HAWKE'S BAY
District Health Board
Whakawateatia

ANNUAL REPORT 2014

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ACRONYMS USED IN THIS REPORT

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

TECHNICAL REFERENCE SOURCES

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

Message from the Chair and Chief Executive

We have celebrated many successes and faced many challenges in the 2013/14 year; a major achievement has been developing a five year strategic vision, Transform and Sustain.

Transform and Sustain is about thinking and working differently, having the time and tools to do this and doing this as one health system. As a health sector we need to work together and act as one rather than as a district health board, a hospital, a PHO or general practice.

Without a clear vision for the future it would be difficult to meet the challenges facing the demands on the health sector.

In the community we have been working hard to develop clinical care pathways to improve our patient's journey district nurses are now closely linked to our GP partners, we have signed off more investment in community services for older people and we have assigned a Health Equity champion to focus on reducing health inequities in our community. The first Health Equity report for this region will be produced later this year and will give us a clear look at where further challenges lie.

This year we completed and officially opened the new Wairoa Health Centre, began work on the new $20 million Mental Health Unit and completed the new Renal Unit at Ballantyne House on the Hawke's Bay Hospital campus. We have also reinvested in two new CT scanners.

Our community can be pleased we met our elective target, which has meant more than 6000 people have had access to publicly funded elective surgery in Hawke's Bay in the past year. A focus for the 2014/15 year will be further work on improving theatre productivity and flexibility so we can meet the increasing demand on this service.

Throughout the year our immunisation services continued to target completion of all scheduled immunisations at 24 months of age and we ended the year meeting or exceeding the national immunisation Health Targets for both Māori and non-Māori effectively eliminating previous inequities.

A unique health issue for Hawke's Bay is the exceptionally high incidence of acute rheumatic fever in our Flaxmere community. Our Say Ahh awareness campaign focuses on children and youth and quick treatment after a positive swab. For the seven quarters to June 2014 everyone who had a positive swab was treated well within the targeted limit of five days.

Smoking remains one of the leading causes of deaths and disability in New Zealand. The national health target Better Help for Smokers to Quit aims to increase the number of times quit advice is offered in health settings. For hospitalised patients the DHB consistently achieves the target of 95 percent of hospitalised smokers being provided advice to quit. Our focus in the coming year will be to support our primary care partners improve their rates of providing smoke free advice to patients.

We continue to respond to the needs of our ageing population and recognise that better coordination of services across community, primary care and hospital settings is needed to support people to live independently at home for longer or access appropriate high quality services.

A summary of our successes and progress against our key performance measures is provided in the statement of service performance section of this our 2014 Annual Report; while we are pleased with progress through the year we also recognise that much remains to be done.

We take this opportunity to thank our staff and our health and social service sector partners for their contribution in the past year without which we would not have been able to post a significant surplus of $3.2 million, which will be reinvested in health services for our community.

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

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

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

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

Chatham Islands Health Centre
PO Box 21
Chatham Islands
Phone: 03 305 0035

Hawke's Bay DHB vision, values and structure

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

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

Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do

Hawke's Bay District Health Board

Board Chair Kevin Atkinson

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

Hawke's Bay District Health Board

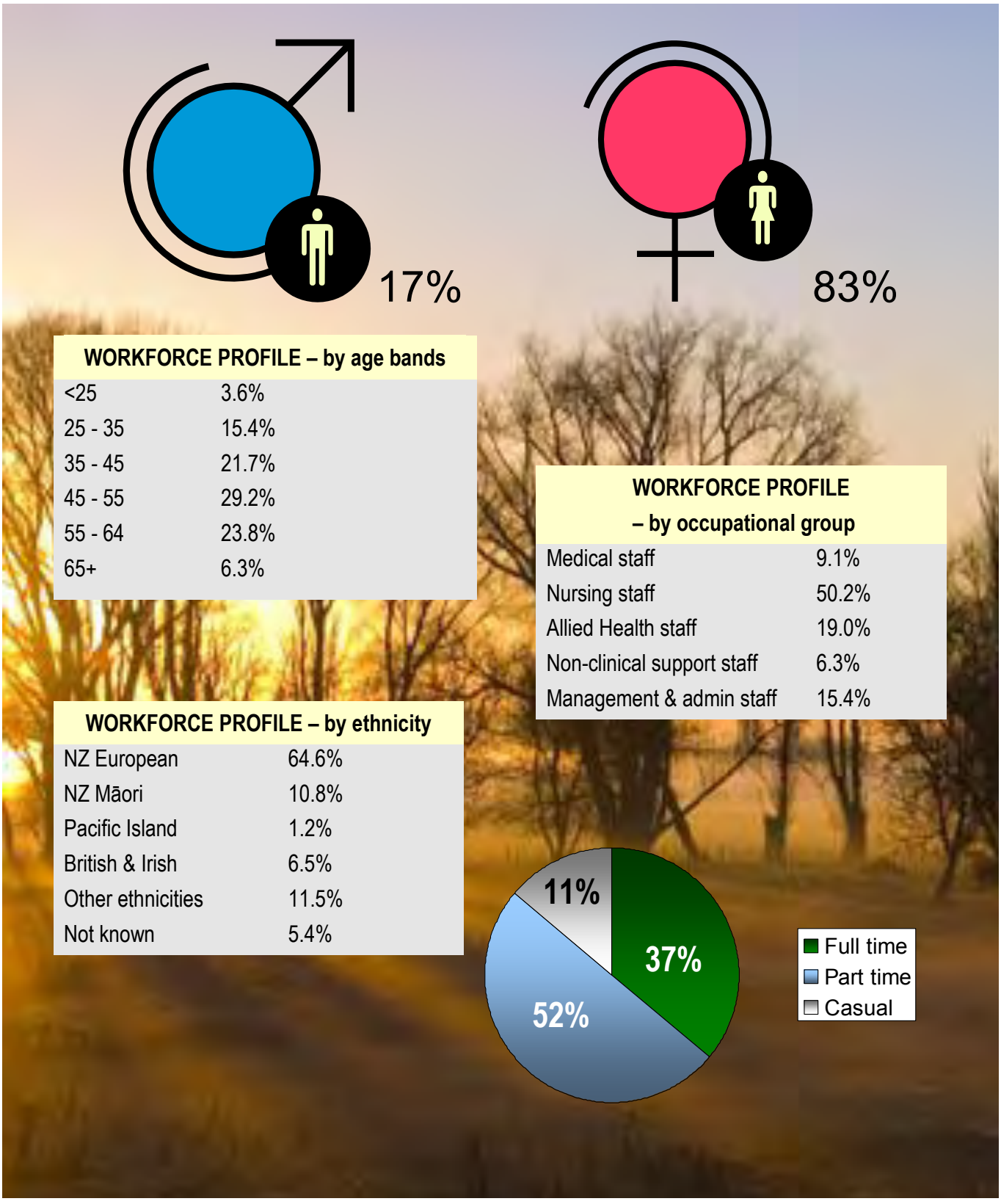
Chief Executive Dr Kevin Snee

Chief Operating Officer
General Manager Integrated Care Service
Director of Population Health / Health Equity Champion
General Manager Human Resources
Chief Financial Officer
General Manager Māori Health
Director Quality Improvement and Patient Safety
Company Secretary

Other members of the Executive Team:
- **Chief Executive Officer Health Hawke's Bay PHO**
- **Director of Allied Health**
- **Chief Medical Officer – Primary**
- **Chief Medical Officer – Hospital**
- **Chief Nursing Officer**
- **Service Quality Improvement Project Manager**

About Hawke's Bay District Health Board

The DHB currently employs **2521** people, a number of whom are multi-jobbed; with **2761** positions held throughout the organisation. Of these **2761** positions:



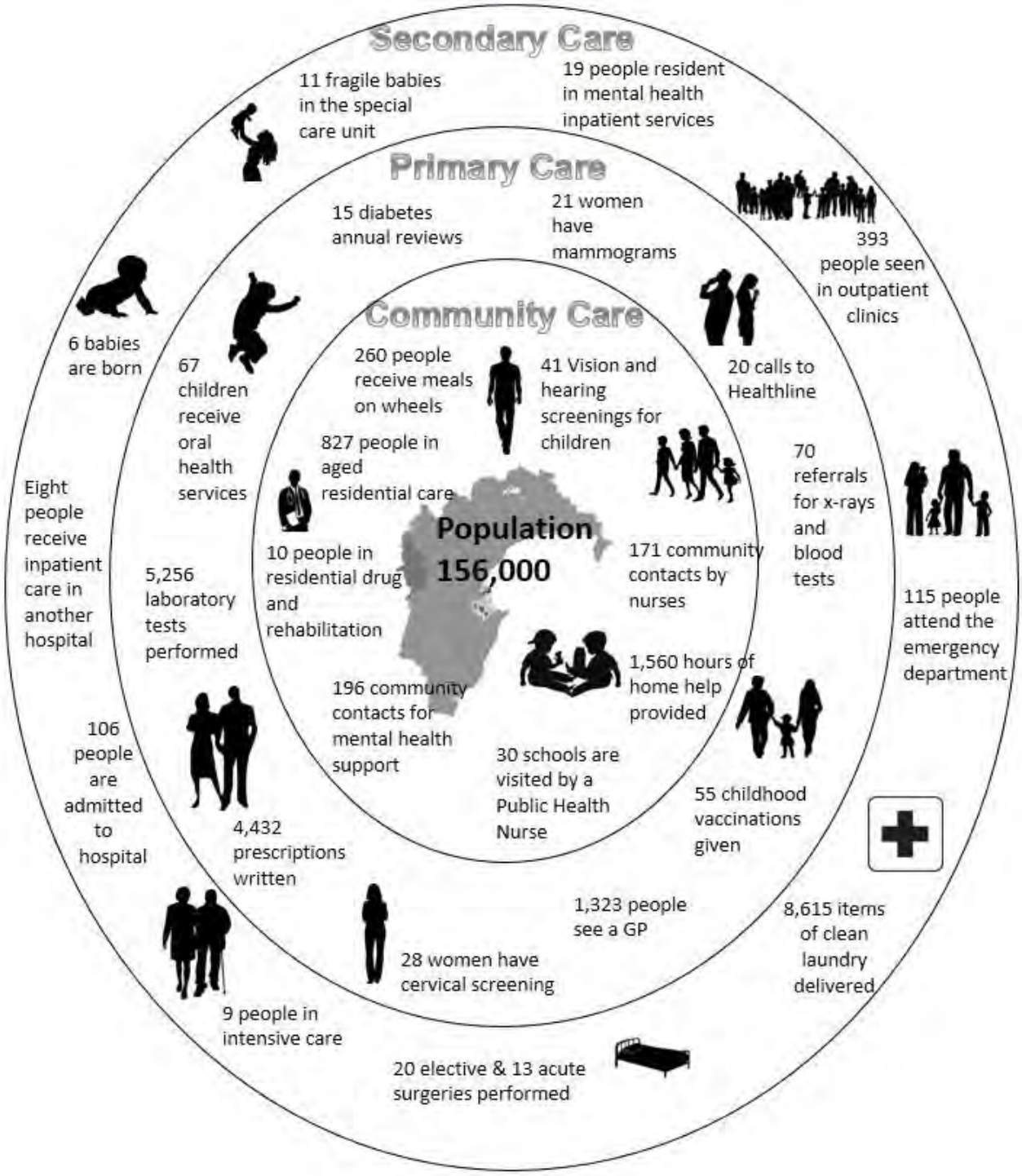
WORKFORCE PROFILE – by age bands	
<25	3.6%
25 - 35	15.4%
35 - 45	21.7%
45 - 55	29.2%
55 - 64	23.8%
65+	6.3%

WORKFORCE PROFILE – by occupational group	
Medical staff	9.1%
Nursing staff	50.2%
Allied Health staff	19.0%
Non-clinical support staff	6.3%
Management & admin staff	15.4%

WORKFORCE PROFILE – by ethnicity	
NZ European	64.6%
NZ Māori	10.8%
Pacific Island	1.2%
British & Irish	6.5%
Other ethnicities	11.5%
Not known	5.4%

Every day the Hawke's Bay District Health Board spends $1.32 million.

Here's some everyday activity that this funding supports...



Report on good employer obligations

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

Current 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.

In December 2013 and following months of discussion and consultation a five year strategy to transform and sustain the Hawke's Bay health system was released. The document put a framework in place to improve performance and develop a culture of cooperation and collaboration across the sector. Underpinning the Transform and Sustain agenda is an organisational development programme to support the workforce so they are highly skilled, empowered and enabled to fulfil their roles.

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

- Clinician and manager partnerships
- Clinical leadership and engagement
- Transformational management and leadership capability
- Staff engagement, health and wellbeing
- High-performing teams –including re-skilling and up-skilling of staff
- Building capability – developing talent, succession planning and recruitment
- Increasing Māori staff representation
- Union engagement

Leadership, Accountability and Culture:
Investing in its people and developing leadership capability, remains a priority for Hawke's Bay DHB. Leadership is visible, and celebrated, through monthly executive briefings, monthly CEO report to all staff, annual Hawke's Bay health sector awards and through Transformational Leadership and Basics Management programmes.

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 members have diverse backgrounds, skills and interests including women's health, alcohol and other drugs, sensory and physical disability, intellectual disability, rural health, Māori health and Pacific health, 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.

In October 2013 and following wide consultation the Chief Executive and clinical leadership structure was changed to ensure clinician/manager service partnerships were embedded at every level of the organisation and across the sector. The new structure better aligns corporate planning and intelligence processes, provides clarity, accountability and improved efficiency of the clinician/manager service partnerships, supports medical, nursing and allied health leaders to have more time to lead and drive up clinical quality and improve patient safety and puts greater focus on integration across primary and secondary care through clinical integration .

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

Hiring mangers are supported through the recruitment and on-boarding process to ensure efficiency and consistency of recruitment. Every quarter a series of HR foundations training programmes are made available for managers, team leaders , clinical leaders and staff to attend, The four modules focus on: Recruitment, Selection and Onboarding; Performance Appraisals; Leave Management and Performance Management/Disciplinary Processes.

Employee Development, Promotion and Exit:
HBDHB has a fair and equitable performance appraisal system in place which is supported by our policies. The Employment Relations Act, and Health and Safety in Employment Amendment Act 2002 continue to reinforce the need to maintain strong relationships with employees and unions. The Union Bipartite Committee continues to be the forum to discuss common issues.

The DHB's performance appraisal process is well documented and available to all staff on its intranet. Training sessions for managers are run bi annually 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. Approximately 42,000 hours of training are directly delivered by the DHB each year. This is in multiple forms including face to face, assessments and online learning through our new system, Ko Awatea. This blended approach provides HBDHB greater ability to provide training opportunities which are more effective and efficient for our clinical and non clinical staff.

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

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

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

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

HBDHB has a number of communication medium which are delivered to all staff and key local health sector leaders which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through regular 'Our People" articles, monthly chief executive In Focus newsletter, regular manager updates/ team cascade brief 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:

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

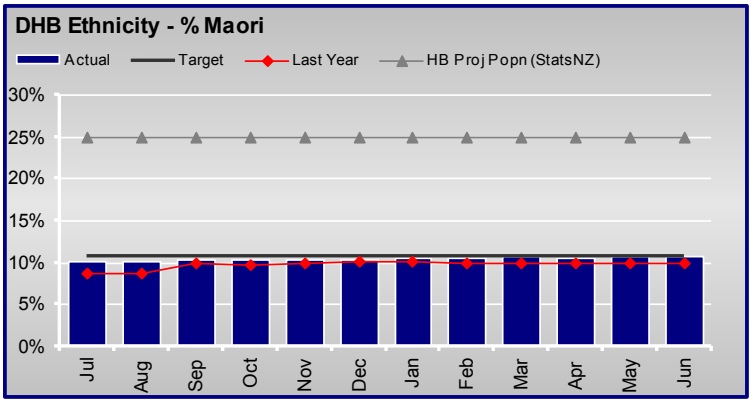
HBDHB maintains entry into the ACC partnership programme at tertiary level which recognises that appropriate systems support a safe environment and are implemented throughout the organisation. HBDHB retains its tertiary status as an outcome of the last audit.

The DHB's Occupational Health and Safety team run a staff wellness programme with a cycle of monthly themed events such as Heat it Up (exercised challenge), Spring into Wellness (focus on individual wellness) and the FISH philosophy (creating a great day and a happy workplace).

Staff Ethnicity:

Increasing the number of Māori employees is a priority for HBDHB. A KPI measuring the number of positions where incumbents identify as Māori is reported the DHB's Board on a quarterly basis. The target is set at 10% improvement on previous year with the ultimate aim that the percent Māori more closely reflect the overall Hawke's Bay population mix where it is estimated the Māori population for Hawke's Bay is 25.0%.

As at the end of the 2013/14 year the target of 11.78% of staff identifying as Māori was not reached although there had been a significant improvement on the previous year being as at June 2014 10.83 percent Māori compared to June 2013 9.94 percent .



Ethnicity breakdown as at June 2014	
	% of Total
NZ European	64.6%
NZ Māori	10.8%
Pacific Island	1.2%
British & Irish	6.5%
Other	11.5%
Not known	5.4%
Total	**100%**

- Support staff (28.16%) and Management & Admin staff (14.55%) exceed the DHB target.
- Allied Health (10.48%) is near the DHB target
- Medical (1.60%) and Nursing staff (9.31%) are below the target. Nursing has been the primary focus for recruitment and has increased from 8.1% to 9.3% in the last year.

What are the health trends of our population?

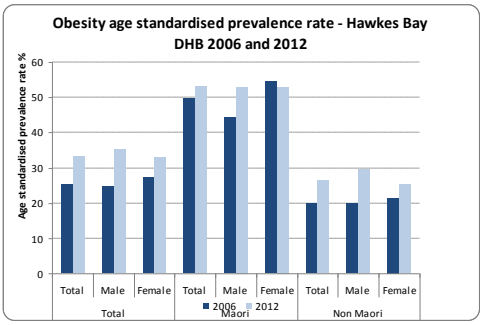
An overview of trends in some of Hawke's Bay District Health Board's main measures[1] as reported in the 2013-16 Statement of Intent[2]

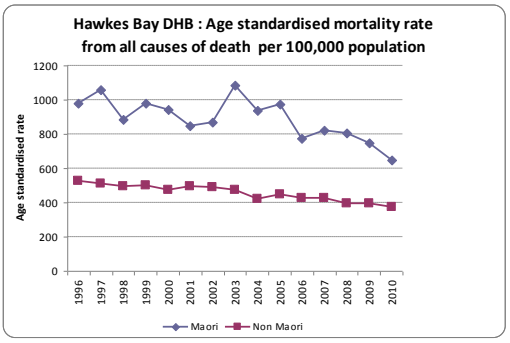
Outcomes

The selection of indicators used to monitor progress towards our intended outcomes is guided by national and regional strategic planning and by HBDHB's own health needs assessment at the district level.

- Using mortality information from the years 2008-2010, we can show that life expectancy for Hawke's Bay residents, at 77.7 years for males and 82.3 years for females, was almost on a par with comparative New Zealand rates. In both groups, a gender gap of almost 4 years exists with females having longer life expectancy. Locally, further analysis of the comparison between Hawke's Bay Māori and Hawke's Bay non-Māori shows a difference of over 8 years for males and over 7 years for females, with Māori life expectancy being shorter. We have a very strong focus on improving Māori health as a key strategy for reducing health inequity. Making a difference to life expectancy can take many years to effect but we expect the time series we are developing with next year's post-census data to show that a reduction of the disparity is occurring.

