ANNUAL REPORT 2017

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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

During the 2016/17 year we faced a number of significant events which challenged and impacted on our staff, our primary care colleagues and our communities

.

In August 2016 we dealt with a major power outage, followed by the Havelock North campylobacter outbreak. In October 2016 and January 2017 Resident Medical Officers (RMOs) took strike action.

Hard work, effective planning and collaboration enabled high levels of service and care for our community to be maintained.

These events, while disruptive operationally and financially, provided an opportunity for us to look at our systems and processes, and reflect on how we can better respond to unforeseen or major events.

Despite the challenges we completed, and commenced, a number of significant developments such as:

- officially opened Waioha the new primary birthing unit,
- refurbished the old Mental Health Inpatient Unit (which now accommodates our Needs Assessment Service Coordination (NASC) and Human Resource teams),
- launched the Go Well travel plan resulting in better transport options for staff and patients, including paid parking and improved public transport options,
- completed a major redevelopment of the organisation's intranet,
- commenced work on the new $11.8 million Ruakopito Endoscopy and Gastroenterology build,
- established the Hawke's Bay Youth Consumer Council,
- launched our people and clinical services long term planning through The Big Listen and Clinical Service Plan review.

Relationships across the health and social service sector continue to be strengthened as together we tackle the health and wellbeing challenges in our communities.

Ensuring warm, dry and healthy homes, delivering more health services in community settings, supporting an aging population and targeting our youngest and most vulnerable – these challenges require a coordinated and collaborative community-wide response.

In addition we are a key stakeholder in the Regional Economic Development Plan for Hawke's Bay, ensuring social wellbeing plays a fundamental role in the on-going development plan for the region.

Numbers presenting, or receiving assessment or treatment at Hawke's Bay Soldiers' Memorial Hospital have consistently increased.

To better manage this demand we established a FLOW project, launched in March 2017, which aims to improve patient journeys, reduce delays and create a safer hospital with reduced harm.

We are pleased to report an operating surplus for 2016/17 of $3.6 million on revenue of $534.7 million.

This is less than the $5.0 million planned surplus projected in the 2016/17 Annual Plan, and mainly reflects the cost to the district health board of the campylobacter outbreak in Havelock North.

Much has been accomplished this year, and we thank our staff and colleagues across the sector for their efforts over what has been a difficult and challenging year.

Kevin Snee
Chief Executive

Kevin Atkinson
Chair

Organisation profile

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

PUBLIC HOSPITAL AND HEALTH FACILITIES

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

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

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

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

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.

HE KAUANUANU RESPECT

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

ĀKINA IMPROVEMENT

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

RARANGA 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.

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

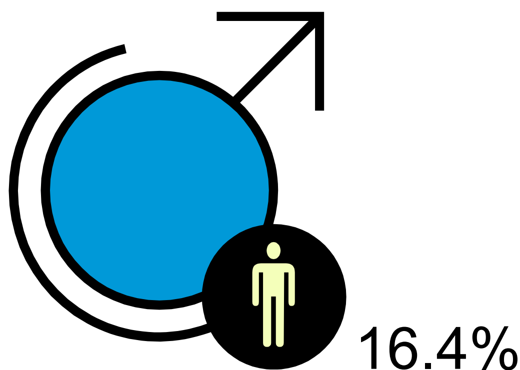
- Māori Relationship Board
- Hawke's Bay Clinical Council
- Hawke's Bay Health Consumer Council
- Pasifika Health Leadership Group
- Finance Risk and Audit Committee
- Combined Committees:
  - Community and Public Health Advisory Committee
  - Disability Support Advisory Committee
  - Hospital Advisory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

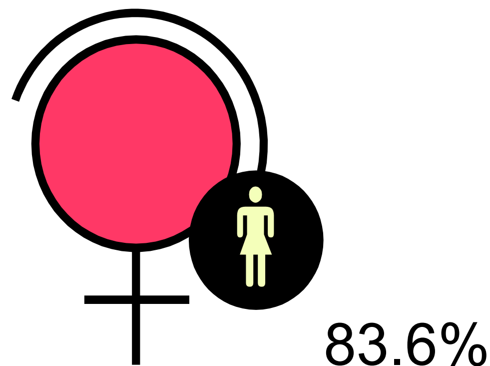
Chief Executive: Dr Kevin Snee

- Chief Medical and Dental Officer (Hospital)
- Chief Allied Health Professions Officer
- Chief Medical Officer (Primary)
- Chief Nursing and Midwifery Officer
- Executive Director Corporate Services
- Executive Director People & Quality
- Executive Director Primary Care
- Executive Director of Provider Services
- Executive Director Strategy and Health Improvement
- General Manager Health Hawke's Bay – Te Oranga Hawke's Bay

About Hawke's Bay District Health Board

The DHB currently employs 2774 people, a number of whom are multi-jobbed; with 3089 positions held throughout the organisation. Of these 3089 positions:

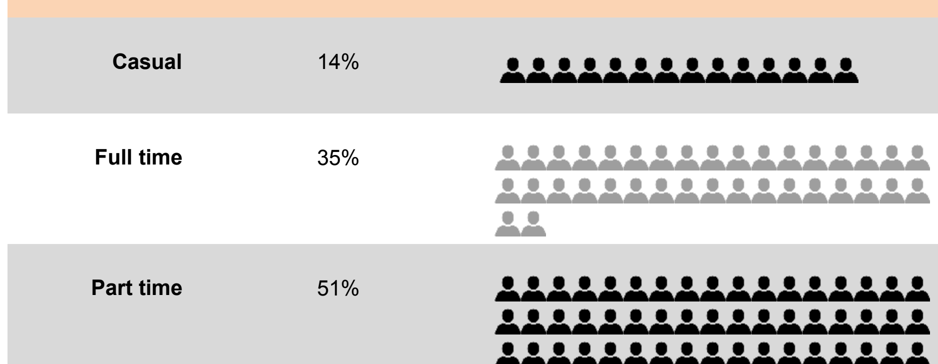

16.4%


83.6%

WORKFORCE PROFILE – by age bands	
<25	4.2%
25 - 34	18.0%
35 - 45	18.8%
45 - 55	28.6%
55 - 64	24.1%
65+	6.3%

WORKFORCE PROFILE – by occupational group	
Medical staff	9.4%
Nursing staff	50.6%
Allied Health staff	18.4%
Non-clinical support staff	6.2%
Management & admin staff	15.4%

	Positions filled	% of Total
NZ & European	2,264	73.7
Māori	438	14.2
Pacific Islands	32	1.0
Other	272	8.9
Not known	67	2.2
Total	3,073	



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 enabling our managers to apply 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, which will be refreshed in the coming 12 months to ensure that our workforce is well supported, highly skilled, empowered and have joy in their work.

The focus of the current organisational development programme is on:

- Transformational management and leadership capability
- Building capability – developing individuals, talent, succession planning and recruitment
- Increasing Māori staff representation

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 programme 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 with the development of a Consumer Engagement Strategy.

Our 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 Mapping 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. Going forward this programme will align to the State Services Commission Leadership Success Profile.

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. This focus will be extended in the coming year ensuring that the workforce is reflective of the whole community that it serves.

Hiring managers are supported through the recruitment process to ensure efficiency and consistency of recruitment. 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; 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 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.

The Employment Relations Act, and Health and Safety in Employment Amendment Act 2002 continues 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.

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 within the Health and Safety Committee. The Board are committed to ensuring that health and safety is embedded across the organisation and have established a Board H&S Champion, providing assurance to our Directors that the organisation is meeting its obligations. The organisation has also undertaken an assessment through Safe365 online tool to identify any gaps in relation to the new health and safety requirements and will continue to build the capability of all and develop a culture whereby health and safety is embedded in everything we do.

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

A Healthy Workplace group has been established and will continue to be refined in the next 12 months ensuring that all our staff are well supported 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 workforce reflects the Hawke's Bay population mix.
As at the end of the 2016/17 year the target of 13.75 percent of staff identifying as Māori was reached.

30 June 2017 (Actual) = 14.25 percent Māori
30 June 2016 (Actual) = 12.47 percent Māori
30 June 2015 (Actual) = 12.27 percent Māori

	Positions filled	% of Total
NZ & European	2,264	73.68
Māori	438	14.25
Pacific Islands	32	1.04
Other	272	8.85
Not known	67	2.18
Total	3,073	

June 2017 breakdown

Support staff (31.58%), Allied Health staff (14.29%) and Management & Admin staff (19.87%) exceed the DHB target. Medical (5.19%) and Nursing staff (12.10%) are below the target, however significant improvements have been made over the last 12 month across the nursing workforce.

Staff Disability

The organisation is focussed on supporting our staff with identifiable disabilities. HBDHB has reviewed its people based policies in relation to recruitment and retention of staff with disabilities. We have 0.3% of our staff who have identified as having a disability. We have identified obstacles with those employees and have removed or reduced those obstacles where possible. We will continue to monitor these situations and address issues as they arise.

Celebrating our people

1. Volunteers making a difference
2. Pacific Health team growing
3. Child health a priority
4. Community support recognised
5. Māori Nurse Practitioner success
6. Student expo encouraging health careers
7. Teamwork tackling the challenges and leading change

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 (to 9 May 2017)
Trustee Te Matau ā Māui Health Trust
Board Member, HB Health Partnerships Ltd (from 9 March 2017)

NGAHIWI TOMOANA - Deputy Chair
Meetings attended 6 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 11 of 11
Trustee of the Hawke's Bay Air Ambulance Trust

PETER DUNKERLEY
Meetings attended 11 of 11
Trustee – Hawke's Bay Rescue Helicopter Trust

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 (until 29 March 2017)

DAN DRUZIANIC
Meetings attended 9 of 11
Director Markhams Hawke's Bay Limited
Director of Hawke's Bay Rugby Football Union (to 9 May 2017)

DR HELEN FRANCIS
Meetings attended 9 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

JACOBY POULAIN
Meetings attended 9 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
Director of Kahungunu Asset Holding Company Ltd (from 26 October 2016)

DENISE EAGLESOME (to 5 December 2016)
Meetings attended 5 of 5
Deputy Mayor of Wairoa District Council
Trustee Te Matau ā Māui Health Trust
Co-ordinator of health contract with Wairoa Rugby

ANDREW BLAIR (to 5 December 2016)
Meetings attended 5 of 5
Owner of Andrew Blair Consulting Limited
Advisor to Chelsea Hospital Trust
Advisor to Hawke's Bay Orthopaedic Group Ltd
Chair of Southern Partnership Group
Director of Breastscreen Auckland Limited
Director St Marks Women's Health (Remuera) Limited
Director of Safer Sleep Limited (from 22 September 2016)

ANA APATU
Meetings attended 6 of 6 (from 5 December 2016)
CEO of U-Turn Trust
Chair of Directions
Chair, Health Promotion Forum

HINE FLOOD
Meetings attended 6 of 6 (from 5 December 2016)
Member, Health Hawke's Bay Priority Populaton Committee
Councillor for the Wairoa District Council

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

Kevin Atkinson

Ngahiwi Tomoana

Dan Druzianic

Helen Francis

Jacoby Poulain

Heather Skipworth

Denise Eaglesome (to 5 December 2016)

Andrew Blair (to 5 December 2016)

Ana Apatu (from March 2017)

Hine Flood (from March 2017)

FINANCE RISK AND AUDIT COMMITTEE (FRAC)

Number of FRAC Meetings held 11

Refer Board interests disclosed

Dan Druzianic - Chairperson
Meetings attended 9 of 11

Kevin Atkinson
Meetings attended 11 of 11

Barbara Arnott
Meetings attended 11 of 11

Peter Dunkerley
Meetings attended 11 of 11

Jacoby Poulain
Meetings attended 11 of 11

Andrew Blair (to 5 December 2016)
Meetings attended 5 of 5

Helen Francis (from March 2017)
Meetings attended 4 of 4

Diana Kirton (from March 2017)
Meetings attended 4 of 4

MĀORI RELATIONSHIP BOARD (MRB)

Number of MRB 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 (to Feb 2017)
Meetings attended 6 of 10
Refer Board interests disclosed

Diana Kirton (to Feb 2017)
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

Trish Giddens
Meetings attended 8 of 9
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 9 of 9
Ngāti Kahungunu Iwi Inc representative
Wife employed at Te Taiwhenua o Heretaunga
Member Tairawhiti DHB Māori Relationship Board

George Mackey
Meetings attended 6 of 9
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-Johnson
Meetings attended 9 of 9
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)

Des Ratima (to 26 May 2017)
Meetings attended 6 of 8
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 Kōhanga Reo

Ana Apatu
Meetings attended 8 of 9
Refer Board interests disclosed

Hine Flood (from March 2017)
Meetings attended 1 of 3
Refer Board interests disclosed

Dr Fiona Cram (since June 2017)
Meetings attended 1 of 1
Board Member, Ahuriri District Health (Wai 692)
Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington

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 2017, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

Kevin Atkinson
Chair

Dan Druzianic
Board Member

31 October 2017

Audit New Zealand
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Hawke's Bay District Health Board's financial statements and performance information for the year ended 30 June 2017

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

Opinion

We have audited:

- the financial statements of the DHB on pages 54 to 91, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the DHB on pages 27 to 52 and 92 to 115.

In our opinion:

- the financial statements of the DHB:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the DHB:
    - presents fairly, in all material respects, the DHB**'s performance for the year ended 30** June 2017, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriation; and
        - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
    - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2017. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

Responsibilities of the Board for the financial statements and the performance information

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

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the DHB for assessing the DHB's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the DHB, or there is no realistic alternative but to do so.

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the DHB's Annual Plan 2016/17.

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 3 to 23 and page 53, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

We are independent of the DHB in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in the DHB.

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

Statement of Service Performance 2016/17

This section outlines Hawke's Bay District Health Board's achievement against the 2016/17 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.

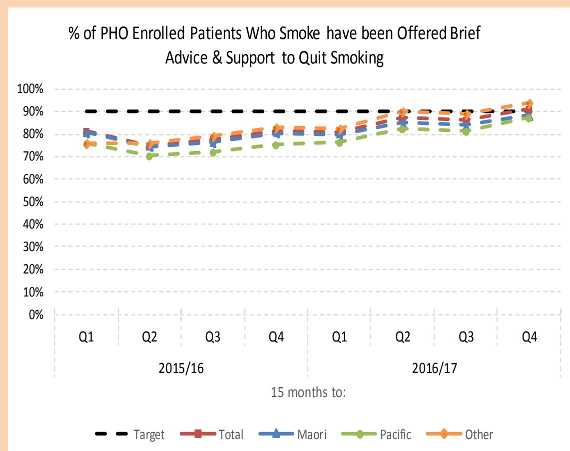
Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly 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.

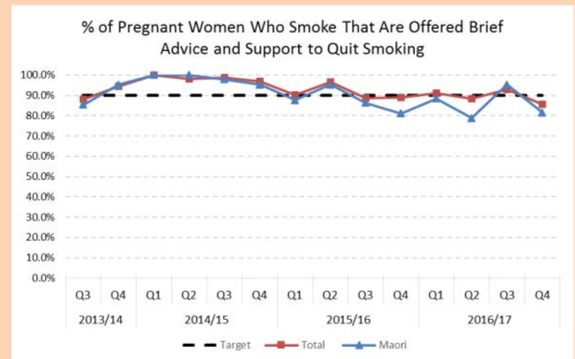
Smokers are offered advice to quit when seen in General Practice

Health Hawke's Bay has been working across the health sector on a number of initiatives to increase the number of smokers to be able to offer them smoking brief advice and cessation support. Health Hawkes Bay has continued to fund a number of independent nurses to contact patients on behalf of their practice. Smoke-free Health Promotions were carried out at Kraft Heinz Wattie's Limited, EIT, and Kahungunu Health Services. Health Hawke's Bay has also carried out Txt2Remind Campaigns on behalf of five practices. As a result Health Hawke's Bay has now met the Primary Health Target with a Smoking Brief Advice coverage rate of 91% for the year. This is compared to 81.3% for the previous year.



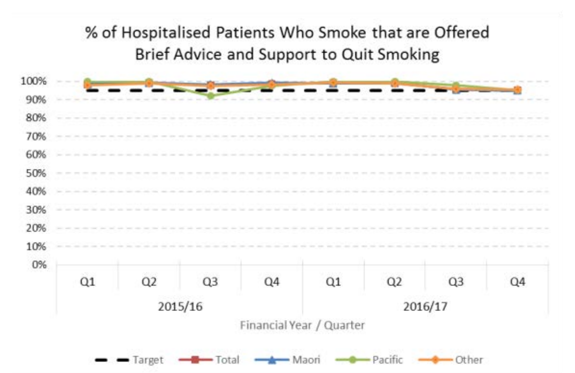
Pregnant women are offered advice and support to quit

Of pregnant women who smoke, an average of 90.0%, over the year, were offered advice and support. This result was lower for Māori at 86.5%. Performance dropped slightly in Q4, ending the year at 85.7%. Data from 2014/15 showed that 43% of pregnant Māori women giving birth in Hawke's Bay were smokers[1]. 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.



Hospitalised smokers are offered advice to quit

In 2016/17, 97.1% of hospitalised patients were offered brief advice and support to quit smoking by a health practitioner. The target of 95% continues to be achieved for Māori and total population with a business as usual approach for the hospital staff however there has been a slow declining trend over the year, for all ethnicities, which needs to be addressed. The Q4 result for total population was 95.2% down from 99.1% in Q1.



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. During the period July to December 2016, 80% of Māori women who gave birth were smokefree at two weeks postnatal. Although this is an improvement on the baseline of 73%, it is still below the target of 95% 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.

