The team has been well placed to support DHB CE's through these challenges.

Maintaining the confidence of the Minister, Ministry of Health and other agencies is also critical to the maintenance of the strategy and programme delivery, as is a strong relationship with Health Workforce New Zealand (HWNZ).

### Safe Staffing Health Workplaces (SSHW)

The Care Capacity and Demand Management (CCDM) programme is developed by the SSHW Unit which sits within SWS. The objective of the programme is to address key elements of the safe staffing healthy workplaces agenda, by balancing the requirement to deliver quality patient outcomes in quality work environments, in ways that make efficient use of health resources. The work has grown to become a whole of system approach involving a range of professional groups with the Public Service Association (PSA) now also involved.



# A Year in Review

## Strategic Workforce Services

### TAS' key achievements:

- Established the DHBs Workforce Strategy Group
- Supported 14 National Multi Employer Collective Agreements (MECAs) through bargaining and ratification
- Supported 20 Single Employer Collective Agreements (SECA) through bargaining and ratification
- Provided costings and analysis to support National Bargaining and 44 DHB SECAs
- In the process of bargaining with 7 National MECAs
- All national and regional bargaining achieved within ER settings, within affordability parameters and government expectations and with very limited industrial action
- Received endorsement by the 20 DHBs of the action plan from the independent evaluation of the CCDM programme
- Received validation of the Full Time Equivalent (FTE) calculation in the CCDM programme through an independent report from MartinJenkins.

*The Strategic Workforce Services (SWS) team has three key programmes which all contribute to the successful delivery of workforce and employment relations services to the DHBs*

## Financials



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# Financial Statements

## Statement of comprehensive revenue and expense for the year ended 30 June 2016

	Note	2016 Actual \$000s	2015 Actual \$000s
<b>Revenue</b>			
DHB revenue		28,464	28,627
Interest revenue		107	156
Other revenue	2	8,194	3,779
<b>Total revenue</b>		<b>36,765</b>	<b>32,562</b>
<b>Expenditure</b>			
Personnel costs	3	20,818	17,195
Depreciation and amortisation expense		244	202
Other expenses	4	15,450	15,009
<b>Total expenditure</b>		<b>36,512</b>	<b>32,406</b>
<b>Net surplus/(deficit)</b>		<b>253</b>	<b>156</b>
Other comprehensive revenue		-	-
<b>Total comprehensive revenue</b>		<b>253</b>	<b>156</b>

The accompanying notes form part of these financial statements.

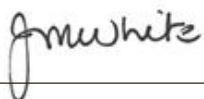
## Statement of financial position

as at 30 June 2016

	Note	2016 Actual \$000s	2015 Actual \$000s
<b>Current Assets</b>			
Cash and cash equivalents	5	9,258	6,481
Receivables	6	2,972	5,836
Prepayments		146	86
GST receivable		143	282
<b>Total current assets</b>		<b>12,519</b>	<b>12,685</b>
<b>Non-current assets</b>			
Property, plant & equipment		324	324
Intangible assets		329	78
<b>Total non-current assets</b>		<b>653</b>	<b>402</b>
<b>Total assets</b>		<b>13,172</b>	<b>13,087</b>
<b>Current liabilities</b>			
Payables	7	3,779	6,528
Funds received in advance		6,017	3,512
Employee entitlements	8	893	817
<b>Total current liabilities</b>		<b>10,689</b>	<b>10,857</b>
<b>Non-current liabilities</b>			
Working capital reserve		715	715
<b>Total non-current liabilities</b>		<b>715</b>	<b>715</b>
<b>Total liabilities</b>		<b>11,404</b>	<b>11,572</b>
<b>Net assets</b>		<b>1,768</b>	<b>1,515</b>
<b>Equity</b>			
Share capital		-	-
General funds		1,768	1,515
<b>Total equity</b>		<b>1,768</b>	<b>1,515</b>

The accompanying notes form part of these financial statements.

For and on behalf of the Board:



Dr Jan White. Chair  
28 September 2016



Murray Bain, Director  
28 September 2016

## Statement of changes in equity

for the year ended 30 June 2016

	Note	2016 Actual \$000s	2015 Actual \$000s
<b>Balance at 1 July</b>		<b>1,515</b>	<b>19,672</b>
Total comprehensive income and expense for the year		253	156
Reclassification of equity	9	-	(18,313)
<b>Balance at 30 June</b>		<b>1,768</b>	<b>1,515</b>

The accompanying notes form part of these financial statements.



## Statement of cash flows

for the year ended 30 June 2016

	Note	2016 Actual \$000s	2015 Actual \$000s
<b>Operating Activities</b>			
Receipts from customers		42,027	37,310
Interest received		107	156
Payments to employees		(20,741)	(17,051)
Payments to suppliers		(18,273)	(15,038)
Goods and services tax (net)		139	(703)
<b>Net Cash Flow from Operating Activities</b>	<b>10</b>	<b>3,259</b>	<b>4,674</b>
<b>Investing Activities</b>			
Purchase of property, plant, equipment		(482)	(5,006)
<b>Net Cash from Investing Activities</b>		<b>(482)</b>	<b>(5,006)</b>
<b>Net (decrease)/increase in cash and cash equivalents</b>		<b>2,777</b>	<b>(332)</b>
Cash and cash equivalents at the beginning of the year		6,481	6,813
<b>Cash and cash equivalents at the end of the year</b>		<b>9,258</b>	<b>6,481</b>
Represented by:			
Cash and cash equivalents		9,258	6,481
<b>Cash and cash equivalents</b>		<b>9,258</b>	<b>6,481</b>

## Notes to the Financial Statements

### 1. Statement of accounting policies

#### Reporting Entity

Central Regions Technical Advisory Service Limited ("TAS") is a multi-parent subsidiary company owned by the six central region DHBs, which are Crown entities as defined by the Crown Entities Act 2004. The relevant legislation governing TAS operations is the Crown Entities Act 2004. TAS' ultimate parent is the Crown.

TAS' primary objective is to provide professional services to the New Zealand health sector. TAS does not operate to make a financial return.

TAS has designated itself as a public benefit entity (PBE) for financial reporting purposes. The financial statements for TAS are for the year ended 30 June 2016, and were approved by the Board on the 28th of September 2016.

#### 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 TAS have been prepared in accordance with New Zealand Generally Accepted Accounting Practice (NZ GAAP). They comply with the PBE accounting standards as appropriate for Tier 1 public sector public benefit entities.

#### Measurement base

The financial statements have been prepared on a historical cost basis.

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars (\$000) unless otherwise stated.

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

There are no new, revised or amended standards that have been issued but are not yet effective that would have a significant impact on the company's financial statements.

### Summary Of Significant Accounting Policies

#### Revenue

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

##### *DHB funding*

TAS is funded by the National and Regional DHBs. DHB revenue is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds if conditions of the National or Regional Work Plans are not met. If there is such an obligation, the funding is initially recorded as revenue in advance and recognised as revenue when conditions of the work plans are met.

##### *Ministry of Health funding*

TAS receives funding from the Ministry of Health ("MoH") for a number of different initiatives, the most significant being interRAI. MoH revenue is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds. If there is such an obligation, the funding is recorded as revenue in advance.

##### *Interest revenue*

Interest revenue is recognised using the effective interest method.

#### Leases

##### *Operating leases*

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 lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

#### Cash and cash equivalents

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.

**Receivables**

Receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that TAS 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.

**Payables**

Short-term payables are recorded at their face value.

**Employee entitlements*****Short-term employee entitlements***

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service, are measured on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date and annual leave earned but not yet taken at balance date.

A liability and an expense are recognised for bonuses where there 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.

***Presentation of employee entitlements***

Annual leave is classified as a current liability.

**Equity**

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

- Accumulated surplus/(deficit)

**Goods and services tax**

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables, which 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 (IRD) is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.

**Income tax**

TAS is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

**Critical judgements in applying accounting policies**

In recognising revenue and funds in advance there is some judgement involved in the allocation of revenue to reporting period. This allocation is done per contract, excess funds received on contracts with pay back clauses are recognised as funds in advance. If a contract period is across year end the revenue will be allocated based on percentage of completion of the contract. If milestones are not obvious in the contract, expenses incurred to date will be used as a guide for the percentage of completion.

**Comparatives**

Certain amounts in the comparative information have been reclassified to ensure consistency with the current year's presentation.

## 2. Other revenue

	2016 Actual \$000s	2015 Actual \$000s
MOH revenue	7,669	2,359
Gain on disposal	-	562
Other revenue	525	858
<b>Total revenue</b>	<b>8,194</b>	<b>3,779</b>

## 3. Personnel costs

	2016 Actual \$000s	2015 Actual \$000s
Salaries and wages	20,549	16,718
Defined contribution plan employer contributions	329	283
Increase/(decrease) in employee entitlements	(60)	194
<b>Total personnel costs</b>	<b>20,818</b>	<b>17,195</b>

Employer contributions to defined contribution plans include contributions to Kiwi Saver.

#### 4. Other expenses

	2016 Actual \$000s	2015 Actual \$000s
Fees to auditor		
- Fees to KPMG (2015: Audit New Zealand) for audit of financial statements	40	59
Office lease	419	392
Travel and transport	1,361	1,276
Consultancy	3,269	2,535
Information Communications Technology - RHIP	4,660	5,467
Information Communications Technology - Non-RHIP	3,643	2,588
Legal Fees	530	334
Facility Reimbursements	246	996
Other	1,282	1,362
<b>Total expenses</b>	<b>15,450</b>	<b>15,009</b>

#### 5. Cash and cash equivalents

	2016 Actual \$000s	2015 Actual \$000s
Cash at bank and on hand	9,258	6,481
<b>Total cash and cash equivalents</b>	<b>9,258</b>	<b>6,481</b>

## 6. Receivables

	2016 Actual \$000s	2015 Actual \$000s
Receivables (gross)	2,539	5,398
Accrued debtors	438	438
Less: provision for impairment	(5)	-
<b>Total receivables</b>	<b>2,972</b>	<b>5,836</b>
Total receivables comprises:		
Receivables from exchange transactions	2,972	5,836
Receivables from non-exchange transactions	-	-

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

	2016 Actual \$000s	2015 Actual \$000s
Not past due	1,897	1,239
Past due 31 - 60 days	257	820
Past due over 60 days	818	3,777
<b>Total</b>	<b>2,972</b>	<b>5,836</b>

All receivables greater than 30 days in age are considered to be past due.