- Obesity rates are measured via the New Zealand Health Survey. Across New Zealand and in Hawke's Bay there is a worrying trend of increasing obesity prevalence.





- Between 2001 and 2010 there was an encouraging reduction in the rate of all cause mortality in Hawke's Bay. Despite a reduction in the inequity, ongoing disparity between the Māori and non-Māori rate continues to be a significant concern and a driver of targeted services.

- We are unable to continue reporting on the number of working age people claiming sickness benefits because the agency that provided the information no longer collects the data in the way that we were using it. We will redefine our indicator of independence and participation in our next Statement of Intent.

Impacts

Impacts are the links between outcomes and outputs. There is often no single measure for the impact of the work undertaken and so population health trends are used to measure success.

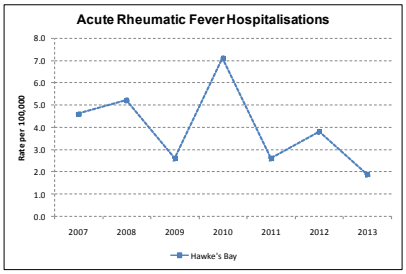
[1] Main measures are population health indicators that we use to assess the outcomes and impact of our work. Most of these indicators take some time to influence as they are the result of effort from a number of sources. Measurement is often somewhat delayed as it relies on national surveys, census data and official mortality statistics, for example.

[2] Technical references are provided in the preface

An overview of trends in some of Hawke's Bay District Health Board's main measures[1] as reported in the 2013-16 Statement of Intent[2]

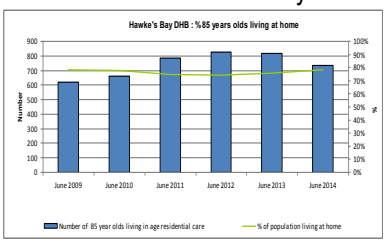
- Smoking is a major risk factor for many chronic health issues. There are several local and national initiatives aimed at reducing the prevalence of smoking and there has been a steady decline for a number of years. There has been a declining prevalence in the Total population for at least 17 years and the 2013 census has confirmed that Māori rates are now declining too. This is very encouraging.
- Putting people in hospital is one way of managing illness but, as science and technology advance, there is an expectation that more and more illness will be managed without resorting to hospitalisation. Ambulatory sensitive hospitalisation (ASH) rates are indicative of how well the whole system works to keep people out of hospital. ASH is a measure of those hospitalisations that are considered to be most responsive to preventative interventions or by better management of patients in the community. A snapshot of rates since the 2009/10 financial year shows that:
    - the rate (per 100,000 people) for all Hawke's Bay 0-74 year olds has dropped 14% from 2,156 to 1,861; the corresponding rate for Maori dropped 16% from 3,490 to 2,935;
    - the rate (per 100,000 people) for 0-4 year olds decreased by 27% for the Total population (from 5,838 to 4,234) and by 34% the Maori population (from 8,659 to 5,747)

We will continue to focus on shifting services out of the hospital environment and into the community in line with the Government's "better, sooner, more convenient" policy. A number of initiatives aimed at integration are in progress and we are confident that these initiatives will continue to impact positively on ASH rates and on reducing the inequity. Continuing to monitor ASH rates will show us when we are succeeding in achieving this important aspect of patient care in Hawke's Bay.



- Because of comparatively high rates of acute rheumatic fever in Hawke's Bay, we have been running a focussed rheumatic fever prevention programme for a number of years. We can see the success of that programme from the rate of ARF hospitalisations which have dropped from 4.3 per 100000 in 2007 to 1.9 per 100000 by the end of calendar year 2013.

- The number of Hawke's Bay residents over the age of 85 living in aged residential care decreased by 10.5% in the year to June 2014. The proportion being supported to remain at home therefore rose - based on available population information, the rate at June 2014 was 78% compared to 75% a year earlier.



Hawke's Bay District Health Board Governance

Role of the Board

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

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

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

Role of the CEO

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

Statutory Advisory Committees

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

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

Apart from these collective meetings, these three committees do not routinely meet, with the HBDHB Board obtaining stakeholder and community input and advice directly from the Māori Relationship Board, Hawke's Bay Clinical Council and the Hawke's Bay Health Consumer Council.

Advisory Committees – other

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

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

Meeting Information & Disclosure of Interests

Number of Board Meetings held 11

KEVIN ATKINSON – Chair
Meetings attended 9 of 11
Chairman, Unison Networks Limited
Director, Unison Fibre Limited
Trustee, HB Medical Research Foundation
Director, Hawke's Bay Rugby Football Union
Principal Shareholder / MD of Information Management Services Limited
Trustee Te Matau ā Māui Health Trust

NGAHIWI TOMOANA - Deputy Chair
Meetings attended 8 of 11
Chairman – Ngati 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
Husband David Arnott – Maxillofacial Surgeon
Trustee of the Hawke's Bay Air Ambulance Trust
Mayor of Napier City (until 9 December 2013)

DAVID BARRY (until 9 December 2013)
Meetings attended 5 of 5
Medical Director and member of the Council of the Hawke's Bay Medical Research Foundation
Patron and Medical Advisor – Asthma Hawke's Bay

DAVID DAVIDSON (until 9 December 2013)
Meetings attended 5 of 5
Family Trust holds shares in Wakefield Health Limited

PETER DUNKERLEY
Meetings attended 11 of 11
Trustee – Hawke's Bay Helicopter Rescue Trust (until 31 July 2013 and reappointed 15 May 2014)

HELEN FRANCIS
Meetings attended 11 of 11
Committee member of Alzheimers Society Napier (until 21 June 2014)
Patron and Lifetime member of Alzheimers Society Napier (from 21 June 2014)
Employee of Hastings Health Centre
Trustee Hawke's Bay Power Consumers' Trust

DIANA KIRTON
Meetings attended 11 of 11
Assistant Head of School – EIT School of Health and Sport Science (until 16 January 2014)
Practim Manager – EIT School of Health and Sport Science (from 16 January 2014)
Manager in charge of Hauora Programme (until 26 February 2014)
EIT Representative on Turuki Steering Committee (until 26 February 2014)
Husband CEO of the Cancer Society, Central District (from 1 June 2013)
Son GP in Wairoa (from 26 February 2014)
Daughter in Law Paediatric Registrar at HBDHB (from 26 February 2014)
Son Medical Registrar at HBDHB, on Short Term Contract for July (from 30 June 2014)
Brother is a surgeon for HBDHB

DAN DRUZIANIC
Meetings attended 11 of 11
Director Markhams Hawke's Bay Limited
Director of Hawke's Bay Rugby Football Union (HBRFU)

DENISE EAGLESOME
Meetings attended 10 of 11
Deputy Mayor of Wairoa District Council
Trustee Te Matau ā Māui Health Trust (from 5 March 2014)

KIRSTEN WISE (until 9 December 2013)
Meetings attended 3 of 5
Director of Black & White Accounting Limited

ANDREW BLAIR (from 9 December 2013)
Meetings attended 6 of 6
Beneficial shareholder of Acurity Heatlh Limited
Owner of Andrew Blair Consulting Limited

JACOBY POULAIN (from 9 December 2013)

Meetings attended 5 of 6
Board Member of Eastern Institute of Technology
Councillor Hastings District Council
Columnist for Hawke's Bay Today

HEATHER SKIPWORTH (from 9 December 2013)
Meetings attended 6 of 6
Mother Kaumatua – Kaupapa Māori HBDHB
Trustee of Te Timatanga Ararau Trust

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)

Number of DSAC and Combined Committee Meetings held 1

Diana Kirton – Chairperson
Meetings attended 1 of 1
Refer Board interests disclosed

Helen Francis
Meetings attended 1 of 1
Refer Board interests disclosed

Denise Eaglesome
Meetings attended Nil
Refer Board interests disclosed

David Davidson (until 9 December 2013)
Meetings attended 1 of 1
Refer Board interests disclosed

Barbara Arnott (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Kevin Atkinson (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Ngahiwi Tomoana (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Dan Druzianic (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Peter Dunkerley (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Andrew Blair (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Jacoby Poulain (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Heather Skipworth (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Heather Campbell (until 18 December 2013)
Meetings attended 1 of 1
Manager at WIT (Whatever it Takes) organisation funded by the HBDHB
Sister is employee of HBDHB

Laureen Sutherland (until 18 December 2013)
Meetings attended Nil
Operations / Quality Manager ACW Ltd
Board Member of Napier Masonic District Trust
Executive Member, NZ Aged Care Association HB Branch
Committee Member, EIT School of Nursing Advisory
Aged Care representative for
Employers Chamber of Commerce Central (ECCC) HB Branch (from 28/9/11)

Dianne Walsh (until 18 December 2013)
Meetings attended 1 of 1

Andy White (until 18 December 2013)
Meetings attended Nil

Terry Kingston (until 18 December 2013)
Meetings attended Nil
Elected Member of CHB District Council

Tatiana Cowan-Greening (until 18 December 2013)
Meetings attended Nil
Refer to MRB interests disclosed

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

Number of CPHAC and Combined Committee Meetings held 1.

Barbara Arnott - Chairperson
Meetings attended 1 of 1
Refer Board interests disclosed

Helen Francis
Meetings attended 1 of 1
Refer Board interests disclosed

Peter Dunkerley
Meetings attended 1 of 1
Refer Board interests disclosed

Ngahiwi Tomoana
Meetings attended Nil
Refer Board interests disclosed

Diana Kirton
Meetings attended 1 of 1
Refer Board interests disclosed

Kevin Atkinson (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Dan Druzianic (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Andrew Blair (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Jacoby Poulain (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Heather Skipworth (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Graeme Norton (until 18 December 2013)
Meetings attended 1 of 1
Director/Shareholder, 3R Group Limited
Deputy Chair, NZ Sustainable Business Council
Chair, HB Diabetes Leadership Team
Chair, Advisory Group, NZ Life Cycle Management Centre
Chair, Hawke's Bay Health Consumer Council

Di Petersen (until 18 December 2013)
Meetings attended 1 of 1
Chair, Central Hawke's Bay Mayoral Health Taskforce
Trustee, CHB Health Nominees (CHB Health Centre Building)
Member, HB Medical Research Council
Trustee, CHB District Community Trust
Chair Lotteries HB Distribution Committee

Joan Sye (until 18 December 2013)
Meetings attended 1 of 1
Assistant Parent Educator, Parentcraft
Son is an independent Physiotherapist in Napier
Daughter in law is a physiotherapist (HBDHB)

John Newland (until 18 December 2013)
Meetings attended Nil
Director Health Hawke's Bay Limited
Director of Direct Imports Limited
Director of Marist Holdings Limited – Mission Wines
Chair of Hawke's Bay Power Consumer Trust

Bayden Barber (until 18 December 2013)
Meetings attended Nil
Director of Health Hawke's Bay Limited
Contracted to Nga Kairauhii Trust
Trustee of He Pataka Hawora Trust

Tatiana Cowan-Greening (until 18 December 2013)
Meetings attended Nil
Refer to MRB interests disclosed

Amber Logan-Riley (until 18 December 2013)
Meetings attended Nil
Refer to MRB interests disclosed

HOSPITAL ADVISORY COMMITTEE (HAC)

Number of HAC and Combined Committee Meetings held 1

David Barry – Chairperson (until 9 December 2013)
Meetings attended 1 of 1
Refer Board interests disclosed

David Davidson (until 9 December 2013)
Meetings attended 1 of 1
Refer Board interests disclosed

Kirsten Wise (until 9 December 2013)
Meetings attended 1 of 1
Refer Board interests disclosed

Dan Druzianic
Meetings attended 1 of 1
Refer Board interests disclosed

Kevin Atkinson
Meetings attended 1 of 1
Refer Board interests disclosed

Ngahiwi Tomoana (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Barbara Arnott (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Diana Kirton (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Peter Dunkerley (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Denise Eaglesome (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Diana Kirton (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Andrew Blair (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Jacoby Poulain (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Heather Skipworth (from 18 December 2013)
Meetings attended Nil
Refer Board interests disclosed

Eileen Page (until 18 December 2013)
Meetings attended 1 of 1
Consultant and Coach in professional life

Des Ratima (until 18 December 2013)
Meetings attended Nil
Refer to MRB interests disclosed

Amber Logan-Riley (until 18 December 2013)
Meetings attended Nil
Refer to MRB interests disclosed

Membership of Advisory Committees - other

MAORI RELATIONSHIP BOARD (MRB)

Number of MRB and Annual Planning Meetings held 6.

Ngahiwi Tomoana – Chairperson
Meetings attended 4 of 6
Refer Board interests disclosed

Denise Eaglesome
Meetings attended 3 of 6
Refer Board interests disclosed

Helen Francis
Meetings attended 5 of 6
Refer Board interests disclosed

Peter Dunkerley (until 18 December 2013)
Meetings attended 4 of 4
Refer Board interests disclosed

Heather Skipworth (from 18 December 2013)
Meetings attended 2 of 2
Refer Board interests disclosed

Tatiana Cowan-Greening
Meetings attended 6 of 6
Ngati Kahungunu Iwi Inc representative
Trustee, Te Matau a Maui Health Trust
Husband is Manager of Te Kupenga Hauora

Kerri Nuku
Meetings attended 5 of 6
Ngati Kahungunu Iwi Inc representative
Kaiwhakahaere New Zealand Nurses Association
Director Hei Nursing
Trustee of Maunga Haruru Tangitu Trust

Des Ratima
Meetings attended 3 of 6
Representative of Ahuiriri District Heatlh (Wai 692)
Chairperson, Ahuriri District Health Trust
Chairperson, Te Whanantahi Trust
Chairperson, Takitimu Māori Wardens Trust

Les Hokianga (until 26 February 2014)
Meetings attended 2 of 4
Ngati Kahungunu Iwi Inc representative

Amber Logan-Riley (until 26 February 2014)
Meetings attended Nil of 4
Ngati Kahungunu Iwi Inc representative
Contractor – Kahungunu Hikoi Whenua

Frances Smiler Edwards (until 26 February 2014)
Meetings attended Nil of 4
Ngati Kahungunu Iwi Inc representative
General Manager of Te Roopu Hiuhuinga Hauora
Chairperson of Hauora Provider Council

Trish Giddens (from 26 February 2014)
Meetings attended 2 of 2
Ngati Kahungunu Iwi Inc representative
Manager Services to Older People, Waiapu Anglican Social Services
Trustee, HB Air Ambulance Trust
Contractor Te Taitimu Trust

Patrick LeGeyt (from 26 February 2014)
Meetings attended 2 of 2
Ngati Kahungunu Iwi Inc representative
Employee of Te Taiwhenua o Heretaunga
Trustee of Omahu Marae
Wife works for Central Health

Na Raihania (from 26 February 2014)
Meetings attended 2 of 2
Ngati Kahungunu Iwi Inc representative
Wife employed at Te Taiwhenua o Heretaunga

George Mackey (from 26 February 2014)
Meetings attended 2 of 2
Ngati Kahungunu Iwi Inc representative
Trustee of Te Timatanga Arararau Trust
Wife employed at Te Timatanga Ararau Trust

Lynlee Aitcheson (from 26 February 2014)
Meetings attended 2 of 2
Ngati Kahungunu Iwi Inc representative
Chair of Maori Party, Heretaunga Branch

FINANCE RISK AND AUDIT COMMITTEE (FRAC)

Number of FRAC Meetings held 11

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

Kevin Atkinson
Meetings attended 9 of 11
Refer Board interests disclosed

Barbara Arnott
Meetings attended 10 of 11
Refer Board interests disclosed

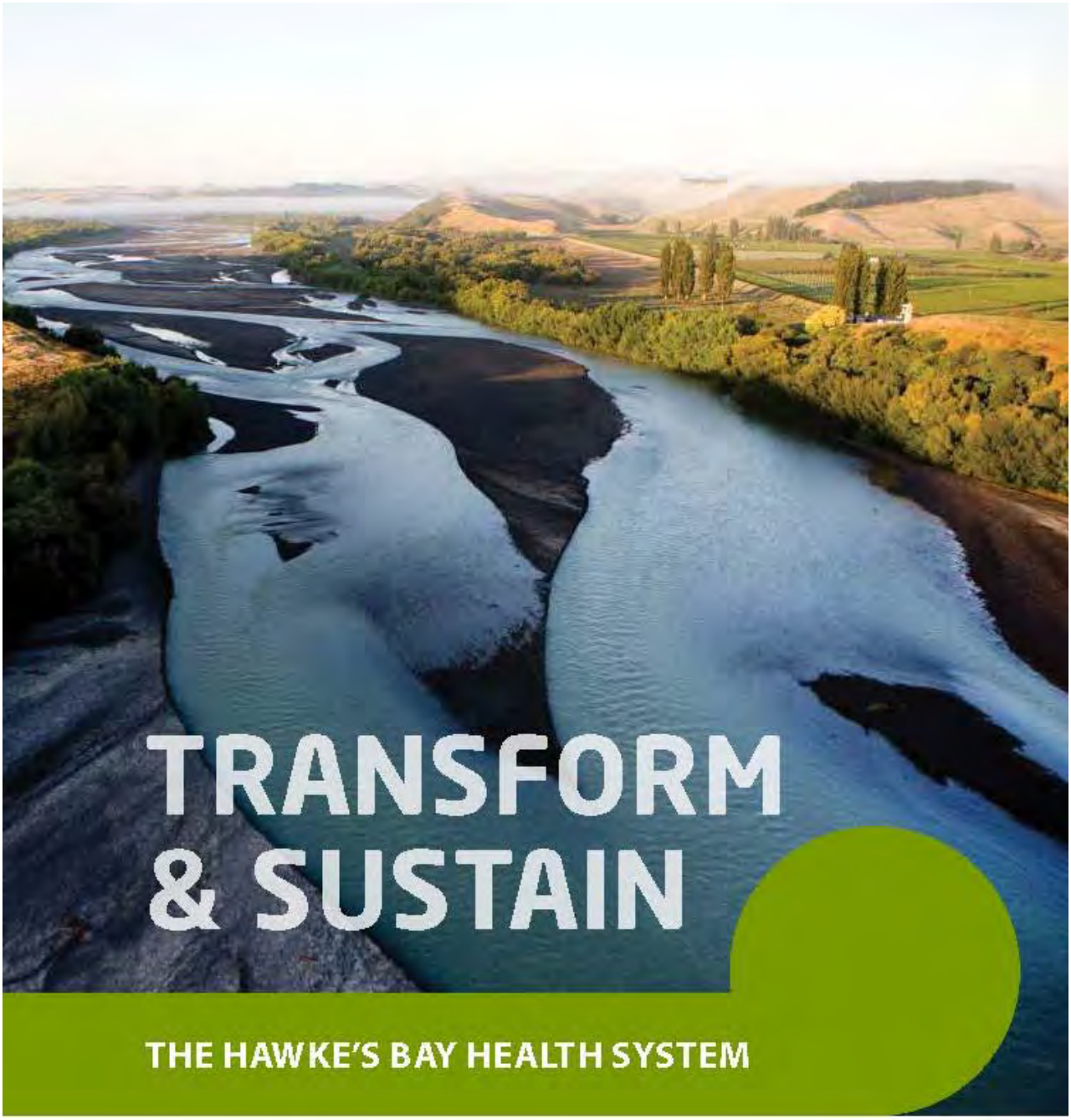
Peter Dunkerley
Meetings attended 11 of 11
Refer Board interests disclosed

David Barry (until 9 December 2013)
Meetings attended 6 of 6
Refer Board interests disclosed

Kirsten Wise (until 9 December 2013)
Meetings attended 4 of 6
Refer Board interests disclosed

Andrew Blair (from 9 December 2013)
Meetings attended 5 of 5
Refer Board interests disclosed

Jacoby Poulain (from 9 December 2013)
Meetings attended 4 of 5
Refer Board interests disclosed



THE NEXT FIVE YEARS

DECEMBER 2013

OURHEALTH
HAWKE'S BAY

Statement of Responsibility

The board and management of Hawke's Bay District Health Board accept responsibility 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 accepts responsibility 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 2014, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

Kevin Atkinson
Chair

Dan Druzianic
Board Member

28 October 2014

Independent auditor's report

To the readers of
Hawkes's Bay District Health Board
financial statements and performance information
for the year ended 30 June 2014

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

We have audited:

- the financial statements of the Health Board on pages 54 to 96, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board that comprises the statement of service performance on pages 27 to 51 and the report about outcomes on pages 97 to 115.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 54 to 96:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
    - financial position as at 30 June 2014; and
    - financial performance and cash flows for the year ended on that date.