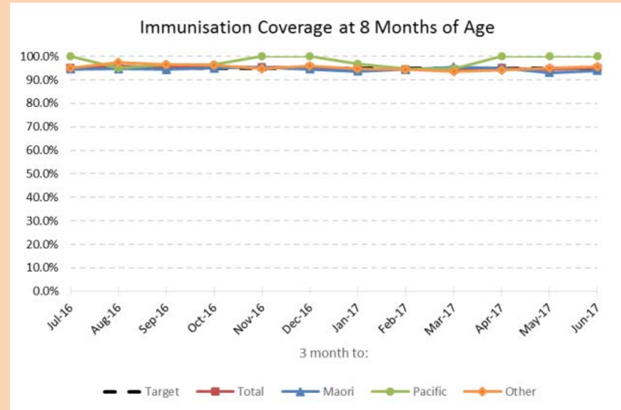
[1] Health Equity in Hawke's Bay Update 2016

National Health Target: Increased Immunisation

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

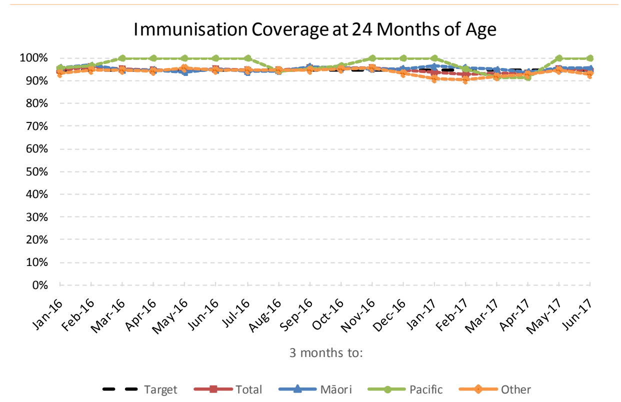
Eight month olds have received their complete primary course of immunisations

Hawke's Bay DHB continues to reach the target of 95% coverage for eight month olds. The average yearly figures came in at 95% for total population, 94.5% for Māori and 97.4% for Pacific. The Q4 result was 95% for total population.



Children are fully immunised at 2 years of age

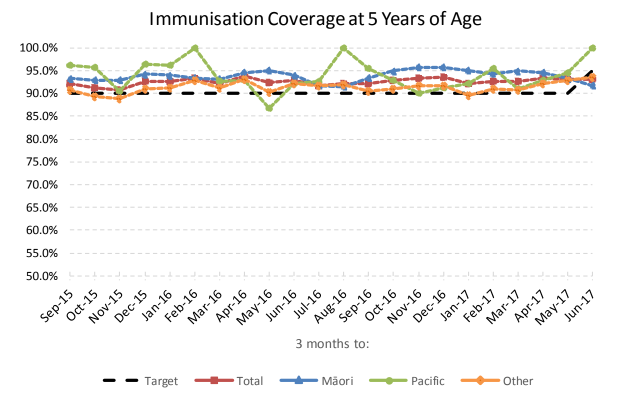
Hawke's Bay DHB is consistently reaching 95% for 2 year coverage over the past 12 months with good equity achieved.



Children are fully immunised by 5 years of age

The number of children fully immunised by 5 years is sitting between 92 and 93%. This coverage is slowly improving and Q4 is higher than the national coverage of 88.8%. This group of children is harder to track due to the length of time that there is between the 15 month and 4 year immunisations. Many have moved so require good collaboration with other services to try to find these children

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 2017, 70.4% of eligible girls had received all three doses of the HPV immunisation. The national target is 70%. Māori girls had a higher rate of immunisation at 76.9% and Pacific were at 72.5%. The schedule change from 1 January this year which enables males to have this immunisation is showing positive early indications of good uptake amongst this group.

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.

The National Immunisation Register shows a coverage of 60% for the 2016 calendar year. This is not a true reflection of coverage for this group as not all influenza immunisations given are on this register. The coverage would be higher than what we see reflected here.

Hawke's Bay 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

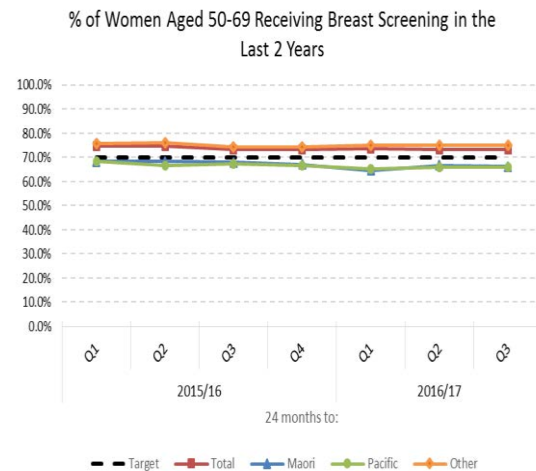
Hawke's Bay has high rates of Rheumatic Fever, a preventable disease which has serious consequences. Ongoing implementation and review of the Rheumatic Fever Prevention Plan over the years has proven to be effective with rates declining in Hawkes Bay, however, the latest results indicate an increase from 1.88 in 2015/16 to 2.48 per 100,000, higher than the target rate of ≤1.5 per 100,000. Of note, we have a small at-risk population with high variance (cases of disease occurring to chance) which results in unstable rate estimates The rate for Māori has remained static from 2015/16, at 7.23 per 100,000.

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.

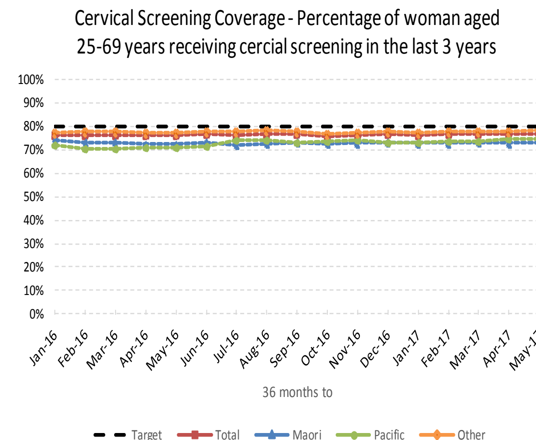
Women aged 50-69 years received breast screening in the last 2 years

Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 45 and 69 (the data is for 50 to 69 years only). Coverage data available as at March 2017, whilst we await new data. Overall our rate at the end of Q3 was 73.4% which is favourable to the national target of ≥70%. Both Māori and Pacific results are slightly below the target at 66.2% and 66.1% respectively. The breast screening mobile visited Wairoa from March through to April.



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 20 and 69 years (the data is for 25 to 69 years only). 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 79.6% which has achieved the target of ≥80%. The DHB Population Screening team, Te Taiwhenua o Heretaunga and Choices are working together in the community offering smears to Māori and Pacific in the home. We continue to work closely with Health Hawke's Bay to identify solutions to increase screening for Māori and Pacific.



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

HBDHB continues to prioritise and support efforts to reduce the risk and rate of sudden unexplained death of infant (SUDI), and to eliminate disparities in SUDI. Data shows that the SUDI rate per 1000 live births for Hawkes Bay has been steadily declining for the total population and, positively for Māori.

	Target	Total	Māori
2005-2009	0.4	1.21	2.24
2010-2014	0.5	1.16	2.09
2011-2015	0.4	0.81	1.34

The latest result is for 2011 - 2015, which was a rate of 0.81 per 1000 live births for total population and 1.34 for Māori both of which remain unfavourable against a target of ≤0.4.

HBDHB have reinvested in a Safe Sleep programme to ensure the prevention of SUDI through the promotion of safe sleep spaces for pēpi, essential safe sleep messages, and the purchase and distribution of safe sleep devices. The programme has a strong emphasis on providing appropriate advice and support for whānau at risk of SUDI by including Wahakura in the provision of safe sleep devices, recognising the cultural needs and preferences of whānau Māori.

The programme is well established and embedded within the hospital and community, and there are strong sector and whānau linkages

Breastfeeding

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	Previous June 2015	Actual 2016/17	Target	Previous Jun 2015	Actual 2016/17	Target	Previous Jun 2015	Actual 2016/17
Māori	≥75%	67% (U)	66% (U)	≥60%	39% (U)	39% (U)	≥65%	48% (U)	50% (U)
Total		73% (U)	72% (U)		53% (U)	51% (U)		58% (U)	61% (U)

Breastfeeding provides the optimum nutrition from birth, and is a foundation for later health and well-being. The measures used to track progress for improving breastfeeding rates include: exclusive breastfeeding at 6 weeks (Target ≥75%) and 3 months (Target ≥60%) as well as receiving breast milk either exclusively, fully or partially at 6 months (Target ≥65%).

At December 2015, the result for the 6 week measure shows an increase of 8% for Māori since December 2014. But, a 12% disparity remains between Māori (66%) and Other (78%). At the 3 month measure there has been a decrease for Māori, Pacific and High Deprivation groups. It is not clear at present what has contributed to this decrease at the 3 month stage. The 6 month measure is looking positive with slight increases for Māori, Pacific, and High Dep groups, and an increase of 3% overall. Information for Other is not available at both the 3 month and 6 month stages. These increases show that mothers who choose to continue breastfeeding their baby at the 3 month stage, are likely to still be breastfeeding at 6 months. This has important learnings for how we can better coordinate and support efforts at the 6 weeks and 3 months stages.

To help eliminate disparities in breastfeeding and improve access to breastfeeding support, HBDHB is funding a specialised breastfeeding support service for Māori mothers and their whānau who are experiencing difficulties establishing and maintaining breastfeeding in the home. An important feature of this programme are linkages with support services such as smoking cessation, safe sleep practices, and healthy homes programmes etc. HBDHB was recently accredited (for the fourth time) as a Baby Friendly Hospital Initiative (BFHI) Facility.

Prevention Services			
$'millions	**2017 Actual**	**Rebased Plan**	**Annual Plan**
Ministry of Health	*8.7*	*10.5*	*10.2*
Other sources	*0.2*	*0.2*	*0.2*
Income by Source	***8.9***	***10.7***	***10.4***
Less:			
Personnel	*1.6*	*1.7*	*1.7*
Clinical supplies	*0.1*	*0.1*	*0.1*
Infrastructure and non clinical supplies	*0.4*	*0.5*	*0.5*
Payments to other providers	*5.9*	*8.3*	*8.3*
Expenditure by type	***8.0***	***10.6***	***10.6***
Net Result	***0.9***	***0.1***	***(0.2)***

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

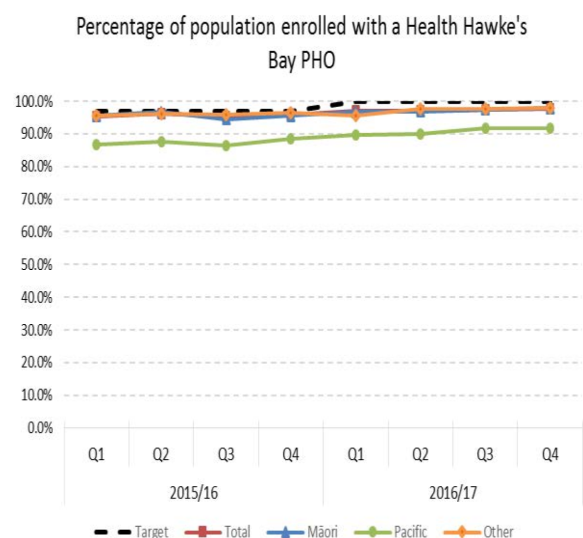
Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, 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. As at June 2017, 97.8% of people are enrolled with the PHO which is just below the target of 100% There has been a steady increase in Māori enrolled with the PHO, reaching 97.9% in Q4. Pacific has also been increasing over recent years reaching 91.9% in Q4. Health Hawkes Bay continues to work closely with Hawke's Bay DHB and general practice to promote enrolments and offer resources to facilitate the process.



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.

The total population rate was 4,892 per 100,000 for the 12 months to March 2017. No target was set for total population as the emphasis was on reducing inequity. The Māori rate for the same period was 5,150 per 100,000, favourable to a target for Māori of <5,282.

The downward trend for Māori is promising but work needs to continue 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

The ASH rates for 45-65 years are decreasing but there is a large inequity observed for Māori and Pacific.

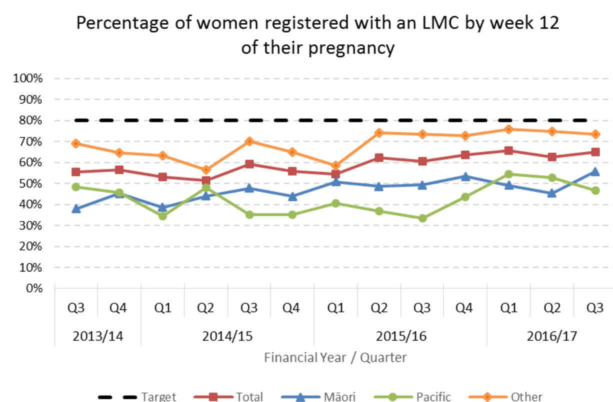
For the 12 months to March 2017 the total population rate was 3,399 per 100,000, favourable to a target of ≤ 3,510 but Māori rate was 6,802. Our focus remains on reducing inequities which are mainly evident in heart disease, skin infections, respiratory infections and diabetes. Over the year attention has been focussed on clinical pathways for both cellulitis and congestive heart failure. Practice nurses have been provided with specialist respiratory training and Health Hawkes Bay has been working with the Specialist Diabetes Team to assess Clinical Nurse Specialist coverage to General Practice.

Early Engagement with Lead Maternity Carers (LMC)

Women booked with an LMC by week 12 of their pregnancy

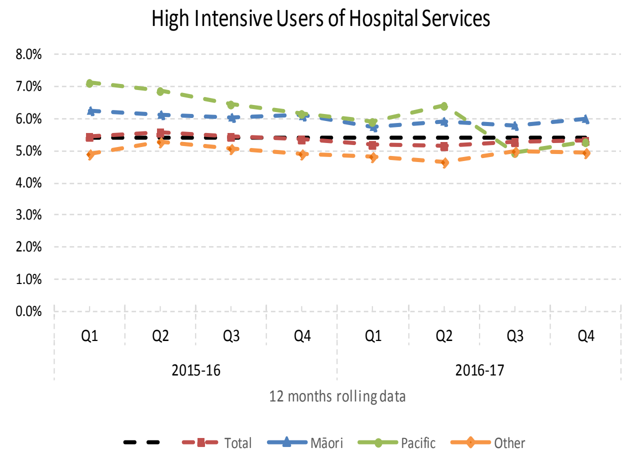
The Early Engagement Project, encouraging General Practitioners to help a pregnant women find an LMC and fill in a referral form for Smokefree services, has continued to be promoted. Te Haa Matea, HB Stop Smoking Service has posted the Increasing Smokefree Pregnancies Programme (ISPP) via facebook and women are starting to self-refer for cessation support. Continuing to provide ISPP resources to GP and LMC clinics and develop a more proactive approach to making the referral process easier for DHB staff with ISPP resource packs to give to women even if they do not want to commit to a referral at the time, allows them to reconsider and contact our 0800 300 377 number in the near future.

The percentage of women registered with an LMC by week 12 has increased from 60.6% in Q3 2015/16 to 64.8% Q3 2016/17. Both Māori and Pacific have made considerable increases over the year from 49.2% to 55.7% and 33.3% to 46.5% respectively.



High intensive users of hospital services

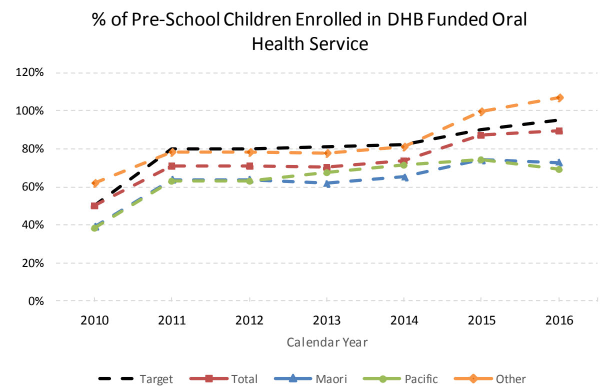
Another indicator of delivering the right care in the right place at the right time is the rate of high intensive users of ED. We are currently **meeting the target of ≤5.4%. Māori** rates remain above the target with Pacific below. ED and primary care are working on a pilot programme to reduce high intensive users of ED through re-engagement with General Practice and the development of integrated care plans.



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, 89.2% of pre-school children were enrolled in DHB funded oral health services (72.7% **Māori and 69.1% Pacific) against a target of 95%.**



Children and youth attending oral health services

2016 calendar year figures show that 2.8% of children were not examined according to planned recall which is favourable against a target of <4.8% and an improvement on last year (3.7%).

The percentage of adolescents using DHB funded dental services in 2016 was 68.8% being unfavourable against a target **of ≥85%. A continued effort is being undertaken to increase use of dental services by adolescents by providing a smooth** transition of information from the Community Oral Health Service to dentists at Year 8, by creating a strong continued awareness of free dental care, particularly among 17-year-olds and by working with schools and dental practices with lower levels of attendance.

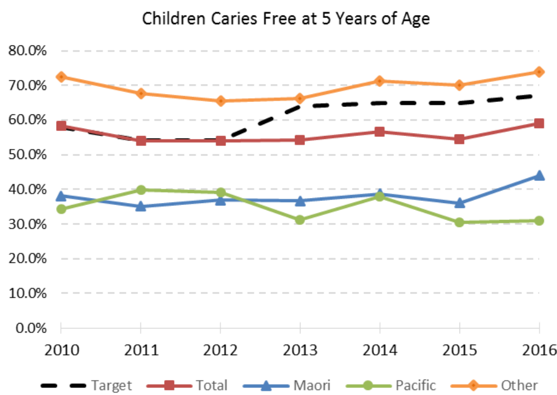
Percentage of children not examined according to planned recall		
Baseline 2015	Target 2016	Actual 2016
4.0%	*<4.8%*	*2.8% (F)*

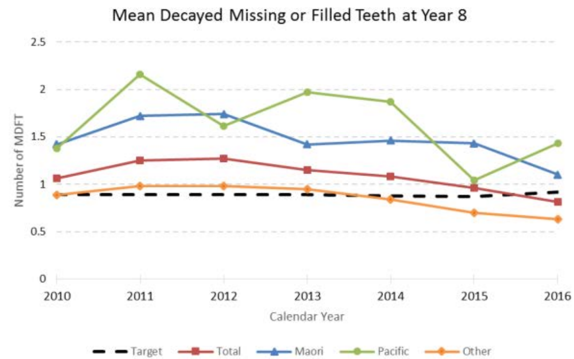
Percentage of adolescents using DHB funded dental services		
Baseline 2015	Target 2016	Actual 2016
78.3%	*≥85%*	*68.8% (U)*

Children without decay

59% of five year olds were caries free in 2016 which is an improvement from 2015 however is still unfavourable against **a target of ≥67%.**

Children are also checked at year 8 for decayed, missing or filled teeth (DMFT). The mean rate of DMFT has reduced from 0.96 to 0.8 in the last year with Māori decreasing from 1.43 to 1.10. 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.