There is a \$5k impairment provision for receivables (2015: nil).

## 7. Payables

	2016 Actual \$000s	2015 Actual \$000s
Creditors	1,929	5,307
Accrued expenses	1,850	1,221
<b>Total payables</b>	<b>3,779</b>	<b>6,528</b>
Total payables comprises:		
Payables from exchange transactions	3,645	6,394
Payables from non-exchange transactions	134	134

## 8. Employee entitlements

	2016 Actual \$000s	2015 Actual \$000s
<b>Current portion</b>		
Accrued salaries	172	86
Annual leave	604	665
Other short term benefits	117	66
<b>Total employment entitlements</b>	<b>893</b>	<b>817</b>

## 9. Reclassification of equity

There have been no equity reclassifications in 2016. During the 2015 year shareholder DHBs decided to take over ownership of the CRISP asset. This was a change to the previous ownership agreement and resulted in the reversal of capital contribution previously included in share capital.

**10. Reconciliation of net surplus/deficit with net cash flow from operating activities**

	2016 Actual \$000s	2015 Actual \$000s
<b>Net surplus</b>	<b>253</b>	<b>156</b>
<b>Add back non-cash items</b>		
Depreciation and amortisation expense	232	(356)
<b>Total non-cash items</b>	<b>232</b>	<b>(356)</b>
<b>Add/(less) movements in statement of financial position items</b>		
Decrease/(increase) in receivables	3,003	7,373
(Increase)/decrease in prepayments	(60)	712
(Decrease)/increase in payables	(2,751)	843
Increase/(decrease) in employee entitlements	77	144
(Decrease)/increase in funds received in advance	2,505	(4,198)
<b>Net movements in working capital items</b>	<b>2,774</b>	<b>4,874</b>
<b>Net cash flow from operating activities</b>	<b>3,259</b>	<b>4,674</b>



## 11. Commitments

### Capital commitments

	2016 Actual \$000s	2015 Actual \$000s
Within 12 months	391	-
Greater than 12 months	-	-
<b>Total Capital Commitments</b>	<b>391</b>	<b>-</b>

Capital commitments relate to leasehold improvements at the premises in Tory Street which TAS will move into in 2017.

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

### Operating Leases as Lessee

	2016 Actual \$000s	2015 Actual \$000s
Not later than one year	578	295
Later than one year and not later than five years	3,282	-
Later than five years	3,864	-
<b>Total non-cancellable operating leases</b>	<b>7,724</b>	<b>295</b>

TAS leases office space at 186 Willis Street, Wellington. The lease expires on 30 April 2017. TAS has signed a lease for a new premises at 69 Tory Street. This lease expires 9 years from commencement.

## 12. Contingencies

TAS has no contingent liabilities or contingent assets. (2015: Nil).

### 13. Related Party Transactions

TAS is a multi-parent subsidiary of a group of Central Region DHBs.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect TAS would have adopted in dealing with the part 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.

The following transactions are not at arm's length.

	Revenue		Accounts Receivable		Expenses		Accounts Payable	
	Year to June 2016 \$000	Year to June 2015 \$000	Year to June 2016 \$000	Year to June 2015 \$000	Year to June 2016 \$000	Year to June 2015 \$000	Year to June 2016 \$000	Year to June 2015 \$000
Auckland DHB	-	-	-	-	75	-	-	-
Bay of Plenty DHB	632	771	-	2	84	97	29	-
Canterbury DHB	1,347	1,568	123	149	501	138	-	-
Capital & Coast DHB	5,192	4,095	823	1,393	262	220	17	40
Counties Manukau DHB	-	-	-	-	77	-	15	-
Hawkes Bay DHB	3,780	2,651	30	55	79	59	10	1
Hutt Valley DHB	3,189	2,371	159	1,883	143	59	26	7
Lakes DHB	289	350	-	67	10	3	-	3
MidCentral DHB	4,490	3,555	125	23	53	1	10	-
Nelson Marlborough DHB	451	514	48	(45)	53	-	10	-
Northern Regional Alliance*	5,031	5,031	-	-	236	622	3	52
Northland DHB	-	-	-	-	53	-	10	-
Tairāwhiti DHB	147	179	-	-	24	-	14	-
Taranaki DHB	314	382	30	-	672	130	5	36
South Canterbury DHB	177	208	(1)	(20)	24	-	-	-
Southern DHB	988	1,216	-	25	150	6	86	-
Waikato DHB	1,006	1,225	-	-	75	3	86	-
Wairarapa DHB	1,925	750	29	18	24	-	5	-
Waitemata DHB	-	-	-	-	75	-	14	-
West Coast DHB	111	127	-	(12)	-	-	-	-
Whanganui DHB	2,450	1,362	216	545	24	-	5	-

\*Revenue is billed to Northern Regional Alliance on behalf of Auckland DHB, Counties Manukau DHB, Northland DHB and Waitemata DHB

**Key management personnel compensation**

	2016 Actual	2015 Actual
<b>Leadership team</b>		
Remuneration	\$1,655,640	\$1,752,734
Full-time equivalent members	8.0	8.4

**14. Board member remuneration**

	2016 Actual \$000s	2015 Actual \$000s
Dr Jan White (Chairperson)	30	31
Murray Bain	15	16
Elaine McCaw	-	16
Deryck Shaw	15	16
Murray Georgel	15	3
Wendy McPhail	15	-
<b>Total Board member remuneration</b>	<b>90</b>	<b>82</b>

There have been no payments made to committee members appointed by the Board who are not Board members during the financial year.

TAS has provided a deed of indemnity to Directors for certain activities undertaken in the performance of TAS' functions.

TAS 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.

**15. Events after Balance date**

There were no significant events after the balance date.

## 16. Financial instruments

TAS is risk averse and seeks to minimise exposure arising from its treasury activity. TAS does not enter into any transaction that is speculative in nature.

TAS has a series of policies providing risk management for interest and currency rates and the concentration of credit.

### Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. TAS' exposure to fair value interest rate risk is limited to its bank deposits which are held at fixed rates of interest. TAS does not actively manage its exposure to fair value interest rate risk.

### Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. TAS has no exposure to currency risk.

### Credit risk

Credit risk is the risk that a third party will default on its obligation to TAS causing it to incur a loss.

Due to the timing of cash inflows and outflows, TAS invests surplus cash with registered banks.

In the normal course of business, TAS is exposed to credit risk from cash and term deposits with banks and receivables. For each of these, the maximum credit exposure is best represented by the carrying amount in the statement of financial position. TAS holds no collateral or other credit enhancements for financial instruments that give rise to credit risk.

### Liquidity Risk

#### Management of liquidity risk

Liquidity risk is the risk that TAS will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash.

TAS mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements.

#### Contractual maturity analysis of financial liabilities

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows.

	Carrying amount \$000	Contractual cash flows \$000	Less than 6 months \$000	6-12 Months \$000	Later than 1 year \$000
<b>2015</b>					
Payables (excluding funds received in advance and taxes payable)	6,394	6,394	6,394	-	-
<b>Total</b>	<b>6,394</b>	<b>6,394</b>	<b>6,394</b>	<b>-</b>	<b>-</b>
<b>2016</b>					
Payables (excluding funds received in advance and taxes payable)	3,621	3,621	3,621	-	-
<b>Total</b>	<b>3,621</b>	<b>3,621</b>	<b>3,621</b>	<b>-</b>	<b>-</b>

## 17. Capital management

TAS capital is its equity which comprises accumulated funds. Equity is represented by net assets.

TAS 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.

TAS manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure TAS effectively achieves its objectives and purpose, whilst remaining a going concern.



## Independent Auditor's Report

### To the shareholders of Central Region's Technical Advisory Services

We have audited the accompanying financial statements of Central Region's Technical Advisory Services ("the company") on pages 24 to 39. The financial statements comprise the statement of financial position as at 30 June 2016, the statements of comprehensive revenue and expenses, changes in equity and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

This report is made solely to the shareholders as a body. Our audit work has been undertaken so that we might state to the company's shareholders those matters we are required to state to them in the auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the company's shareholders as a body, for our audit work, this report or any of the opinions we have formed.

#### Directors' responsibility for the financial statements

The directors are responsible on behalf of the company for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting practice in New Zealand (being Public Benefit Entity Standards (Public Sector)) and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement whether due to fraud or error.

#### Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the company's preparation and fair presentation of the financial statements 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 company's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates, as well as evaluating the presentation of the financial statements.

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

Our firm was also engaged by the company to assist with an internal audit review at one of the company's shareholders. This matter has not impaired our independence as auditor of the company. The firm has no other relationship with, or interest in, the company.

#### Opinion

In our opinion, the financial statements on pages 24 to 39 comply with generally accepted accounting practice in New Zealand and present fairly, in all material respects, the financial position of Central Region's Technical Advisory Services as at 30 June 2016 and its financial performance and cash flows for the year then ended in accordance with Public Benefit Entity Standards (Public Sector).

The financial statements of Central Region's Technical Advisory Services, for the year ended 30 June 2015, were audited by another auditor who expressed an unmodified opinion on those statements on 28 October 2015.

xx October 2016

Wellington

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 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Allied Laundry Services Ltd</b> <b>Annual General Meeting</b>	122
	For the attention of: <b>HBDHB Board</b>	
Document Owner:	Ken Foote, Company Secretary	
Reviewed by:	Executive Management Team	
Month:	October 2016	
Consideration:	For Discussion / Decision	

### RECOMMENDATION

#### That the Board

- Note the Chairman's Report and the Financial Statements for Allied Laundry Services Ltd (Allied) for the year ended 30 June 2016.
- Appoint Ken Foote as the HBDHB Shareholder representative to attend the Allied Annual General Meeting to be held on Tuesday 29 November 2016, with Peter Kennedy appointed as his Alternate.