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

Reason for our qualified opinion

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

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 27 to 51 and 97 to 115:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:

- its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
- its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 28 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

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

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand;

- fairly reflect the Health Board's financial position, financial performance and cash flows; and
- fairly reflect its service performance achievements and outcomes.

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

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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

Mark Maloney
Audit New Zealand
On behalf of the Auditor-General
Palmerston North, New Zealand

Statement of Service Performance 2013/14

Service performance considers two questions in relation to our services – how much was done and how well it was done. In the ensuing report, how much was done is simply reflected as numbers of, for example, attendances, contacts or enrolments. How well it was done reflects our quality framework.

Quality measurement helps us to embed continuous improvement and review into practice. To achieve that, our concept of quality mirrors the "STEEEP" (safety, timeliness, effectiveness, efficiency, equity and patient-focus) working definition of the Patients First[3] initiative. Under this framework, quality improvement is systematic and sector-wide and aims to apply measurements and indicators to achieve effective service performance that improves patient outcomes.

The dimensions of the framework are explained in Figure 1 below.

Dimension	Ref	Examples
Safety	**S**	Absence of errors, prevention of harm, conformance to standards, reliability
Timeliness	**T**	Time between and clearly defined points in the process of care
Effectiveness	**E**	Has the desired effect in terms of clinical outcomes, absences of complications
Efficiency	**Ef**	Improvements on cost, consumption of resources, consumption of patient time
Equity	**Eq**	Greater access to all or to targeted groups, cultural sensitivity, closing disparities
Patient-focus	**P**	Ease of understanding, convenience, choice, experience of care

Figure 1: STEEEP framework of quality

The reference symbol for each of these dimensions of quality will be reflected in the ensuing report on service performance to assist with understanding of this holistic view of quality.

District Health Boards report performance quarterly, semi-annually and annually depending on the availability of data. This report relies on our most recent result for each indicator. Technical details along with historical and other in-year results (where available) can be found in Appendix One.

The symbols F (favourable) and U (unfavourable) have been inserted next to the actual result to clarify whether or not the forecast performance target has been achieved.

For the purposes of our Statement of Service Performance, we have grouped the measures in each output class according to the overarching health system objective of better, sooner, more convenient health care.

[3] Patients First is a joint programme of work between The Royal New Zealand College of General Practitioners and General Practice New Zealand. One of it's objectives is integrating quality and information for primary care. www.patientsfirst.org.nz accessed February 2012. Note: there have been recent developments driven by the Health Quality and Safety Commission to define quality in terms of the NZ Triple Aim framework. Hawke's Bay District Health Board will be realigning our framework over the next 2 years. For details see the website of Health Quality Measures New Zealand: www.hqmnz.org.nz

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 aim to protect and promote health in the whole population or identifiable sub-populations and comprise 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 wellbeing. Prevention Services include health promotion and education services, statutory and regulatory services, population based screening programmes, immunisation services, and well child and school services.

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.

Better, *sooner, more convenient* health care

Reducing smoking and achieving a smokefree Aotearoa by 2025 requires a comprehensive, multi-pronged approach across a number of agencies and services. Our progress against the smokefree national health targets is reported below. Another part of the approach is supporting compliance with smokefree legislation [E] and we work with tobacco retailers to help them to understand their obligations as well as to protect the community from illegal practices [S]. Across the year, 100% of tobacco retailers were visited.

100% of tobacco retailers visited for smokefree health promotion			
	Baseline	**Target** 2013/14	**Actual** (2013/14)
	new	*100%*	*100% (F)*

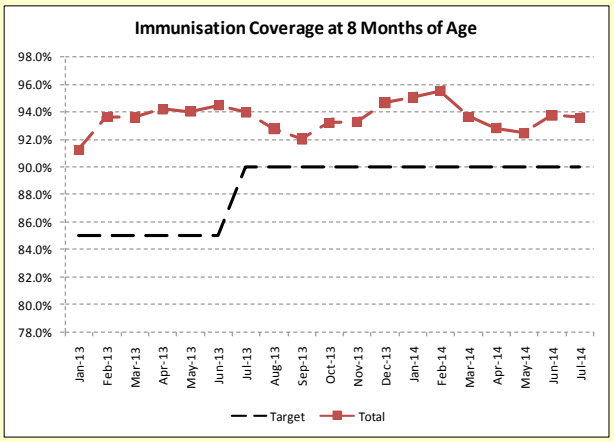
NATIONAL HEALTH TARGET

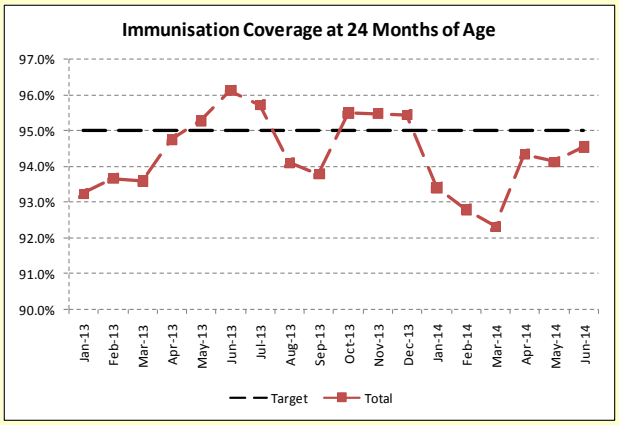
The main goal of immunisation services is to prevent the outbreak of vaccine-preventable diseases. Evidence shows that children who receive their first scheduled immunisations by 8 months of age, tend to be better engaged with the health sector and are more likely to have all the recommended immunisations by the time they are 2 years old. At 93.8% for our total population [E] and 92.7% for our Maori population [Eq], we have once again maintained exceptional performance against the national target, which increased to 90%.

A high coverage rate is indicative of a well co-ordinated and targeted service because it relies on a concerted effort by all providers, especially in reaching some of our more transitory population [P].

Throughout the year our immunisation services continued to target completion of all scheduled immunisations at 24 months of age too. There was a dip in performance in quarter 3 due to changes in the National Immunisation Register and the consequent messaging that is relied on to track and trace children. However, we have worked through those issues and ended the year on 94.6% for total and 94.5% for Māori. This is almost back on target. Commendably, we have maintained an equitable result [Eq]. The consistently high rate of coverage is great for children in Hawke's Bay and is a result of having good systems and processes in place, identifying issues and intervening early, tracking and tracing and making personal contact [T, P].

Hawke's Bay immunisation services also focused on its older population offering influenza vaccinations to high-needs people [Eq] aged 65 and over. Seasonal influenza is a contributory factor in the high number of (preventable) hospitalisations amongst older people, particularly older Maori. Although we have improved the rate over last year, from 66.5% to 69.0%, we are still committing resources to ongoing cross-sector work in order to achieve the target rate of coverage.

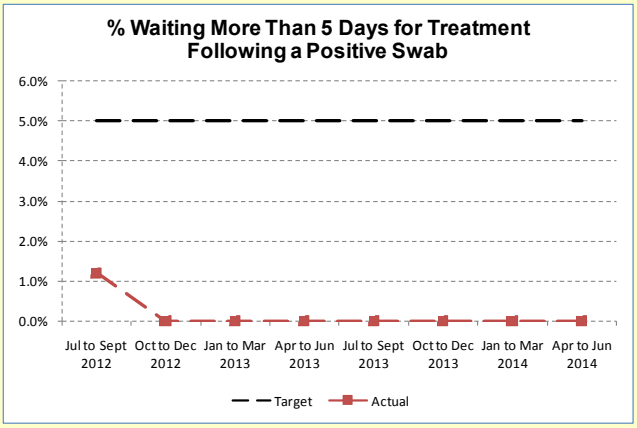




Percentage of high needs 65 years olds and over influenza immunisation rate			
	Baseline	**Target** 2013/14	**Actual** (2013 calendar year)
Overall	*66.5%*	*≥75%*	*69.0% (U)*

A unique health issue for Hawke's Bay is the exceptionally high incidence rates of acute rheumatic fever (ARF) in our Flaxmere community. Our rheumatic fever awareness campaign (Say Ahh) focuses on children and youth, and quick treatment after a positive swab shows that care-givers understand the potential impact of delayed treatment. For the seven quarters up to June 2014, everyone who had a positive swab was treated well within the targeted limit of 5 days [T].

A good prevention campaign will reduce ARF hospitalisation and provisional information[4] shows that rate has reduced in Hawke's Bay from 4.3 per 100000 to 1.9 per 100000 for the year to June 2014 [E].



Better, sooner, *more convenient* health care

Successful well child and school health services enhance the health status of currently disadvantaged groups and result in more resilient children living healthy and safe lives. Services must work together across a number of settings to detect and respond to health problems as early as possible in a child's life.

A high number of children receiving 'Before School Checks' (B4SC) helps to ensure that young people are getting the best possible start in life. Volumes of B4SC is determined by the number of 4 year-olds in the population – the service has delivered 2,307 against a target of 1,971 [Ef].

Areas of deprivation are targeted and a high rate of B4SC in those areas indicates good co-ordination and integration [P] as programme delivery requires co-operation of early childhood centres, Kohanga Reo and primary care givers. Once again, we exceeded our target of numbers in areas of Quintile 5 deprivation index - this time by 13%. This contributes positively to reducing inequalities [Eq]. It is commendable that 94% of the eligible population received the service, against a target of 80%. This indicates efficient service delivery [Ef] and means that all children are likely to have the opportunity to have the checks.

Number of Children receiving a B4 school check			
	Baseline	**Target** 2013/14	**Actual** (2013/14)
Overall	*2,045*	*≥1,971*	*2,307 (F)*
Quintile 5	*660*	*≥667*	*755 (F)*

% of eligible population receiving a B4 school check			
	Baseline	**Target** 2013/14	**Actual** (2013/14)
	87%	*≥80%*	*94% (F)*

[4] Ministry of Health, provisional data. August 2014.

The school environment is a great place for early identification of child health issues that can be responded to with preventative strategies and early intervention [E, T]. Maintaining a high volume of contacts by Public Health Nurses with school-aged children indicates that School Health Services are user-friendly and patient-centred [P].

Many of our programmes are targeted at health behaviours that start in childhood or youth and Public Health Nurses in schools are key agents [S]. The service delivered 5,963 contacts with school aged youth - 18% over the target – demonstrating the significant effort and excellent working relationships that exist in this cross-sector service [E, Ef].

The number of 5 to 18 year olds seen by Public Health Nurses			
	Baseline	**Target** 2013/14	**Actual** 2013/14
	new	*≥5,050*	*5,963 (F)*

HEADSSS[5] assessments are a validated method of screening teens about their health behaviours or risks. Better performance in this area will enable improved co-ordination, inter-sectoral integration and patient-centredness [P]. Early intervention on referral from these services can prevent more intensive interventions by initiating support around smoking cessation, smokefree homes and other socio-environmental concerns. [E]. Although the rate achieved is lower than last year and lower than baseline, the service was expanded to decile 3 schools this year [Ef]. Achieving 95.5% was, therefore, a great result and is indicative of another area where we are targeting the root cause of inequalities [Eq].

% of year 9's in low decile schools who have a HEADSSS assessment completed			
	Baseline 2012/13	**Target** 2013/14	**Actual** 2013/14
	98.3%	*≥91%*	*95.5% (F)*

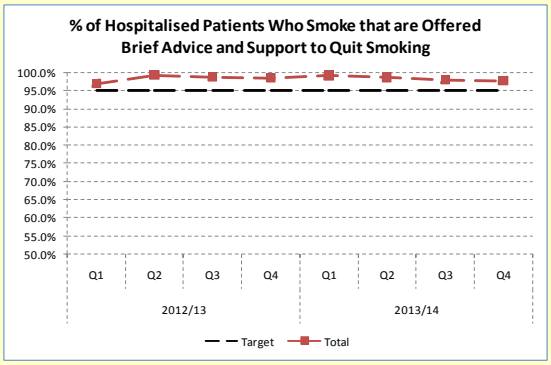
Better, sooner, more convenient health care

NATIONAL HEALTH TARGET

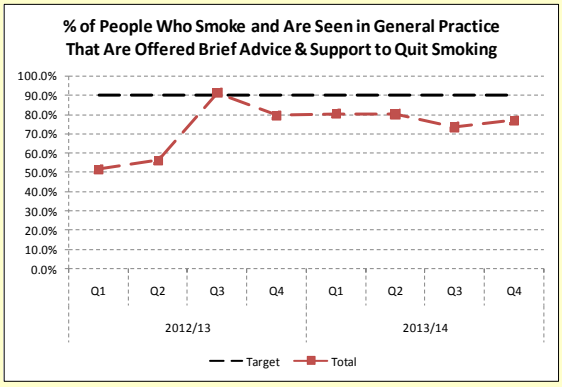
The national health target (better help for smokers to quit) aims to increase the number of times quit advice is offered in health settings. The DHB's smokefree team provide leadership and advice on smokefree systems, training and support across the hospital, primary care and maternity services so that patients can conveniently access regular advice and help to quit. Performance against this target is measured quarterly.

[5] HEADSSS – Home, education, activities, drugs, sex, suicide/depression, safety

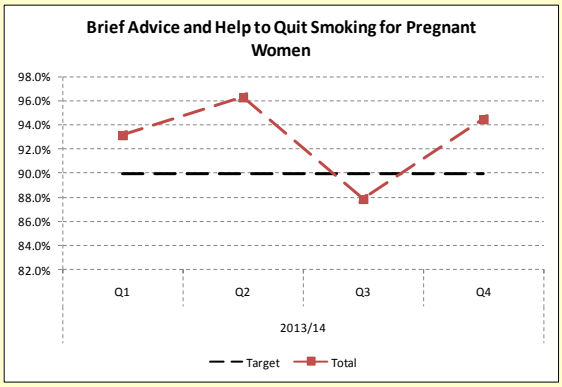
For hospitalised patients, Hawke's Bay DHB achieved the current national target from quarter 1 of 2012/13. Our best result was in quarter 2 of 2012/13 but, throughout 2013/14 we have exceeded the 95% target with the highest rate of 99.2% being achieved in quarter 1. We are confident of being able to sustain this achievement due to the ongoing commitment by hospital-based clinicians [P] and service management.



The target for primary care patients was set at 90% and was baselined at just 30.8% in the year ending December 2011. Significant effort from the DHB Smokefree team, using a systems based approach, supported by the PHO led to commendable improvement. In quarter 3 of 2012/13, HBDHB was the first DHB in New Zealand to reach the target. Unfortunately, however, this has not been sustained and we have been unfavourable through 2013/14 and even deteriorated in the last 2 quarters. In response, we have developed a Primary Care Smokefree Plan in partnership with Health Hawke's Bay for the coming year. This plan includes a full-time post moving from the HBDHB Smokefree Team to Primary Care in order to support Primary Care to sustain best outcomes.



The third aspect of the smokefree target adds focus on quit advice offered to pregnant women at the time of confirmation of pregnancy [T]. This is because of the significant risks [S] of smoking in pregnancy and of second-hand smoke to babies living in an environment that is not smokefree [Eq]. We targeted 90% and exceeded the target in quarters 1, 2 and 4, achieving 94.5% in quarter 4. Achieving this target requires excellent co-ordination of a standardised approach across all the services providing care to pregnant women [P].



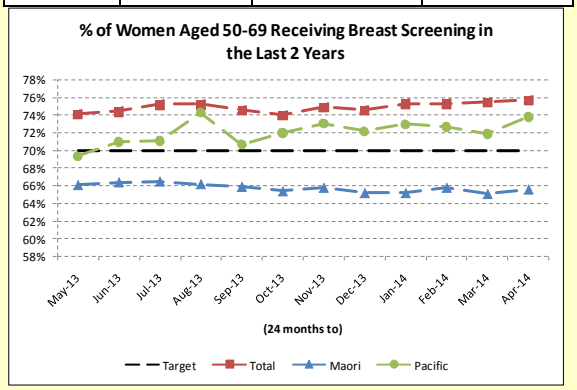
The "Green Prescription" programme (GRx) is an example of a health promotion initiative that connects people to convenient, publicly funded physical activity and nutrition programmes. The objective is to lower rates of obesity and reduce the risk of long-term conditions. For the last 2 years, we amended the targets to channel more effort to high-needs individuals [Eq]. Working closely with referrers and providers [Ef], we were able to improve service performance to achieve the targeted volumes and exceed the targeted proportion of high-needs clients.

The number of people participating in GRx programmes in primary, secondary care or community settings

	Baseline	Target 2013/14	Actual (2013/2014)
Total	*2,030*	*≥1,741*	*1,740 (F)*
Maori/Pacific	*16%*	*≥50%*	*51.2% (F)*

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

Percentage of women aged 50-69 years receiving breast screening in the last 2 years			
	Baseline (24 months to Nov 2012)	**Target** 2013/14	**Actual** (24 months to 31 May 2014)
Overall rate:	*73.6 %*	*≥70 %*	*75.7% (F)*
Māori	*62.7%*	*≥70 %*	*65.6% (U)*
Pacific	*70.1 %*	*≥70 %*	*73.8% (F)*



Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 50 and 69. Overall, we have improved our rate to 75.7% - this is better than the target and shows consistent improvement. This year we have also surpassed the target and achieved near-equity for Pacific women (73.8%). However, we are still not quite on target with Maori women (65.6%) and have slipped slightly since last year (66.1%). We are taking extra steps again next year to work with our community health partners to improve this rate in 2014/15 through recruitment campaigns and incentives using common patient/client registers.

Screening for cervical cancer is offered every 3 years, free of charge, to all women between the ages of 25 and 69 years. Overall (80.7%) we have passed the target of 80% and, with much ongoing effort, we have maintained above the target for Pacific women too (83.9%). The result for Maori women has improved slightly over last year, from 74.1% to 74.2% by March 2014 but is still a little way off the target. Our focus for next year is strongly on a partnership approach to recruit Māori women in to the programme.

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years.			
	Baseline (36 months to Sep 2012)	**Target** 2013/14	**Actual** (36 Months to March 2014)
Overall rate:	*81.2 %*	*≥80 %*	*80.7% (F)*
Māori	*72.6 %*	*≥80 %*	*74.2% (U)*
Pacific	*82.7 %*	*≥80 %*	*83.9% (F)*

Prevention Services (in millions of dollars)	**2014 Actual**	**2014 Budget**	**2013 Actual**
Ministry of Health	*9.9*	*6.7*	*4.2*
Other sources	*0.4*	*0.3*	*0.3*
Income by source	**10.3**	**7.0**	**4.5**
Personnel	*1.4*	*1.4*	*1.4*
Clinical supplies	*0.1*	*0.1*	*0.1*
Infrastructure and non clinical supplies	*0.4*	*0.4*	*0.4*
Payments to other providers	*6.7*	*4.7*	*4.7*
Expenditure by type	**8.6**	**6.6**	**6.6**
Net Result	**1.7**	**0.4**	**(2.1)**

Early Detection and Management Services

Impact: People's health issues and risks are detected early and treated to maximise well-being.