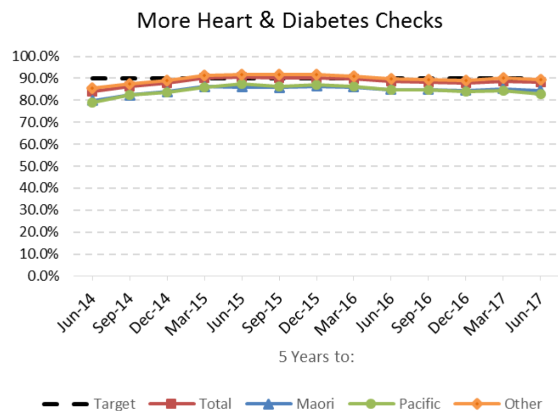




More Heart and Diabetes Checks

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

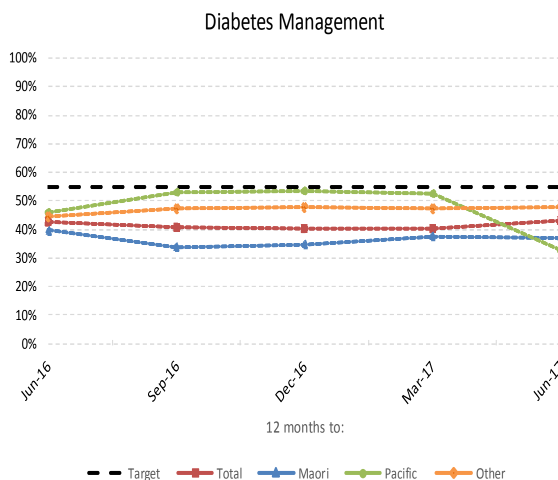
The More Heart and Diabetes Checks indicator monitors the proportion of the eligible population who have had blood tests for Cardiovascular disease (CVD) risk assessment in the preceding five year period. CVD disproportionately affects Māori and is preventable with lifestyle advice and treatment for 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%. Q4 shows it sitting at 88.2% compared to 88.5% in Q4 last year. A similar profile has occurred for all ethnicities but with persistent inequities. This indicator has been removed as a Health target for 2017/18 but Health Hawkes Bay will continue to put emphasis into this indicator through System Level Measures framework.

Management of Diabetes

Good glycaemic control reduces the risk of CVD and renal and other complications and is an indicator of long term conditions management. The number of people with good or acceptable glycaemic control remains unfavourable to the target of 55% with Q4 performance at 43%. The drop in the figures for Pacific is likely to be indicative of a small population rise combined with very slightly lower numbers. Collective work with Health Hawkes Bay on identifying patients at risk and reviewing specialist nursing roles is ongoing. Stanford self-management programmes, "Feel Good' and Whanau Wellness programmes are all targeting Māori and Pacific.

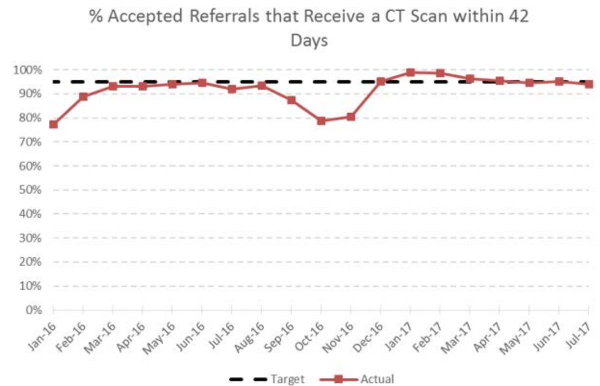


Less Waiting for Diagnostic Services

Timely access to diagnostic services is vital for early diagnosis 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.

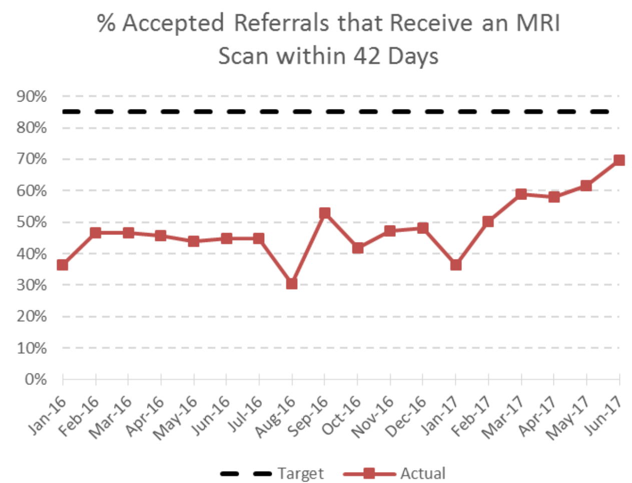
Computed Tomography

For Computed Tomography (CT), the standard is that 95% of 'routine' referrals receive a CT scan within 42 days. In Q3 and Q4, this target has been met.



Magnetic Resonance Imaging

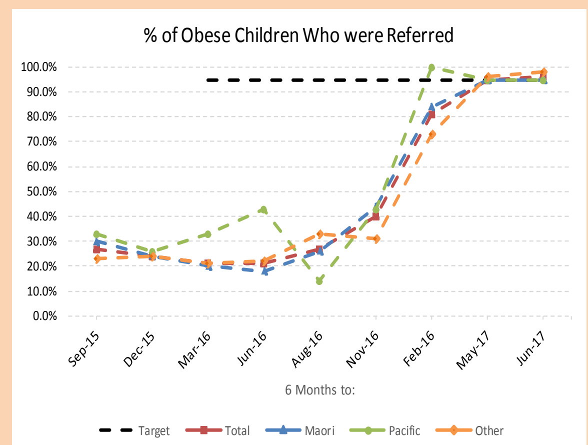
For Magnetic Resonance Imaging (MRI) the target is that 85% of referrals receive an MRI within 42 days. Q4 shows a figure of 69.7% compared to 44.7% at the end of the last financial year. This has slowly been rising since February due to additional sessions. A seven day MRI service is planned for implementation in July 2017 and additional capacity will see a sustained improvement in compliance.



National Health Target: Raising Healthy Kids

95% of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

There has been a steady increase in the rate of referrals each quarter and in Q4 the target was met for all populations. This is six month earlier than the government set deadline of December 2017.



We also monitor the percentage of 4 year olds who receive a B4SC. This has a target of > 90%. As at June 2017, we have reached **109% for total population, 107% for Māori** and 130% for Pacific. The figures are over 100% due to movement of people throughout NZ and coming into the country from overseas whilst working with a birth cohort established by the Ministry of health.

Early Detection and Management			
$'millions	**2017 Actual**	**Rebased Plan**	**Annual Plan**
Ministry of Health	*129.9*	*134.4*	*120.3*
Other District Health Boards (IDF)	*2.1*	*1.8*	*1.8*
Other sources	*3.4*	*2.7*	*2.7*
Income by Source	***135.4***	***138.9***	***124.8***
Less:			
Personnel	*26.9*	*27.3*	*27.3*
Outsourced services	*5.3*	*3.5*	*3.1*
Clinical supplies	*3.0*	*2.2*	*2.0*
Infrastructure and non clinical supplies	*8.1*	*8.9*	*9.0*
Payments to other District Health Boards	*2.6*	*2.4*	*2.4*
Payments to other providers	*87.6*	*93.4*	*92.1*
Expenditure by type	***133.5***	***137.7***	***135.9***
Net Result	***1.9***	***1.2***	***(11.1)***

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.

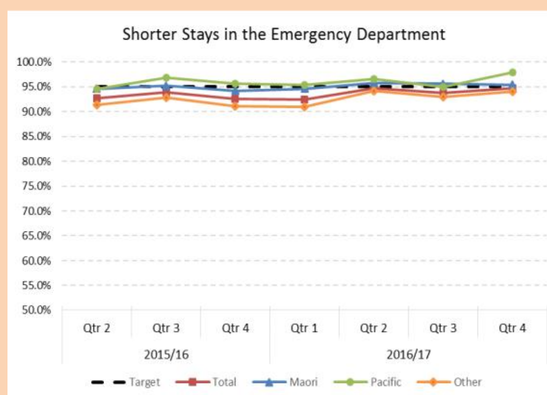
National Health Target: Shorter Stays in the Emergency Department

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 and lack of hospital beds 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

The target for the percentage of people waiting less than six hours in ED is 95%. Monthly figures have fluctuated over the year with the yearly average of 93.9%, higher than the previous year's result of 92.8%. Of note, the target was met over two quarters of the year. Q4 result was 94.7%.

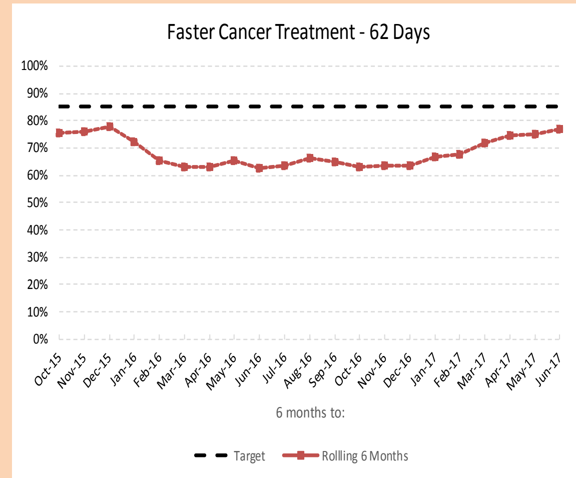
ED has been working with external consultants to develop a plan to move forward to improve patient journeys.



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.

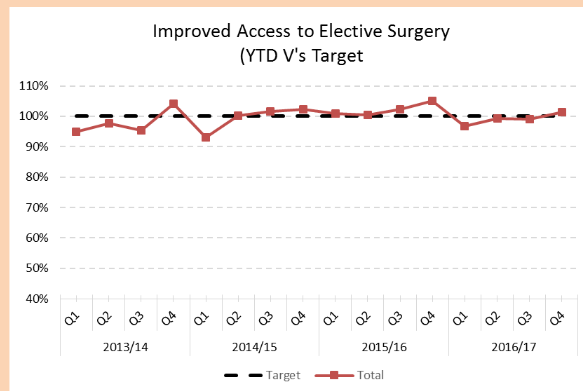
The yearly average for people referred with a high suspicion of cancer receiving their first cancer treatment within 62 days was 69.3%, unfavourable to the target of 85%. This has, however, been slowly rising over the year with a Q4 result of 77.1%.



The FCT governance team has started a rebranding exercise with the question "Is it OK to wait. A monthly report to the Board, a weekly case meeting and surgical capacity discussion plan, are all highlighting barriers and facilitating access to diagnostics and treatments. The Oncology project has been initiated, with external consultants working with consumers and staff to provide recommendations to meet current and future demand for Oncology.

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

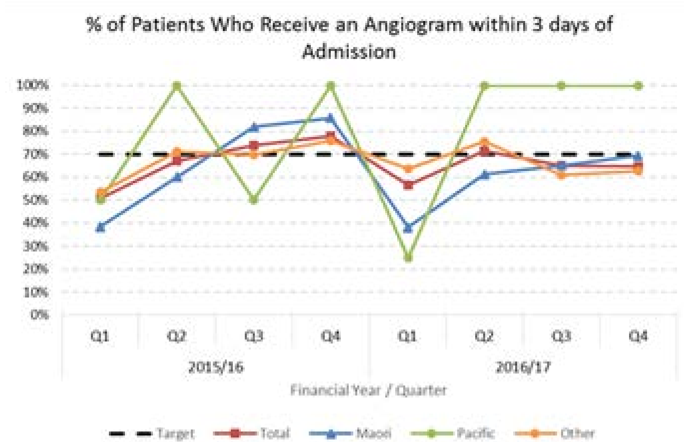
Many initiatives to improve productivity and throughput have been successfully implemented this year resulting in HBDHB achieving 7,467 elective surgery discharges, exceeding our target of 7,374.

Better Management of Long Term Conditions (LTC)

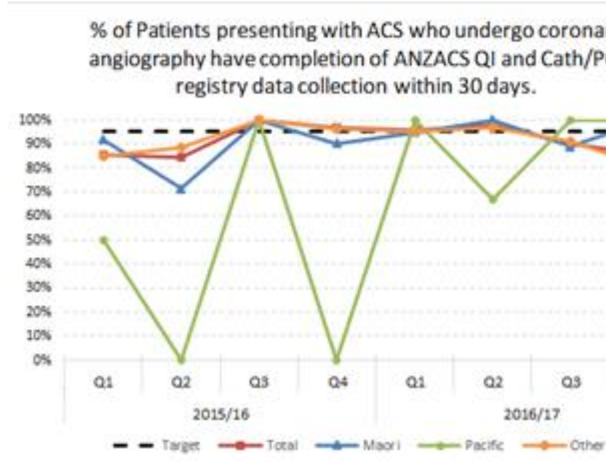
Across the Central Region there is a commitment to improved and timelier access to cardiac services. HBDHB supports the regional programme outlined in the Regional Service Plan and also works locally to:

- 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, 65% of high risk patients received an angiogram within 3 days (target 70%). For Māori we achieved 69.2% 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.



The 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.



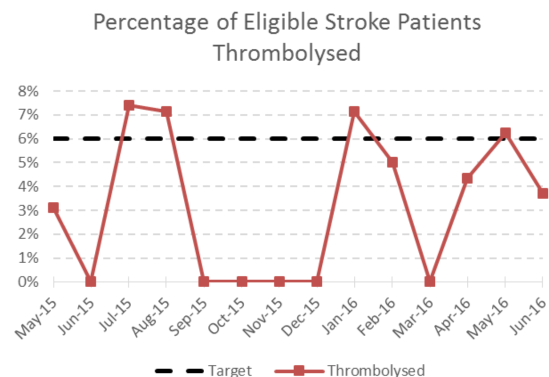
Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

The Q4 result was 85.2%, unfavourable against the target of 95%. This was lower than the five previous months whereby the target had been reached

Stroke thrombolysis and stroke pathway

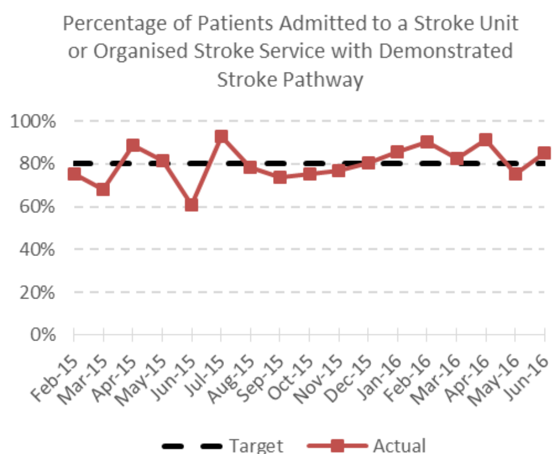
HBDHB's aim is to provide a timely, organised acute stroke service so that more patients survive stroke events and the likelihood of subsequent stroke events is reduced.

In Q3, 8.0% of eligible patients were thrombolysed, favourable against a target of 6%.



The percentage of patients admitted to the demonstrated stroke pathway was 82% in Q3 which is favourable against the target of ≥80%.

The target for percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services, who are transferred within 7 days of acute admission is ≥80%. Results over the year have fluctuated with the last result at Q3 being 71%.



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 20.6 per 10,000 which is just below the target but an improvement from 19.4 per 10,000 in December 2015.

Cardiac surgery intervention rates unfavourable against the target rate of 6.5 per 10,000 reaching 5.9 per 10,000, a decrease from 6.8 in December 2015.

There has been a decrease in percutaneous revascularization rates from 12.8 per 10,000 in December 2015 to 12.4 which comes in just under the target of 12.5.

Intervention rates for cataracts procedure and coronary angiography are above the target intervention rates at 52.5 and 35.1 per 10,000 respectively.

Elective Services Standardised Intervention Rates (per 10,000 population)			
Key Performance Measures	Baseline December 2015	Actual March 2017	Target 2016/17
Major joint replacement	19.4	20.6 (U)	≥21.0
Cataract procedures	47	52.5 (F)	≥27.0
Cardiac procedures	6.8	5.9 (U)	≥6.5
Percutaneous revascularization	12.8	12.4 (F)	≥12.5
Coronary angiography services	38.6	35.1 (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.

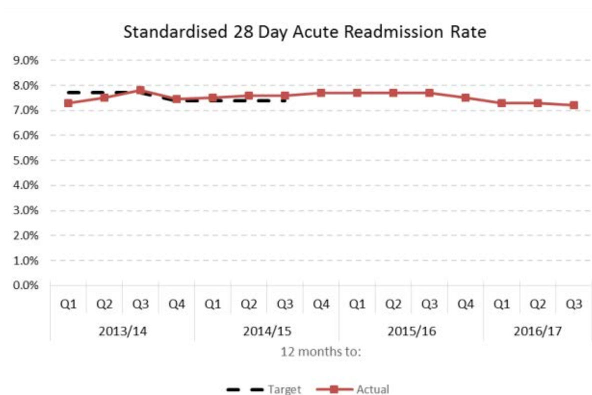
By delivering a more patient-centred elective service we expected to reduce the ALOS for elective inpatients. The target was set at ≤1.55 days. Over the year results have fluctuated between 1.56 and 1.61 days.

Acute ALOS has fluctuated between 2.42 and 2.50 over the year, not meeting the target of ≤ 2.35. We continue to focus on work to improve patient flow through the hospital to ensure good hospital productivity.

Average Length of Stay			
	Baseline December 2016	Target 2016/17	Actual March 2017
Elective	1.66	≤1.55 days	1.61 (U)
Acute	2.55	≤2.35 days	2.5 (U)

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. The latest result is for Q3 which was 7.2%. We will continue to target a reduction in readmission rates through better integration with primary and community services.