### ATTACHMENTS

- Notice of AGM
- Minutes of 2015 AGM
- Financial Statements
- Deloitte Management Report to the Board of Allied
- Chair's Report

### FINANCIAL STATEMENTS

The attached financial statements are in draft due to some ongoing discussions with the Auditors around two "technical" issues. It is expected that these issues will be resolved by the date of the meeting and that neither will have any impact on the results reflected in this draft. A copy of the final accounts and Auditors Report will be forwarded once completed.

### AGM REPRESENTATIVE

The Shareholders Agreement requires each shareholder to appoint a representative for the AGM.

As the HBDHB appointed Director on the Board of Allied (and the current Chair) it would be appropriate for Ken Foote to be appointed as the HBDHB shareholder representative to attend and vote at the AGM. If for some reason Ken is unable to attend, it is recommended that Peter Kennedy be appointed as his Alternate.



Notice is hereby given that the Annual Meeting of shareholders of Allied Laundry Services Limited will be held:

At **Allied Laundry Services Limited; Palmerston North.**

On Tuesday 29<sup>th</sup> November 2016

## **BUSINESS**

### **1 Apologies**

### **2 Shareholders Representatives**

To clarify who is attending the meeting and has voting rights as the representative of a shareholder

### **3. Minutes**

To review and accept the minutes of the Annual Meeting held on 24 November 2015.

*Recommendation: That the minutes of the Annual Meeting held on 24 November 2015 be accepted as a true and accurate record of that meeting.*

### **4 Financial Statements and Reports**

To receive, consider and adopt the company's financial statements for the year ended 30 June 2016 together with the auditor's report thereon and the Chairperson's Annual Report.

*Recommendation: That the annual report of the company for the year ended 30<sup>th</sup> June 2016 be required to include only the signed financial statements for the accounting period completed and an auditors report.*

*That the annual report for the year ended 30<sup>th</sup> June 2016 is received.*

*That the Chairpersons report for the year ended 30<sup>th</sup> June 2016 is received.*

*That the letter of representation for the year ended 30<sup>th</sup> June 2016 be signed by 2 Directors.*

**5 Payment of Dividend.**

To declare a dividend of \$0.08 cents per share to the six shareholding District Health Boards. The Directors to complete a solvency certificate approving the payment of the dividend.

*Recommendation: That a dividend payment of \$0.08 per share is declared to each shareholding District Health Board.*

**6 Appointment of Auditors**

To record the continuance of Deloitte as auditors on behalf of the Office of the Auditor-General for Allied Laundry Services Limited.

*Recommendation: That the continuance of Deloitte as auditors on behalf of the Office of the Auditor-General be recorded.*

**7 General**

To deal with any other business that may be properly brought before the meeting.

By Order of the Board

9 September 2016

Ken Foote

Chair

Allied Laundry  
Services Limited.  
Minutes Annual General  
Meeting 24<sup>th</sup> November  
2015.



**ANNUAL GENERAL MEETING**

**Minutes**

**24<sup>th</sup> November 2015**

Venue: Fitzherbert Regency, 250 Fitzherbert Avenue, Palmerston North

**Present:**

Shareholder representatives: Jeff Small, Simon Barrett, Ken Foote, Brian Walden proxy for Julie Patterson

1. Apologies: Julie Patterson
2. Share Holders Representatives

Letters of appointment from the DHB shareholding representatives have been received from Taranaki District Health Board for Simon Barrett, Hawkes Bay District Health Board for Ken Foote, MidCentral District Health Board for Jeff Small and Whanganui District Health Board for Julie Patterson in her absences Brian Walden.

The Shareholder representatives to the Allied Laundry Board are Simon Barrett, Jeff Small, Brian Walden and Ken Foote.

3. Minutes

It was noted that the 2014 AGM minutes were not dated to be corrected  
Recommendations should read "Carried" not "Board carried"  
Minutes of the Annual General Meeting of the 25 November 2014 have been received and approved.

*Moved: Simon Barrett*

*Second: Jeff Small*

*Carried*

4. Financial Statements and Reports

*Recommendation: That the annual report of the company for the year ended 30<sup>th</sup> June 2015 be required to include only the signed financial statements for the accounting period completed and an auditor's report.*

*That the annual report for the year ended 30<sup>th</sup> June 2015 is received.*

*That the letter of representation for the year ended 30<sup>th</sup> June 2015 be signed by 1 Director and the CEO of Allied Laundry.*

*Moved: Jeff Small  
Seconded: Simon Barrett  
Carried*

5. Payment of Dividend

The board have appointed the dividend payment of \$0.08 per share (\$60,000) is paid to each shareholding District Health Board on completion of the solvency certificates and as and when the cash flow permits within in the 2015/16 financial year.

*Moved: Simon Barrett  
Seconded: Brian Walden  
Carried*

6. Auditors

The board have appointed Deloitte as auditors for Allied Laundry.

*Moved: Jeff Small  
Seconded: Ken Foote  
Carried*

5. General Business

Meeting Closed at 10.30 am.

Signed:

\_\_\_\_\_  
Ken Foote  
Chairman

Date: \_\_\_\_\_



Thursday 15<sup>th</sup> September 2016

Chair of the Boards and CEO's Allied Laundry Shareholders.

MidCentral District Health Board  
Taranaki District Health Board  
Whanganui District Health Board  
Hawkes Bay District Health Board  
Capital & Coast District Health Board  
Hutt Valley District Health Board.

Dear Sir or Madam,

Regarding Allied Laundry financial accounts for the 2015/16 financial year.

Please find attached the final accounts for Allied Laundry Services for the 2015/16 financial year.

The accounts show a small loss to Allied Laundry for the 2015/16 financial year. Considering the level of change with the integration of CCDB and HVDHB into the Allied Laundry operation the loss is not substantial and will be passed into the next financial year. With the loss there will not be a rebate to shareholders.

The shareholding customers received, in effect a 10% price reduction from 1 March. Due to cost pressures a small price increase of 1.5% has been passed on from 1 July 2016 to all customers.

The Allied Laundry Board will declare a dividend of 8% to the shareholders for the 2015/16 financial year.

The Allied Laundry Board of Directors have reviewed and received the accounts.

Yours sincerely  
Mark Mabbett

CEO  
Allied Laundry Services Limited

BY HEALTH, FOR HEALTH.





**DRAFT**

# Allied Laundry Services Ltd

## Financial Statements For the Year ended 30 June 2016

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**Allied Laundry Services Ltd****Directory****As at 30 June 2016**

<b>Nature of Business</b>	During the year the company has continued to provide a laundry and linen services to Taranaki, Whanganui, Hawkes Bay, MidCentral, Hutt Valley, Capital & Coast and Wairarapa District Health Boards and commercial customers.	
<b>Registered Office</b>	Palmerston North Hospital, Ruahine Street Palmerston North	
<b>Directors</b>	Ken Foote (Chair) Simon Barrett Brian Walden Jeffrey Small Ashley Bloomfield (appointed March 2016) Tony Hickmott (appointed March 2016) Julie Patterson (resigned February 2016) Jillian Matthews (resigned February 2016) David Ritchie (resigned February 2016)	
<b>Shareholders</b>	MidCentral District Health Board	1,150,000 Ordinary Shares
	Whanganui District Health Board	1,150,000 Ordinary Shares
	Taranaki District Health Board	1,150,000 Ordinary Shares
	Hawkes Bay District Health Board	1,150,000 Ordinary Shares
	Capital & Coast District Health Board	1,150,000 Ordinary Shares
	** Hutt Valley District Health Board	300,000 Ordinary Shares
<b>Accountants</b>	Naylor Lawrence & Associates Limited Chartered Accountants 196 Broadway Avenue Palmerston North 4410	
<b>Bankers</b>	BNZ Bank Palmerston North	
<b>Solicitors</b>	Buddle Findlay Wellington	
<b>Company Number</b>	877063	

*\*\* Hutt Valley District Health Board have committed to purchasing a full parcel of 1,150,000 shares in a phased approach by 1 January 2019.*

**Allied Laundry Services Ltd**



**Annual Report**

**For the Year Ended 30 June 2016**

The board of directors submit their annual report including the financial statements for Allied Laundry Services Ltd for the year ended 30 June 2016, and the auditors report.

The shareholders of Allied Laundry Services Ltd have exercised their right under section 211(3) of the Companies Act 1993 and unanimously agreed that this annual report need not comply with any of paragraphs (a) and (e) - (j) of section 211(1).

**Auditor**

The Auditor-General is the auditor of Allied Laundry Services Ltd. The Auditor-General has appointed Deloitte to carry out the audit of the financial statements of the Company on her behalf. Messrs Deloitte, the present auditors have signified their willingness to continue in office.