Statement of Service Performance Output Class 2

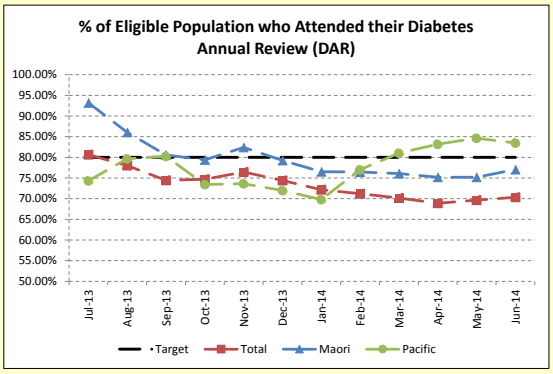
Early Detection and Management Services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes,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

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

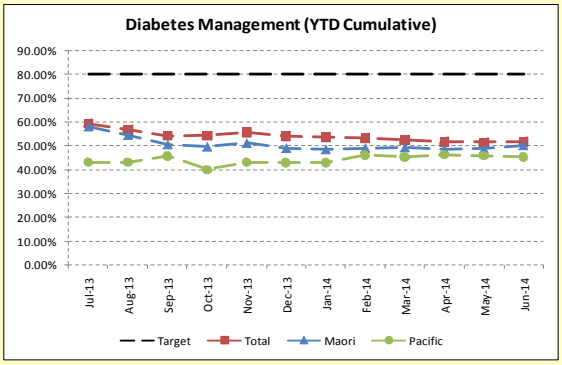
Better, *sooner, more convenient* health care

In 2012/13, we worked closely with the PHO to implement a service improvement programme to clearly put primary care in control of managing their enrolled diabetic population. Having identified risks and conditions through the health target (More heart and diabetes checks), the second step is to ensure that people are registered with the diabetes programme at their general practice. This is tracked through attendance at an annual review. [E].

At 73.4%, the result for this indicator is lower than target (80%) and lower than last year (80.6%). As a quality exercise to establish a reliable PHO diabetes register, Health Hawke's Bay is undertaking a review of all patients at individual practice level, with read codes for diabetes, to validate a diabetes assessment claim and monitor the incidence of diabetes and the quality of services being provided under the Diabetes Care Improvement Plans. Thereafter they plan to maintain quarterly monitoring and report for "on time diabetes annual reviews" being provided.



Another important component for diabetics is support for them to understand and self-manage their condition. For those whose conditions are complex, we need assurance that the case management efforts supported by the PHO and community providers continues to be effective and that ethnic variations are identified and targeted [E, Eq]. An increasing proportion of those checked must be meeting a clinical indicator (HBa1C) threshold. There have been some systematic data issues with this indicator in the last year (see note below) and Hawke's Bay results are unfavourable against the target.



NOTE: in 2013/14 the denominator for this indicator changed to include all people on the PHO register between the ages of 15-74 with a diagnosis of diabetes. Prior to 2013/14 the HbA1c indicator had monitored glycaemic control of people who had attended the Diabetes Annual Review and the target for that was ≥80%. The 80% target was continued into 2013/14 even though the denominator had changed – this was an error and made it appear that the PHOs performance had dropped significantly. The target for 2014/15 will be ≥ 55%.

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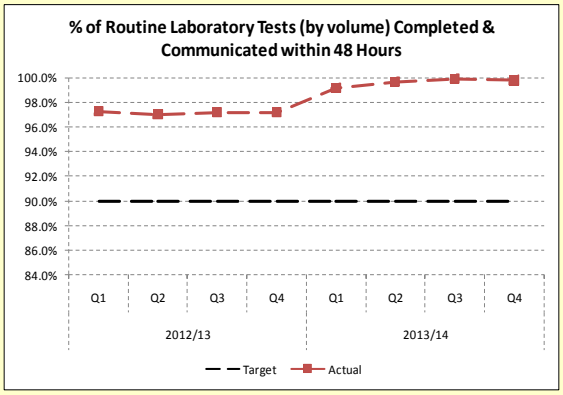
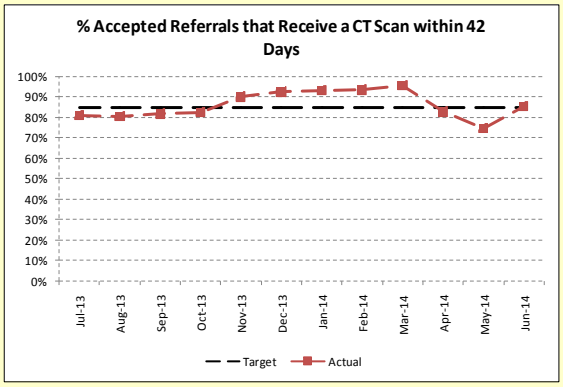
People are referred for tests and diagnostic services to help diagnose a health condition or as part of treatment. Demand for community referred tests and diagnostic services are expected to increase as more people engage with health services and more promotional messages about early diagnosis are responded to. High compliance with turn-around times in referred services continues to be expected [T]. Our laboratories have consistently achieved close to 100% in each quarter this year [S], which is well-above the acceptable threshold of 90%.



Source: Southern Community Laboratories and HBDHB Laboratory

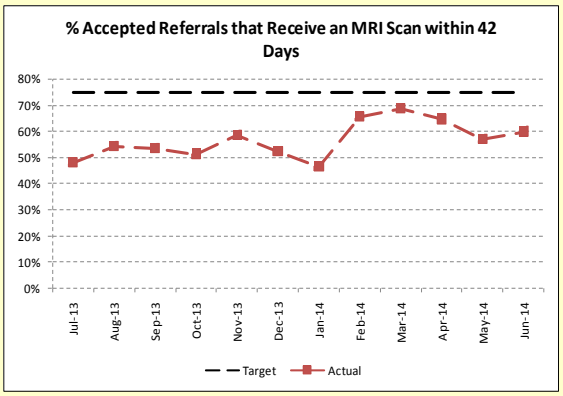
Another important area of diagnostic support for the health sector is radiology. Compliance with standards contributes to timely diagnosis and is crucial in the drive to support more community-based care delivery [T, S].



For Computed Tomography (CT), our final unfavourable quarter 4 result (80.5% v 85% target) belies the actual service delivery. Our CT scanner was replaced in May 2014 and this necessitated some downtime during that month. Although some scans were completed using the nuclear medicine facilities, the May result was only 74.7% and brought the whole

quarter result under target. However, we had previously worked hard to get ahead of referrals as is evidenced by the 94.1% result in quarter 3.

For Magnetic Resonance Imaging (MRI), Urgent and ACC referrals continue to be achieved within timeframes. At year-end, routine patients were waiting up to nine weeks for their scans and so the indicator is unfavourable (60.2% v 75% target) overall. Extra lists/sessions have been introduced recently to further reduce wait times and to meet the target in the future.



Good oral health at an early age is a recognised indicator of good lifetime health. Good oral health relies on sound oral hygiene, engagement with the health sector and action around health promotion messages.

Our community oral health service enrols children at school and pre-school (see below) to check-up on their teeth. Those identified as needing further examination or treatments are scheduled for a recall. In the last year, only 4.2% of children were not examined according to their planned schedule. This continues to be a favourable result against a target of less than 5% and it indicates a safe [S] and efficient service [Ef].

Percentage of enrolled preschool and primary school children not examined according to planned recall			
	Baseline	**Target** 2013/14	**Actual** (2013 calendar year)
	4%	*<5%*	*4.2% (F)*

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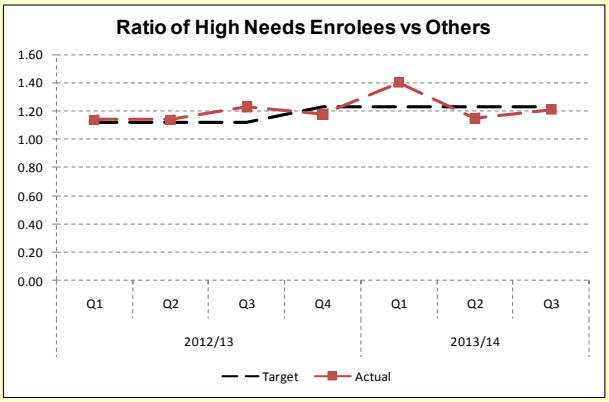
Across New Zealand, people are required and encouraged to enrol with a general practice that is affiliated to a Primary Healthcare Organisation (PHO) in order for that practice to receive a subsidy (capitation) for their care, the PHO co-ordinates and manages the targeting of many services to those populations who are known to have the poorer health status – Maori, Pacific people and those living in the most deprived neighbourhoods. A high rate of GP utilisation by high-needs enrolees indicates access by those who need it most and is a quality measure in terms of equity [Eq]. Although we have not quite achieved the target rate this year (1.21 against a target of 1.23), Hawke's Bay has been consistently above the national rate of 1.06 (3 months to December 2012) since quarter 2 of 2011/12.

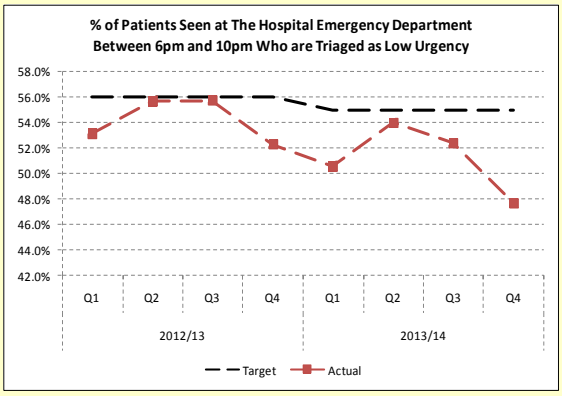
Ratio of high needs enrolees vs others			
	Baseline	**Target 2013/14**	**Actual January to March 2014**
	1.14	*≥1.23*	*1.21 (U)*

Source: DHB Shared Services



Use of the hospital emergency department (ED) is seen as a barometer of accessibility of services across the urgent care spectrum. Since 2010 there has been an ongoing effort by the DHB and primary care to ensure that people have access to all urgent care services in the most appropriate place whatever time care is needed [T, E]. Reducing utilisation of the emergency department by low-urgency patients between 6pm and 10pm at night has dropped to 47.7% and this is a reflection of that accessibility [P]. For 3 years, we have seen a gradual reduction and this implies that the system is offering more suitable alternatives for meeting the need and that patients are using them. We will continue to support system improvements that offer appropriate choice to patients for convenient care.

Of patients seen at the hospital emergency department between 6pm and 10pm, percentage who are triaged as lower urgency.			
	Baseline	**Target** 2013/14	**Actual** (April to June 2014)
	55.7%	*<55%*	*47.7% (F)*



Sub-acute Community Support (SCS) is an initiative that provides special funding for responding to increasing need with more convenient, community-based pathways [Ef] while still ensuring that all providers are co-ordinated. These initiatives are more patient-centred [P] and lead to reduced hospitalisation [E].

Sub-acute Community Support (Volumes)			
	Baseline	**Target** 2013/14	**Actual** 2013/14
	25	*≥ 35*	*54 (F)*

A high volume of sub-acute community support reflects our response to meeting increasing need with more convenient, community-based pathways that have been co-ordinated to include innovative funding and better access. In 2013/14 we funded 54 volumes against a target of at least 35 - this is favourable.

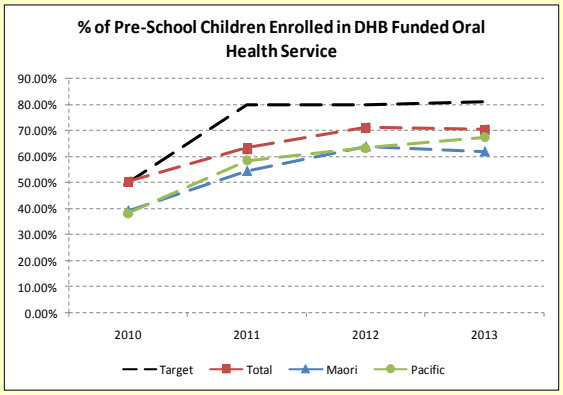
Due to the poor oral health status of Hawke's Bay children, especially Māori and Pacific, we are now targeting enrolments of pre-school aged children into DHB-funded oral health services to drive earlier connection with the health sector.

Percentage of eligible preschool enrolments in DHB-funded oral health services:			
	Baseline	**Target** 2013/14	**Actual** 2013 calendar year
Total:	*71.1%*	*≥81%*	*70.4% (U)*
Māori:	*63.8%*	*≥81%*	*61.9% (U)*
Pacific:	*63.3%*	*≥81%*	*67.4% (U)*

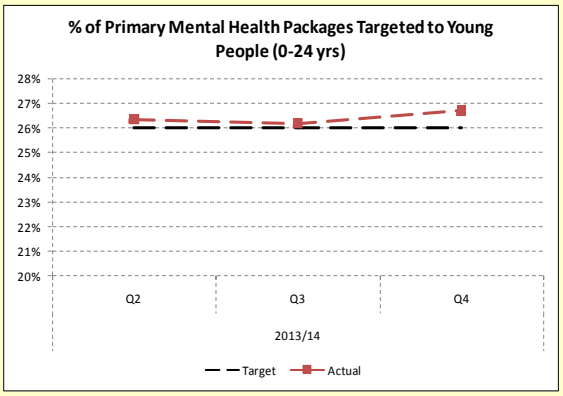
Although we still have not hit our target enrolment rate (81%), All ethnicities continue to improve, with the number of Maori and Pacific pre-school children enrolled continuing to trend upwards. The four Maori health providers and Plunket continue to support Oral health services to target the 0 - 5 yr olds. Discussions

have begun for oral health services to be part of the Triple enrolment process - when that happens, the oral health service will be offered at birth.

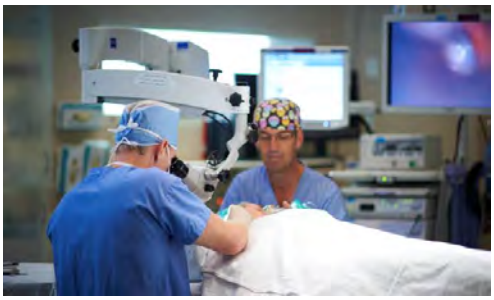
Service enrolment is an important activity indicator that will contribute to improvements in the oral health status indicator for 5-year olds. The results are a reflection of the work that Oral Health Services and the NGO providers have done this year in early enrolment and timely access to services. With increasing numbers being the trend, we expect to achieve the target within the next year.



The Prime Minister's youth mental health project requires us to focus on mental health services for youth [Eq]. In addition, our emergency department attendance data shows that many regular users of ED attend for mental health issues. 26.7% of primary mental health packages were used to support youth in 2013/14. This is better than target and shows improving youth [P] access to mental health packages and provision of better options [E] for young people.



Early Detection and Management (in millions of dollars)	**2014 Actual**	**2014 Budget**	**2013 Actual**
Ministry of Health	*142.5*	*135.1*	*141.1*
Other District Health Boards	*2.8*	*2.6*	*1.9*
Other sources	*4.5*	*3.6*	*3.3*
Income by source	**149.8**	**141.3**	**146.3**
Personnel	*23.4*	*23.6*	*22.5*
Outsourced services	*4.6*	*3.0*	*3.9*
Clinical supplies	*2.5*	*2.8*	*2.4*
Infrastructure and non clinical supplies	*7.8*	*7.5*	*7.4*
Payments to other District Health Boards	*2.5*	*2.5*	*2.5*
Payments to other providers	*87.9*	*100.5*	*104.9*
Expenditure by type	**128.7**	**139.9**	**143.6**
Net Result	**21.1**	**1.4**	**2.7**



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 emergency department, 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 co-ordinated and work as seamlessly as possible.

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 co-ordinate 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.

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NATIONAL HEALTH TARGET

Elective services are hospital services for patients that are planned and do not require immediate (acute) hospital treatment. Elective services involve many teams across the organisation including access into outpatients, the surgical booking system, surgical procedures, treatment and delivery of care. Increasing volumes of elective surgery requires good collaboration between all these parts of the system.

Achieving or surpassing the Health Target (Improved access to elective surgery) supports the Government's focus on elective services. Target volumes are agreed nationally based on intervention rates. HBDHB exceeded our targeted volume by 4% [Ef] meaning that there were 237 extra elective surgical discharges in the last year.

Health target: Improved access to elective surgery (discharges)			
	Baseline	**Target** 2013/14	**Actual** 2013/14
Number of Elective discharges (volumes)	*5,729*	*≥5,866*	*6, 103 (F)*

Source: Ministry of Health

As we target more and more elective surgeries, we have to ensure that our system is optimised for handling the inevitable acute cases that must be prioritised. If the system works well then the elective schedules will have minimal disruption. Following investment in additional operating theatre capacity, our targeted rate for cancellations of elective cases due to prioritised acute demand [S, P] was no more than 6% of cases. We have not been able to achieve this yeat and the result of 15.5% is still some way off. We are now monitoring cancellations on a weekly basis in order to provide better oversight and understanding of the cause of these unsatisfactory results.

Percentage of cancelled elective cases as a result of prioritised acute demand			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	14.4%	*≤6%*	*15.5% (U)*

NATIONAL HEALTH TARGET

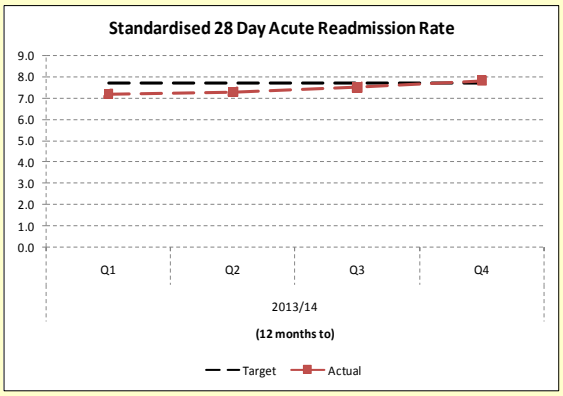
Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in the ED therefore improves the health services DHBs are able to provide. It also results in a more unified health and disability system, because a coordinated, whole of system response is needed to address factors across the whole system that influence ED length of stay.

At 90.6%, performance in quarter 4 has declined compared to quarter 4 (93.3%) in the previous year and remains lower than target (95%). Attendances to the Emergency Department for the quarter were 6.5% higher than for the same period in 2013 and admissions from ED to inpatient areas 4.3% higher. Compared to the same quarter in 2013, 6% more patients (based on actual numbers) were admitted, transferred or discharged from ED within six hours. Overall hospital occupancy was higher than originally planned and largely due to increased surgical throughput. Based on midnight census data, bed days were 8% higher for the quarter compared to the same period in 2013 with surgical bed days 24.5% higher. This means that the ED was busier with more complex patients.

We acknowledge the difficulty in achieving the ED health target in this environment. However, a number of initiatives are being run across the system to improve performance including, for 2014/15, a big focus on the functioning of the hospital outside of "normal" hours.