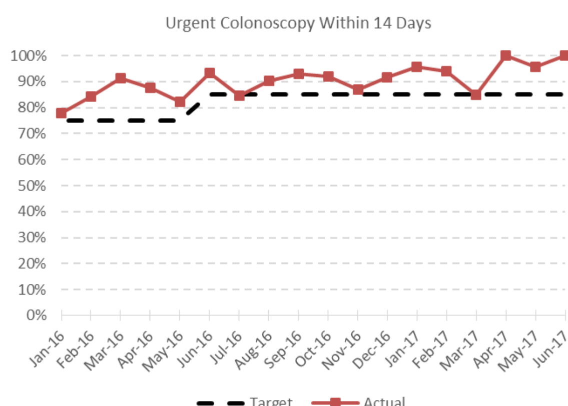


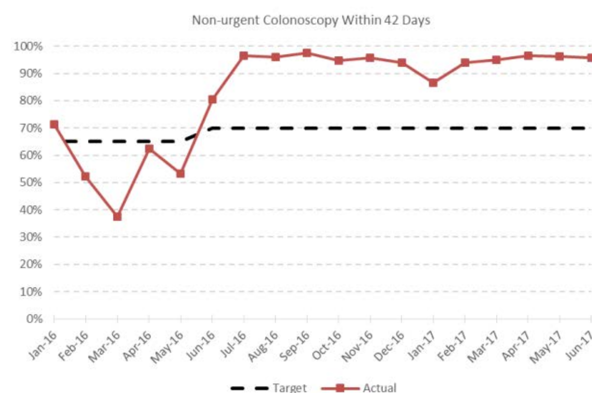
Quicker access to diagnostics

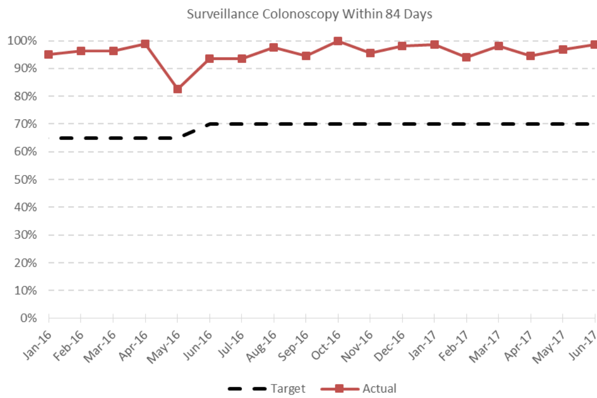
Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care, and therefore improve patient outcomes in a range of areas.

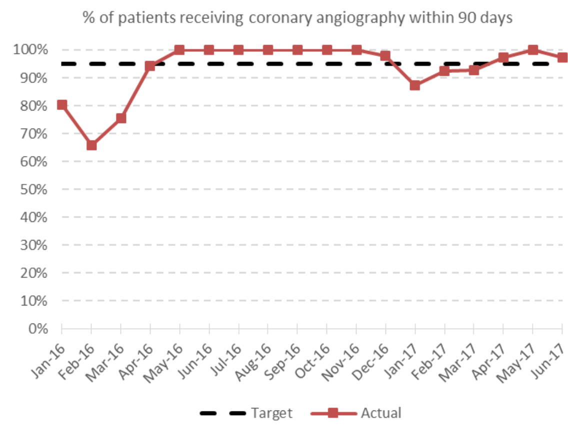
In June 2017, 100% of urgent diagnostic colonoscopies were performed within 14 days and 95.7% of routine cases performed within 42 days. These are above the targets of 85% and 70% respectively. The target for surveillance colonoscopy was also achieved with 98.6% of people waiting less than 84 days beyond planned date (target ≥70%).

The percentage of patients receiving coronary angiography within 90 days has fluctuated throughout the year. We ended the year achieving 97.2 % however, favourable to the target of ≥95%.





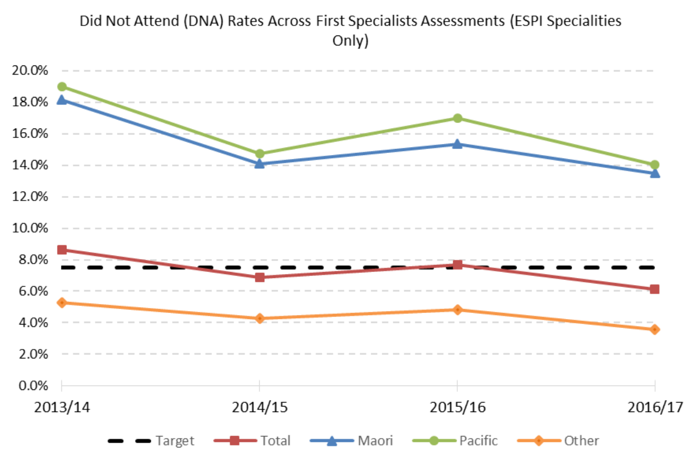




Attendance at First Specialist Appointment

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 in Q4 is 5.2% which is favourable against the target. However, the Māori DNA rate is 12.3% and Pacific 9.4% indicating significant inequity gaps. Of note, all three indicators have decreased significantly from Q4 of the previous year. 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.

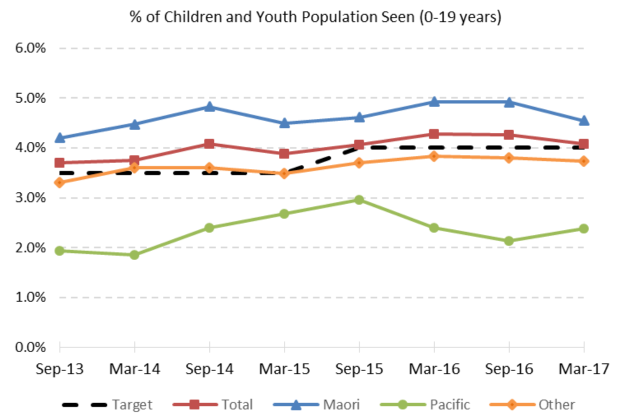


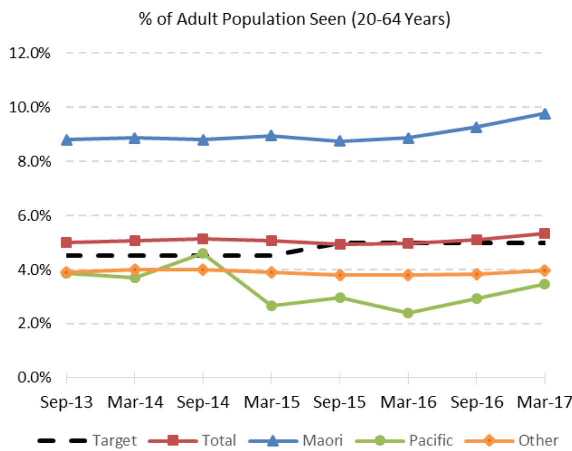
Mental Health and Addiction Services

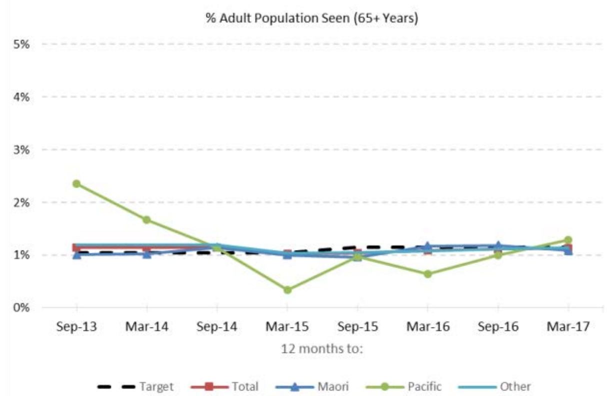
Specialist mental health and addiction services are funded for people who are severely affected by mental illness or addictions. There has been a sustained year-on-year increase in the number of clients seen by Hawke's Bay Mental Health Services. Better and timelier access to a broad range of services 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 whilst the proportion of adults and older adults has remained constant, although Māori are increasing. In the year ending March 2017, 4.08% of 0-19 year old (target ≥4%), 5.35% of 20-64 year olds (target ≥5%) and 1.13% of 65+ year olds (target ≥1.15%) accessed mental health services.

Māori rates are favourable to target in the younger groups with Pacific unfavourable. Of interest, in the 65+ group both total and Māori are unfavourable but Pacific favourable.



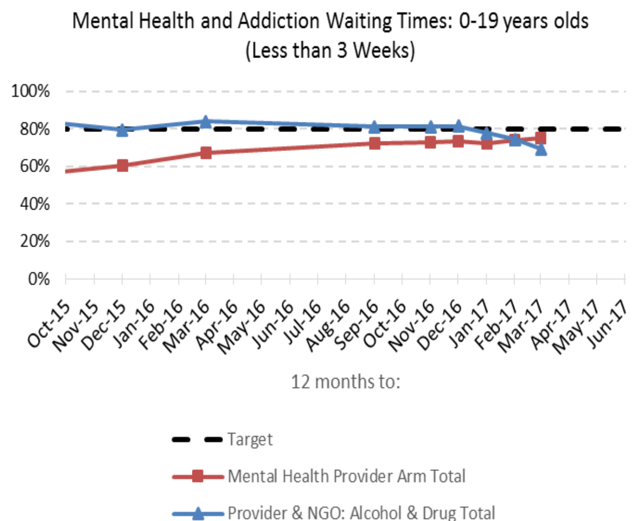




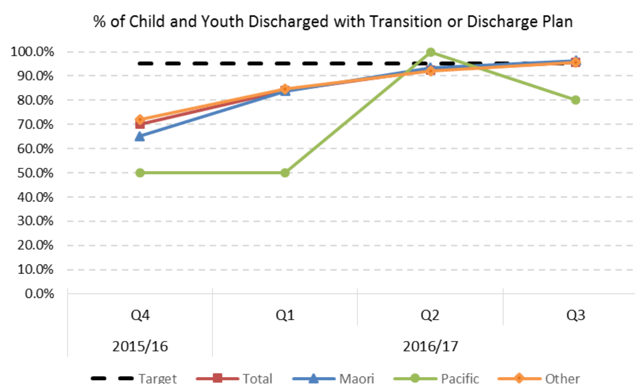
Improved Waiting Times: Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. We differentiate the targets in 2 ways: firstly, between the mental health services that are delivered by our provider arm and the addiction services 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 74.8% of cases and the 8 week result was 90.9%. 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, 69.2% were seen within 3 weeks and 90.8% 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 in the Children & Family Service (CAFS) has been a real focus over the last year which is reflected in the improved performance. The result for Q3 was 96% against a target of 95%, well up from last year.



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 was 90.7 which is higher than the target of ≤81.5 per 100,000. The rate for Māori was high at 175 per 100,000 but has been trending down. 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 the Harekeke acute day programme based in Nga Rau Rakau as well as partnership with police and education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts.

Intensive Assessment and Treatment			
$'millions	**2017 Actual**	**Rebased Plan**	**Annual Plan**
Ministry of Health	*294.4*	*288.8*	*307.9*
Other District Health Boards (IDF)	*4.2*	*3.7*	*3.7*
Other sources	*12.9*	*13.6*	*13.6*
Income by Source	***311.5***	***306.1***	***325.2***
Less:			
Personnel	*160.3*	*162.9*	*162.8*
Outsourced services	*12.9*	*8.4*	*9.1*
Clinical supplies	*44.1*	*32.1*	*32.0*
Infrastructure and non clinical supplies	*35.6*	*38.4*	*38.4*
Payments to other District Health Boards	*47.6*	*44.4*	*44.1*
Payments to other providers	*11.9*	*16.9*	*15.8*
Expenditure by type	***312.4***	***303.1***	***302.2***
Net Result	***(0.9)***	***3.0***	***23.0***

Rehabilitation and support services

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

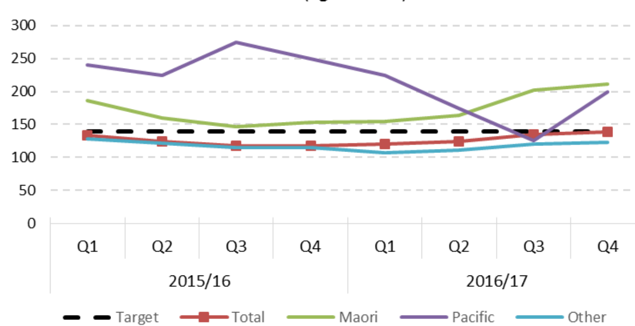
Statement of Service Performance Output Class 4

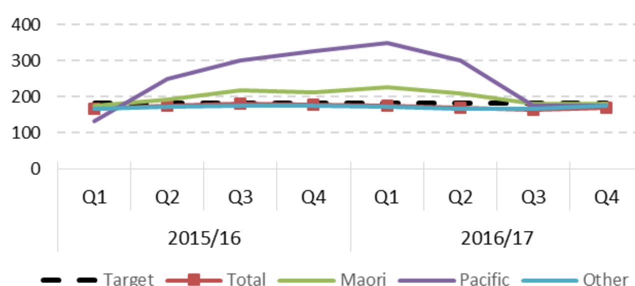
This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input 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.

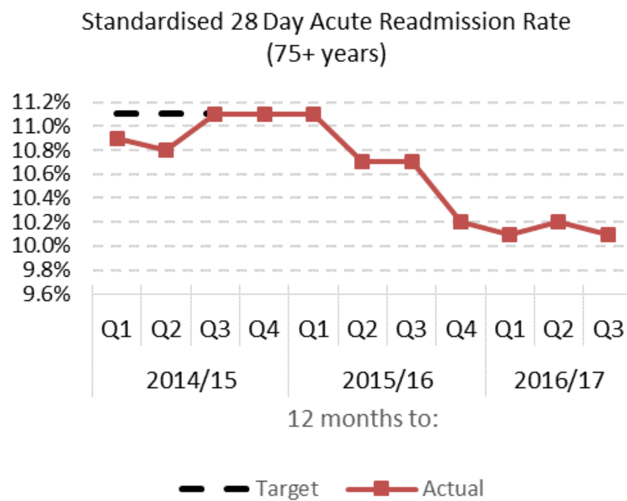
Better access to care for older people

Age specific rate of non-urgent and semi urgent attendances at the Emergency Department are monitored for ages 75-79, 80-84 and 85+. A decrease in these rates is an indicator of the services available to keep elderly safe and independent in their own homes. For the 75-79 group, the Q4 result was 139.4, favourable to target of 139.5. The 80-84 group result was 170.6, favourable to a target of 183.1. The 85+ result also came in favourably at 216.9 against a target of 231.0. An equity gap remains visible for Māori and Pacific in the younger age brackets. The engAGE model was developed in 2015 whereby the ORBIT interprofessional allied health team and six engAGE community teams support frail older people to remain independent at home. These teams continue to work in this area whilst the ageing population increases.





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. At March 2017 our rate was 10.1%.



Better community support for older people

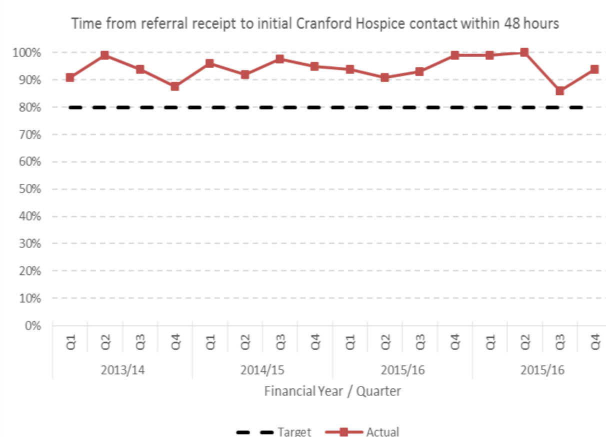
Delivering coordinated high quality services to older people supports New Zealanders to live longer, healthier and more independent lives. By providing better community support for elderly, we would expect that they are able to maintain independence and function in their own homes, therefore reducing 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 2016/17, 100% of the people using long term home support received a comprehensive clinical assessment and completed care plan.

The CHESS scale is designed to identify individuals at serious risk of decline. There are 6 levels (0 – 5) where 0 is stable and 5 is unstable. In Q4 we had no people who scored level 5 on first assessment and only 10.3% of all first assessments who were at level 4. The target for percentage of total first assessments showing a 4 or 5 score is <13.8. This tells us that a reasonably low proportion of older people living independently in the community were at risk of decline when they were assessed. We want to keep decreasing this proportion so that we can be sure we are recognising emerging instability in a timely way.

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 94% of cases in Q4 and the target of 80% was well exceeded all year.



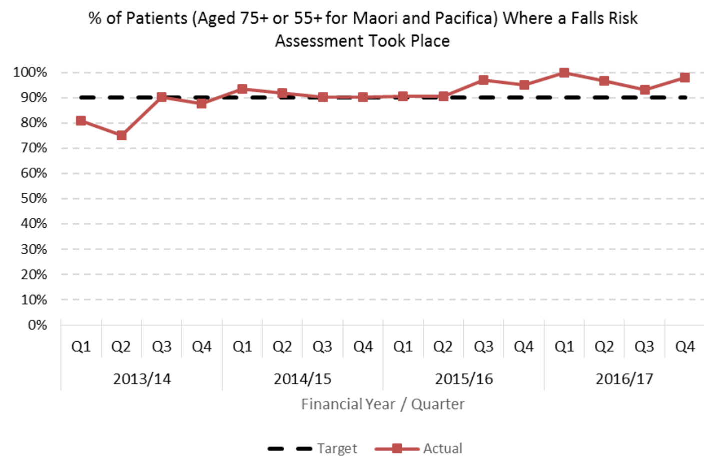
More Day Services

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 has fallen short of the target, however recent figures for the last quarter have not been included.