For and on behalf of the Board

\_\_\_\_\_  
Ken Foote (Chair)                      Director                      Date \_\_\_\_\_

\_\_\_\_\_  
Simon Barrett                      Director                      Date \_\_\_\_\_

\_\_\_\_\_  
Brian Walden                      Director                      Date \_\_\_\_\_

\_\_\_\_\_  
Jeffrey Small                      Director                      Date \_\_\_\_\_

\_\_\_\_\_  
Ashley Bloomfield (Appointed March 2016)                      Director                      Date \_\_\_\_\_

**Allied Laundry Services Ltd**



**Annual Report (continued)**

**For the Year Ended 30 June 2016**

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\_\_\_\_\_  
Tony Hickmott (Appointed March 2016)

**Director**

**Date** \_\_\_\_\_

## Allied Laundry Services Ltd



## Statement of Comprehensive Income

For the Year Ended 30 June 2016

Note	2016	2015
	\$	\$
<b>Operating Revenue</b>		
Revenue - Capital & Coast DHB	2,009,425	1,451,762
Revenue - Wairarapa DHB	384,560	385,968
Revenue - External	590,058	508,944
Revenue - Other Customers	29,039	-
Revenue - MidCentral DHB	2,233,095	2,282,725
Revenue - Taranaki DHB	1,059,483	1,022,663
Revenue - Whanganui DHB	656,245	648,623
Revenue - Hawkes Bay DHB	1,693,532	1,700,962
Revenue - Hutt Valey DHB	583,545	-
<b>Gross Surplus</b>	<b>9,238,982</b>	<b>8,001,647</b>
<b>Less Expenses</b>		
<b>Operating Expenses</b>		
Assembling Supplies	221,491	200,333
Chemicals & Detergents	192,161	156,782
Delivery - Transport	1,121,973	957,765
Freight	18,440	11,019
Loss of Stock	172,175	210,500
Steam & Electricity	412,667	426,048
Maintenance plant	340,181	255,378
Protective Clothing/Uniforms	14,102	5,089
Health & Safety	23,267	22,169
Travel Expenses	5,677	6,890
Wages/Labour costs	3,722,189	2,844,228
Water & Waste	49,206	42,762
	<b>6,293,529</b>	<b>5,138,963</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



## Statement of Comprehensive Income (continued)

For the Year Ended 30 June 2016

	Note	2016	2015
		\$	\$
<b>Administration Expenses</b>			
Audit fees		53,088	39,588
Bank Charges		6,539	2,746
Cleaning		51,316	47,757
Communication expenses		9,743	11,082
CCDHB & HVDHB Integration		103,911	44,366
Directors fees		115,000	97,500
Fringe Benefit Tax		6,061	8,033
General expenses		51,957	40,122
HBL Reponses & Process		-	17,816
Management fee		84,000	84,000
Motor Vehicle expenses		7,314	4,200
Postage & Stationery		35,742	36,307
Professional Fees		38,579	19,621
Staff Training		18	2,791
Superannuation Contributions		43,638	49,076
		<b>606,906</b>	<b>505,005</b>
<b>Interest Rent and Lease</b>			
Interest Paid - Loans		37,562	-
Rent		315,715	307,971
		<b>353,277</b>	<b>307,971</b>
<b>Rates and Insurance</b>			
ACC Levies		55,283	11,546
Insurance		44,550	58,436
Rates		180	180
		<b>100,013</b>	<b>70,162</b>
<b>Non Cash Expenses</b>			
Depreciation		1,593,412	1,258,071
<b>Total Expenses</b>		<b>8,947,137</b>	<b>7,280,173</b>
<b>Operating Surplus before Other Income</b>		<b>291,845</b>	<b>721,474</b>
<b>Other Income</b>			
Foreign Currency Gains/Losses		25,305	-
Interest Received		12,168	38,253
Profit/(Loss) on Sale of Fixed Assets		24,426	(3,026)
<b>Total Other Income</b>		<b>61,899</b>	<b>35,227</b>
<b>Net Surplus</b>		<b>353,744</b>	<b>756,701</b>
Other comprehensive revenue		-	-
<b>Total Comprehensive Income for the Year</b>		<b>353,744</b>	<b>756,701</b>
Net Surplus and Total Comprehensive Income attributable to:			
Owners of the parent		353,744	756,701

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



## Statement of Movements in Equity

For the Year Ended 30 June 2016

	Note	2016 \$	2015 \$
<b>Total Comprehensive Income</b>			
Total Comprehensive Income for the year		353,744	756,701
<b>Total Comprehensive Income for the year</b>		<b>353,744</b>	<b>756,701</b>
<b>Contributions and Distributions</b>			
<b>Contributions</b>			
Paid in Capital	2	3,050,000	-
<b>Distributions</b>			
Dividend Payable		(404,933)	(240,000)
Retained Earning reinvested as Share Capital		(1,600,000)	
Equity at the Beginning of the Year		4,600,000	4,083,299
<b>Equity at the End of the Year</b>		<b>5,998,812</b>	<b>4,600,000</b>
<b>Movements in Retained Earnings</b>			
Opening Balance		1,600,000	1,083,299
<b>Plus:</b>			
Total Comprehensive Income for the year		353,745	756,701
<b>Less:</b>			
Dividend Payable		404,933	240,000
Retained Earning reinvested as Share Capital		1,600,000	
<b>Retained Earnings Closing Balance</b>		<b>(51,188)</b>	<b>1,600,000</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



## Statement of Financial Position

As at 30 June 2016

	Note	2016 \$	2015 \$
<b>Equity</b>			
Paid up Share Capital	2	6,050,000	3,000,000
Retained Earnings	3	(51,188)	1,600,000
<b>Total Equity</b>		<b>5,998,812</b>	<b>4,600,000</b>
<b>Represented by:</b>			
<b>Current Assets</b>			
BNZ Bank		-	1,949,464
Accounts Receivable	4	1,030,502	1,026,923
GST Receivable		68,809	-
Prepayments	5	1,503	-
Stock on Hand		72,459	40,809
<b>Total Current Assets</b>		<b>1,173,273</b>	<b>3,017,196</b>
<b>Non Current Assets</b>			
Property, Plant & Equipment	6	8,449,494	3,004,497
Goodwill	7	795,427	-
<b>Total Non Current Assets</b>		<b>9,244,921</b>	<b>3,004,497</b>
<b>Total Assets</b>		<b>10,418,194</b>	<b>6,021,693</b>
<b>Current Liabilities</b>			
BNZ Bank		51,866	-
Trade Creditors		370,792	336,668
Accruals - Dividends & Rebates	15	896,666	491,731
Accruals - General		498,279	245,683
Holiday Pay Liability		409,615	302,483
Shareholding Received in Advance		100,000	-
Term Loans - Current portion	9	243,992	-
BNZ Credit Plus Facility	9	950,260	-
GST Payable		-	33,827
Provision for Gratuity	8	11,995	11,301
<b>Total Current Liabilities</b>		<b>3,533,464</b>	<b>1,421,693</b>
<b>Non Current Liabilities</b>			
Term Loan - BNZ	9	727,118	-
Term Loan - EECA	9	158,800	-
<b>Total Non Current Liabilities</b>		<b>885,918</b>	<b>-</b>
<b>Total Liabilities</b>		<b>4,419,382</b>	<b>1,421,693</b>
<b>Net Assets</b>		<b>5,998,812</b>	<b>4,600,000</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.





## Allied Laundry Services Ltd



## Statement of Cash Flows

For the Year Ended 30 June 2016

	Note	2016 \$	2015 \$
<b>Cash Flows from Operating Activities</b>			
<b>Cash was provided from:</b>			
Receipts from Customers		9,335,403	8,039,956
Interest Receivable		12,168	38,253
GST Received		-	37,421
		<b>9,347,571</b>	<b>8,115,630</b>
<b>Cash was disbursed to:</b>			
Payments to Suppliers and Employees		6,954,766	5,588,409
Goods and Services Tax Paid		102,636	-
Interest Paid		47,449	-
		<b>7,104,851</b>	<b>5,588,409</b>
<b>Net Cash Flows from Operating Activities</b>		<b>2,242,720</b>	<b>2,527,221</b>
<b>Cash Flows from Investing Activities</b>			
<b>Cash was provided from:</b>			
Sale of Fixed Assets		27,700	4,486
Foreign Exchange Gains - Forward Exchange Contracts		25,305	-
		<b>53,005</b>	<b>4,486</b>
<b>Cash was disbursed to:</b>			
Purchase of Fixed Assets		6,075,684	872,473
Goodwill acquired through Business Combinations		795,427	-
		<b>6,871,111</b>	<b>872,473</b>
<b>Net Cash Flows from Investing Activities</b>		<b>(6,818,106)</b>	<b>(867,987)</b>
<b>Cash Flows from Financing Activities</b>			
<b>Cash was provided from:</b>			
Issue of Share Capital		484,000	-
Advances from Term Loans		2,220,000	-
		<b>2,704,000</b>	<b>-</b>
<b>Cash was disbursed to:</b>			
Repayment of Term Loans		129,944	52,500
Dividend Paid		-	240,000
		<b>129,944</b>	<b>292,500</b>
<b>Net Cash Flows from Financing Activities</b>		<b>2,574,056</b>	<b>(292,500)</b>
Net Decrease in Cash Held		(2,001,330)	1,366,734
Cash at the Beginning of the Year		1,949,464	582,730
<b>Cash at the End of the Year</b>		<b>(51,866)</b>	<b>1,949,464</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



### Notes to and forming part of the Financial Statements

#### For the Year Ended 30 June 2016

## 1 Statement of Accounting Policies

### Reporting Entity

The financial statements and notes are for Allied Laundry Services Limited (the Company). It is a profit oriented entity incorporated and domiciled in New Zealand and is a company registered under the Companies Act 1993.

The address of its registered office is 196 Broadway Avenue, Palmerston North, New Zealand. Its principal place of business is 12/50 Ruahine Street, Roslyn, Palmerston North, New Zealand.

The principal activities of the Company during the financial period were the provision of laundry and linen services to Taranaki, Whanganui, Hawkes Bay, MidCentral, Hutt Valley, Capital & Coast and Wairarapa District Health Boards and commercial customers.

### Statement of Compliance and Basis of Preparation

The Company has adopted the New Zealand equivalents to International Financial Reporting Standards - Reduced Disclosure Regime ("NZ IFRS - RDR") as set out in the External Reporting Board's "Accounting Standards Framework".

The financial statements are general purpose financial statements that have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand ("NZ GAAP"). They comply with New Zealand equivalents to NZ IFRS - RDR. The Company has elected to report under NZ IFRS - RDR as the Company is a for-profit Tier 2 entity for financial reporting purposes on the basis that it does not have public accountability and is not a large for-profit public sector entity. The financial statements have been prepared in accordance with the requirements of the Companies Act 1993 and the Financial Reporting Act 2013.

The financial statements for the year ended 30 June 2016 were approved and authorised for issue by the Board of Directors.

The accounting principles recognised as appropriate for the measurement and reporting of the Statement of Comprehensive Income and Statement of Financial Position on a tax value basis are followed by the company, unless otherwise stated in the Specific Accounting Policies. The information is presented in New Zealand dollars. All values are rounded to the nearest \$.