Health Target: Emergency Department *% of patients admitted, discharged or transferred from an emergency department within 6 hours*			
	Baseline	**Target** 2013/14	**Actual** 2013/14
	94.3%	*≥95%*	*90.6% (U)*

In our quest to increase hospital throughput it is important that we measure "error rates". Acute unplanned readmissions occur when treatment has not been effective and a readmission is required urgently. A low rate is an indication of hospital reliability [S, E]. Our target is a rolling 12-month rate and it was reduced this year from 11.2% to 7.7%. The target was beaten in the first 3 measurement periods but deteriorated to 7.8% in the 12 months to March 2014. This is attributed to unanticipated increased admission numbers and acuity for acute services in February and March 2014. We will continue to target a reduction and monitor accordingly.



Reducing health-service related harm is a key objective of the Health Quality and Safety Commission. An important indicator of hospital safety [S] is the rate of bloodstream infections. Apart from an unusual spike in April 2014, our hospital has been favourable against the target rate for the whole 2013/14 year.

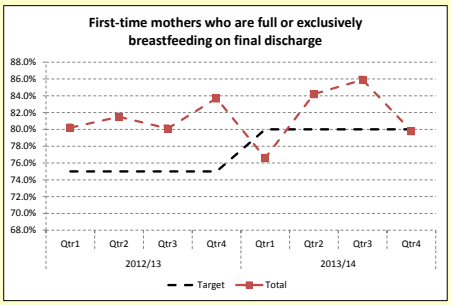
We continue to target a level below the contemporary standard to show that we are keeping the hospital environment safe.

Rate of hospital-acquired bloodstream infections per 1000 occupied bed days			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	0.17	*≤0.29*	*0.19 (F)*

Maintaining a high rate of first time mothers breastfeeding at the time of discharge supports other efforts in respect of increasing breastfeeding rates [P]. Good quality maternity services can demonstrate that they are successfully educating new mothers about the health benefits of this practice and supporting initiation[E]. We are maintaining performance against a rising standard.

Percentage of first time mothers delivering who are breastfeeding (Full or exclusive) at the time of discharge			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	81.5%	*≥80%*	*79.8% (F)*

The target rate was increased from 75% to 80% this year. HBDHB was under target in quarter 1, over target and improving in quarter 2 and 3 and very slightly under target in quarter 4 (79.8%). Overall this is a good result for the services, the mothers and importantly, for the babies.



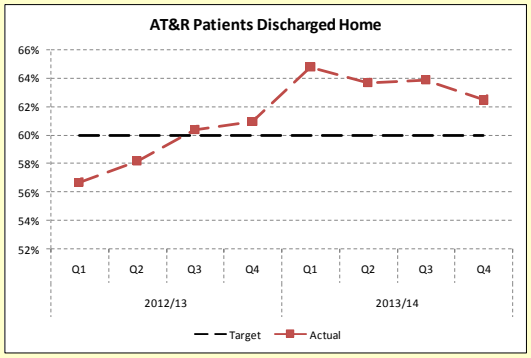
Our hospital is part of the 'Baby Friendly Hospitals' initiative so it is pleasing to see ongoing improvement.

With an ageing population we expect to see an increase in Assessment, Treatment and Rehabilitation (AT&R) patients and bed-day volumes. If our services are successful [E], an increasing rate of patients will be discharged home with support [P], if appropriate, rather than into a residential care or hospital environment.

Our 2013/14 result improved slightly over the previous year and we have continued to achieve a favourable result of 62.5% against a minimum target of 60%. Ongoing work with families and patients [P] to ensure safe discharging [S] is paramount. In addition, we continue to forge strong links with community-based support systems so that there is more collaboration and co-ordination for patients.

Over the last three years, we have increased our focus on quality and safety in the hospital and other inpatient environments. Inpatient falls are a leading cause of hospital-acquired injury and, therefore, a measure of patient safety [S]. Decreasing this rate is part of our focus on improving hospital quality. Falls in hospital are also a major factor leading to extended length of stay [Ef] for older people in particular. Against a tougher target of less than 1.0 falls per 100 bed days, we have managed a favourable result in each quarter and ended up with 0.9 for quarter 4. Over a few years, there has been a step-decrease in the rate of falls due to investment in falls reduction and alert systems [E].

Percentage of AT&R patients discharged home			
	Baseline	**Target** 2013/14	**Actual** 2013/14
	58.2%	*≥60%*	*62.5% (F)*



AT&R Inpatient falls per 100 bed days			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	0.6	*≤1.0*	*0.9 (F)*

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Specialist mental health and addiction services are funded for people who are severely affected by mental illness or addictions. Quick access to drug and alcohol services [T] is an important aspect of our intersectoral commitment to reducing dependency (e.g. with WINZ and the Department of Corrections). Shorter waits are also important to patients and contribute to earlier treatment and better outcomes [P, E].

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

Shorter waits for non-urgent drug and alcohol services			
	Baseline	**Target** 2013/14	**Actual** 12 months to March 2014
Mental Health Provider Arm			
Seen within 3 weeks of referral	*64.6%*	*≥80%*	*75.3% (F)*
Seen within 8 weeks of referral	*87.7%*	*≥92.5%*	*91.4% (U)*

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. In all cases, the targets were increased from last year.

For mental health services provided by our provider arm, the waiting time expectations at 3 weeks improved to 75.3% but did not achieve the new target of 80%. The 8 week rate improved to 91.4% but fell just short of the target of 92.5%.

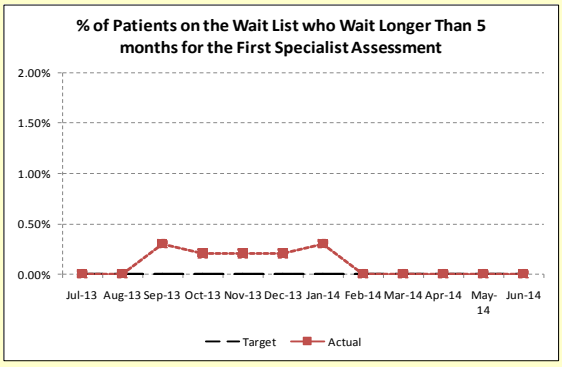
For addictions services with a range of providers, the waiting times expectations have been exceeded with 74.8% of people seen within 3 weeks and 93.4% seen within 8 weeks. This follows some clear focus on referral response and turnaround time.

	Baseline	Target 2013/14	Actual 12 months to March 2014
Addictions (Provider Arm & NGO)			
Seen within 3 weeks of referral	*61.3%*	*≥70%*	*74.8% (F)*
Seen within 8 weeks of referral	*88.6%*	*≥92.5%*	*93.4% (F)*

NOTE: Within our own provider, the rates were achieved in all age-groups except the 0-19 years and that was due to a significant number of vacancies in Child and Youth services. Recruitment to those vacancies should be complete within the first quarter of 2014/15 and so performance will improve.

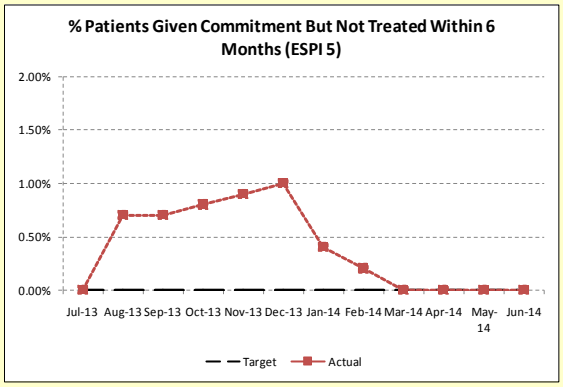
Elective Services Patient Flow Indicators (ESPIs) are a national-level monitoring framework for elective services. ESPI2 and ESPI5 are used to show that our elective services are well-coordinated [P] and efficient [Ef]. Over the last 2 years there has been an ongoing programme to reduce the amount of waiting for elective services. At the end of June 2014, we had no-one waiting longer than 5 months for a first specialist appointment and no-one who had been given a commitment to treatment waiting more than 5 months.

	Baseline	Target 2013/14	Actual June 2014
(ESPI2) % patients waiting longer than 5 months for their First Specialist Assessment (FSA)			
	new	*0%*	*0%*
(ESPI5) % of patients given a commitment but not treated within 5 months			
	new	*0%*	*0%*



With increasing elective surgery being a Government priority, we have had to work extremely hard across the sector to maintain the ESPI targets that we had already achieved by the end of the previous financial year. Despite some non-compliant months in both measures, we have been able to bring them back on track by the end of the year. The target timeframe will be

reduced again in 2014/15 - from 5 months to 4 months. We are committed to the goal because less waiting [T] leads to better outcomes for patients [Ef].



NATIONAL HEALTH TARGET

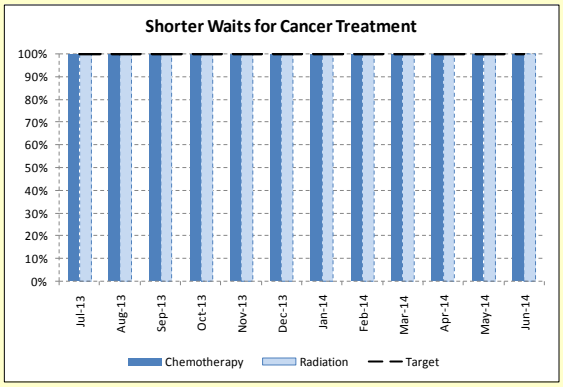
In a system where people are referred for a number of assessments before treatment is offered, the key principles underlying the system are clarity, timeliness and fairness.

Compliance with the health target (shorter waits for cancer treatment) confirms that our population is receiving radiation and chemotherapy cancer treatments as early as possible [T]. As this is a regional service, maintaining this high rate relies on effective co-ordination, efficient booking and referrals and good patient relationship-management [Ef, P].

The majority of radiation therapy is provided at Palmerston North hospital for Hawke's Bay district residents.

100% compliance with target waiting times is vital as it ensures that people in need of intensive cancer treatment are having that need met on time [T]. Meeting need as early as possible will contribute to better survival and, therefore, to a lower premature cancer mortality rate.

Health Target: Shorter waits for cancer treatment - Treatment Waiting Times less than 4 weeks			
	Baseline	**Target** 2013/14	**Actual** 2013/14
Radiation	*100%*	*100%*	*100% (F)*
Chemotherapy	*100%*	*100%*	*100% (F)*



Source: MidCentral DHB

A key facet of current health policy is the delivery of more traditional "hospital" services in community settings. If well co-ordinated, this concept also contributes to sustainability through better management of acute demand and of long-term conditions [Ef]. Our district nursing service provides specialised nursing care in people's homes and this often reduces the need for hospitalisation. For the service to be effective, it is important that referrals receive a timely response [T]. The target turnaround time of 48 hours was met more than 80% of the time in quarters 1, 3 and 4 ending up on 87.8% in quarter 4.

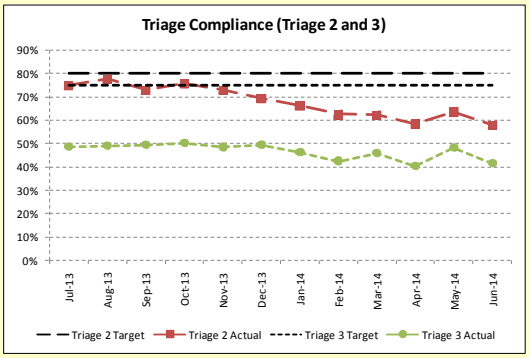
Initial contact by District Nursing Service within 48 hours of receipt of referral			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	78.1%	*≥80%*	*87.8%*

As described above, we are seeing growth in ED attendance and a rise in the proportion of ED attendees who are admitted to hospital. As well as strategies to understand and influence that demand, we have to focus on meeting standard response times [T] so that services are safe [S] and people are seen in accordance with clinical priority.

Emergency Department Triage compliance rates			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
Triage 1	*100.0%*	*100 %*	*100% (F)*
Triage 2	*59.8%*	*≥80 %*	*60.0% (U)*
Triage 3	*43.3%*	*≥75 %*	*43.4% (U)*

Triage category 1 (most urgent) has almost always been compliant with the standard wait time (immediate).

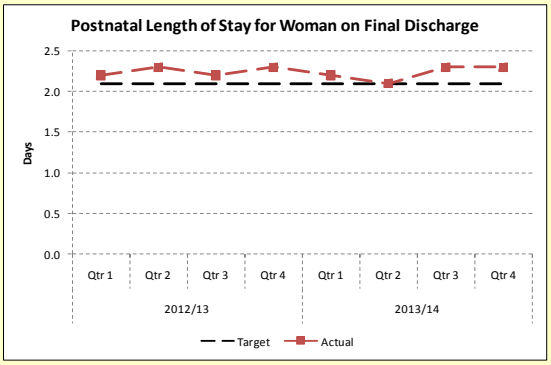
Performance in triage category 2 initially improved in the first half of the year and then declined again to 60.0% in quarter 4 against a target of 80%. In category 3, performance declined slightly in each quarter for the whole year ending up at 43.4% against a target of 75%. The declining performance has been attributed to the impact of increased demand and access block (low availability of beds in the hospital) associated with high levels of hospital occupancy. There is now a focus on the whole acute pathway and we are hopeful that these efforts will enable improvement in our triage wait time performance.



Maternity Services are provided to women and their families throughout pregnancy, childbirth and for the first six weeks after birth. The maternity service specifications envisage a post-natal stay (following a hospital birth) of longer than 48 hours only if there are problems or complexities. Mothers and new babies should be ready to go home as soon as possible [T] if the entire service is well co-ordinated and patient-centred.

Post natal Average length of stay (days)			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	2.3 days	*≤2.1 days*	*2.3 days (U)*

The average length of stay has barely changed for the last 2 years and is attributed to a higher than average rate of caesarean sections plus the number of medically and socially complex women and babies every month. Length of stay is monitored as part of Maternity Statistics that are generated for Clinical Indicators and Maternal Governance Group Committees. Sometimes a longer stay is appropriate [Eq].



Better, sooner, more convenient health care

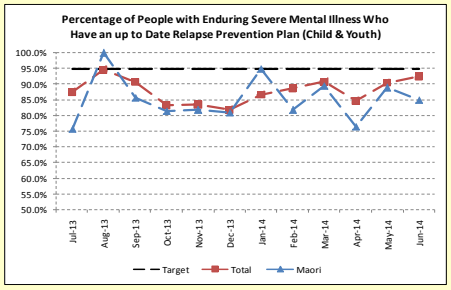
Relapse prevention plans are used for people with enduring mental illness and are effective if they are maintained. High rates of "up-to-date" plans are an indication of service responsiveness [P] and reliability [S].

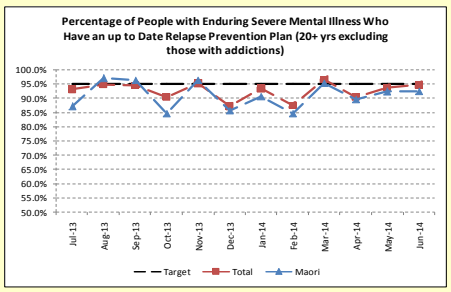
The target for the year was 95% completion and, although we have seen a consistent improvement since October 2011, we have still not quite achieved the goal across the board.

In the final quarter of the year, for the child and youth indicator, we achieved 92.4% for the total population and 85.0% for the Maori population. For adults, the result was 94.7% for the total population and 92.5% for the Maori population.

In the final quarter there was a positive trend upwards due to assertive clinical management of the work force to ensure that relapse prevention plans are in place. Additionally recruitment to the associate Clinical Nurse Manager role was completed and had a direct positive result on compliance. For adults, the DHB Health Services division was meeting targets and the slight downward trend was related to NGO compliance. Support is routinely extended to address any systemic issues.

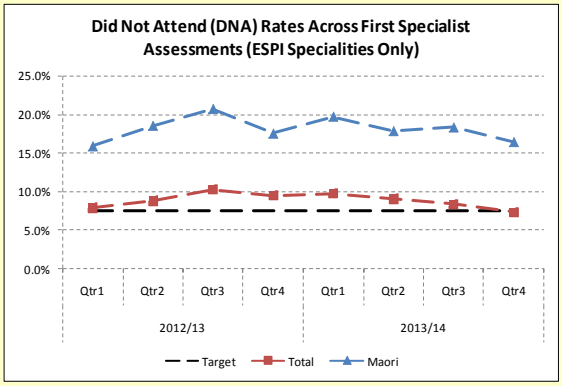
% of people with enduring severe mental illness who have an up to date relapse prevention plan			
	Baseline	**Target** 2013/14	**Actual** As at 10th July 2014
0-19 years Child & Youth			
Total	*82.1%*	*≥95%*	*92.4% (U)*
Māori	*64%*	*≥95%*	*85.0% (U)*
20 years and over Adults (excluding addictions)			
Total	*83.6%*	*≥95%*	*94.7% (U)*
Māori	*62.9%*	*≥95%*	*92.5% (U)*





An indicator of convenience in respect of elective services is attendance at scheduled first specialist appointments (FSAs). Arranging FSAs requires good communication between patient, referrer and specialist services. A reduction in the rate of scheduled first specialist appointments (FSA) that do not proceed due to patient non-attendance (did not attends – DNAs) is targeted because a high rate is an indication of poor co-ordination [P] and leads to significant waste and rework [Ef]. Furthermore, if patients fail to attend specialist appointments they will miss out on getting the treatment they need as soon as possible [E, Eq]. Our DNA rate (total population) has improved from last year to 7.4% by the end of 2014/15 but the rate for Māori is still unacceptably high (16.5%).

Did not attend (DNA) rate across first specialist assessments			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
Total	*8.8%*	*≤7.5%*	*7.4% (F)*
Māori	*18.5%*	*≤7.5%*	*16.5% (U)*



A number of co-ordinated initiatives, including reminder texts and dedicated Kaitakawaenga support roles, are underway to try and address this better in 2014/15.

HBDHB commissioned a 7th operating theatre in 2012/13 to improve the safety [S] of surgical services by enabling more secure scheduling of elective lists. By delivering a more patient-centred elective service we expected to reduce the average length of stay (ALOS) for elective inpatients [P]. The target was set at 3.21 days but we have been unable to move it under 3.4 days except in the 3rd quarter when it came down marginally to 3.3 days.

Elective inpatient ALOS			
	Baseline	**Target** 2013/14	**Actual** 12 months to March 2014
	3.49 days	*≤3.21 days*	*3.4 days (U)*

Intensive Assessment and Treatment (in millions of dollars)	**2014 Actual**	**2014 Budget**	**2013 Actual**
Ministry of Health	*247.3*	*256.5*	*245.0*
Other District Health Boards	*5.8*	*5.4*	*6.5*
Other sources	*10.1*	*10.4*	*10.1*
Income by source	**263.2**	**272.3**	**261.6**
Personnel	*139.8*	*140.8*	*134.9*
Outsourced services	*11.3*	*7.3*	*9.7*
Clinical supplies	*36.8*	*41.1*	*32.8*
Infrastructure and non clinical supplies	*33.9*	*32.2*	*32.0*
Payments to other District Health Boards	*45.9*	*45.5*	*46.4*
Payments to other providers	*14.0*	*4.5*	*3.6*
Expenditure by type	**281.7**	**271.4**	**259.4**
Net Result	**(18.5)**	**0.9**	**2.2**

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 co-ordination (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 co-ordination 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 of Planning and Performance. Other services are provided by our Provider Arm, General Practice and a number of community-based NGOs and private organisations.

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 dependence. 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. Early identification and recognition of end-of-life care choices heavily influence the quality of life an individual experiences during the dying process.