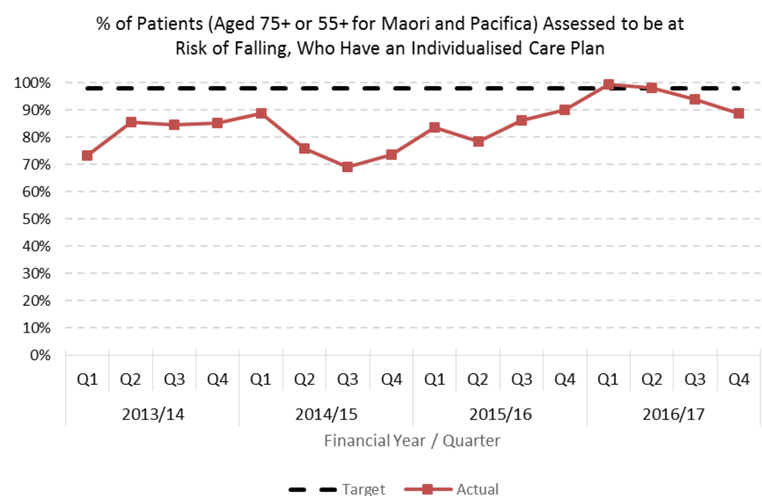
Number of Day Services	
Target	Actual
21,791	13,264

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 in increasing awareness. In Q4, a falls risk assessment was completed for 97.9% of elderly patients which is well 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 at 88.9% still below the target of 98% but hope to see this continue to increase over the coming year.



Rehabilitation and Support			
$'millions	**2017 Actual**	**Rebased Plan**	**Annual Plan**
Ministry of Health	*76.5*	*74.3*	*69.6*
Other District Health Boards (IDF)	*2.3*	*2.0*	*2.0*
Other sources	*0.2*	*0.2*	*0.2*
Income by Source	***79.0***	***76.5***	***71.8***
Less:			
Personnel	*7.1*	*7.2*	*7.2*
Clinical supplies	*0.8*	*0.6*	*0.5*
Infrastructure and non clinical supplies	*1.9*	*2.1*	*2.1*
Payments to other District Health Boards	*3.9*	*3.7*	*3.7*
Payments to other providers	*63.6*	*62.2*	*65.0*
Expenditure by type	***77.3***	***75.8***	***78.5***
Net Result	***1.7***	***0.7***	***(6.7)***

Output classes

HBDHB's annual plan includes projections of revenue and expenditure by output class. To provide useful comparisons, the revenue budget has been rebased so that the surplus is divided across the output classes in proportion to the size of each output class. The same relative adjustments have been made for the allocations to both the 2017 Actual and Rebased Plan so that the calculation of the two columns is consistent. Note however that this means the budget does not match that in the published 2016/17 Annual Plan and reported in the Annual Plan column below.

Total District Health Board			
$'millions	**2017 Actual**	**Rebased Plan**	**Annual Plan**
Expenditure by output class			
Prevention services	*8.0*	*10.6*	*10.6*
Early detection and management	*133.5*	*137.7*	*135.9*
Intensive assessment and treatment	*312.4*	*303.1*	*302.2*
Rehabilitation and support	*77.3*	*75.8*	*78.5*
Total expenditure	***531.2***	***527.2***	***527.2***
Surplus/deficit by output class			
Prevention services	*0.9*	*0.1*	*(0.2)*
Early detection and management	*1.9*	*1.2*	*(11.1)*
Intensive assessment and treatment	*(0.9)*	*3.0*	*23.0*
Rehabilitation and support	*1.7*	*0.7*	*(6.7)*
Net Result	***3.6***	***5.0***	***5.0***

Comparison to rebased plan

The DHB planned a strategic re-allocation of resources from intensive assessment and treatment to the other three classes in 2016/17, and that re-allocation was reflected in the Annual Plan. However, other than rehabilitation and support that is affected by demographic impacts on the health of older people, expenditure within the other two classes declined. This reflects both the efficiencies achieved and vacancies carried within prevention services, and lower community pharmaceutical and primary care payments within the early detection and management output class, and the pressures faced by services providing intensive assessment and treatment. Those pressures included outsourced elective surgery costs to meet MOH targets, leave and vacancy cover for medical personnel, and additional nursing costs from pressure in the emergency department and the wards.

Financial Report for the year ended 30 June 2017

The board members are pleased to present the Financial Statements of HBDHB for the year ended 30 June 2017.

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

Kevin Atkinson
Chair

Dan Druzianic
Board Member

31 October 2017

2016/17 Financial Performance

Result

The operating surplus for 2016/17 is $3.6 million on revenue of $534.7 million. This is in comparison to the $4.4 million surplus reported last year.

The surplus is $1.4 million less than the $5.0 million planned surplus projected in the 2016/17 Annual Plan, and mainly reflects the cost to the DHB of the gastroenteritis outbreak in Havelock North. MOH agreed to the DHB achieving a lower surplus for the 2016/17 year. They then contributed $1.0 million to help fund the cost of the outbreak early in the 2017-18 year.

Cash flow

The operating cash surplus of $10.8 million, an equity injection of $5.0 million from the Crown, and a $0.1 million reduction in short term investments, were used to fund the $14.4 million spend on property, plant and equipment, intangible assets and investments, repay equity of $0.4 million, and increase cash holdings by $1.1 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 2016/17 annual report, amount to $125,460.

Ministerial directions

No new directions were issued during the year. Directions that remain current include:

- The direction on the use of authentication services (2008)
- The Health and Disability Services Eligibility Direction (2011)
- Directions to support a whole of government approach to procurement and ICT (2014)
- The requirement to implement the NZ Business Number (NZBN) in key systems by December 2018 (2016)

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	2017	2016	2015	2014	2013
Return on net funds employed	10.4%	7.3%	9.8%	8.3%	11.2%	9.4%
Operating margin to revenue	2.3%	1.8%	2.2%	1.4%	1.4%	1.2%
Revenue to net funds employed	3.9	3.8	3.8	4.5	5.7	5.5
Debt to debt plus equity ratio	33.5%	-	31.7%	32.7%	46.5%	48.2%
Net result before financing & abnormals	14.2m	10.3m	13.2m	9.1m	9.5m	8.1m
Net result	5.0m	3.6m	4.4m	3.1m	3.2m	2.1m
Debt servicing coverage ratio	10.5	23.5	9.9	8.5	7.5	7.5
Ratio of earnings to revenue	5.4%	4.5%	5.2%	4.7%	4.8%	4.5%
Average cost per paid FTE	$89,693	$87,731	$86,563	$84,085	$81,948	$80,483
Average revenue per paid FTE	$239,837	$239,610	$238,939	$232,975	$233,937	$234,014

Comparative figures for return on net funds employed and revenue on net funds employed were misreported in 2015/16 and have been corrected above.

Statement of comprehensive revenue and expense

For the year ended 30 June 2017

in thousands of New Zealand Dollars

	Notes	30 June 2017	Budget 30 June 2017	30 June 2016
Patient care revenue	2.5	529,121	527,279	510,496
Interest revenue		912	885	1,419
Other operating revenue	2.6	4,680	4,035	5,149
Total revenue		534,713	532,199	517,064
Personnel costs	2.7	195,883	199,028	187,322
Outsourced services		18,236	12,248	15,116
Clinical supplies		44,605	34,619	40,766
Infrastructure and non-clinical expenses		23,152	21,606	22,228
Payments to other DHBs		54,542	50,959	52,097
Payments to non-health board providers		168,579	180,302	167,759
Other operating expenses	2.8	5,704	4,759	4,962
Depreciation and amortisation expense	3.6, 3.7	13,883	14,440	13,695
Financing costs	2.9	777	2,052	2,018
Capital charge	2.10	5,906	7,186	6,783
Total expenses		531,267	527,199	512,746
Share of associate surplus/(deficit)	3.9	121	-	48
Surplus/(deficit)		3,567	5,000	4,366
Other comprehensive revenue and expense				
Revaluation of land and buildings		-	-	-
Total comprehensive revenue and expense		3,567	5,000	4,366

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 2017 was underspent by $0.6 million (2016: overspent by $0.4 million). Mental health payments in excess of funding since 1 July 2001 is $0.1 million (30 June 2016: $0.7 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 2017

in thousands of New Zealand Dollars

	Notes	30 June 2017	Budget 30 June 2016	30 June 2016
Balance at 1 July		91,637	89,464	87,627
Total comprehensive revenue and expense		3,567	5,000	4,366
Owner transactions				
Equity injections from the Crown		47,500	-	-
Equity repayments to the Crown		(359)	(357)	(356)
Balance at 30 June	4.5	142,345	94,107	91,637

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 2017

in thousands of New Zealand Dollars

	Notes	30 June 2017	Budget 30 June 2017	30 June 2016
Assets				
Current assets				
Cash and cash equivalents	3.1	16,592	9,022	15,537
Short term investments	3.1	1,638	1,741	1,739
Receivables and prepayments	3.2	26,722	18,605	22,421
Loans (Hawke's Bay Helicopter Rescue Trust)	3.3	13	13	13
Inventories	3.4	4,435	4,044	4,293
Non-current assets held for sale	3.5	625	-	1,220
Total current assets		50,025	33,425	45,223
Non-current assets				
Property, plant and equipment	3.6	152,216	166,028	151,796
Intangible assets *(see note below)*	3.7	11,464	9,066	10,743
Investment property	3.8	131	131	131
Investment in associate *(see note below)*	3.9	1,092	1,045	1,045
Loans (Hawke's Bay Helicopter Rescue Trust)	3.3	29	29	42
Total non-current assets		164,932	176,299	163,758
Total assets		214,957	209,724	208,981
Liabilities				
Current liabilities				
Interest-bearing loans and borrowings	4.1	-	6,000	-
Payables and deferred revenue	4.2	35,635	31,194	38,318
Employee entitlements	4.3	34,138	34,485	33,588
Provisions	4.4	334	-	300
Total current liabilities		70,107	71,679	72,206
Non-current liabilities				
Interest-bearing loans and borrowings	4.1	-	41,500	42,500
Employee entitlements	4.3	2,505	2,438	2,638
Total non-current liabilities		2,505	43,938	45,138
Total liabilities		72,612	115,617	117,344
Net assets		142,345	94,107	91,637
Equity				
Contributed capital	4.5	82,357	34,859	35,216
Property revaluation reserves	4.5	67,392	67,392	67,392
Restricted funds	4.5	3,516	3,125	3,013
Accumulated surpluses/(deficits)	4.5	(10,920)	(11,269)	(13,984)
Total equity		142,345	94,107	91,637

The Regional Health Informatics Programme was an investment in associate in the 2016/17 Annual Plan, and has been reclassified to intangible assets in the budget column above. 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 2017

in thousands of New Zealand Dollars

	Notes	30 June 2017	Budget 30 June 2017	30 June 2016
Cash flows from operating activities				
Receipts from patient care		521,886	531,229	508,871
Receipts from donations, bequests and clinical trials		453	-	510
Other receipts		9,399	-	2,351
Payments to suppliers		(318,774)	(303,309)	(297,889)
Payments to employees		(195,465)	(198,449)	(187,513)
Goods and services tax (net)		(180)	-	1,258
Cash generated from operations		17,319	29,471	27,588
Interest received		912	885	1,419
Interest paid		(1,558)	(2,476)	(1,855)
Capital charge paid		(5,906)	(7,186)	(6,783)
Net cash inflow/(outflow) from operating activities		10,767	20,694	20,369
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		38	1,220	123
Acquisition of property, plant and equipment		(13,255)	(22,042)	(16,733)
Acquisition of intangible assets		(197)	-	(395)
Acquisition of investments		(1,040)	-	(2,440)
Net cash inflow/(outflow) to investing activities		(14,454)	(20,822)	(19,445)
Cash flows from financing activities				
Proceeds from borrowings		-	5,000	-
Proceeds from equity injections by the Crown		5,000	-	-
Proceeds from movement in short term investments (net)		101	-	-
Repayment of equity to the Crown		(359)	(357)	(356)
Net cash inflow/(outflow) from financing activities		4,742	4,643	(356)
Net increase/(decrease) in cash and cash equivalents		1,055	4,515	568
Add: opening cash		15,537	4,507	14,969
Cash and cash equivalents at end of year	3.1	16,592	9,022	15,537

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 2017

in thousands of New Zealand Dollars

	Notes	30 June 2017	Budget 30 June 2017	30 June 2016
Surplus/(deficit) for the year		3,567	5,000	4,366
Add back non-cash items:				
Share of associate surplus		(121)	-	(48)
Depreciation and amortisation		13,883	14,440	13,695
Add back items classified as investing activity:				
Net loss/(gain) on disposal of property, plant and equipment		103	-	23
Debt forgiven (Hawke's Bay Helicopter Rescue Trust)		13	13	13
Movement in working capital:				
(Increase)/decrease in receivables and prepayments		(4,371)	(382)	(4,571)
(Increase)/decrease in inventories		(142)	(83)	(412)
Increase/(decrease) in payables and deferred revenue		(2,729)	(526)	7,495
Increase/(decrease) in employee entitlements		391	2,397	(281)
Increase/(decrease) in provisions		40	(231)	(206)
Net movement in working capital		(6,811)	1,175	2,025
Other movements not in working capital				
Increase/(decrease) in employee entitlements		133	66	295
Net cash inflow/(outflow) from operating activities		10,767	20,694	20,369

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 2017

In preparing the 2017 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 18.25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited which is controlled by the six DHB's in the central region.

The financial statements for HBDHB are for the year ended 30 June 2017, and were approved by the Board on 31 October 2017.

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 January 2017, the External Reporting Board issued 2016 Omnibus Amendments to PBE Standards for reporting periods beginning on or after 1 January 2017. HBDHB will apply the updated standards in preparing its 30 June 2018 financial statements. The DHB expects there will be minimal or no change in applying the updated standards.

Notes to the financial statements

For the year ended 30 June 2017

In January 2017, the External Reporting Board issued the following new accounting standards that will be effective for periods beginning on or after 1 January 2019:

- PBE IPSAS 34 *Separate Financial Statements*
- PBE IPSAS 35 *Consolidated Financial Statements*
- PBE IPSAS 36 *Investments in Associates and Joint Ventures*
- PBE IPSAS 37 *Joint Arrangements*
- PBE IPSAS 38 *Disclosure of Interests in Other Entities*

The DHB has yet to review the new accounting standards to determine their impact, and consequently has yet to set the date from when it will apply the new standards.

In January 2017, the External Reporting Board issued PBE IFRS 9 *Financial Instruments*, for reporting periods beginning on or after 1 January 2021. Treasury has signalled it is considering early adoption of PBE IFRS 9 for the Financial Statements of the Government in 2018/19. HBDHB is likely to early adopt PBE IFRS 9 to align with the Crown, and to avoid any mixed group reporting issues. However the type and level of financial instruments held by the DHB means the impact of the new standard is likely to be minimal.

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 2016/17 year.

	Achieved $'millions	Plan $'millions	Variance $'millions
Revenue			
Funding health services	513.5	511.8	1.7
Governance and funding administration	3.2	3.3	(0.1)
Providing health services	298.8	292.6	6.8
Eliminations	(280.8)	(275.5)	(5.3)
	534.7	532.2	3.1
Surplus/(Deficit)			
Funding health services	3.6	5.0	(1.4)
Governance and funding administration	0.2	-	0.2
Providing health services	(0.2)	-	(0.2)
	3.6	5.0	(1.4)

Note: Providing health services includes $6.0 million (2016: $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 was helped by additional revenue for the Primary Health Organisation, increasing remuneration to home care workers for travel between clients and high cost treatment, and reduced expenditure in health of older people, Whanau Ora, and public health. However the net cost of patient flows with other DHBs was significantly over plan, and brought the funding surplus down to $1.4 million short of plan.

The governance and funding administration surplus relates to vacancies and reduced provider audit costs.

Notes to the financial statements (continued)

For the year ended 30 June 2017
in thousands of New Zealand Dollars

Higher patient volumes in a number of areas increased internal revenue to the providing health services arm. This was supported by lower allied health costs due to vacancies, but **outweighed by only partial achievement of the DHB's efficiency programme,** the cost of elective surgery to meet discharge targets, additional nursing staff in the emergency department and the wards, management restructuring costs, cover for administration staff, locums for vacancy and leave cover, and costs of the gastroenterology outbreak.

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 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 $2.5 million higher than plan. This reflects:

- additional funding of $1.5 million from MOH for first contact services, In Between Travel (travel time between home care clients), and high cost treatment;
- increased revenue of $1 million from the treatment of patients from other districts; and
- sundry income of $0.6 million including an unbudgeted $0.5 million from donations, bequests and clinical trials;

partly offset by:

- reduced revenue of $0.5 million from ACC as the DHB prioritised elective surgery targets over ACC volumes; and
- a small reduction in audiology patient co-payments

Financial Position

The projections in the 2016/17 Annual Plan was based on forecasts prepared well before the end of the 2015/16 year. A comparison of the actual balances with the plan would include amounts reflecting differences between the forecast and reported 2015/16 balances. These amounts comprised increases of $11.7 million in assets, $9.6 million in liabilities and $2.1 thousand in equity. Excluding these differences results in a reduction in liabilities and an increase in equity that reflects the MOH decision to swap DHB term debt to equity in February 2017.

Cash Flow

Cash from operating activities was $9.9 million lower than plan reflecting the lower surplus, the effect of the debt to equity swap on capital charges and interest costs, and movements in working capital. The $6.4 million lower cash invested related to the transfer of major radiology purchases into later years, and lower expenditure on information technology.

2.3 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.

Estimating useful lives of property, plant and equipment and intangible assets with definite lives

Assessing the appropriateness of useful life estimates requires the DHB to consider a number of factors such as the physical condition of the asset and advances in medical technology. An incorrect assessment of the useful life or residual value will affect the depreciation expense recognised in the surplus of deficit and the asset's carrying value. The DHB minimises the risk of this estimation uncertainty by physical inspection of the assets and asset replacement programmes. The DHB has not made significant changes to past assumptions concerning useful lives.

Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $4.995 million (2016: $5.225 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.

2.4 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 2017.

Impairment of intangible assets with indefinite lives

Investment in the National Oracle Solution (NOS), and the Regional Health Information Project (RHIP, formally CRISP) will provide the DHB's main financial, procurement and clinical systems. The systems will have indefinite life, and in both cases no impairment of the investments is necessary (refer Note 3.6).

Notes to the financial statements (continued)

For the year ended 30 June 2016

in thousands of New Zealand Dollars

2.5 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.

	30 June 2017	30 June 2016
Ministry of Health population-based revenue	473,987	457,148
Ministry of Health contract revenue	35,477	34,647
Revenue from other DHBs	12,592	11,455
Other Crown entity contracted revenue	5,861	5,933
Other patient care related revenue	1,204	1,313
	529,121	510,496

Vote Health: Health and Disability Support Services **– Hawke's Bay DHB (the appropriation)**

Reconciliation (in millions of dollars) of the appropriation to Ministry of Health population-based revenue (above).