### Specific Accounting Policies

The following specific accounting policies which materially affect the measurement of the Statement of Comprehensive Income and Statement of Financial Position have been applied:

#### (a) Revenue

Revenue comprises amounts received and receivable by the business for goods and services supplied in the ordinary course of business.

Interest income and expenses are reported on an accrual basis using the effective interest method.

#### (b) Expenses

Operating expenses are recognised in profit or loss upon utilisation of the service or at the date of their origin.

#### (c) Inventories

Inventories are stated at the lower of cost and net realisable value. Cost includes all expenses directly attributable to the manufacturing process as well as suitable portions of related production overheads, based on normal operating capacity. Costs of ordinarily interchangeable items are assigned using the first in, first out cost formula. Net realisable value is the estimated selling price in the ordinary course of business less any applicable selling expenses.

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

**Allied Laundry Services Ltd**



**Notes to and forming part of the Financial Statements (continued)**

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**For the Year Ended 30 June 2016**

(d) Trade Receivables

Trade Receivables are recognised at estimated realisable value.

(e) Property, Plant & Equipment

The cost of purchased assets is the value of consideration given to acquire the assets and the value of other directly attributable costs which have been incurred in bringing the assets to the location and condition necessary for their intended service. Costs include financing costs that are directly attributable to the purchase of those assets.

Depreciation is calculated at the maximum rates approved for taxation purposes. The rates are as follows:

Linen 33% Straight Line  
Plant 10-40% Straight Line  
Office Equipment 18.6% Straight Line

Work in progress is not depreciated. The total cost of a project is transferred to property and/or plant and equipment on its completion and then depreciated.

The internal controls over Textiles & Linen movement are limited.

(f) Operating Leases

Operating lease payments are representative of the pattern of the benefits derived from the leased assets and accordingly are charged to the Statement of Financial Performance in the periods in which they occur.

(g) Income Tax

The company is exempt from income tax under Section 38 (2) of the Income Tax Act 2007.

(h) Goodwill

Goodwill represents the excess of the purchase consideration over the fair value of the net tangible asset and intangible assets, acquired at the time of acquisition of a business or an equity interest in a subsidiary or associate company. Goodwill is tested annually for impairment. Brand names are recognised at cost. They are regarded as having indefinite useful lives because there is no foreseeable limit to the period over which they are expected to be useful. They are therefore not amortised. Instead, they are tested annually for impairment.

**Allied Laundry Services Ltd****Notes to and forming part of the Financial Statements (continued)****For the Year Ended 30 June 2016****(i) Financial Instruments****(1) Recognition, initial measurement and derecognition**

Financial assets and financial liabilities are recognised when the Company becomes a party to the contractual provisions of the financial instrument, and are measured initially at fair value adjusted by transaction costs, except for those carried at fair value through profit or loss, which are measured initially at fair value. Subsequent measurement of financial assets and financial liabilities are described below.

Financial assets are derecognised when the contractual rights to the cash flows from the financial asset expire, or when the financial asset and all substantial risks and rewards are transferred.

A financial liability is recognised when it is extinguished, discharged, cancelled or expires.

**(2) Classification and subsequent measurement of financial assets**

For the purpose of subsequent measurement, financial assets other than those designated and effective as hedging instruments are classified into the following categories upon initial recognition:

- Loans and receivables
- Financial assets at Fair value through profit or loss (FVTPL)
- Held-to-Maturity investments (HTM)
- Available-for-sale financial assets (AFS)

All financial assets except for those at FVTPL are subject to review for impairment at least at each reporting date to identify whether there is any objective evidence that a financial asset or a group of financial assets is impaired. Different criteria to determine impairment are applied for each category of financial assets, which are described below.

**(3) Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial recognition, these are measured at amortised cost using the effective interest method, less an allowance for credit losses. Discounting is omitted where the effect of discounting is immaterial. The Company's trade and most other receivables fall into this category of financial instruments.

Individually significant receivables are considered for impairment when they are past due or when other objective evidence is received that a specific counterparty will default. Receivables that are not considered to be individually impaired are reviewed for impairment in groups, which are determined by reference to the industry and region of a counterparty and other shared credit risk characteristics. The impairment loss estimate is then based on recent historical counterparty default rates for each identified group.

**(j) Foreign currencies**

The financial statements are presented in New Zealand Dollars (NZD), which is also the functional currency of the Company.

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions (spot exchange rate). Foreign exchange gains and losses resulting from the settlement of such transactions and from the re-measurement of monetary items at year end exchange rates are recognised in profit and loss.

**(k) Goods and Services Taxation (GST)**

Revenues and expenses have been recognised in the financial statements exclusive of GST except that irrecoverable GST input tax has been recognised in association with the expense to which it relates. All items in the Statement of Financial Position are stated exclusive of GST except for receivables and payables which are stated inclusive of GST.

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

**Allied Laundry Services Ltd**



**Notes to and forming part of the Financial Statements (continued)**

**For the Year Ended 30 June 2016**

**(l) Impairment**

For impairment assessment purposes, assets are grouped at the lowest levels for which there are largely independent cash inflows (cash-generating units). As a result, some assets are tested individually for impairment and some are tested at cash-generating unit level. Goodwill is allocated to those cash-generating units that are expected to benefit from synergies of the related business combination and represent the lowest level within the Company at which management monitors goodwill.

Cash-generating units to which goodwill has been allocated are tested for impairment at least annually. All other individual assets or cash-generating units are tested 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 or cash-generating unit's carrying amount exceeds its recoverable amount, which is the higher of fair value less costs to sell and value-in-use. To determine the value-in-use, management estimates expected future cash flows from each cash-generating unit and determines a suitable interest rate in order to calculate the present value of those cash flows.

Impairment losses for cash-generating units reduce first the carrying amount of goodwill allocated to that cash-generating unit. Any remaining impairment loss is charged pro rata to the other assets in the cash-generating unit. With the exception of goodwill, all assets are subsequently reassessed for indications that an impairment loss previously recognised may no longer exist. An impairment charge is reversed if the cash-generating unit's recoverable amount exceeds its carrying amount.

**(m) Cash and Cash Equivalents**

Cash and cash equivalents comprise cash on hand and demand deposits, together with other short-term, highly liquid investments that are readily convertible into known amounts of cash and which are subject to an insignificant risk of changes in value.

**(n) Employee Benefits**

**(1) Short-term employee benefits**

Short-term employee benefits are benefits, other than termination benefits, that are expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. Examples of such benefits include wages and salaries and non-monetary benefits. Short-term employee benefits are measured at the undiscounted amounts expected to be paid when the liabilities are settled.

**(2) Other long-term employee benefits**

The Company's liability for annual and long service leave are included in other long term benefits as they are not expected to be settled wholly within 12 months after the end of the period in which the employees render the related service. They are measured at the present value of the expected future payments to be made to employees. The expected future payments incorporate anticipated future wage and salary levels, experience of employee departures and periods of service, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the timing of the estimated future cash outflows. Any re-measurement arising from experience adjustments and changes in assumptions are recognised in profit or loss in the periods in which the changes occur.

The Company presents employee benefit obligations as current liabilities in the statement of financial position if the Company does not have an unconditional right to defer settlement for at least twelve months after the reporting period, irrespective of when the actual settlement is expected to take place.

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



### Notes to and forming part of the Financial Statements (continued)

#### For the Year Ended 30 June 2016

##### (o) Equity, Reserves and Dividend Payments

Share capital represents the fair value of shares that have been issued. Any transaction costs associated with the issuing of shares are deducted from share capital.

Retained earnings include all current and prior period retained profits.

Dividend distributions payable to equity shareholders are included in other liabilities when the dividends have been approved in a general meeting prior to the reporting date.

Dividends are paid by the company after reviewing the financial position and impact of the dividend on the solvency of the company. All dividends are approved by the Board before payment.

##### (p) Business Combinations

The Company applies the acquisition method in accounting for business combinations. The consideration transferred by the Company to obtain control of a subsidiary is calculated as the sum of the acquisition-date fair values of assets transferred, liabilities incurred and the equity interests issued by the Company, which includes the fair value of any asset or liability arising from a contingent consideration arrangement. Acquisition costs are expensed as incurred.

The Company recognises identifiable assets acquired and liabilities assumed in a business combination regardless of whether they have been previously recognised in the acquiree's financial statements prior to the acquisition. Assets acquired and liabilities assumed are generally measured at their acquisition-date fair values.

Goodwill is stated after separate recognition of identifiable intangible assets. It is calculated as the excess of the sum of: (a) fair value of consideration transferred; (b) the recognised amount of any non-controlling interest in the acquiree; and (c) acquisition-date fair value of any existing equity interest in the acquiree, over the acquisition-date fair values of identifiable net assets. If the fair value of identifiable net assets exceed the sum calculated above, the excess amount (i.e. gain on bargain purchase) is recognised in profit or loss immediately.

##### (q) Provisions and Contingent Liabilities

Provisions are recognised when the Company has a present obligation or constructive obligation as a result of a past event, it is probable that an outflow of economic resources will be required from the Company and amounts can be estimated reliably. Timing or amount of the outflow may still be uncertain.

Provisions are measured at the estimated expenditure required to settle the present obligation, based on the most reliable evidence available at the reporting date, including the risks and uncertainties associated with the present obligation. Where there are a number of similar obligations, the likelihood that an outflow will be required in settlement is determined by considering the class of obligation as a whole. Provisions are discounted to their present values, where the time value of money is material.

No liability is recognised in an outflow of economic resources as a result of present obligation is not probable. Such instances are disclosed as contingent liabilities, unless the outflow of resources is remote in which case no liability is recognised.

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

**Allied Laundry Services Ltd**



**Notes to and forming part of the Financial Statements (continued)**

**For the Year Ended 30 June 2016**

**(r) Statement of Cash Flows**

The Statement of Cash Flows is prepared exclusive of gst, which is consistent with the method used in the Statement of Financial Performance.

The following are definitions of the terms used in the Statement of Cash Flows:

(a) Cash is considered to be cash on hand, current accounts in banks, and other highly liquid investments in which the entity invests as part of its day to day cash management. Cash includes borrowings from financial institutions such as bank overdrafts, where such borrowings are at call and are used as part of the day to day cash management.