Better, *sooner, more convenient* health care

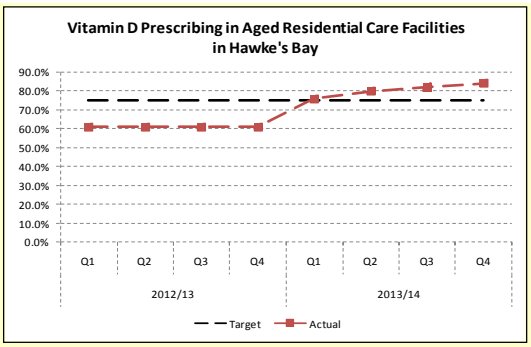
We implemented year 3 (of 3) of our 'health of older persons service improvement programme' (HOPSI) during 2013/14 aimed at delivering better co-ordination of higher quality services to older people. Comprehensive clinical assessments and completed care plans are an important component of keeping people safe [S] in their own homes [P] and maintaining their independence [E]. This was a new requirement last year and, against a target of at least 95% for the current year, we achieved 100% by June 2014.

Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	93.8%	*≥95%*	*100% (F)*

Research has shown that vitamin D deficiency is a common contributor to falls causing hospitalization amongst the elderly. Increasing vitamin D prescribing is encouraged [E] and relies on aged care services and other primary carers to promote and monitor [S] this practice appropriately.

Vitamin D prescribing			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	61.0%	*≥75%*	*84% (U)*

Last year, we have had difficulty making progress in this indicator but audits of prescribing practices identified opportunities for amending prescriptions to include vitamin D for some individuals. Supporting our primary and community partners to raise the uptake of this preventative measure meant that, by year-end coverage had reached 84.0%, which is better than the target of at least 75%.



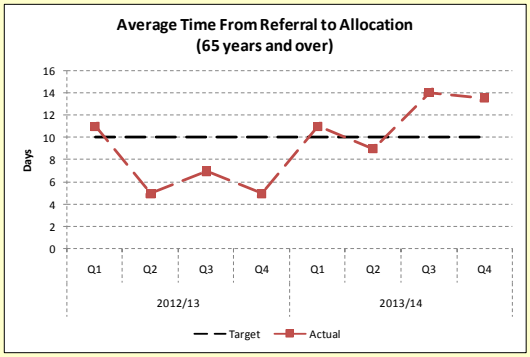
Better, sooner, *more convenient* health care

Needs Assessment and Service Coordination (NASC) services work with people who have support needs because of long-term health conditions and disabilities. NASC services determine eligibility for public funding and assist the person to define the best mix of supports based on their own strengths, resources and goals. Traditionally, NASC services focused on age-related disability. As the older population is increasing in number, we would expect to see an increase in the number of referrals completed. Referrals processed increased by nearly 5% in the year with 7,215 completed against a forecast of at least 5,500.

Number of referrals processed (65 years and over)			
	Baseline	**Target** 2013/14	**Actual** 2013/14
	6,098	*≥5,500*	*7,215 (F)*

To confirm that we are coping with this increase and providing a prompt service [Ef, T], we expect a decrease in the time from referral to assessment. Last year we brought the average wait down to 5 days by year end. However, an amended service design during the 2nd half of 2013/14 necessitated a reassessment of a significant number of existing clients. This resulted in the average time falling to 14 days. Ultimately, a more appropriate and consistent support package will eventuate for all clients [E]. We expect to have dealt with the backlog and be back on track for normal processing times within the first quarter of 2014/15.

Average time from referral to allocation (65 years and over)			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	5 days	*≤10 days*	*14 days (U)*



On 1 July 2011, the Ministry of Health devolved NASC for disability services for people under 65 years of age to DHBs. We started monitoring these volumes separately in the 2012/13 financial year and have delivered 618 assessments against a forecast of 300. This is a 33% increase over last year and is a result of an ongoing upwards trend in new clients [P] plus a rise in requests for reassessments.

Number of needs assessments completed (Disability Services)			
	Baseline	**Target** 2013/14	**Actual** 2013/14
	415	*≥300*	*618 (F)*

We have continued to improve on turnaround time [T] by bringing the average time from referral to assessment down to 2 days by the end of quarter 4. Together with the increased volumes, this result shows that the service is doing an excellent job [E, Ef] for people in Hawke's Bay with disabilities.

Average time from referral to assessment (Disability Services)			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	4 days	*≤13 days*	*2 days (F)*

Palliative care is an approach that improves the quality of life [P] 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 [P], affirm that the service is responding in a timely way [T] and show that capacity constraints are being appropriately managed [E]. In each quarter of 2013/14, the target response standard was beaten. In the final quarter 87.5% of referrals (against the target of at least 80%) were responded to within 48 hours from referral receipt.

Time from referral receipt to initial Cranford Hospice contact within 48 hours			
	Baseline	**Target** 2013/14	**Actual** April to June 2014
	92.0%	*≥80%*	*87.5% (F)*

Better, sooner, more convenient health care

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

Access to restorative care has resulted in a higher number of clients being able to remain safely in their own homes [S, E]. Although performance appears to have slipped over the year, we actually increased the underlying number of funded packages from 130 in quarter 1 to 210 in quarter 4 - an increase of 62%. This was done progressively to align with the phasing of supply capability. By year-end we had 166 clients on the programme. Although this was only 79% of funded POC, we accept an inevitable lag between funding allocation, appointment of staff and full use of packages as referrals increase. That we were funding an extra 80 POC by year-end is a good result for Hawke's Bay. We intend to continue this approach in 2014/15.

Utilisation of restorative care (packages of care) funding			
	Baseline	**Target** 2013/14	**Actual** Apr - Jun 2014
	106.7%	*≥97.0%*	*79% (U)*

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

Typically, the mix of respite and day services delivered will change dependent on where the need is highest. Having respite beds available in the right area has been challenging but centre-based day care has increased, particularly for dementia. We have under-delivered on targeted respite care by 15% but over-delivered on targeted day services by 19%. This is an ongoing trend: since June 2011, respite days have remained relatively static while day services have increased by 116%. We believe that this is more in line with demonstrated preferences and need [P].

Number of respite days and day services			
	Baseline	**Target** 2013/14	**Actual** 2013/14
Number of respite days	*4,242*	*≥5,577*	*4,765 (U)*
Number of day services	*13,510*	*≥17,374*	*20,754 (F)*

Rehabilitation and Support (in millions of dollars)	**2014 Actual**	**2014 Budget**	**2013 Actual**
Ministry of Health	*59.5*	*61.9*	*60.0*
Other District Health Boards	*3.0*	*2.8*	*2.0*
Other sources	*0.4*	*0.4*	*0.5*
Income by source	**62.9**	**65.1**	**62.5**
Personnel	*6.2*	*6.2*	*5.9*
Clinical supplies	*0.7*	*0.8*	*0.7*
Infrastructure and non clinical supplies	*1.8*	*1.7*	*1.6*
Payments to other District Health Boards	*3.9*	*3.8*	*3.9*
Payments to other providers	*51.4*	*52.3*	*51.1*
Expenditure by type	**64.0**	**64.8**	**63.2**
Net Result	**(1.1)**	**0.3**	**(0.7)**

WAIROA HEALTH

Financial Report for the year ended 30 June 2014

The board members are pleased to present the Financial Statements of Hawke's Bay District Health Board for the year ended 30 June 2014.

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

Kevin Atkinson
Chair

Dan Druzianic
Board Member

28 October 2014

2013/14 Financial Performance

Result

Total comprehensive income for 2013/14 is a $3.2 million surplus on income of $486.1 million. This is in comparison to the $2.1 million surplus reported last year.

Income was $0.4 million ahead of plan despite not drawing down the $5 million revenue banking . Income included extra revenue from the Ministry of Health for additional services provided, Mid Central DHB for oncology clinics, and donations and clinical trial revenue, partly offset by a reduction in ACC income. The Ministry of Health income includes the achievement of 200 elective surgery discharges above plan to secure $1 million of additional income.

Performance by Arm

The funding arm surplus is $11.2 million which is $8.2 million better than plan. The variance from plan includes the elimination of $4.6 million of pharmaceutical expenditure resulting from claims by the provider arm, that was not adjusted in the plan. Otherwise the result would have been $3.6 miilion favourable to plan due to lower payments to other district health boards for Hawke's Bay domiciled patients treated outside the district, and lower expenditure on pharmaceuticals.

The governance and funding administration surplus is close to plan. The provider arm deficit of $8.1 million includes the $4.6 million of pharmaceutical claims as mentioned above, with the remainings $3.5 million relating to increased expenditure to meet Ministry of Health targets, and high patient volumes.

A breakdown of income and the surplus/(deficit) is tabled below:

	Achieved $'millions	**Plan** $'millions	**Variance** $'millions
Income			
Funding health services	455.3	457.4	(2.1)
Governance and funding administration	3.0	3.0	-
Providing health services	264.3	265.7	(1.4)
Eliminations	(236.5)	(240.4)	3.9
	486.1	485.7	0.4
Surplus/(Deficit)			
Funding health services	11.2	3.0	8.2
Governance and funding administration	0.1	-	0.1
Providing health services	(8.1)	-	(8.1)
	3.2	3.0	0.2

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.

Cash flow

The operating cash surplus of $24.1 million was sufficient to fund the $14.4 million spend on property, plant and equipment and intangible assets, repay debt and equity of $0.7 million, and increase cash holdings by $9.0 million.

Auditors

The Auditor-General is required under section 14 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2013/14 financial statements, amount to $114,806.

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	2014	2013	2012	2011	2010
Return on net funds employed	11.7%	11.2%	9.4%	9.6%	14.5%	(1.3)%
Operating margin to revenue	1.4%	1.4%	1.2%	1.1%	1.7%	(0.7)%
Revenue to net funds employed	6.3	5.7	5.5	5.9	6.5	6.0
Debt to debt plus equity ratio	47.2%	46.5%	48.2%	49.4%	47.2%	57.9%
Net result before financing & abnormals	9.0m	9.5m	8.1m	7.5m	10.0m	(0.9)m
Net result	3.0m	3.2m	2.1m	2.0m	5.3m	(5.5)m
Debt servicing coverage ratio	8.1	7.5	7.5	7.5	8.5	3.4
Ratio of earnings to revenue	4.6%	4.8%	4.5%	4.3%	4.9%	2.3%
Average cost per paid FTE	$84,371	$81,948	$80,483	$79,093	$76,947	$74,847
Average revenue per paid FTE	$240,360	$233,937	$234,014	$228,359	$223,878	$212,102

Statement of comprehensive income

For the year ended 30 June 2014

in thousands of New Zealand Dollars

	Notes	30 June 2014	Budget 30 June 2014	30 June 2013
Patient care revenue	1	478,842	479,359	468,373
Interest income		1,246	840	1,022
Other operating income	2	6,033	5,497	5,360
Gain on sale of surplus properties		-	-	62
Total income		486,121	485,696	474,817
Employee benefit costs	3	170,287	170,489	163,299
Outsourced services		15,925	10,315	13,597
Clinical supplies		40,713	42,755	39,480
Infrastructure and non-clinical expenses		22,723	21,643	21,164
Payments to other district health boards		50,043	52,385	52,750
Payments to non-health board providers		157,715	161,583	158,417
Other operating expenses	4	5,279	4,078	4,882
Depreciation and amortisation expense	12,13	13,992	13,408	13,251
Financing costs		2,634	2,316	2,357
Capital charge	5	3,664	3,724	3,624
Total expenses		482,975	482,696	472,821
Share of associate surplus/(deficit)	15	76	-	85
Surplus/(deficit) for the year	7,21	**3,222**	3,000	**2,081**
Revaluation of land and buildings		-	-	-
Total comprehensive income for the year		**3,222**	3,000	**2,081**

Explanations of major variance against budget are provided in note 30.

District Health Boards are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2014 was underspent by $2.0 million (2013: $2.2 million). The surplus for 2014 has been transferred to the asset replacement reserve, reflecting that along with previous year surpluses it would be used for the development of the mental health intensive care unit. Consequently mental health payments in excess of funding since 1 July 2001, remains at the 30 June 2013 level of $0.3 million.

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

Statement of changes in equity

For the year ended 30 June 2014

in thousands of New Zealand Dollars

	Notes	30 June 2014	Budget 30 June 2014	30 June 2013
Balance at beginning of year		46,278	45,998	44,554
Total comprehensive income for the year				
Surplus/(deficit) for the year		3,222	3,000	2,081
Equity repayments to the Crown		(359)	(357)	(357)
Balance at end of year	21	**49,141**	**48,641**	**46,278**

Explanations of major variance against budget are provided in note 30.

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 2014

in thousands of New Zealand Dollars

	Notes	30 June 2014	Budget 30 June 2014	30 June 2013
Assets				
Cash and cash equivalents	6	18,536	8,015	9,549
Short term investments	6	1,536	-	-
Trade and other receivables	8	17,516	16,601	16,495
Loans (Hawke's Bay Helicopter Rescue Trust)	9	11	11	11
Inventories	10	3,713	3,269	3,466
Non current assets held for sale	11	1,742	188	-
Total current assets		43,054	28,084	29,521
Property, plant and equipment	12	110,044	111,348	112,668
Intangible assets	13	7,171	10,247	2,980
Investment property	14	153	153	153
Investment in associate	15	961	2,008	884
Other investments	16	-	1,814	4,663
Loans (Hawke's Bay Helicopter Rescue Trust)	9	67	78	78
Total non-current assets		118,396	125,648	121,426
Total assets		**161,450**	**153,732**	**150,947**
Liabilities				
Interest-bearing loans and borrowings	17	10,268	10,268	5,344
Trade and other payables	18	35,859	26,979	30,219
Employee benefits	19	31,109	32,669	28,913
Provisions	20	278	262	253
Total current liabilities		77,514	70,178	64,729
Interest-bearing loans and borrowings	17	32,500	33,142	37,799
Employee benefits	19	2,295	1,771	2,141
Total non current liabilities		34,795	34,913	39,940
Total liabilities		**112,309**	**105,091**	**104,669**
Net assets		**49,141**	**48,641**	**46,278**
Equity				
Crown equity	21	37,584	37,588	37,943
Land and building revaluation reserves	21	31,744	31,744	31,744
Asset replacement reserve	21	14,437	12,398	12,411
Retained earnings/(accumulated deficit)	21	(34,624)	(33,089)	(35,820)
Total equity		**49,141**	**48,641**	**46,278**

Explanations of major variance against budget are provided in note 30.

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 2014

in thousands of New Zealand Dollars

	Notes	30 June 2014	Budget 30 June 2014	30 June 2013
Cash flows from operating activities				
Receipts from patient care		476,281	483,984	466,275
Receipts from donations, bequests and clinical trials		750	-	780
Other receipts		6,660	-	5,485
Payments to suppliers		(287,035)	(291,972)	(288,888)
Payments to employees		(168,683)	(168,853)	(163,641)
Goods and services tax (net)		921	-	1,023
Cash generated from operations		**28,894**	**23,159**	**21,034**
Interest received		1,246	840	1,022
Interest paid		(2,375)	(2,320)	(2,405)
Capital charge paid		(3,664)	(3,724)	(3,624)
Net cash inflow/(outflow) from operating activities	7	**24,101**	**17,955**	**16,027**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		-	-	309
Acquisition of property, plant and equipment		(12,551)	(16,850)	(15,899)
Acquisition of intangible assets		(897)	(551)	(449)
Acquisition of investments		(932)	(1,461)	(4,110)
Net cash inflow/(outflow) to investing activities		**(14,380)**	**(18,862)**	**(20,149)**
Cash flows from financing activities				
Proceeds from borrowings		-	-	-
Proceeds from equity injections from the Crown		-	-	-
Repayment of borrowings		-	-	-
Repayment of finance lease liabilities		(375)	(375)	(344)
Repayment of equity to the Crown		(359)	(357)	(357)
Net cash inflow/(outflow) from financing activities		**(734)**	**(732)**	**(701)**
Net increase/(decrease) in cash and cash equivalents		8,987	(1,639)	(4,823)
Add: opening cash		9,549	9,654	14,372
Cash and cash equivalents at end of year	6	**18,536**	**8,015**	**9,549**

The Cash paid to suppliers 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 30.

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

Statement of significant accounting policies

For the year ended 30 June 2014

in thousands of New Zealand Dollars

REPORTING ENTITY

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

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

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

The financial statements for the Hawke's Bay District Health Board are for the year ended 30 June 2014, and were approved by the Board on 28 October 2014.

BASIS OF PREPARATION

Statement of compliance

The financial statements of the district health board have been prepared in accordance with the requirements of the Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

The accounting policies set out below have been applied consistently to all periods presented in these financial statements.

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings at fair value.

The preparation of financial statements in conformity with NZ IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management in the application of NZ IFRSs that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in the notes to the accounts.

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars unless otherwise specified. The functional currency of the District Health Board and its associate is New Zealand dollars (NZ$).

Changes in accounting policy

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

Early adopted amendments to standards

No new standards or amendments to standards have been early adopted since the issue of XRB A1 Application of Accounting Standards (see Standards not applicable to public benefit entities below).

Standards, amendments and interpretations issued but not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the District Health Board, are:

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets.

  The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2016. However as a new accounting standards framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied to public benefit entities.

Standards, amendments and interpretations issued and effective, that have been deferred

Standards, amendments and interpretations issued and effective that the District Health Board has elected to defer, and which are relevant to the District Health Board, are:

- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction, or production of a qualifying asset. In November 2008, the mandatory adoption of NZ IAS 23 *(revised 2007)* by public benefit entities was deferred pending the completion of the Financial Reporting Standard Board's research project into the application of NZ IAS 23 *(revised 2007)* by public benefit entities. The District Health Board has elected to defer the adoption of the revised IAS 23. Accordingly, all borrowing costs that are directly attributable to the acquisition, construction, or production of a qualifying asset continue to be recognised as an expense.

Standards not applicable to public benefit entities

The Minister of Commerce has approved a new accounting standards framework (incorporating a tier strategy) developed by the External Reporting Board (XRB). Under this accounting standards framework, Hawke's Bay District Health Board is classified as a Tier 1 reporting entity and it will be required to apply full public benefit entity accounting standards (PAS). These standards have been developed by the XRB and are mainly based on current international Public Sector Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. This means the District Health Board expects to transition to the new standards in preparing its 30 June 2015 financial statements. The District Health Board has assessed the implications of the new accounting standards framework, and has determined they are not material.

The External Reporting Board (XRB) issued XRB A1 Application of Accounting Standards in August 2011, as an interim step towards the new accounting standards framework. This general (accounting) standard defines the NZ IFRS to be applied by public benefit entities. XRB A1 effectively means that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not apply to public benefit entities. Hawke's Bay District Health Board has applied XRB A1 since 1 July 2011, and as a result there has been no impact on the District Health Board's accounting policies for the years ended 30 June 2012, 30 June 2013 and 30 June 2014, from new or amended NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012.

Basis for consolidation

Subsidiaries

Hawke's Bay District Health Board has no subsidiaries.

Associates

Associates are those entities in which Hawke's Bay District Health Board has significant influence, but not control, over the financial and operating policies.

The financial statements include Hawke's Bay District Health Board's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. The investment in an associate is initially recognised at cost and the carrying amount is increased or decreased to recognise the District Health Board's share of the surplus or deficit of the associate after the date of recognition as an associate. When the District Health Board's share of losses exceeds its interest in an associate, the carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that the District Health Board has incurred legal or constructive obligations or made payments on behalf of an associate. If the associate subsequently reports surpluses, the District Health Board will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised. Distributions received from the associate reduce the carrying amount of the investment.