	30 June 2017	30 June 2016
Appropriation	470.2	461.3
Transferred to 2016/17	4.2	(4.2)
Appropriation not attributed to population-based revenue	(0.4)	-
Ministry of Health population-based revenue	474.0	457.1

Ministry of Health population-based revenue is the income received by the DHB and equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure under the Public Finance Act 1989.

Notes to the financial statements (continued)

For the year ended 30 June 2017

in thousands of New Zealand Dollars

2.6 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 2017	30 June 2016
Donations and bequests received	280	333
Rental revenue	680	576
Cafeteria and food sales	963	965
Other operating revenue	2,693	3,239
Gain on sale of property, plant and equipment	64	36
	4,680	5,149

2.7 Personnel costs

	30 June 2017	30 June 2016
Salaries and wages	189,847	182,031
Employer contributions to defined contribution plans	5,619	5,279
Increase/(decrease) in employee entitlements	417	12
	195,883	187,322

Notes to the financial statements (continued)

For the year ended 30 June 2017

in thousands of New Zealand Dollars

2.8 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 2017	30 June 2016
Impairment of receivables (bad and doubtful debts)	147	132
Loss on disposal of property, plant and equipment	133	27
Fees to auditor for the audit of the financial statements	125	123
Fees to board members	251	275
Operating lease expenses	4,501	4,160
Increase/(decrease) in provisions	544	243
Koha	3	2
	5,704	4,962

2.9 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 2017	30 June 2016
Interest on Crown loans	777	2,018
Attributed interest on finance leases	-	-
	777	2,018

2.10 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 2017 was 7% for the first half of the year and 6% for the second half (2016: 8% all year).

Notes to the financial statements (continued)

For the year ended 30 June 2017

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.

Cash and cash equivalents	30 June 2017	30 June 2016
Cash	4	4
Bank balances	1	35
Credit balance (NZ Health Partnerships Limited)	15,254	14,223
Call deposits – special funds	459	423
Call deposits – clinical trials	874	852
Cash and cash equivalents	16,592	15,537

Short term investments		
Term deposits – special funds	1,419	1,397
Term deposits – clinical trials	219	342
	1,638	1,739

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	1,820	1,804
Donations and bequests	210	233
Interest received	52	61
Expenditure during the year	(204)	(278)
	1,878	1,820

Special funds include funding from the Ministry of Education for early childhood education purposes. Receipts in 2017 amounted to Nil (2016: $165 thousand), and the balance of funds as at 30 June 2017 amounted to $362 thousand (30 June 2016: $358 thousand).

Notes to the financial statements (continued)

For the year ended 30 June 2017

in thousands of New Zealand Dollars

Clinical Trials	30 June 2017	30 June 2016
Opening balance	1,193	1,321
Receipts	254	312
Interest received	21	32
Expenditure during the year	(375)	(472)
	1,093	1,193

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 2017 this limit for HBDHB was $26.1 million (2016: $24.9 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.

	30 June 2017	30 June 2016
Ministry of Health receivables	1,754	3,423
Trade receivables	3,185	2,111
Ministry of Health accrued revenue	12,833	6,489
Other accrued revenue	6,495	9,842
Prepayments	2,455	556
	26,722	22,421

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 $274 thousand (2016: $33 thousand)

Receivables are shown net of impairments amounting to $329 thousand (2016: $216 thousand) recognised in the current year and arising from non-resident fees and small service charges that can be uneconomic to collect.

Notes to the financial statements (continued)

For the year ended 30 June 2017

in thousands of New Zealand Dollars

As at 30 June 2017 and 2016, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

	Gross 30 June 2017	Impairment 30 June 2017	Net 30 June 2017	Gross 30 June 2016	Impairment 30 June 2016	Net 30 June 2016
Not past due/past due<30days	2,265	(17)	2,248	3,426	(43)	3,383
Past due 31-60 days	353	(2)	351	256	(4)	252
Past due 61-90 days	1,940	(9)	1,931	1,045	(13)	1,032
Past due >90 days	710	(301)	409	1,023	(156)	867
	5,268	(329)	4,939	5,750	(216)	5,534

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:

	30 June 2017	30 June 2016
Balance at beginning of year	215	139
Additional provisions made during the year	153	142
Receivables written-off during period	(39)	(65)
Balance at end of year	329	216

3.3 Loans

Accounting policy

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

Loan to Hawke's Bay Helicopter Rescue Trust	30 June 2017	30 June 2016
Non-current	29	42
Current	13	13
	42	55

The fair value of loans receivable is $45 thousand (2016 $60 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 2.60% (2016 2.14%).

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 2017

in thousands of New Zealand Dollars

Inventories held for distribution	30 June 2017	30 June 2016
Pharmaceuticals	939	775
Surgical and medical supplies	2,361	2,432
Other supplies	1,135	1,086
	4,435	4,293

Write-down of inventories amounted to $11 thousand (2016: $28 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 2017 was $41.2 million (2016: $34.2 million). No inventories were held at current replacement cost at 30 June 2017 (30 June 2016: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

3.5 Non-current assets held for sale

Accounting policy

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

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

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

	30 June 2017	30 June 2016
Land	330	730
Buildings	295	490
	625	1,220

Changes and improvements to the mental health service delivery model, resulted in three properties being declared surplus in October 2013, their transfer at their book values from property, plant and equipment to non-current assets held for sale, and their write-down by $518 thousand to fair value less costs to sell. One property has subsequently been transferred back to property, plant and equipment. 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. The remaining properties are now expected to be sold within the next twelve months.

3.6 Property, plant and equipment

Accounting policy

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

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

Revaluations

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

materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

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	7 to 20 years	5% to 14%
Other equipment	3 to 30 years	3% to 33%

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

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

Impairment of property, plant and equipment

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 2017

in thousands of New Zealand Dollars

30 June 2017	1 July 2016									30 June 2017		
	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions	Transfers from work in progress	Transfer from assets held for sale	Disposals	Depreciation expense	Depreciation write back on disposal	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Owned assets												
Land	8,130	-	8,130	-	-	400	-	-	-	8,530	-	8,530
Buildings	127,576	(7,521)	120,055	-	7,837	195	(32)	(8,461)	3	135,576	(15,979)	119,597
Clinical equipment	33,304	(19,633)	13,671	-	2,282	-	(1,547)	(3,249)	1,477	34,039	(21,405)	12,634
Information tech.	7,224	(5,307)	1,917	-	791	-	(491)	(977)	491	7,524	(5,793)	1,731
Motor vehicles	1,807	(1,063)	744	-	65	-	(48)	(150)	46	1,824	(1,167)	657
Other equipment	3,110	(1,437)	1,673	-	450	-	(132)	(331)	96	3,428	(1,672)	1,756
	181,151	(34,961)	146,190	-	11,425	595	(2,250)	(13,168)	2,113	190,921	(46,016)	144,905
Leased assets												
Alterations	1,434	(217)	1,217	-	67	-	-	(124)	-	1,501	(341)	1,160
	1,434	(217)	1,217	-	67	-	-	(124)	-	1,501	(341)	1,160
Work in Progress												
Buildings	4,056	-	4,056	9,117	(7,904)	-	-	-	-	5,269	-	5,269
Clinical equipment	201	-	201	2,902	(2,319)	-	-	-	-	783	-	783
Information tech.	74	-	74	778	(754)	-	-	-	-	99	-	99
Motor vehicles	-	-	-	65	(65)	-	-	-	-	-	-	-
Other equipment	58	-	58	392	(450)	-	-	-	-	-	-	-
	4,389	-	4,389	13,254	(11,492)	-	-	-	-	6,151	-	6,151
	186,974	(35,178)	151,796	13,254		595	(2,250)	(13,292)	2,113	198,573	(46,357)	152,216

Notes to the financial statements (continued)

For the year ended 30 June 2017

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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 2017.

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 2017

in thousands of New Zealand Dollars

30 June 2016	1 July 2015								30 June 2016		
Owned assets	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions	Transfers from work in progress	Disposals	Depreciation expense	Depreciation write back on disposal	Cost/ valuation	Accumulated Depreciation	Carrying Amount
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
Leased assets											
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
Work in Progress											
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)

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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:

Type of asset	Estimated life	Amortisation rate
Acquired computer software	1.5 to 15 years	7% to 67%
Developed computer software	3 to 15 years	7% to 33%
NOS rights	Indefinite	Nil
RHIP assets (PACS Archive)	10 years	10%

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)

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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 2016								30 June 2017		
30 June 2017 Owned assets	Cost/ Valuation	Accumulated Amortisation	Carrying Amount	Acquisitions	Transfers	Disposals	Amortisation Expense	Amortisation written back	Cost/ Valuation	Accumulated Amortisation	Carrying Amount
Software	10,999	(8,963)	2,036	-	373	(50)	(591)	50	11,322	(9,504)	1,818
	10,999	(8,963)	2,036	-	373	(50)	(591)	50	11,322	(9,504)	1,818
Work in Progress											
Software	17	-	17	197	(149)	-	-	-	65	-	65
NOS rights	2,504	-	2,504	-	-	-	-	-	2,504	-	2,504
RHIP assets	6,186	-	6,186	1,115	(224)	-	-	-	7,077	-	7,077
	8,707	-	8,707	1,312	(373)	-	-	-	9,646	-	9,646
	19,706	(8,963)	10,743	1,312		(50)	(591)	50	20,968	(9,504)	11,464

The NOS rights represent the DHB's right to access, under a service agreement, shared finance, procurement and supply chain 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 NOS 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 NOS assets to the DHB s will be used to, and is sufficient to maintain the NOS 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)

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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 2017 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 2015									30 June 2016		
30 June 2016 Owned assets	Cost/ Valuation	Accumulated Amortisation	Carrying Amount	Acquisitions	Transfers	Adjustments	Disposals	Amortisation Expense	Amortisation written back	Cost/ Valuation	Accumulated Amortisation	Carrying Amount
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
Work in Progress												
Software	71	-	71	396	(450)	-	-	-	-	17	-	17
NOS 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

Notes to the financial statements (continued)

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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 2017	30 June 2016
Balance at beginning of year	131	131
Fair value adjustments	-	-
Balance at end of year	131	131

No revaluation was completed for investment properties as at 30 June 2017 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.

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 provide 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 2017 was 18.25% (30 June 2016: 19%). ALSL has six DHB shareholders holding 1,150,000 shares each, all fully paid except for Hutt Valley DHB (HVDHB) whose shares are paid to $550,000, with the remainder to be paid over the next two 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)

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Summarised financial information of Allied Laundry Services Limited	30 June 2017	30 June 2016
Presented on a gross basis		
Assets	10,497	10,418
Liabilities	4,095	4,419
Revenue	10,432	9,239
Surplus/(deficit)	560	354
HBDHB ownership interest	18.25%	19%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Other contracted commitments (operating leases)	-	-

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 accounts as at 30 June 2017, and their audited financial statements as at 30 June 2016.

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.

Non-current	30 June 2017	30 June 2016
Crown loans	-	42,500
	-	42,500

Treasury has determined that the borrowings regime applied to DHBs was not serving any useful purpose. Consequently borrowings from the Ministry of Health converted into equity on 15 February 2017. Funding from the Ministry was adjusted to make the conversion cost neutral.

The DHB had no finance leases at balance date.

Notes to the financial statements (continued)

For the year ended 30 June 2017

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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 2017	30 June 2016
Trade payables	5,034	6,308
Income in advance relating to contracts with specific performance obligations	3,307	2,933
Other non-trade payables and accrued expenses	23,142	25,327
	31,483	34,568
Payables and deferred revenue under non exchange transactions		
ACC levy payable	188	482
Goods and services tax	3,964	3,268
	4,152	3,750
Total payables and deferred revenue	35,635	38,318

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

4.3 Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on: likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlement information; and the present value of the estimated future cash flows.

Superannuation schemes

Defined contribution schemes

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

Notes to the financial statements (continued)

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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.

Non-current liabilities	30 June 2017	30 June 2016
Long service leave	2,413	2,497
Retirement gratuities	92	141
	2,505	2,638
Current liabilities		
Accrued salaries and wages	7,852	7,465
Annual leave	19,474	18,807
Sick leave	345	342
Continuing medical education leave and expenses	4,322	4,729
Sabbatical leave	546	619
Long service leave	1,521	1,470
Retirement gratuities	78	156
	34,138	33,588

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 1.97% in year one to 4.75% after 31 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 $208 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 $207 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 2017

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	30 June 2017	30 June 2016
Balance at beginning of year	300	506
Additional provisions made	544	243
Amounts used	(510)	(449)
Unused amounts reversed	-	-
Balance at end of year	334	300

All provisions are classified as current.

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 $2.2 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 generally are the result of an isolated event involving an individual employee.

An independent consulting actuary, Peter Davies B.Bus.Sc, FIA, FNZSA has calculated the DHB's liability, and the valuation is effective 30 June 2017. The actuary 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 consulting actuary'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.

Notes to the financial statements (continued)

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4.5 Equity

	Crown Equity	Property Revaluation Reserves	Restricted Funds	Asset Replace Reserve	Accumulated Deficit	Total Equity
Balance at 1 July 2016	35,216	67,392	3,013	-	(13,984)	91,637
Surplus/(deficit) for the year	-	-	-	-	3,567	3,567
Equity injections *(Debt / Equity swap)*	42,500	-	-	-	-	42,500
Equity injections *(Mental Health Inpatient Unit)*	5,000	-	-	-	-	5,000
Transfers between reserves	-	-	503	-	(503)	-
Repayment to the Crown	(359)	-	-	-	-	(359)
Balance at 30 June 2017	82,357	67,392	3,516	-	(10,920)	142,345

	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	-
Balance at 30 June 2016	35,216	67,392	3,013	-	(13,984)	91,637

Asset Replacement Reserves

For the prior year, 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 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 2017	30 June 2016
Land	7,060	7,060
Buildings	60,332	60,332
	67,392	67,392

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)

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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 2017	30 June 2016
Property, plant and equipment		
Buildings	8,399	1,148
Clinical equipment	582	451
Plant	4	7
Information technology	3	56
Intangible assets		
Software	3	12
Regional Health Information Project (RHIP)	1,288	1,539
	10,279	3,213

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 2017	30 June 2016
Not more than one year	2,898	2,730
One to five years	7,162	7,524
Later than five years	2,754	3,682
	12,814	13,936

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 Omahu Road was renewed in December 2014, for the first of three right of renewal periods of two years each, with a review to market on each renewal date.
- The Central Hawke's Bay Health Centre 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 2017	30 June 2016
Cash and cash equivalents	16,592	15,537
Short term investments	1,638	1,739
Loans	42	55
Trade and other receivables	26,722	22,421
	44,994	39,752
Financial Liabilities		
Financial liabilities measured at amortised cost		
Secured bank loans (Ministry of Health)	-	42,500
Trade and other payables	35,635	38,318
	35,635	80,818

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)

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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.

30 June 2017	Effective Interest Rates	Total	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
Cash and cash equivalents							
Cash	-	4	4				
Bank balances	-	1	1				
Credit balance (HBL)	2.24%	15,254	15,254	-	-	-	-
Short term deposits	1.29%	1,333	1,333	-	-	-	-
Short term investments	3.41%	1,638	1,638	-	-	-	-
Repricing gap		18,230	18,230	-	-	-	-

Borrowings from the Ministry of Health converted into equity on 15 February 2017 (refer Note 4.1).

30 June 2016	Effective Interest Rates	Total	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
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		(25,224)	17,276	-	(6,000)	(21,500)	(15,000)

Currency risk

Currency risk is the risk that the fair value or future cash flows on a financial instrument will fluctuate because of changes in foreign exchange rates. 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)

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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 95% (30 June 2016: 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 2017, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2017/18, as the DHB has no term debt, 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 2017	30 June 2016
Counterparties with credit ratings		
Cash, cash equivalents and investments		
AA-	2,972	3,053
Total cash and cash equivalents	2,972	3,053
Counterparties without credit ratings		
Cash and cash equivalents		
NZ Health Partnerships Limited – no defaults in the past	15,254	14,223
Receivables and prepayments		
Receivables and prepayments with no defaults in the past	26,448	22,388
Receivables and prepayments with defaults in the past	274	33
Total Receivables and prepayments	26,722	22,421
Loans		
Hawke's Bay Helicopter Rescue Trust - no defaults in the past	42	55

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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

HBDHB's financial liabilities comprise payables and deferred revenue that have a contractual maturity date of six months or less.

Forecasted transactions

HBDHB does not hedge forecasted transactions.

5.4 Contingent assets

There are no contingent assets at 30 June 2017.

5.5 Contingent liabilities

Holidays Act compliance

A number of organisations, including DHBs, have identified issues with the calculation of holiday pay. DHBs are individually investigating the possibility and extent to which they are affected. DHB shared services is coordinating an interpretation of the Act with DHBs and the New Zealand Council of Trade Unions, to establish a base-line solution for those who are affected. Until clarification of the correct calculation process is established, no assessment of the financial effect can be made.

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 and increased share of any deficit.

As at March 2017, the scheme had a past service surplus of $8.0 million (6.2% 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.

Notes to the financial statements (continued)

For the year ended 30 June 2017

in thousands of New Zealand Dollars

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 2017	30 June 2016
Board Members		
Remuneration	277	275
Full time equivalent members	*1.3*	*1.3*
Executive management team		
Remuneration	2,886	2,864
Full time equivalent members	*11.2*	*10.6*
Total key management personnel remuneration	3,163	3,139
Total full time equivalent personnel	*12.5*	*11.9*

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.

5.7 Remuneration

Remuneration – Board members

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

	30 June 2017		30 June 2016	
	Board	Committees	Board	Committees
Kevin Atkinson *Chair*	42,000	2,500	42,000	2,500
Ngahiwi Tomoana *Deputy Chair*	25,500	2,000	25,500	1,438
Ana Apatu *(elected October 2016)*	11,900	2,000	-	-
Barbara Arnott	20,400	3,250	20,400	3,250
Andrew Blair *(retired October 2016)*	8,500	1,312	20,400	2,500
Dan Druzianic	20,400	2,808	20,400	3,120
Peter Dunkerley	20,400	2,562	20,400	2,562
Denise Eaglesome *(retired October 2016)*	8,500	750	20,400	1,000
Hine Flood *(appointed October 2016)*	11,900	250	-	-
Helen Francis	20,400	1,500	20,400	1,000
Diana Kirton	20,400	2,250	20,400	1,750
Jacoby Poulain	20,400	2,750	20,400	2,500
Heather Skipworth	20,400	1,750	20,400	1,813
	251,100	25,682	251,100	23,433

Notes to the financial statements (continued)

For the year ended 30 June 2017

in thousands of New Zealand Dollars

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

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 Pacifika Health Leadership Group.