(b) Investing activities are those activities relating to the acquisition, holding and disposal of fixed assets and of investments. Investments can include securities not falling within the definition of cash.

(c) Financing activities are those activities which result in changes in the size and composition of the capital structure of the group. This includes both equity and debt not falling within the definition of cash. Dividends paid in relation to the capital structure are included in financing activities.

(d) Operating activities includes all transactions and other events that are not financing or investing activities.

(e) The reconciliation of the surplus (deficit) after tax with the net cash flow from operating activities is set out in the Statement of Cash Flows.

**(s) Significant Management Judgement in applying Accounting Policies and Estimation Uncertainty**

When preparing the financial statements, management undertakes a number of judgements, estimates and assumptions about the recognition and measurement of assets, liabilities, income and expenses.

Information about estimates and assumptions that have the most significant effect on recognition and measurement of assets, liabilities, income and expenses is provided below. Actual results may be substantially different.

**Impairment**

In assessing impairment, management estimates the recoverable amount of each asset or cash-generating unit based on expected future cash flows and uses an interest rate to discount them. Estimation uncertainty relates to assumptions about future operating results and the determination of a suitable discount rate.

**Useful life of depreciable assets**

Management reviews its estimate of the useful life of depreciable assets at each reporting date, based on the expected utility of the assets. Uncertainties in these estimates relate to technical obsolescence that may change the utility of certain software and IT equipment.

Furthermore, the useful life for linen stocks is based on the an assumption that linen stocks last for 36 months (3 years). The policy is based on the life of the total pool of circulating linen stocks and reflects linen life, linen ragging and unidentified stock losses.

**(t) Changes in Accounting Policies**

For the year ended 30 June 2015, the Company prepared financial statements using the New Zealand equivalents to International Financial Reporting Standards (NZ IFRS) with differential reporting concessions applied. As of 1 July 2015, these have now been restated to NZ IFRS - RDR. The transition to Tier 2 For-Profit Accounting Standards has had no material affect on the reporting Statement of Financial Position and Statement of Comprehensive Income.

There have been no other changes in accounting policies. All policies have been applied on a basis consistent with those from previous financial statements.

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.



**Allied Laundry Services Ltd****Notes to and forming part of the Financial Statements (continued)****For the Year Ended 30 June 2016****2 Share Capital****Paid in Capital**

Opening Balance

Movements

**Closing Balance****Total Share Capital**

2016	2015
\$	\$
3,000,000	3,000,000
3,050,000	-
<b>6,050,000</b>	<b>3,000,000</b>
<b>6,050,000</b>	<b>3,000,000</b>

The share capital of the Company consists only of fully paid ordinary shares; the shares do not have a par value. All shares are equally eligible to receive dividends and the repayment of capital and represents one vote at the shareholders' meeting.

**3 Retained Earnings**

Opening Balance

**Plus:**

Net Surplus

**Less:**

Dividend Payable

Retained Earnings reinvested as Share Capital

**Retained Earnings Closing Balance**

2016	2015
\$	\$
1,600,000	1,083,299
353,744	756,701
404,933	240,000
1,600,000	
<b>(51,189)</b>	<b>1,600,000</b>

**4 Current Receivables****Accounts Receivable**

Trade Debtors

**Total Current Receivables**

2016	2015
\$	\$
1,030,502	1,026,923
<b>1,030,502</b>	<b>1,026,923</b>

All amounts are short-term. The net carrying value of trade receivables is considered a reasonable approximation of fair value.

All of the Company's trade and other receivables have been reviewed for indicators of impairment, and no evidence of impairment has been identified.

**5 Prepayments**

Prepayments

**Total Prepayments**

2016	2015
\$	\$
1,503	-
<b>1,503</b>	<b>-</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



## Notes to and forming part of the Financial Statements (continued)

## For the Year Ended 30 June 2016

## 6 Property, Plant &amp; Equipment

	Leasehold - At cost	Textiles & Linen - At cost	Buildings - At valuation	Capital Work in Progress	Plant	Motor Vehicles	Office Equipment	Total
<b>Gross carrying amount</b>								
Balance 1 July 2015	97,613	2,866,741	23,403	-	5,280,680	36,060	71,352	8,375,849
Write off nil value assets	(61,253)	(1,058,553)	-	-	(70,099)	-	(11,201)	(1,201,107)
Additions	-	1,943,898	9,389	468,094	3,775,699	-	4,605	6,201,684
Additions through business combinations	-	490,000	-	-	350,000	-	-	840,000
Disposals	-	-	-	-	(40,000)	-	-	(40,000)
Balance 30 June 2016	36,360	4,242,086	32,792	468,094	9,296,279	36,060	64,756	14,176,426
<b>Depreciation and impairment</b>								
Balance 1 July 2015	86,937	1,656,920	3,382	-	3,567,192	14,051	42,870	5,371,352
Write off nil value assets	(61,253)	(1,058,553)	-	-	(70,099)	-	(11,201)	(1,201,107)
Disposals	-	-	-	-	(36,726)	-	-	(36,726)
Depreciation	4,004	1,149,394	729	-	422,581	6,022	10,683	1,593,413
Balance 30 June 2016	29,688	1,747,760	4,111	-	3,882,947	20,073	42,352	5,726,932
<b>Carrying amount as at 30 June 2016</b>	6,672	2,494,325	28,681	468,094	5,413,332	15,987	22,404	8,449,495

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



## Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2016

**7 Goodwill**

Goodwill

**Total Goodwill**

2016	2015
\$	\$
795,427	-
<b>795,427</b>	<b>-</b>

**8 Provisions****Provision for Gratuity**

Opening Balance

Movement for period

**Closing Balance****Total Provisions**

2016	2015
\$	\$
11,301	10,276
694	1,025
<b>11,995</b>	<b>11,301</b>
<b>11,995</b>	<b>11,301</b>

**9 Term Loans**

The carrying amount of the term loans is considered to be a reasonable approximation of the fair value.

The BNZ Term Loan carries interest at 5.71% per annum.

The BNZ Credit Plus facility carries interest at 4.82% per annum.

The Energy Efficiency and Conservation Authority (EECA) facility is interest free. The facility totaled \$220,000.

**Non-current portion**

Term Loan - BNZ

Term Loan - EECA

**Total Non-current portion**

2016	2015
\$	\$
727,118	-
158,800	-
<b>885,918</b>	<b>-</b>

**Current portion**

Term Loan - BNZ - Current portion

Term Loan - EECA - Current portion

BNZ - Credit Plus Facility

**Total Current portion****Total Term Loans**

2016	2015
\$	\$
199,992	-
44,000	-
243,992	-
950,260	-
<b>1,194,252</b>	<b>-</b>
<b>2,080,170</b>	<b>-</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

**Allied Laundry Services Ltd****Notes to and forming part of the Financial Statements (continued)****For the Year Ended 30 June 2016****10 Financial Instruments****(a) Categories of Financial Assets and Financial Liabilities**

The carrying amount of financial assets and financial liabilities in each category are as follows:

**Financial Assets - Loans and receivables**

	2016	2015
	\$	\$
Accounts Receivable	1,030,502	1,026,923
BNZ Bank	(51,865)	1,949,464
	<b>978,637</b>	<b>2,976,387</b>

**Financial Liabilities - At amortised cost**

	2016	2015
	\$	\$
Trade Creditors	370,792	336,668
Accruals	498,279	737,414
Holiday Pay Liability	409,615	302,483
Provision for Gratuity	11,995	11,301
Term Loans	2,090,056	-
Income received in advance	100,000	-
	<b>3,480,737</b>	<b>1,387,866</b>

The carrying amounts of the financial assets and financial liabilities disclosed above are considered a reasonable approximation of fair value.

**11 Events Occurring After Balance Date**

No adjusting or significant non-adjusting events have occurred between the reporting date and the date of authorisation.

**12 Operating Lease Commitments**

	2016	2015
	\$	\$
Within one year	-	7,496
Greater than one year and less than five years	-	-
Greater than five years	-	-
<b>Total Operating Lease Commitments</b>	<b>-</b>	<b>7,496</b>

The operating lease related to the lease of two towel folding machines and a garment tunnel finisher between Alleasing NZ Limited and Allied Laundry Services Limited.

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

## Allied Laundry Services Ltd



## Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2016

## 13 Transactions with Key Management Personnel

	2016	2015
	\$	\$
<b>Director Fees</b>		
Whanganui DHB	25,000	23,750
MidCentral DHB	25,000	23,750
Hawkes Bay DHB	40,000	32,500
Capital & Coast DHB	5,000	-
Hutt Valley DHB	5,000	-
Taranaki DHB	15,000	17,500
<b>Total Director Fees</b>	<b>115,000</b>	<b>97,500</b>
Executive Management remuneration	164,818	139,644
<b>Total Transactions with Key Management Personnel</b>	<b>279,818</b>	<b>237,144</b>

Key Management Personnel of the Company are members of the Board of Directors and members of the Executive Management team. Key Management Personnel remuneration includes the expenses listed above. There have been no other transactions with Key Management Personnel.

## 14 Acquisition of Capital &amp; Coast DHB laundry operations

	2016	2015
	\$	\$
On 29 February 2016, the Company acquired the laundry operations of Capital & Coast DHB. The details of the business combination are as follows:		
<b>Fair value of consideration transferred</b>		
Amount settled in cash	310,000	-
Fair value of assets transferred	840,000	-
<b>Total</b>	<b>1,150,000</b>	<b>-</b>
<b>Recognised amounts of identifiable net assets</b>		
Property, plant and equipment	840,000	-
Other liabilities and expenses	(44,573)	-
<b>Goodwill on acquisition</b>	<b>795,427</b>	<b>-</b>

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

**Allied Laundry Services Ltd****Notes to and forming part of the Financial Statements (continued)****For the Year Ended 30 June 2016****15 Related Party Transactions**

Allied Laundry Services Limited has provided laundry services to the MidCentral, Whanganui, Hawkes Bay, Hutt Valley, Wairarapa, Capital & Coast and Taranaki DHB's. These entities are related to Allied Laundry Services Limited by common ownership. MidCentral DHB leases a building and charges electricity, steam and gas costs to Allied Laundry Services Limited. These transactions are entered into on a commercial basis. A management fee of \$84,000 was paid to ALSCO during the 2016 financial year for management services (2015: \$84,000). The revenue from the shareholders is disclosed in the Statement of Comprehensive Income.