Where the District Health Board transacts with an associate, surplus or deficits are eliminated to the extent of the interest in the associate.

Dilutions gains or losses arising are recognised in the surplus or deficit.

Foreign currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit.

Budget figures

The budget figures are those approved by the District Health Board in its Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures are prepared in accordance with NZGAAP, using accounting policies that are consistent with those adopted by the District Health Board for the preparation of these financial statements.

SIGNIFICANT ACCOUNTING POLICIES

Revenue

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

Crown funding

The Hawke's Bay District Health Board is primarily funded through revenue received from the Crown under a Crown Funding Agreement. The funding is restricted in its use for the purpose of meeting the District Health Board's objectives as specified in the statement of intent.

Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates, unless and to the extent any conditions imposed by agreements with the Crown are not yet met.

Revenue from other DHBs

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

ACC contracted revenue

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

Sale of goods

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

Provision of services

Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance sheet date . The stage of completion is assessed by reference to surveys of work performed.

Vested assets

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

The activities of the Hawke's Bay District Health Board are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the District Health Board due to the difficulty of measuring their fair value with reliability.

Rental income

Rental income 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.

Interest income

Interest income comprises interest received and receivable on funds invested calculated using the effective interest rate method.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Borrowing costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, and losses on hedging instruments that are recognised in the surplus or deficit.

The interest expense component of finance lease payments is recognised in the surplus or deficit using the effective interest rate method.

Capital charge

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

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of Hawke's Bay District Health Board's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Debtors and other receivables

Short-term debtors and other receivables are recorded at their face value, less any provision for impairment. Long-term debtors are initially recognised at fair value and subsequently stated at amortised cost using the effective interest method, less impairment losses.

A provision for impairment of receivables is established when there is objective evidence that Hawke's Bay District Health Board will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is the difference between the receivable's carrying amount and the present value of estimated future cash flows, discounted using the effective interest method. The amount of the loss is recognised in the surplus or deficit.

When the receivable is uncollectible, it is written off against the provision for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

For bank deposits, impairment is established when there is objective evidence that the District Health Board will not be able to collect amounts due according to the original terms of the deposit.

Derivative financial instruments

Derivative financial instruments are occasionally used to manage exposure to interest rate and foreign exchange risks arising from Hawke's Bay District Health Board's operational activities. The District Health Board does not hold or issue derivative financial instruments for trading purposes. The District Health Board has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into are subsequently remeasured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

The full fair value of a forward foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date; otherwise, foreign exchange derivatives are classified as non-current.

Inventories

Inventories held for distribution

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost, adjusted where applicable for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Inventories held for sale

Inventories held for sale or use in the production 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.

Non-current assets held for sale

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.

Property, plant and equipment

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

- freehold land
- freehold buildings
- clinical equipment
- information technology
- motor vehicles
- other equipment
- work in progress.

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

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually by an independent valuer 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 income 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 income 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 income. Surplus property is carried at the book value on the date the property was declared surplus until it is disposed of.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the District Health Board and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, 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 value of the asset. Gains and losses on disposals are reported net in the surplus or deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to Hawke's Bay District Health Board and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

Class of Asset	Estimated Life	Depreciation Rate
• Buildings	3 to 40 years	2.5% to 33%
• Clinical equipment	3 to 23 years	4.3% to 33%
• Information technology	3 to 10 years	10% to 33%
• Motor vehicles	3 to 20 years	5% to 33%
• Other equipment	3 to 40 years	2.5% 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.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development, employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the District Health Boards website are recognised as an expense when incurred.

Amortisation

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

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

Type of Asset	Estimated Life	Amortisation Rate
• Acquired computer software	3 to 15 years	6.7% to 33%
• Developed computer software	3 to 15 years	6.7% to 33%
• Health Benefits Limited - Class B Shares	Indefinite	Nil
• Interest in CRISP	Indefinite	Nil

Impairment of property, plant and equipment and intangible assets

Property, plant and equipment and intangible assets 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 amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the Hawke's Bay District Health Board would, if deprived of the asset, replace its remaining future economic benefits or service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

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

Investment properties

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

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

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

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

Interest-bearing loans and borrowings

Interest-bearing loans and borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, interest-bearing loans and borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Hawke's Bay District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date. Borrowings where the District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date are classified as current liabilities if the District Health Board expects to settle the liability within 12 months of the balance date.

Creditors and other payables

Creditors and other payables are recorded at their face value.

Employee benefits

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured 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.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as 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 entitlements 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.

Defined benefit schemes

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

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

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present legal or constructive obligation 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.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either has been announced publicly to those affected, of for which implementation has already commenced. While restructuring relating to the financial, procurement and supply chain project facilitated by Health Benefits Limited meets this criteria, no provision has been made because of the current uncertainty over when the District Health Board will transition to the new system, and because the costs of restructuring are to be borne by the project.

ACC Partnership Programme

The Hawke's Bay District Health Board belongs to the ACC Partnership Programme whereby the District Health Board accepts the management and financial responsibility for employee work related illnesses and accidents. Under the full self cover plan the District Health Board is liable for all its claims costs up to a stop loss limit of 250% of risk (levy rate x total liable payroll x loss ratio).

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

Goods and services tax

All amounts 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 (IRD) is included as part of receivables or payables in the statement of financial position.

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hawke's Bay District Health Board is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 2007.

Income and cost allocation

Output classes

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

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

Direct income and costs are charged directly to output classes. Indirect costs are charged to output classes using appropriate cost drivers such as the historical mix of purchase unit production. Indirect income is allocated to each output class based on the cost of the purchase units provided.

Critical accounting estimates and assumptions

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

Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $4.508 million (2013: $4.318 million). Refer note 19.

Workplace accident self insurance

Note 20a provides information about estimates and assumptions applied in determining the District Health Board's liability under the ACC Partnership Programme.

Critical judgements in applying accounting policies

In the process of applying Hawke's Bay District Health Board's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. Management has exercised the following critical judgements in applying accounting policies for the year ended 30 June 2014.

Revaluation of land and buildings

The revaluation of land and buildings as at 30 June 2008, included assumptions relating to the timing of the redevelopment of the Hastings hospital campus, in accordance with the site redevelopment plan under discussion at that time. Site redevelopment has not proceeded due to a re-evaluation of the District Health Board's requirements and the availability of funding. A valuation of land and buildings as at 30 June 2011 was commissioned due to the change in circumstances and the passage of time.

Management determined that re-development of the Hastings hospital campus was likely in the medium term and would have a significant effect on the values of the existing buildings. Ahead of the planning process to determine the District Health Board's requirements going forward, the assumptions made regarding the lives of certain buildings were subject to high uncertainty. Nevertheless management decided to accept the valuation as at 30 June 2011 as the valuations provided the best estimate of fair value available at that time.

The District Health Board is currently carrying out a planning exercise to determine building renovation and replacement needs, in the context of service delivery requirements and financial constraints. The information provided by the planning exercise will be used to inform an independent land and buildings revaluation to be completed in November 2014. As there have been no other factors that have caused a material change in the valuation of land and buildings during the year ended 30 June 2014, management considers the valuation as at 30 June 2011 continues to provide the best estimate of fair value available at this time.

Notes to the financial statements

For the year ended 30 June 2014

in thousands of New Zealand Dollars

1. Patient care revenue	30 June 2014	30 June 2013
Ministry of Health contracted revenue	459,136	450,349
Revenue from other district health boards	11,613	10,402
Other Crown entity contracted revenue	6,375	6,492
Other patient care related revenue	1,718	1,130
	478,842	**468,373**

2. Other operating income	30 June 2014	30 June 2013
Donations and bequests received	575	529
Rental income	545	558
Cafeteria and food sales	1,018	934
Other operating income	3,860	3,299
Gain on sale of property, plant and equipment	35	40
Release of unused provisions	-	-
	6,033	**5,360**

3. Employee benefit costs	30 June 2014	30 June 2013
Wages and salaries	163,636	159,332
Employer contributions to defined contribution plans	4,301	3,384
Increase/(decrease) in employee benefit provisions	2,350	583
	170,287	**163,299**

4. Other operating expenses	30 June 2014	30 June 2013
Impairment of trade receivables (bad and doubtful debts)	310	25
Loss on disposal of property, plant and equipment	313	203
Fees to auditor for the audit of the financial statements	115	111
Fees to board members and commissioners	237	276
Operating lease expenses	3,761	3,564
Increase/(decrease) in provisions	542	588
Koha	1	2
Restructuring expenses	-	113
	5,279	**4,882**

5. Capital charge

District Health Boards pay a capital charge every six months to the Crown. The charge is based on actual closing equity as at 30 June and 30 December each year. The capital charge rate for the year ended 30 June 2014 was 8% (2013: 8%).

in thousands of New Zealand Dollars

6. Cash and cash equivalents and short term investments

	30 June 2014	30 June 2013
Cash and cash equivalents		
Cash	7	8
Bank balances	0	8
Credit balance (Health Benefits Limited)	17,001	6,683
Call deposits – special funds	644	1,576
Call deposits – clinical trials	884	1,274
Cash and cash equivalents in the statement of financial position	**18,536**	**9,549**
Debit balance (Health Benefits Limited)	-	-
Cash and cash equivalents for the purposes of the cash flow statement	**18,536**	**9,549**

The carrying value of cash and cash equivalents approximate fair value.

Special funds		
Opening balance	1,576	1,657
Donations and bequests	362	278
Interest received	37	36
Expenditure during the year	(170)	(395)
	1,805	**1,576**

Special funds include funding from the Ministry of Education for early childhood education purposes. Receipts in 2014 amounted to $46 thousand (2013: $152 thousand), and the balance of funds as at 30 June 2014 amounted to $353 thousand (30 June 2013: $306 thousand).

Clinical trials		
Opening balance	1,274	1,363
Receipts	293	261
Interest received	27	27
Expenditure during the year	(335)	(377)
	1,259	**1,274**

Special funds and clinical trials invested as follow:		
Cash and cash equivalents	1,528	-
Term deposits (3-12 months) – refer to note 16	1,536	-
	3,064	**-**

DHB Treasury Services Agreement

The Hawke's Bay District Health Board is a party to the DHB Treasury Services Agreement under which Health Benefits Limited (HBL) has been mandated by its shareholding ministers, to put in place a sweep facility amongst the DHBs to reduce the overall cost of their banking arrangements. 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: HBL; the Ministry of Health; or any other private sector entity with the consent of the Minister of Finance and the Minister of Health
- It will not invest any cash surpluses on deposit or investment with any person other than HBL

in thousands of New Zealand Dollars

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

	30 June 2014	30 June 2013
Surplus/(deficit) for the year	3,222	2,081
Add back non-cash items:		
Share of associate surplus	(76)	(85)
Depreciation and amortisation	13,992	13,251
Add back items classified as investing activity:		
Net loss/(gain) on disposal of investment property	-	(65)
Net loss/(gain) on disposal of property, plant and equipment	313	203
Debt forgiven (Hawke's Bay Helicopter Rescue Trust)	10	10
Interest attributed to Finance Leases	-	(48)
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(816)	(295)
(Increase)/decrease in inventories	(247)	(273)
Increase/(decrease) in trade and other payables	5,328	899
Increase/(decrease) in employee benefits	2,196	846
Increase/(decrease) in provisions	25	(10)
Net movement in working capital	6,486	1,167
Other movements not in working capital		
Increase/(decrease) in employee benefits	154	(487)
Net cash inflow/(outflow) from operating activities	**24,101**	**16,027**

8. Trade and other receivables

	30 June 2014	30 June 2013
Ministry of Health receivables	1,225	2,422
Trade receivables	1,803	2,280
Ministry of Health accrued income	7,650	7,269
Other accrued income	6,255	4,146
Prepayments	583	378
	17,516	**16,495**

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 $19 thousand (2013: $111 thousand)

Trade receivables are shown net of impairments amounting to $74 thousand (2013: $487 thousand) recognised in the current year and arising from non-resident fees and small service charges which can be uneconomic to collect.

As at 30 June 2014 and 2013, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

in thousands of New Zealand Dollars

	Gross 30 June 2014	Impairment 30 June 2014	Net 30 June 2014	Gross 30 June 2013	Impairment 30 June 2013	Net 30 June 2013
Not past due/past due<30days	2,441	(21)	2,420	4,173	(32)	4,141
Past due 31-60 days	121	(6)	115	109	(7)	102
Past due 61-90 days	96	(8)	88	188	(10)	178
Past due >90 days	444	(39)	405	698	(438)	260
	3,102	**(74)**	**3,028**	**5,168**	**(487)**	**4,681**

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

	30 June 2014	30 June 2013
Balance at beginning of year	487	140
Additional provisions made during the year	272	349
Receivables written-off during period	(685)	(2)
Balance at end of year	74	487

Note 9 Loans

	30 June 2014	30 June 2013
Loan to Hawke's Bay Helicopter Rescue Trust		
Non current	67	78
Current	11	11
	78	**89**

The fair value of loans receivable is $83 thousand (2013 $99 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 tatalling 4.331% (2013 3.21%).

Note 10 Inventories

	30 June 2014	30 June 2013
Pharmaceuticals	783	714
Surgical and medical supplies	1,937	1,818
Other supplies	993	934
	3,713	**3,466**

Write-down of inventories amounted to $20 thousand for 2014 (2013: nil). The amount of inventories recognised as an expense during the year ended 30 June 2014 was $32.3 million (2013: $34.9 million). No reversal of previously recognised write-down was made in the current year. No inventories were held at current replacement cost at 30 June 2014 (30 June 2013: 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.

Note 11 Non current assets held for sale

Changes and improvements to the mental health service delivery model, resulted in three properties being declared surplus in October 2013. Subsequently the three properties were transferred at their book values from property, plant and equipment to non current assets held for sale. All three properties are expected to be sold within the next twelve months.

Notes to the financial statements (continued)

For the year ended 30 June 2014
in thousands of New Zealand Dollars

12. Property, plant and equipment

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

Notes to the financial statements (continued)

For the year ended 30 June 2014
in thousands of New Zealand Dollars

Valuation

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid (MPropertyStudies BCom(VPM) ANZIV SNZPI) of Logan Stone Limited. The valuation is effective as at 30 June 2011.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Restrictions on the district health board's ability to sell land, would normally not impair the value of the land because it has operation 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 district health board expects to make use of each asset.
- The estimated remaining life has been applied in determining depreciated replacement cost .

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

The district health board is currently working on a strategic asset planning exercise. The results of that exercise will affect the period that the district health board expects to make use of each asset, and therefore may have a material impact on the value of the buildings on the Hawke's Bay Hospital site. The results of that exercise will also be used for a valuation of land and buildings timed for November 2014. In the meantime the board considers the net book value of land and buildings is the best estimate of their fair value at 30 June 2014.

The board believes that the net book value of plant and equipment is the fair value at 30 June 2014.

Notes to the financial statements (continued)

For the year ended 30 June 2014
in thousands of New Zealand Dollars

	1 July 2012										30 June 2013		
30 June 2013	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions	Transfers	Disposals	Depreciation Expense	Depreciation write back on disposal/ transfer	Revaluations / Impairment charge	Depreciation write back on revaluation	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Owned assets													
Land	6,658	-	6,658	-	-	-	-	-	-	-	6,658	-	6,658
Buildings	81,712	(5,771)	75,941	-	8,507	-	(6,443)	-	-	-	90,219	(12,214)	78,005
Clinical equipment	27,853	(13,138)	14,715	-	3,503	(1,563)	(3,466)	1,431	-	-	29,793	(15,173)	14,620
Information tech.	5,973	(3,130)	2,843	-	973	(148)	(1,152)	148	-	-	6,798	(4,134)	2,664
Motor vehicles	1,735	(458)	1,277	-	53	(34)	(176)	24	-	-	1,754	(610)	1,144
Other equipment	6,810	(2,410)	4,400	-	1,397	(112)	(674)	63	-	-	8,095	(3,021)	5,074
	130,741	(24,907)	105,834	-	14,433	(1,857)	(11,911)	1,666	-	-	143,317	(35,152)	108,165
Leased assets													
Buildings	3,525	(2,899)	626	-	26	-	(237)	-	-	-	3,551	(3,136)	415
	3,525	(2,899)	626	-	26	-	(237)	-	-	-	3,551	(3,136)	415
Work in Progress													
Buildings	1,595	-	1,595	10,202	(8,533)	-	-	-	-	-	3,264	-	3,264
Clinical equipment	226	-	226	3,599	(3,503)	-	-	-	-	-	322	-	322
Information tech.	345	-	345	923	(973)	-	-	-	-	-	295	-	295
Motor vehicles	-	-	-	59	(53)	-	-	-	-	-	6	-	6
Other equipment	483	-	483	1,115	(1,397)	-	-	-	-	-	201	-	201
	2,649	-	2,649	15,898	(14,459)	-	-	-	-	-	4,088	-	4,088
	136,915	(27,806)	109,109	15,898		(1,857)	(12,148)	1,666	-	-	150,956	(38,288)	112,668

in thousands of New Zealand Dollars

Restrictions

The disposal of certain land may be subject to legislation such as the Reserves Act 1977 and the "offer-back" provisions of the Public Works Act 1981. The Crown may require land the District Health Board has declared surplus and wishes to sell, to be sold to it for use in the redress of Treaty of Waitangi claims. The District Health Board may also be required to assist the Crown to meet its obligations over Maori 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.

13. Intangible assets

	1 July 2013									30 June 2014		
30 June 2014	Cost/	Accumulated	Carrying	Acquisitions	Transfers	Adjustments	Amortisation	Amortisation	Impairment	Cost/	Accumulated	Carrying
Owned assets	Valuation	Amortisation	Amount				Expense	written back	charges	Valuation	Amortisation	Amount
Software	9,151	(6,373)	2,778	-	122	96	(861)	-	-	9,369	(7,234)	2,135
	9,151	(6,373)	2,778	-	122	96	(861)	-	-	9,369	(7,234)	2,135
Work in Progress												
Software	202	-	202	266	(122)	-	-	-	-	346	-	346
Class B Shares in HBL	-	-	-	622	999	-	-	-	-	1,621	-	1,621
CRTAS	-	-	-	9	3,060	-	-	-	-	3,069	-	3,069
	202	-	202	897	3,937	-	-	-	-	5,036	-	5,036
	9,353	(6,373)	2,980	897	4,059	96	(861)	-	-	14,405	(7,234)	7,171

The shareholding in Health Benefits Limited (HBL) was reclassified from an investment to an intangible asset during the year. HBL issued 2,504,000 Class B shares to Hawke's Bay District Health Board in December 2012, and are using the proceeds of the share issue to fund the finance, procurement and supply chain shared services programme it is implementing on behalf of all the district health boards. As at 30 June 2014 a total of 1.621 million shares (2013: 999 thousand shares) had been called at $1 per share. The shares confer a right to use the shared service and carry no voting rights. The district health board expects to be using the shared service from February 2016. The intangible asset is considered to have indefinite life.

The class B shares were tested for impairment during the year by PricewaterhouseCoopers, at the request of HBL on behalf of the sector, and no impairment is required.

Notes to the financial statements (continued)

For the year ended 30 June 2014
in thousands of New Zealand Dollars

The investment in Central Region's Technical Advisory Services Limited (CRTAS) relating to the Central Region Information Services Plan (CRISP) shared service, was also reclassified from an investment to an intangible asset during the year. The intangible asset recognises the District Health Boards right to use the shared services clinical information systems, and is considered to have indefinite life. As at 30 June 2014 the investment in CRISP amounted to $3.068 million (2013: $3.664 million), after CRTAS determined that $604,000 of the investment incurred in the 30 June 2013 year should be expensed.