Employee Remuneration

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

	30 June 2017	30 June 2016		30 June 2017	30 June 2016
100,000-109,999	67	55	300,000-309,999	3	6
110,000-119,999	32	29	310,000-319,999	1	5
120,000-129,999	31	21	320,000-329,999	5	3
130,000-139,999	19	16	330,000-339,999	1	1
140,000-149,999	18	8	340,000-349,999	3	2
150,000-159,999	9	15	350,000-359,999	3	1
160,000-169,999	9	9	360,000-369,999	-	2
170,000-179,999	6	12	370,000-379,999	1	1
180,000-189,999	11	10	380,000-389,999	-	1
190,000-199,999	9	9	390,000-399,999	2	-
200,000-209,999	12	8	400,000-409,999	-	1
210,000-219,999	6	9	410,000-419,999	-	-
220,000-229,999	8	6	420,000-429,999	-	1
230,000-239,999	5	7	430,000-439,999	1	-
240,000-249,999	4	5	440,000-449,999	-	-
250,000-259,999	11	8	450,000-459,999	-	-
260,000-269,999	5	6	460,000-469,999	-	-
270,000-279,999	8	9	470,000-479,999	-	-
280,000-289,999	6	-	480,000-489,999	2	1
290,000-299,999	6	6	490,000-500,000	-	-

During the year, eleven (30 June 2016: 10) employees received compensation and other benefits in relation to cessation totalling $428,595 (30 June 2016: $144,923).

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

Baseline	Latest available data for planning purpose
Target 2016/17	Target 2016/17
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target (above or within 0.5% of target)
U (Unfavourable)	Actual to date is unfavourable to target

OUTPUT CLASS 1: PREVENTION SERVICES

Population and Individual Dimensions

Better help for smokers to quit - % of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	99.1% – October to December 2015	≥95%	99.1% (F) – July to September 2016
			99.0% (F) – October to December 2016
			95.6% (F) – January to March 2017
			95.2% (F) – April to June 2017

Better help for smokers to quit - % of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months			
Financial Year Source: Ministry of Health	Baseline	Target	Actual to Date
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
2016/17	81.2% July to September 2015 (Source: DHBNZ)	≥90%	80.9% (U) – July to September 2016
			87.4% (U) – October to December 2016
			86.4% (U) – January to March 2017
			91.0% (F) – April to June 2017

Better help for smokers to quit - % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking			
Financial Year Source: Ministry of Health	Baseline	Target	Actual to Date
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
2016/17	96.5% October - December 2015	≥90%	91.2% (F) – July to September 2016
			88.5% (U) – October to December 2016
			92.8% (F) – January to March 2017
			85.7% (U) – April to June 2017

Better help for smokers to quit - % of pregnant Māori women that are smokefree at 2 weeks postnatal			
Financial Year	Baseline	Target	Actual to Date
2015/16	58% July to December 2013	≥86%	65.6% (U) January to June 2015
2016/17	73.0% July to December 2014	≥95%	80% (U) July to December 2016

Increase Immunisation coverage in Children - % of 8 month olds who complete their primary course of Immunisations			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
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
2016/17	93.3% 3 months to December 2015	≥95%	95.4% (F) – July to September 2016
			95.3% (F) – October to December 2016
			94.4% (U) – January to March 2017
			95.0% (F) – April to June 2017
MAORI			
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
2016/17	92.6% 3 months to December 2015	≥95%	94.4% (U) – July to September 2016
			94.4% (U) – October to December 2016
			95.4% (F) – January to March 2017
			94.0% (U) – April to June 2017

Increase Immunisation coverage in Children - % of 2 year olds fully immunised			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
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
2016/17	93.9% 3 months to December 2015	≥95%	95.6% (F) – July to September 2016
			94.7% (F) – October to December 2016
			93.2% (U) – January to March 2017
			94.7% (F) – April to June 2017
MAORI			
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
2016/17	95.1% 3 months to December 2015	≥95%	96.3% (F) – July to September 2016
			95.4% (F) – October to December 2016
			95.1% (F) – January to March 2017
			95.7% (F) – April to June 2017

Increase Immunisation coverage in Children - **% of 4 year olds fully immunised by age 5**			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
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
2016/17	92.7% 3 months to December 2015	≥95%	92.1% (U) – July to September 2016
			93.5% (U) – October to December 2016
			92.6% (U) – January to March 2017
			93.2% (U) – April to June 2017
MAORI			
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
2016/17	94.2% 3 months to December 2016	≥95%	93.4% (U) – July to September 2015
			95.8% (F) – October to December 2015
			94.9% (F) – January to March 2016
			91.8% (U) – April to June 2016

Increase HPV immunisation rates - **% of girls that have received HPV dose three**			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2015/16	New	≥65%	68.4% (F) 2002 – June 2016
2016//17	68.4% 2002 – June 2016	≥70%	70.4% (F) 2003 – June 2017
MAORI			
2015/16	New	≥65%	87.8% (F) 2002 – June 2016
2016/17	87.8% 2002 – June 2016	≥70%	76.9% (F) 2003 – June 2017

Increase the rate of seasonal influenza immunisations in over 65 year olds - **% of high needs 65 years olds and over influenza immunisation rate**			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
2015/16	67.9% - January to December 2014	≥70%	Data no longer available from PHO
2016/17	67.9% - January to December 2014	≥75%	60% (U) January 2016 – December 2016

Reduced incidence of first episode Rheumatic Fever - **Acute rheumatic fever initial hospitalisation rate per 100,000**			
Financial Year	Baseline	Target	Actual to Date
2015/16	2.6 per 100,000 July 2013 – June 2014	≤1.9	1.88 per 100,000 (F) July 2015 – June 2016
2016/17	0.6 per 100,000 July 2014 – June 2015	≤1.5	2.48 per 100,000 (U) July 2016 – June 2017

POPULATION BASED SCREENING SERVICES

More women are screened for cancer - **% of women aged 50-69 years receiving breast screening in the last 2 years**			
Financial Year Source: Breast Screen Coast to Coast	Baseline	Target	Actual to Date
OVERALL RATE			
2015/16	75.8% 24 months to October 2014	≥70%	73.4% (F) - 24 months to 31 March 2016
2016/17	74.7% 24 months to December 2015	≥70%	73.4% (F) - 24 months to 31 March 2017
MAORI			
2015/16	62.7% 24 months to October 2014	≥70%	67.9% (U) - 24 months to 31 March 2016
2016/17	68.4% 24 months to December 2015	≥70%	66.2% (U) - 24 months to 31 March 2017
PACIFIC			
2015/16	79.0% 24 months to October 2014	≥70%	67.2% (U) - 24 months to 31 March 2016
2016/17	66.5% 24 months to December 2015	≥70%	66.1% (U) - 24 months to 31 March 2017

More women are screened for cancer - **% of women aged 25–69 years who have had a cervical screening event in the past 36 months**			
Financial Year Source: Breast Screen Coast to Coast	Baseline	Target	Actual to Date
OVERALL RATE			
2015/16	76.9% 36 months to 31 December 2014	≥80%	76.6% (U) - 36 months to 30 June 2016
2016/17	75.8% 36 months to 31 December 2015	≥80%	79.6% (F) - 36 months to May 2017
MAORI			
2015/16	73.8% 36 months to 31 December 2014	≥80%	73.2% (U) - 36 months to 30 June 2016
2016/17	74.1% 36 months to 31 December 2015	≥80%	73.0% (U) - 36 months to May 2017
PACIFIC			
2015/16	72.8% 36 months to 31 December 2014	≥80%	71.4% (U) - 36 months to 30 June 2016
2016/17	71.2% 36 months to 31 December 2015	≥80%	74.8% (U) - 36 months to May 2017

Reduce the rate of Sudden Unexplained Death of Infants (SUDI) - **Rate of SUDI deaths per 1,000 live births**			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
2015/16	1.77 per 1,000 live births 2011 Calendar Year	≤0.5	1.16 (U) 2010-2014 (five year annualised)
2016/17	1.16 (U) 2010-2014 (five year annualised)	≤0.4	0.81 (U) 2011-2015 (five year annualised)

Reduce the rate of Sudden Unexplained Death of Infants (SUDI) - **% of caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1**			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
2015/16	New	New	New
2016/17	Data was expected from the Tamariki Ora Quality Improvement Framework however no new data was provided during the year. This indicator was not reported during the 2016/17 year.		

Better rates of breastfeeding - **% of infants that are exclusively or fully breastfed at 6 weeks of age** ****Although the DHB has reported the breastfeeding rates for a number a years, from 2016/17 a new combined data set of Tamariki Ora and Plunket data was used. As a result previous year's baselines are no longer comparable and for the purpose of this report have been set as new.***			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
At 6 Weeks Total:			
2015/16	New	≥75%	73% (U) - December 2014 to June 2015
2016/17	68% July 2014 to December 2014	≥75%	72% (U) - July 2015 to December 2015
At 6 Weeks Maori:			
2015/16	New	≥75%	67% (U) - December 2015 to June 2015
2016/17	58% July 2014 to December 2014	≥75%	66% (U) - July 2015 to December 2015
Better rates of breastfeeding - **% of infants that are exclusively or fully breastfed at 3 months of age**			
At 3 Months Total			
2015/16	52% 6 months to June 2015	≥60%	53% (U) - June 2015 to December 2015
2016/17	54% January 2015 to June 2015	≥60%	51% (U) – January 2016 to June 2016
At 3 Months Maori:			
2015/16	New	≥60%	39% (U) - June 2015 to December 2015
2016/17	46% January 2015 to June 2015	≥60%	39% (U) - January 2016 to June 2016

Better rates of breastfeeding - **% of infants that are exclusively or fully breastfed at 3 months of age**			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
AT 6 Month Total			
2015/16	New	≥65%	58% (U) – June to December 2015
2016/17	56% January 2015 to June 2015	≥65%	61% (U) – June to December 2016
AT 6 Months Maori			
2015/16	New	≥65%	48% (U) – June to December 2015
2016/17	46% January 2015 to June 2015	≥65%	50% (U) – June to December 2016

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Improved access primary care - % of the population enrolled in the PHO			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
TOTAL:			
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
2016/17	96.4% December 2015	≥100%	97.0% (U) - July to September 2016
			97.1% (U) – October to December 2016
			97.3% (U) – January to March 2017
			97.8% (U) - April to June 2017
MĀORI:			
2015/16	94.7% December 2014	≥97%	95.9% (U) - July to September 2015
			97.2% (F) – October to December 2015
			97.8% (F) – January to March 2016
			95.6% (U) - April to June 2016
2016/17	97.2% December 2015	≥100%	96.6% (U) - July to September 2016
			96.8% (U) – October to December 2016
			97.5% (U) – January to March 2017
			97.9% (U) - April to June 2017

Avoidable hospitalisation is reduced - Ambulatory sensitive hospitalisation rate per 100,000 0-4 years			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2015/16	New	NA	4974 - 12 months to September 2015
			4725 -12 months to March 2016
2016/17	4,725 October 2014 to September 2015	NA	5,272 - 12 months to September 2016
			4,892 -12 months to March 2017
MĀORI			
2015/16	New	NA	5599 - 12 months to September 2015
			5336 - 12 months to March 2016
2016/17	5,336 October 2014 to September 2015	NA	5,755 - 12 months to September 2016
			5,150 - 12 months to March 2017

*The way the DHB and Ministry report ASH rates has changed from previous financial years. We have included previous year's data in the same format as this year's data to allow comparison.

Avoidable hospitalisation is reduced - Ambulatory sensitive hospitalisation rate per 100,000 45-64 years			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2015/16	New	NA	3,725 - 12 months to September 2015
			3,463 -12 months to March 2016
2016/17	3,510 October 2014 to September 2015	<3,510	4,063 - 12 months to September 2016
			3,399 -12 months to March 2017
MĀORI			
2015/16	New	NA	6,536 - 12 months to September 2015
			6,433 - 12 months to March 2016
2016/17	6,310 October 2014 to September 2015	<3,510	7,801 - 12 months to September 2016
			6,802 - 12 months to March 2017

*The way the DHB and Ministry report ASH rates has changed from previous financial years. We have included previous year's data in the same format as this year's data to allow comparison.

More pregnant women under the care of a Lead Maternity Carer (LMC) - **% of women booked with an LMC by week 12 of their pregnancy**			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
TOTAL:			
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
2016/17	54.5% October to December 2015	≥80%	63.7% (U) – April to June 2016
			65.7% (U) – July to September 2016
			62.5% (U) – October to December 2016
			64.8% (U) – January to March 2017
MĀORI:			
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
2016/17	50.7% October to December 2015	≥80%	53.3% (U) – April to June 2016
			49.2% (U) – July to September 2016
			45.3% (U) – October to December 2016
			55.7% (U) – January to March 2017

Hospital service users are reconnected with primary care - **Rate of high intensive users of hospital ED as a proportion of Total ED visits**			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
TOTAL:			
2015/16	5.5% October to December 2014	≤5.4%	5.4% (F) - 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
2016/17	5.57% October to December 2015	≤5.4%	5.2% (F) - July to September 2016
			5.2% (F) – October to December 2016
			5.3% (F) – January to March 2017
			5.3% (F) - April to June 2017
MĀORI:			
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
2016/17	6.13% October to December 2015	≤5.4%	5.8% (U) - July to September 2016
			5.9% (U) – October to December 2016
			5.8% (U) – January to March 2017
			6% (U) - April to June 2017

Better oral health - % of eligible pre-school enrolments in DHB-funded oral health services			
Financial Year	Baseline	Target	Actual to Date
TOTAL:			
2015/16	73.9% 2014 calendar year	≥90%	87.1% (U) - 2015 calendar year
2016/17	73.9% 2014 calendar year	≥95%	89.2% (U) - 2016 calendar year
MAORI:			
2015/16	65.3% 2014 calendar year	≥90%	74.1% (U) - 2015 calendar year
2016/17	65.3% 2014 calendar year	≥95%	72.7% (U) - 2016 calendar year
PACIFIC:			
2015/16	71.7% 2014 calendar year	≥90%	74.2% (U) - 2015 calendar year
2016/17	71.7% 2014 calendar year	≥95%	69.1% (U) - 2016 calendar year

Better oral health - % of children who are carries free at 5 years of age			
Financial Year	Baseline	Target	Actual to Date
2015/16	56.5% 2014 calendar year	≥66%	54.4% (U) – 2015 calendar year
2016/17	54.4% 2015 calendar year	≥67%	59.0% (U) – 2016 calendar year

Better oral health - % of enrolled preschool and primary school children not examined according to planned recall			
Financial Year	Baseline	Target	Actual to Date
2015/16	4.0% 2014 calendar year	≤5%	3.7% (F) - 2015 calendar year
2016/17	4.0% 2014 calendar year	≤4.8%	2.8% (F) - 2016 calendar year

Better oral health - % of adolescents using DHB-funded dental services			
Financial Year	Baseline	Target	Actual to Date
2015/16	84.5% 2013 calendar year	≥85%	75.9% (U) – 2015 calendar year
2016/17	78.3% 2014 calendar year	≥85%	68.8% (U) – 2016 calendar year

Better oral health - Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8			
Financial Year	Baseline	Target	Actual to Date
2015/16	1.08 2014 calendar year	≤0.87	0.96 (U) – 2015 calendar year
2016/17	0.96 2015 calendar year	≤0.92	0.81 (F) – 2016 calendar year

Improved management of long-term conditions - **Proportion of people with diabetes who have good or acceptable glycaemic control**			
Financial Year	Baseline	Target	Actual to Date
TOTAL:			
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
2016/17	41.4% 12 months to December 2015	≥55%	40.8% (U) – July to September 2016
			40.3% (U) – October to December 2016
			40.1% (U) – January to March 2017
			43.0% (U) – April to June 2017
MAORI:			
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
2016/17	37.8% 12 months to December 2015	≥55%	33.8% (U) – July to September 2016
			34.8% (U) – October to December 2016
			37.6% (U) – January to March 2017
			37.0% (U) – April to June 2017
PACIFIC:			
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
2016/17	45.5% 12 months to December 2015	≥55%	52.9% (U) – July to September 2016
			53.6% (U) – October to December 2016
			52.7% (U) – January to March 2017
			33.0% (U) – April to June 2017

Improved management of long-term conditions - % of the eligible population having had a CVD risk assessment in the last 5 years			
Financial Year Source: DHB Shared Services	Baseline	Target	Actual to Date
TOTAL:			
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% (F) – 5 years to March 2016
			88.5% (U) – 5 years to June 2016
2016/17	90.3% 5 years to December 2015	≥90%	88.1% (U) – 5 years to September 2016
			87.8% (U) – 5 years to December 2016
			88.7% (U) – 5 years to March 2017
			88.2% (U) – 5 years to June 2017
MAORI			
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
2016/17	86.3% 5 years to December 2015	≥90%	84.9% (U) – 5 years to September 2016
			84.5% (U) – 5 years to December 2016
			85.3% (U) – 5 years to March 2017
			84.4% (U) – 5 years to June 2017
PACIFIC			
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
2016/17	87.0% 5 years to December 2015	≥90%	84.6% (U) – 5 years to September 2016
			84.0% (U) – 5 years to December 2016
			84.3% (U) – 5 years to March 2017
			82.7% (U) – 5 years to June 2017

Less waiting for diagnostic services - % of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2015/16	92.6% December 2014	≥95%	96.4% (F) September 2015
			84.4% (U) December 2015
			93.2% (U) March 2016
			94.6% (F) June 2016
2016/17	84.4% December 2015	≥95%	87.4% (U) September 2016
			95.1% (F) December 2016
			96.4% (F) March 2017
			95.1% (U) June 2017