	2016	2015
	\$	\$
Allied Laundry Services Limited paid rent to		
MidCentral DHB	303,345	299,495
Taranaki DHB	2,781	3,286
Whanganui DHB	5,190	5,190
Capital & Coast DHB	1,600	-
Hutt Valley DHB	2,800	-
Accounts Receivable		
MidCentral DHB	211,104	216,430
Taranaki DHB	97,528	99,798
Whanganui DHB	62,997	65,484
Hawkes Bay DHB	158,394	167,058
Capital & Coast DHB	282,219	-
Hutt Valley DHB	95,035	-
Accounts Payable		
MidCentral DHB	43,573	47,680
Taranaki DHB	-	1,721
Whanganui DHB	2,104	673
Hawkes Bay DHB	3,625	4,381
Capital & Coast DHB	6,210	-
Hutt Valley DHB	460	-
Accruals - General		
MidCentral DHB	92,300	77,500
Taranaki DHB	1,515	-
Hawkes Bay DHB	-	1,250
ALSCO	109,000	101,636
Accruals - Rebate payments owing by Allied Laundry Services Limited		
MidCentral DHB	101,087	101,087
Taranaki DHB	45,676	45,676
Whanganui DHB	28,924	28,924
Hawkes Bay DHB	76,044	76,044
Accruals - Dividend payments owing by Allied Laundry Services Limited		
MidCentral DHB	146,667	60,000
Taranaki DHB	146,667	60,000
Whanganui DHB	146,667	60,000
Hawkes Bay DHB	146,667	60,000
Capital & Coast DHB	50,267	-
Hutt Valley DHB	8,000	-

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.

**Allied Laundry Services Ltd****Notes to and forming part of the Financial Statements (continued)****For the Year Ended 30 June 2016****16 Board Representatives Attendance at Meetings**

	July	August	September	October	November	December	January	February	March	April	May	June
David Ritchie		Apologies				No Meeting			N/A	N/A	N/A	N/A
Ken Foote						No Meeting						
Simon Barrett						No Meeting						
Julie Patterson						No Meeting		Apologies	N/A	N/A	N/A	N/A
Brian Walden			Apologies			No Meeting						
Jeffrey Small						No Meeting						
Jillian Mathews		Apologies				No Meeting			N/A	N/A	N/A	N/A
Ashley Bloomfield	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
Tony Hickmott	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A				

**17 Contingent Liabilities**

The Company has no contingent liabilities as at 30 June 2016, (2015 Nil).

**18 Capital Commitments**

The Company has no capital commitments as at 30 June 2016, (2015 Nil).

These financial statements are to be read in conjunction with the accompanying Notes and the audit report.



# Allied Laundry Services Limited

Report to the Board of Directors  
For the year ended 30 June 2016







10 October 2016

Chairman  
Board of Directors  
Allied Laundry Services Limited  
PO Box 4355  
**PALMERSTON NORTH**

Dear Chairman

**REPORT TO THE BOARD OF DIRECTORS FOR THE YEAR ENDED 30 JUNE 2016**

In accordance with our normal practice, we include in the attached report all matters arising from our audit of the financial statements of Allied Laundry Services Limited for the year ended 30 June 2016 which we consider appropriate for the attention of the Board of Directors ("the Board"). These matters have been discussed with management of the Company and their comments have been included, where appropriate.

This correspondence is part of our ongoing discussions as auditor in accordance with our engagement letter dated 1 March 2016 and as required by New Zealand auditing standards. This report includes only those matters that have come to our attention as a result of performing our audit procedures and which we believe are appropriate to communicate to the Board. The audit of the financial statements does not relieve management or the Board of their responsibilities. The ultimate responsibility for the preparation of the financial statements rests with the Board.

We have prepared this report solely for the use of the Board and it would be inappropriate for this report to be made available to third parties and, if such a third party were to obtain a copy without our prior written consent, we would not accept responsibility for any reliance that they might place on it.

If you would like to discuss any matters raised in this report please do not hesitate to contact us.

Yours faithfully  
**DELOITTE**

Melissa Youngson  
**On behalf of the Office of the Auditor-General**



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## 1. Status of the audit and outstanding matters

Our audit of the financial statements is now complete. There are no outstanding matters noted.

## 2. Purpose of report

This report has been prepared for Allied Laundry Services Limited's Board of Directors and is part of our ongoing discussions as auditor in accordance with our engagement letter dated 1 March 2016 and as required by New Zealand auditing standards. This report includes only those matters that have come to our attention as a result of performing our audit procedures and which we believe are appropriate to communicate to the Board. The ultimate responsibility for the preparation of the financial statements rests with the Board of Directors.

## 3. Scope

We are responsible for conducting an audit of Allied Laundry Services Limited for the year ended 30 June 2016 in accordance with New Zealand auditing standards issued by the External Reporting Board. Our audit is performed pursuant to the requirements of the Companies Act 1993 and the Financial Reporting Act 2013, with the objective of forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of the Board of Directors. The audit of the financial statements does not relieve management or the Board of Directors of their responsibilities.

## 4. Key areas of focus and audit response

Our audit procedures were focused on those areas of Allied Laundry Services Limited's activities that are considered to represent the key audit risks identified during the risk assessment process undertaken during the planning stage of our engagement. Provided below is a summary of these key areas of focus and our responses in respect of each matter following the completion of our audit. We are satisfied that these areas have been addressed appropriately and are properly reflected in the financial statements.

Focus area	Response
Linen Textiles has remained a focus area for our audit and more so in the current year as there was no physical stock count being performed at year end.	<p>In order to assess that the value of the linen textiles remains appropriate and not materially misstated at year end we:</p> <ul style="list-style-type: none"> <li>• Discussed with management the controls and procedures that were in place with regard to the recording of linen textiles;</li> <li>• Selected a sample of purchases made during the year to ensure that the value of the linen textiles remains appropriate;</li> <li>• Ensured that the useful life of linen textiles continued to remain appropriate; and</li> <li>• Obtained the lost stock provision calculation and performed a retrospective review of the provision in previous years to determine that the current year provision was reasonable.</li> </ul> <p>We have noted that there are no controls in place with regard to the textile and linen stock. There is currently no process where linen that comes back in is counted or checked off to ensure that the linen shipped to customers is sent back to Allied Laundry services after use.</p>



Focus area	Response
	<p>Due to there being no controls in place for the quantity of textile and linen stock in the current year we are unable to obtain sufficient audit evidence over the balance which is recorded in the FS at a carrying amount of \$2,494,325. We have therefore issued a non-standard audit report. We have referred to the guidance of AG ISA (NZ) 705 Modifications to the opinion in the independent auditors report and concluded a qualified opinion is appropriate.</p> <p>The relevant wording to be included within our audit opinion will be as follows:</p> <p><b>Qualified opinion – Our work was limited because of the limited control over textiles and linen stock</b></p> <p><b><i>Reason for our qualified opinion</i></b></p> <p>Textile and linen stock is disclosed in note 6 on page 17. As stated in note 1 on page 11, control over the identification and disclosure of textile and linen stock is limited, and there are no practical audit procedures to determine the effect of this limited control.</p>
Business combination relating to the Acquisition of Capital & Coast DHB Laundry Services.	<p>We understand that BDO Wellington performed a review of the initial treatment of the business combination in the current year. Although we were involved in the number of email communications, we do note that that there was no formal process in place where BDO confirmed all the facts prior to the consultation.</p> <p>Deloitte have reviewed the consultation paper by BDO Wellington and performed our own assessment of the standard and determined that the transaction between ALSL and CCDHB does meet the definition criteria of a business combination under "NZ IFRS 3 – Business Combinations". We consulted with our internal technical team and determined that the initial business combination transaction has been reported and accounted for as appropriate.</p>
Goodwill attributable to the Acquisition of Capital & Coast DHB Laundry Services.	<p>As ALSL have treated this transaction as a business combination they have accounted for \$795k of goodwill during the period. Under "NZ IAS36 – Impairment of Assets" this goodwill must be tested for impairment annually [IAS 36.96]. An impairment assessment was provided by management which showed the goodwill attributable to the CCDHB business combination as not being impaired. Deloitte have assessed these workings which appear reasonable.</p>



## 5. Other Matters

Other Matter	Response
<b>Miscalculation of Holiday Pay Liability</b> <p>The Holidays Act 2003 (the Act) provides employees with minimum entitlements to annual holidays, public holidays, sick leave and bereavement leave. The Act specifies how the minimum payment for each type of leave is to be calculated however is open to interpretation. The calculations require accurate processing by payroll staff, interpretation of legislation and sophisticated payroll systems to calculate leave entitlements for an employee's individual circumstances.</p>	<p>In response to a request from the Auditor-General for each appointed auditor to consider this area, we have performed a high-level assessment of the processes undertaken by Management to ensure that holiday pay and accrued leave balances are appropriate.</p> <p>We have considered the findings of ALSL's payroll systems and gained an understanding of the actions that ALSL has taken. We did not identify any matters to bring to the Committee's attention, however, we note that the interpretation of the legislation continues to evolve and that in our experience many companies are finding immaterial errors. Therefore we have recommended to Management that they continue to monitor developments in the New Zealand market and as necessary reassess compliance in the future rather than consider this a onetime exercise.</p>

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## 6. Assessment of internal controls

Our audit approach requires us to obtain an understanding of an entity's internal controls, sufficient to identify and assess the risks of material misstatement of the financial statements whether due to fraud or error but is not designed to provide assurance as to the overall effectiveness of controls operating within the Company.

We have identified one material weakness in internal controls relating to the fixed assets which has impacted upon our ability to provide our opinion on the financial statements for the ended 30 June 2016. We also noted some housekeeping matters and have reported our recommendations for improvement to management, these have been noted below.