Less waiting for diagnostic services - % of accepted referrals for MRI scans who receive their scans within 6 weeks			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
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
2016/17	31.0% December 2015	≥85%	52.8% (U) September 2016
			48.0 % (U) December 2016
			59.0% (U) March 2017
			69.7% (U) June 2017

More pre-schoolers receive Before School Checks - % of 4-year olds that receive a B4 School Check			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2015/16	81% April 2015	≥90%	107% (F) July 2015 to June 2016
2016/17	54% January 2015	≥90%	109% (F) July 2016 to June 2017
MĀORI			
2015/16	New	≥90%	101% (F) July 2015 to June 2016
2016/17	52% January 2015	≥90%	107% (F) July 2016 to June 2017

Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions - % of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	-
			-
			-
			-
2016/17	27%	≥95%	27% (U) – March to August 2016
			40% (U) – June to November 2016
			81% (U) – August to February 2017
			95% (F) – December to May 2017

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Less waiting for ED treatment - % of patients admitted, discharged or transferred from an ED within 6 hours			
Financial Year	Baseline	Target	Actual to Date
2015/16	91.5% – October to December 2014	≥95%	92.1% (U) – July to September 2015
			94.7% (U) – October to December 2015
			93.9% (U) – January to March 2016
			92.5% (U) – April to June 2016
2016/17	94.7% – October to December 2015	≥95%	92.4% (U) – July to September 2016
			94.7% (F) – October to December 2016
			93.8% (U) – January to March 2017
			94.7% (F) – April to June 2017

Faster cancer treatment - % of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks from Q1 2016/17			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	77.6 % October to December 2015	≥85%	65.1% (U) - April to September 2016
			63.6% (U) – July to December 2016
			71.8% (U) – October 2015 to March 2017
			77.1% (U) – January to June 2017

More elective surgery - Number of elective surgery discharges			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
NUMBER OF ELECTIVE DISCHARGES (VOLUMES)(Source: Ministry of Health)			
2015/16	6,103 2013/2014	≥7,109	7,469 (F) - July 2015 to June 2016
2016/17	6,154 2015/2015	7,374	7,467 (F) - July 2016 to June 2017

Patients with ACS receive seamless, coordinated care across the clinical pathway			
Financial Year	Baseline	Target	Actual to Date
% of high-risk patients will receiving an angiogram within 3 days of admission.			
TOTAL			
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
2016/17	68.7% October to December 2015	≥70%	56.4% (U)- July to September 2016
			71.6% (F)– October to December 2016
			64.9% (U) – January to March 2017
			65.4% (U) - April to June 2017
MAORI			
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
2016/17	60.0% October to December 2015	≥70%	38.1% (U)- July to September 2016
			61.1% (U)– October to December 2016
			65.0% (U) – January to March 2017
			69.2% (U) - April to June 2017
% of angiography patients whose data is recorded on national databases			
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% (F) - April to June 2016
2016/17	84.1% October to December 2015	≥95%	95.5% (F) - July to September 2016
			97.7% (F) – October to December 2016
			90% (U) – January to March 2017
			85.2% (U) - April to June 2017
MAORI			
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
2016/17	71.4% October to December 2015	≥95%	94.7% (F) - July to September 2016
			100% (F) – October to December 2016
			88.9% (U) – January to March 2017
			100% (F) - April to June 2017

Equitable access to care for stroke patients - % of potentially eligible stroke patients who are thrombolysed			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
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
2016/17	4.1% October to December 2015	≥6%	4.5% (U) - April to June 2016
			5.7% (U) - July to September 2016
			8.2% (F) – October to December 2016
			8.0% (F) – January to March 2017

Equitable access to care for stroke patients - % of patients admitted to the demonstrated stroke pathway			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
2015/16	82.1% October to December 2014	≥80%	69.2% (U) - July to September 2015
			78.4% (U) – October to December 2015
			84.6% (F) – January to March 2016
			90.9% (F) - April to June 2016
2016/17	78.4% October to December 2015	≥80%	90.9% (F) - April to June 2016
			84.9% (F) - July to September 2016
			83.6% (F) – October to December 2016
			82.0% (F) – January to March 2017

Equitable access to care for stroke patients - % of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
2015/16	New	New	-
			-
			-
			-
2016/17	77.4% October to December 2015	≥80%	90.9% (F) - April to June 2016
			79.0% (U) - July to September 2016
			58% (U) – October to December 2016
			71% (U) – January to March 2017

Equitable access to surgery - **Standardised intervention rates for surgery per 10,000 population for:**			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
Major joint replacement			
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
2016/17	17.6 12 months to December 2015	≥21.0	20.3 (U) – July 2015 to June 2016
			21.5 (F) – October 2015 to September 2016
			20.0 (U) – January 2016 to December 2016
			20.6 (U) - April 2016 to March 2017
Cataract procedures			
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
2016/17	51.2 12 months to December 2015	≥27.0	53.5 (F) – July 2015 to June 2016
			58.7 (F) – October 2015 to September 2016
			56.6 (F) – January 2016 to December 2016
			52.5 (F) - April 2016 to March 2017
Cardiac surgery			
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
2016/17	6.3 12 months to December 2015	≥6.5	6.4 (U) – July 2015 to June 2016
			6.6 (F) – October 2015 to September 2016
			6.3 (U) – January 2016 to December 2016
			5.9 (U) - April 2016 to March 2017
Percutaneous revascularisation			
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
2016/17	12.4 12 months to December 2015	≥12.5	13.0 (F) – July 2015 to June 2016
			13.1 (F) – October 2015 to September 2016
			13.1 (F) – January 2016 to December 2016
			12.4 (F) - April 2016 to March 2017
Coronary angiography			
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
2016/17	39.5 12 months to December 2015	≥34.7	38.4 (F) – July 2015 to June 2016
			39.0 (F) – October 2015 to September 2016
			37.5 (F) – January 2016 to December 2016
			35.1(F) - April 2016 to March 2017

Shorter stays in hospital - Average length of stay Elective (days)			
Financial Year	Baseline	Target	Actual to Date
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 2015
			1.61 (U) – April 2015 to March 2016
2016/17	1.66 days 12 months to December 2015	≤1.55 days	1.58 (F) – July 2015 to June 2016
			1.56 (F) – October 2015 to September 2016
			1.57 (F) – January 2016 to December 2016
			1.61 (U) – April 2016 to March 2017

*staggered target for this indicator. U or F refers to the staggered target at the end of each quarter

Shorter stays in hospital - Average length of stay Acute (days)			
Financial Year	Baseline	Target	Actual to Date
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 2015
			2.47 (F) – April 2015 to March 2016
2016/17	2.55 12 months to December 2015	≤2.35 days	2.49 (F) – July 2015 to June 2016
			2.48 (U) – October 2015 to September 2016
			2.42 (U) – January 2016 to December 2016
			2.5 (U) – April 2016 to March 2017

*staggered target for this indicator. U or F refers to the staggered target at the end of each quarter

Fewer readmissions - Acute readmissions to hospital			
Financial Year	Baseline	Target	Actual to Date
2015//16	NA	Reduce	NA
			NA
			NA
			NA
2016/17	7.7% 12 months to September 2015	TBC	7.5 July 2015 to June 2016
			7.3 October 2015 to September 2016
			7.3 January 2016 to December 2016
			7.2 April to 2016 to March 2017

*the Ministry of Health are currently reviewing this measure. For 2015/16 and 2016/17 the DHB was supplied results by the Ministry however the DHB was not measured against the data as the measure is still under development.

Quicker access to diagnostics - % accepted referrals for elective coronary angiography completed within 90 days			
Financial Year	Baseline	Target	Actual to Date
2015/16	92.6% December 2014	≥95%	95.8% (F) - September 2015
			78.9% (U) –December 2015
			75.6% (U) – March 2016
			100.0% (F) - June 2016
2016/17	82.4% December 2015	≥95%	100.0% (F) - September 2016
			97.7% (F) –December 2016
			92.9% (F) – March 2017
			97.2% (F) - June 2017

Quicker access to diagnostics - % of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	82.4% December 2015	≥85%	93.0% (F) - September 2016
			91.7% (F) –December 2016
			84.8% (F) – March 2017
			100% (F) - June 2017

Quicker access to diagnostics - % of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 30 days			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	New
			New
			New
			New
2016/17	100% December 2016	≥100%	100% (F) - September 2016
			100% (F) –December 2016
			100% (F) – March 2017
			100% (F) - June 2017

*this indicator was a supplementary indicator and was not reported to the Ministry or the board.

Quicker access to diagnostics - % of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	87.1% December 2015	≥70%	97.6% (F) - September 2016
			93.9% (F) –December 2016
			94.9% (F) – March 2017
			95.7% (F) - June 2017

Quicker access to diagnostics - % of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 90 days			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	New
			New
			New
			New
2016/17	100% December 2016	≥99.3%	100% (F) - September 2016
			99.1% (F) –December 2016
			100% (F) – March 2017
			100% (F) - June 2017

*this indicator was a supplementary indicator and was not reported to the Ministry or the board.

Quicker access to diagnostics - **70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date**			
Financial Year	Baseline	Target	Actual to Date
2015/16	50.7% December 2014	≥65%	88.5% (F) - September 2015
			79.3% (U) –December 2015
			96.3% (F) – March 2016
			93.5% (F) - June 2016
2016/17	79.3% December 2015	≥70%	94.6% (F) - September 2016
			98.1% (F) –December 2016
			98.1% (F) – March 2017
			98.6% (F) - June 2017

Quicker access to diagnostics - **% of people waiting for a surveillance colonoscopy will wait no longer than 120 days beyond the planned date**			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	New
			New
			New
			New
2016/17	86.2% December 2015	≥70%	97.6% (F) - September 2016
			93.9% (F) –December 2016
			84.9% (F) – March 2017
			95.7% (F) - June 2017

*this indicator was a supplementary indicator and was not reported to the Ministry or the board.

Fewer missed outpatient appointments - **Did not attend (DNA) rate across first specialist assessments**			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
TOTAL			
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
2016/17	8.1% October to December 2015	≤7.5%	7.5% (F) - July to September 2015
			6.7% (F) – October to December 2015
			5.1% (F) – January to March 2016
			5.2% (F) - April to June 2016
MAORI			
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
2016/17	14.9% October to December 2015	≤7.5%	15.4% (U) - July to September 2016
			14.2% (U) – October to December 2016
			11.8% (U) – January to March 2017
			12.3% (U) - April to June 2017

Better mental health services, Improving access, Better access to mental health and addiction services			
Financial Year Please note data is subject to change over time	Baseline	Target	Actual to Date
Child and Youth (0-19)			
TOTAL			
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
2016/17	4.07% October 2014 to September 2015	≥4.0%	4.26% (F) – October 2015 to September 2016 4.08% (F) - April 2016 to March 2017
MAORI			
2015/16	4.20% October 2013 to September 2014	≥4.0%	4.62% (F) – October 2014 to September 2015 4.93% (F) - April 2015 to March 2016
2016/17	4.62% October 2014 to September 2015	≥4.0%	4.92% (F) – October 2015 to September 2016 4.55% (F) - April 2016 to March 2017
Adult (20-64)			
TOTAL			
2015/16	5.1% October 2013 to September 2014	≥5.0%	4.94% (U) – October 2014 to September 2015 4.98% (U) - April 2015 to March 2016
2016/17	4.94% October 2014 to September 2015	≥5.0%	5.11% (F) – October 2015 to September 2016 5.35% (F) - April 2016 to March 2017
MAORI			
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
2016/17	8.75% October 2014 to September 2015	≥5.0%	9.26% (F) – October 2015 to September 2016 9.76% (F) - April 2016 to March 2017
Older Adult (65+)			
TOTAL			
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
2016/17	1.04% October 2014 to September 2015	≥1.15%	1.12% (U) – October 2015 to September 2016 1.13% (U) - April 2016 to March 2017
MAORI			
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
2016/17	0.96% October 2014 to September 2015	≥1.15%	1.19% (F) – October 2015 to September 2016 1.09% (U) - April 2016 to March 2017

Reducing waiting times 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
% of 0-19 year olds seen within 3 weeks of referral			
MENTAL HEALTH PROVIDER ARM			
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
2016/17	60.1% 12 months to December 2015	≥80%	71.2% (U) - July 2015 to June 2016
			72.3% (U) - October 2015 to September 2016
			73.2% (U) – January 2016 to December 2016
			74.8% (U) - April 2016 to March 2017
ADDICTIONS (PROVIDER ARM AND NGO)			
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% (F) - April 2015 to March 2016
2016/17	84.2% 12 months to September 2015	≥80%	81.2% (F) - July 2015 to June 2016
			81.1% (F) - October 2015 to September 2016
			81.4% (F) – January 2016 to December 2016
			69.2% (U) - April 2016 to March 2017
% of 0-19 year olds seen within 8 weeks of referral			
MENTAL HEALTH PROVIDER ARM			
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
2016/17	81.5% 12 months to September 2015	≥95%	91.2% (U) - July 2015 to June 2016
			91.7% (U) - October 2015 to September 2016
			91.9% (U) – January 2016 to December 2016
			90.9% (U) - April 2016 to March 2017
ADDICTIONS (PROVIDER ARM AND NGO)			
2015/16	96.1% 12 months to September 2014	≥95%	92.9% (U) - July 2014 to June 2015
			100% (F) - October 2014 to September 2015
			97.1% (F) – January 2015 to December 2015
			96.0% (F) - April 2015 to March 2016
2016/17	99.5% 12 months to September 2015	≥95%	92.8% (U) - July 2015 to June 2016
			94.6% (F) - October 2015 to September 2016
			95.7% (F) – January 2016 to December 2016
			90.8% (U) - April 2016 to March 2017

Improving mental health services using discharge planning - % children and youth with a transition (discharge) plan			
Financial Year	Baseline	Target	Actual to Date
2015/16	24% January 2014 to December 2014	≥95%	22.95% (U) - July to June 2015
			24.16% (U) – October 2014 to September 2015
			36.17% (U) – January 2015 to December 2015
			44.83% (U) – April 2015 to March 2016
2016/17	36.2% January 2015 to December 2015	≥95%	70.0% (U) - July to June 2016
			84.0% (U) – October 2014 to September 2016
			93.0% (U) – January 2015 to December 2016
			96.0% (F) – April 2015 to March 2017

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders - Rate of s29 orders per 100,000 population			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	97.0 October to December 2015	≤81.5	89.7 (U) - July to September 2016
			89.3 (U) – October to December 2016
			93.2 (U) – January to March 2017
			90.7 (U) - April to June 2017

Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)			
Financial Year	Baseline	Target	Actual to Date
75-79 Years			
2015/16	139.2 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
2016/17	136.5 January 2015 to December 2015	≤139.5	120.1 (F) - October 2015 to September 2016
			124.0 (F) – January 2016 to December 2016
			135.1 (F) – April 2016 to March 2017
			139.4 (F) - July 2016 to June 2017
80-84 Years			
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
2016/17	178.9 October to December 2015	≤183.1	176.8 (F) - October 2015 to September 2016
			167.8 (F) – January 2016 to December 2016
			164.9 (F) – April 2016 to March 2017
			170.6 (F) - July 2016 to June 2017
85+ Years			
2015/16	254 October to December 2014	≤231.0	231.5 (U) - October 2015 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
2016/17	229.2 October to December 2014	≤231.0	216.3 (F) - October 2015 to September 2016
			216.6 (F) – January 2016 to December 2016
			218.3 (F) – April 2016 to March 2017
			216.9 (F) - July 2016 to June 2017

Better community support for older people - Acute readmission rate: 75 years +			
Financial Year	Baseline	Target	Actual to Date
2015//16	NA	Reduce	NA
			NA
			NA
			NA
2016/17	11.1% 12 months to September 2015	<10%	10.2 July 2015 to June 2016
			10.1 October 2015 to September 2016
			10.2 January 2016 to December 2016
			10.1 April to 2016 to March 2017

*the Ministry of Health are currently reviewing this measure. For 2015/16 and 2016/17 the DHB was supplied results by the Ministry however the DHB was not measured against the data as the measure is still under development.

Better community support for older people - % of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	100% October to December 2015	≥95%	100% (F) April to June 2016
			100% (F) July to September 2016
			100% (F) October to December 2017
			100% (F) January to March 2017

Better community support for older people - Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	-
			-
			-
			-
2016/17	63% October 2015 to December 2015	≥77%	83% (F) - July to September 2016
			77% (F) - October to December 2016
			83% (F) - January to March 2017
			89% (F) - April to June 2017

Better community support for older people - The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	-
			-
			-
			-
2016/17	-	Improve on Current Performance	78% - July to September 2016
			85% - October to December 2016
			69% - January to March 2017
			88% - April to June 2017

Increased capacity and efficiency in needs assessment and service coordination services - Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment			
Financial Year	Baseline	Target	Actual to Date
2015/16	New	New	-
			-
			-
			-
2016/17	13.8% October 2015 to December 2015	<13.8%	11% (F) - July to September 2016
			10% (F) - October to December 2016
			7.0% (F) - January to March 2017
			9% (F) - April to June 2017

Prompt response to palliative care referrals - **Time from referral receipt to initial Cranford Hospice contact within 48 hours**			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	91.0% October to December 2015	≥80%	99.0% (F) – July to September 2015
			100% (F) - October to December 2015
			86.0% (F) – January to March 2016
			94.0% (F) – April to June 2016

More day services - **Number of day services**			
Financial Year	Baseline	Target	Actual to Date
2014/15	20,754 July 2013 to June 2014	≥21,791	21,546 (U) – July 2015 to June 2016
2016/17	21,546 July 2015 to June 2016	≥21,791	13,264 – July 2016 to March 2017

More older patients receive falls risk assessment and care plan - **% of older patients given a falls risk assessment**			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	90.5% October to December 2015	≥90%	100% (F) – July to September 2016
			96.7% (F) - October to December 2016
			93.0% (F) – January to March 2017
			97.9% (F) – April to June 2017

More older patients receive falls risk assessment and care plan - **% of older patients assessed as at risk of falling receive an individualised care plan**			
Financial Year	Baseline	Target	Actual to Date
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
2016/17	78.4% October to December 2015	≥98%	99.3% (F) – July to September 2016
			98.0% (F) - October to December 2016
			93.9% (U) – January to March 2017
			88.9% (U) – April to June 2017

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