Observation	Recommendation	Management Response
<b>Credit Notes</b> <p>We note that credit notes are not significant (approx. \$20k in 2015/16), however it has been noted that credit notes are not being appropriately reviewed and authorised, this poses the risk that credit notes could be issued inappropriately.</p>	<p>All credit notes should be reviewed and appropriately approved to ensure credit notes raised are valid and appropriate.</p>	<p>Noted; all credit notes to be checked counter signed by Office coordinator.</p>
<b>Maintaining Payroll Master file</b> <p>Payroll Master file exception report is not being run, to ensure that changes in the payroll systems are being appropriately reviewed. The risk here is that changes in the payroll Masterfile can be done, without appropriate manager/CEO approval.</p>	<p>A payroll Masterfile exception report/spreadsheet should be maintained to keep track of all the payroll changes. Furthermore, this report/spreadsheet should be approved by the CEO/manager to ensure that the changes are appropriate and reasonable.</p>	<p>Allied Laundry has a newish payroll system and we are still working through what it can and cannot do. Will explore if a Master File can be extracted from the system and changes recorded. Will contact MYOB and Naylor Lawrence to see if there are reports that can be run. Will set up manual recording of changes and have the CE or Office Coordinator sign off.</p>



### Supplier Masterfile Exception Report

During the review of supplier master file changes it was noted that not all supporting documentation for supplier master file changes are kept. Furthermore there is no formal review process for Masterfile changes.

This raises a risk that inappropriate changes to the master file are authorised with no reference to supporting documentation and that unauthorised changes are processed.

Management implement a formal process for reviewing the supplier master file on a frequent basis. This involves ensuring all documentation to support the Masterfile changes are kept for the financial year as a formal trail of evidence. Furthermore all supporting documentation is authorised by the CEO and checked to the system to ensure the changes made are appropriate.

Have just loaded all of the suppliers on to the new MYOB system, from middle of September 2016. Still ascertaining how the system works and if a Master file can be extracted. As we are loading and reviewing all suppliers a natural review will occur over October from there will review the MYOB system and see how a Masterfile can be extracted and reviewed regularly and changes recorded.

### Fleet Cars

It was noted that the fleet card expenses are not being appropriately authorised by the Board (i.e someone other than Mark Mabbett - CEO)

Deloitte recommends that fleet card expenses be authorised by the Board to ensure that the fleet card expense is appropriate and reasonable each month.

When Louise Moore (Administration Manager) left and Denise Climo started the information was not passed to Denise. This has now happened and the expenses are being signed by the Board member Jeff Small each month.

### IRD Mileage Rate

Noted that the mileage rate being used for chairperson expense claims is 0.77c which is higher than the recommended rate per the IRD website.

Recommend that the IRD rate used should be checked consistently and that the correct IRD rate is applied.

The IRD mileage rate will be checked every 3 months to see if it has changed.

### Low/High Reports

It has been noted that there is no paper trail of the low/high report variances being investigated, as the initial report is shredded once the variances have been adjusted.

Recommend management keep the pages where there are variances, to ensure that these variances are adjusted accordingly.

When the high / low pricing was reviewed and changes made the pages were kept to ensure the price had been adjusted, then the pages were discarded. From now on will keep the pages even though the price will have been confirmed as having been adjusted. Allied Laundry has moved to a new ordering system 'Bundle'. Bundle uses a master file for pricing. A Master file has been created and reviewed, signed and will be retained, and changes from now on will be recorded and signed on the master file.



## 7. Summary of unadjusted differences

In performing our audit we have identified the following misstatement that has not been adjusted in the financial statements for the year ended 30 June 2016.

Management believe that uncorrected error does not have a material effect on the financial statements for the year 30 June 2016.

It was noted that ACC ley accrual has a variance of \$29.5k between the ACC accrual and the actual expense as such and adjustment to the amount was recommended to the client.

Unadjusted misstatements identified	Assets Dr/(Cr)	Liabilities Dr/(Cr)	Equity Dr/(Cr)	Profit & loss Dr/(Cr)
Prior Year Misstatement impacting on Current Year		33,660	(33,660)	
Over accrual of ACC payable				
Current Year Misstatement		29,516		(29,516)
Over accrual of ACC payable				

## 8. Summary of omitted disclosures

Omitted disclosures assessed by management as not being material	Ref	Management Response
The Goodwill of \$795k presented in the financial statements most likely contains an intangible asset because Allied Laundry Services Limited is acquiring not just the tangible assets but also customer contracts which will provide future cash flows. This intangible asset would have to be valued and recognised separately from goodwill. The financial statements does not split out the value of the intangible assets from goodwill. The goodwill has been assessed for impairment.	NZ IAS 38 <i>Intangible Assets</i>	Noted. Allied will investigate the split of the possible intangible asset from Goodwill for the year ended June 2017, and will also continue year end testing of Impairment on the Goodwill.



## 9. Other communications

The following matters relevant to our audit of Allied Laundry Services Limited for the year ended 30 June 2016 are communicated in accordance with the requirements of New Zealand auditing standards.

Matter to be communicated	Response
Written representations	A copy of the representation letter to be signed on behalf of the Board has been circulated separately.
Non-compliance with applicable laws and regulations	No significant noncompliance with laws and regulations has been noted.  We do note that as part of the Companies Act 1993, the Directors of ALSL should implement appropriate internal control procedures with regard to Textile and Linen Stock to ensure the financial statements are materially accurate.
Fraud	No matters relating to fraud, concerning either employees or management came to our attention.
Accounting policies and financial reporting	There were a change in accounting policies during the year ended 30 June 2016. ALSL transitioned to NZ IFRS / NZ IFRS RDR from 'Old' NZ GAAP'. We have not become aware of any significant qualitative aspects of the entity's accounting practices, including judgements about accounting policies, accounting estimates and financial statement disclosures that need to be communicated to the Board, other than those already communicated in this report.
Related parties	No significant related party matters other than those reflected in the financial statements came to our attention that, in our professional judgement, needs to be communicated to the Board.
Independence	We confirm that we have maintained our independence in accordance with the independence requirements of the <i>Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners</i> issued by the External Reporting Board and, in our professional judgement, we are independent of Allied Laundry Services Limited.





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## CHAIR'S REPORT FOR THE YEAR ENDED 30 JUNE 2016

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It is with great pleasure that I present this Annual Report on what has been perhaps the most significant year in the Company's history, post inception. Last year I was able to report on all the planning undertaken and approvals received, to implement the very ambitious expansion of the Company's plant operation and shareholding, to incorporate Capital & Coast (CCDHB) and Hutt Valley DHBs (HVDHB). 2015/16 was all about making this a successful reality.

With so much happening during the year, it is appropriate to record here just some of the key achievements:

- Over \$6m spent on fixed assets, including expanding and updating the linen processing equipment, associated energy saving additions and doubling the value of linen stock.
- Full service provision taken over at CCDHB and HVDHB from 1 March 2016, and integrated into Allied business processes.
- CCDHB and HVDHB became shareholders from 1 March 2016.
- New Constitution, Shareholders Agreement and Contracts for the Supply of Laundry Services approved by / for all six shareholding DHBs
- 10% price reductions implemented from 1 March 2016, to recognise benefits anticipated in original Contingency Scenario.
- Strategic alliances entered into with New South Wales Healthshare, Canterbury Linen Services, and other (non Spotless) DHB laundries.
- Planning completed for introduction of new linen and financial management systems
- "Launch" event held at the plant on 28 June 2016 to unveil the new branding for the expanded Company, and to thank all key participants for their part in 'transforming' and transitioning the Company to the modern, efficient and sizeable business it has become.

It has taken a massive effort by the CEO and senior staff to achieve the year's results. For that I would like to extend the Board's sincere thanks and appreciation. Our thanks are also extended to all other Allied staff, and to the relevant staff in CCDHB, and HVDHB who were involved in the 'integration' process, for their very early adoption of the 'cooperative' spirit.

The change in shareholding also brought changes to the Board. I would like to acknowledge the service of retiring Directors David Ritchie, Julie Patterson and Jill Matthews, and thank them for their contributions in getting the Company to its new beginning. I would also like to welcome Ashley Bloomfield and Tony Hickmott to the Board, and thank them along with continuing directors Brian Walden, Jeff Small and Simon Barrett, for guiding the Company through this significant expansion process.

The Company is now well established and needs to consolidate on these new foundations to extract the value envisaged when the Contingency Scenario and Business Case was approved in February 2015. Although disappointed with the small operating loss recorded for the year (after one-off integration costs and 'interest on capital dividends'), I believe the Company is well placed financially and strategically, to be a significant operational shared service cooperative that all shareholding DHBs should be proud of.

Ken Foote  
Chair



Thursday 15<sup>th</sup> September 2016

To Chairs; Boards of District Health Boards; Allied Laundry Services Limited Shareholders.

Regarding; appointment of Shareholding District Health Board Annual General Meeting Representatives.

The Allied Laundry Annual General Meeting is being held on Monday 31<sup>st</sup> October 2016 at Allied Laundry Services Ltd. Palmerston North.

The Shareholders' Agreement for Allied Laundry Services Limited requires each shareholder to appoint a representative for the Annual General Meeting.

Could the shareholding DHB's nomination for representative to the Allied Laundry AGM please be forwarded as soon as possible to Denise Climo (dclimo@alliedlaundry.co.nz) at Allied Laundry.

Regards

Mark Mabbett

CEO

Allied Laundry Services Limited.





## **Recommendation to Exclude the Public**

### ***Clause 32, New Zealand Public Health and Disability Act 2000***

That the public now be excluded from the following parts of the meeting, namely:

- 19. Confirmation of Minutes of Board Meeting  
- Public Excluded**
- 20. Matters Arising from the Minutes of Board Meeting  
- Public Excluded**
- 21. Board Approval of Actions exceeding limits delegated by CEO**

#### **For Information /Discussion**

- 22. Havelock North Gastroenteritis Outbreak Review – draft**
- 23. Urgent Care Proposal**

#### **Reports and Recommendations from Committee Chairs**

- 24. Finance Risk and Audit Committee Report**

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).