CRISP was tested for impairment during the year by CRTAS on behalf of the central region DHBs and the assessment is that no impairment is required.

	1 July 2012									30 June 2013		
30 June 2013	Cost/	Accumulated	Carrying	Acquisitions	Transfers	Disposals	Amortisation	Amortisation	Impairment	Cost/	Accumulated	Carrying
Owned assets	Valuation	Amortisation	Amount				Expense	written back	charges	Valuation	Amortisation	Amount
Software	8,792	(5,270)	3,522	-	359	-	(1,103)	-	-	9,151	(6,373)	2,778
	8,792	(5,270)	3,522	-	359	-	(1,103)	-	-	9,151	(6,373)	2,778
Work in Progress												
Software	112	-	112	449	(359)	-	-	-	-	202	-	202
	112	-	112	449	(359)	-	-	-	-	202	-	202
	8,904	(5,270)	3,634	449		-	(1,103)	-	-	9,353	(6,373)	2,980

in thousands of New Zealand Dollars

14. Investment property

	30 June 2014	30 June 2013
Balance at beginning of year	153	222
Disposals	-	(69)
Fair value adjustments	-	-
Balance at end of year	**153**	**153**

Investment properties are valued to fair value annually as at 30 June. Analysis of the investment properties and the property market performed within the DHB indicated valuation changes were immaterial, and no valuation adjustment has been made. The previous valuation as at June 2012 were performed by John Reid (MPropertyStudies BCom(VPM) ANZIV SNZPI) of Logan Stone. The fair value of investment property has been determined using market based evidence.

15. Investments in associates

Hawke's Bay District Health Board had the following investments in associates:

General information

Name of entity	Principal activities	Interest held at 30 June 2014	Balance date
• Allied Laundry Services Limited	Laundry services	25%	30 June
• Te Matau a Maui Health Trust	PHO Governance	No reliable measure	30 June

The Te Matau a Maui Health Trust (the Trust) holds all the shareholding of the Hawke's Bay Primary Health Organisation (PHO). The Hawke's Bay District Health Board appoints four of the ten trustees to represent the general community in consultation with all of the territorial local authorities within the Hawke's Bay region. One of these trustees must be ordinarily resident in the Wairoa District and one of these trustees must be ordinarily resident in the Central Hawke's Bay District. Through its association with the Trust in appointing four of the ten trustees, and its association with the Hawke's Bay PHO as the PHO's primary funder, the District Health Board has significant influence over both the Trust and the PHO. Significant influence is the power to participate in the financial and operating policy decisions of the Trust and the PHO, but is not control over those policies.

The District Health Board is required to equity account for its associate organisations, recording the initial investment at cost and adjusting it thereafter for any changes in the District Health Board's share of the net assets/equity of the associate. However the equity structure of the Trust is not clearly defined from an equity accounting perspective, and it is not possible to obtain a reliable measure of the ownership interest. Consequently the Trust is excluded from the remainder of this note.

Movements in the carrying amount of the investment in Allied Laundry Services	30 June 2014	30 June 2013
Balance at beginning of year	884	799
New investments during the year	-	-
Disposal of investments during the year	-	-
Dilution gain/(loss)	-	-
Share of total comprehensive income	58	85
Adjustment for difference between estimated and final 2013 surplus	19	-
Dividend	-	-
Balance at end of year	**961**	**884**

in thousands of New Zealand Dollars

There are no significant restrictions on the ability of the associate to transfer funds to Hawke's Bay District Health Board in the form of cash dividends.

Summarised financial information of Allied Laundry Services Limited	30 June 2014	30 June 2013
Presented on a gross basis		Restated
Assets	5,283	4,898
Liabilities	1,201	1,250
Revenue	7,588	7,195
Surplus/(deficit)	426	417
Hawke's Bay District Health Board ownership interest	25%	25%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Other contracted commitments (operating leases)	17	26

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited management accounts as at 30 June 2014, and their audited financial statements as at 30 June 2013.

Summarised financial information of Te Matau a Maui Health Trust	30 June 2014	30 June 2013
Presented on a gross basis		Restated
Assets	8,767	10,309
Liabilities	4,384	5,135
Revenue	34,276	33,557
Total comprehensive Income	(727)	(958)
Share of trust's contingent liabilities incurred jointly with other investors	-	-
Contingent liabilities that arise because of several liability	-	-
Contracted capital commitments	-	-
Other contracted commitments	-	-

The trust exists as sole owner of Health Hawke's Bay Limited (the Company) which is a primary health organisation. The figures above are for the Company as they appear in their unaudited management accounts as at 30 June 2014, and their audited financial statements as at 30 June 2013.

16. Other investments

	30 June 2014	30 June 2013
Balance at beginning of year	4,663	553
New investments during the year	-	4,110
Term Deposits (3 – 12 months)	1,536	-
Interest in Central Region Information Services Plan reclassified as an expense	(604)	-
Class B shares in Health Benefits Limited transferred to intangible assets	(999)	-
Interest in Central Region Information Services Plan transferred to intangible assets	(3,060)	
	1,536	**4,663**

Current portion		
Term Deposits (3 – 12 months)	1,536	-
Non-current portion		
Class B shares in Health Benefits Limited	-	999
Interest in Central Region Information Services Plan	-	3,664
	1,536	**4,663**

in thousands of New Zealand Dollars

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

The shareholding in Health Benefits Limited was reclassified from an investment to an intangible asset during the year. This reflects the nature of the shares that confer a right to use the finance, procurement and supply chain shared service developed by Health Benefits Limited, and carry no voting rights.

Also reclassified from an investment to an intangible asset during the year is the interest in the Central Region Information Systems Plan (CRISP), which is a co-operative venture involving the district health boards in the central region. The legal form of the interest in CRISP is likely to be ownership of Class B shares in Central Region's Technical Advisory Services Limited (CRTAS). This reflects the nature of the interest that confers a right to use the clinical information services provided by CRTAS.

The District Health Board has a 16.7% (2013: 16.7%) interest in Central Region Technical Advisory Services Limited , and participates in its commercial and financial policy decisions. The total share capital of 600 shares is uncalled, and as a result no investment has been recorded in the statement of financial position for this investment.

17. Interest-bearing loans and borrowings

	30 June 2014	30 June 2013
Non-current		
Secured bank loans (Ministry of Health)	32,500	37,500
Finance lease liabilities	-	299
	32,500	**37,799**
Current		
Secured bank loans (Ministry of Health)	10,000	5,000
Finance lease liabilities	268	344
	10,268	**5,344**

Secured Bank Loans

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

Weighted average interest rate		
Ministry of Health	5.36%	5.39%

Repayable as follows:		
Less than one year	10,000	5,000
One to two years	-	10,000
Two to three years	-	-
Three to fours years	6,000	-
Four to five years	11,500	6,000
Later than five years	15,000	21,500

Term loan facility limits:		
Ministry of Health	42,500	42,500

The fair value of Crown loan borrowings is $44.01 million (2013 $44.72 million). Fair value has been determined using contractual cash flows discounted using a rate based on market quoted Government stock at balance date plus a margin for District Health Board risk ranging from 3.76% to 4.58% (2013 2.84% to 4.15%).

Credit card facility

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

in thousands of New Zealand Dollars

Security and Terms

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

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

The Government of New Zealand does not guarantee term loans.

Finance Lease Liabilities

Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance lease are disclosed on note 12. Finance lease liabilities are payable as follows:

	30 June 2014			30 June 2013		
Minimum Lease payments payable:	**Total**	**Interest**	**Principal**	**Total**	**Interest**	**Principal**
Less than one year	276	8	268	415	40	375
Between one and five years	-	-	-	276	8	268
	276	8	268	691	48	643
Future finance charges	(17)	-	(17)	(29)	(1)	(28)
	259	**8**	**251**	**662**	**47**	**615**

	30 June 2014			30 June 2013		
Present value of minimum lease payments payable:	**Total**	**Interest**	**Principal**	**Total**	**Interest**	**Principal**
Less than one year	259	8	251	400	38	362
Between one and five years	-	-	-	262	9	253
	259	**8**	**251**	**662**	**47**	**615**

Hawke's Bay District Health Board leases a building under a lease classified as a finance lease. The lease is for the Central Hawke's Bay Health Centre which is leased for a period of fifteen years ending February 2015, with right of renewal for a further three periods of six years each, and an escalation clause allowing for increases in line with the inflation rate. Under the terms of the lease agreements, no contingent rents are payable.

The fair value of finance lease is $272 thousand (2013 $656 thousand). The fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date of 3.71% (2013 2.89%).

in thousands of New Zealand Dollars

18. Trade and other payables

	30 June 2014	30 June 2013
Trade payables	4,908	3,848
ACC levy payable	832	792
Goods and services tax	2,678	2,017
Income in advance relating to contracts with specific performance obligations	1,729	2,091
Other non-trade payables and accrued expenses	25,712	21,471
	35,859	**30,219**

Trade and other payables 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 trade and other payables approximates their fair value.

Note 19 Employee benefits

	30 June 2014	30 June 2013
Non-current liabilities		
Long service leave	2,143	1,991
Retirement gratuities	152	150
	2,295	**2,141**
Current liabilities		
Accrued salaries and wages	6,556	5,509
Annual leave	18,265	17,279
Sick leave	288	240
Continuing medical education leave and expenses	4,075	3,948
Sabbatical leave	514	505
Long service leave	1,278	1,299
Retirement gratuities	133	133
	31,109	**28,913**

Actuarial valuations

An external independent actuarial valuer, Paul Dalebroux (BSc(Hons), FIA, FNZSA) has calculated the Hawke's Bay District Health Board's liability for long service leave, retirement gratuities, sabbatical leave and sick leave, and the valuations are effective 30 June 2014.

20. Provisions (ACC Partnership Programme)

	30 June 2014	30 June 2013
Balance at beginning of year	253	262
Additional provisions made	542	587
Amounts used	(517)	(596)
Unused amounts reversed	-	-
Balance at end of year	**278**	**253**

All provisions are classified as current.

a. ACC Partnership Programme

Liability valuation

The liability for the ACC Partnership Programme is measured at the 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.

An external independent actuarial valuer, Peter Davies (B.Bus.Sc, FIA, FNZSA, AIAA) has calculated the Hawke's Bay District Health Board's liability, and the valuation is effective 30 June 2014. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

The key assumptions used in determining the outstanding claims liability are:

- that the number of reopening claims are similar to those derived from other valuations of entities that are members of the Full Self Cover Plan;
- that claims incurred but not reported (IBNR) will be similar to past claim reporting patterns of weekly compensation and 'medical only' claims, and that further approximate additions for weekly compensation claims to allow for the possibility of long term gradual process claims will be sufficient;
- that a 7.5% factor will be sufficient for future claim management expenses; and
- that liabilities can be carried at their face value as there are insufficient long-term claims to be able to carry out any meaningful discounting.

Risk margin

A risk margin of 12.5% (2013 12.5%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. The risk margin has been determined after consideration of past claims history, costs and trends. The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Insurance risk

The District Health Board operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibilities for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.

The District Health Board is responsible for managing claims for a period of up to five years following the lodgement date. At the end of five years, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis. A stop loss limit of 250% of risk (levy rate x total liable payroll x loss ratio) is used. The stop loss limit means the District Health Board will carry the total cost of all claims only up to a total of $1.3 million per annum. The Hawke's Bay District Health Board is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee. The value of the liability is not material for the District Health Board's financial statements; therefore, any changes in assumptions will not have a material impact on the financial statements.

b. Other provisions

There are no provisions for site restoration or onerous contracts as at 30 June 2014 (30 June 2013: Nil).

in thousands of New Zealand Dollars

21. Equity

	Crown Equity	Land Revaluation Reserve	Buildings Revaluation Reserve	Asset Replace Reserve	Accumulated Deficit	Total Equity
Balance at 1 July 2013	37,943	5,410	26,334	12,411	(35,820)	46,278
Surplus/(deficit) for the year	-	-	-	-	3,222	3,222
Transfers between reserves	-	-	-	2,026	(2,026)	-
Contribution from the Crown	-	-	-	-	-	-
Repayment to the Crown	(359)	-	-	-	-	(359)
Revaluation of land and buildings	-	-	-	-	-	-
Balance at 30 June 2014	**37,584**	**5,410**	**26,334**	**14,437**	**(34,624)**	**49,141**
Balance at 1 July 2012	38,300	5,410	26,334	10,048	(35,538)	44,554
Surplus/(deficit) for the year	-	-	-	-	2,081	2,081
Transfers between reserves	-	-	-	2,363	(2,363)	-
Contribution from the Crown	-	-	-	-	-	-
Repayment to the Crown	(357)	-	-	-	-	(357)
Balance at 30 June 2013	**37,943**	**5,410**	**26,334**	**12,411**	**(35,820)**	**46,278**

Asset Replacement Reserve

The asset replacement reserve includes cash proceeds from the sale of the Napier Hill site of $7.850 million, and underspends relating to mental health funding from the Ministry of Health of $2.026 million (prior years: $4.561 million). These funds have been reserved for the development of the mental health intensive care unit.

Land and Buildings Revaluation Reserves

Where land and buildings are reclassified as investment property, the cumulative increase in the fair value of the land and buildings at the date of reclassification in excess of any previous impairment losses is included in the revaluation reserve.

22. Commitments

	30 June 2014	30 June 2013
Capital commitments		
Property, plant and equipment	11,830	1,096
Health Benefits Limited – Class B shares	883	1,505
Central Region Information Systems Plan (CRISP)	2,776	1,831
	15,489	**4,432**

Capital commitments include orders issued for property, plant and equipment, and future agreed contributions to Health Benefits Limited and CRISP.

in thousands of New Zealand Dollars

Non-cancellable commitments – operating leases	30 June 2014	30 June 2013
Not more than one year	2,299	2,353
One to two years	1,734	2,027
Two to five years	3,736	3,502
Later than five years	4,520	5,455
	12,289	**13,337**

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

- The Napier Health Centre is leased and the 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 store building on Omahu Road is leased for four years and eleven months ending December 2014, with right of renewal for a further three periods of two years each, and a review to market after three years and thereafter on each renewal date.

Note 23 Financial instruments

	30 June 2014	30 June 2013
a. Financial instrument categories		
Financial Assets		
Loans and receivables		
Cash and cash equivalents	18,536	9,549
Short term investments	1536	-
Loans	83	89
Trade and other receivables	17,516	16,495
	37,671	**26,133**
Financial Liabilities		
Financial liabilities at amortised cost		
Secured bank loans (Ministry of Health)	42,500	42,500
Finance lease liabilities	268	643
Trade and other payables	35,859	30,219
	78,627	**73,362**

b. Fair value hierarchy disclosures

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

c. Financial instrument risks

The Hawke's Bay District Health Board's activities expose it to a variety of financial instrument rate risks, including market risk, credit risk and liquidity risk. The District Health Board has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

in thousands of New Zealand Dollars

Market risk

Fair value interest rate risk

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable interest rates expose the Hawke's Bay District Health Board to cash flow interest rate risk.

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

The Hawke's Bay District Health Board's borrowing policy requires a spread of interest rate repricing 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 reprice. The repricing 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 2014	Effective Interest Rates	Total	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
Cash and cash equivalents							
Bank balances	-	7	7				
Credit balance (HBL)	4.55%	17,001	17,001	-	-	-	-
Short term deposits	2.73%	1,528	1,528	-	-	-	-
Short term investments	4.26%	1,536	1,321	215	-	-	-
Secured bank loans:							
NZD fixed rate loans	5.36%	(42,500)	-	(10,000)	-	(17,500)	(15,000)
Finance lease liabilities	8.40%	(268)	-	(268)	-	-	-
Repricing gap		**(22,696)**	**19,857**	**(10,053)**	**-**	**(17,500)**	**(15,000)**

During the year $5 million of borrowings matured and was re-borrowed to April 2023 at an interest rate of 4.74%.

30 June 2013	Effective Interest Rates	Total	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
Cash and cash equivalents							
Bank balances	-	16	16				
Credit balance (HBL)	4.02%	6,683	6,683	-	-	-	-
Short term deposits	2.17%	2,850	2,638	-	212	-	-
Secured bank loans:							
NZD fixed rate loans	5.39%	(42,500)	-	(5,000)	(10,000)	-	(27,500)
Finance lease liabilities	8.40%	(642)	-	-	(642)	-	-
Repricing gap		**(33,593)**	**9,337**	**(5,000)**	**(10,430)**	**-**	**(27,500)**

Foreign Currency risk

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

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

Sensitivity analysis

The effect of a general increase of one percentage point in the value of NZD against other foreign currencies would reduce earnings dependent on how New Zealand based suppliers reflect the increase through the prices they charge. Direct import of goods from overseas is restricted to major capital investment, with no major items planned for 2014/15.

Credit risk

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 96% (30 June 2013: 95%) of the District Health Board's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Sensitivity analysis

At 30 June 2014, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2014/15, as most of the District Health Board's term debt is at fixed rates, and only the net interest from cash holdings would be affected

Credit quality of financial assets

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

in thousands of New Zealand Dollars

	2014	2013
Counterparties with credit ratings		
Cash and cash equivalents		
AA-	18,536	9,549
Total cash and cash equivalents	18,536	9,549
Short term investments		
AA-	1,536	-
Total short term investments	1,536	-
Counterparties without credit ratings		
Trade and other receivables		
Existing counterparty with no defaults in the past	17,516	16,495
Total trade and other receivables	17,857	16,495
Loans (Hawke's Bay Helicopter Rescue Trust)		
Existing counterparty with no defaults in the past	78	89
Total Loans (Hawke's Bay Helicopter Rescue Trust)	78	89

Liquidity risk

Liquidity risk is the risk that the Hawke's Bay District Health Board will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions. The District Health Board aims to maintain flexibility in funding by keeping committed credit lines available. In meeting its liquidity requirements the Hawke's Bay District Health Board maintains a target level of investments that must mature within specified time frames.

Contractual maturity analysis of financial liabilities

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

30 June 2014	Carrying amount	Contractual cash flows	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
Trade and other payables	35,859	35,859	35,859	-	-	-	-
Secured loans (Ministry of Health)	42,500	52,203	1,147	10,989	1,609	21,573	16,885
Finance lease liabilities	268	285	215	70	-	-	-
	78,627	**88,374**	**37,221**	**11,059**	**1,609**	**21,573**	**16,885**

30 June 2013	Carrying amount	Contractual cash flows	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
Trade and other payables	30,219	30,219	30,219	-	-	-	-
Secured loans (Ministry of Health)	42,500	52,351	1,154	6,083	11,900	9,890	23,324
Finance lease liabilities	643	788	236	237	315	-	-
	73,362	**83,358**	**31,609**	**6,320**	**12,215**	**9,890**	**23,324**

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

24. Contingent Assets

The Hawke's Bay District Health Board has a guarantee from Honeywell that energy efficiency and conservation measures managed by Honeywell will result in significant savings within a four year time period. Savings were not achieved as quickly or to the extent expected and as a result payments were received from Honeywell between 2009 and 2014 for periods up to 30 November 2012. It is likely that a further payment will be received from Honeywell relating to the guarantee, although the value of the payment cannot be measured reliably.

25. Contingent Liabilities

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

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

As at March 2014, the scheme had a past service surplus of $16.2 million (8.0% of the liabilities) exclusive of employer superannuation contribution tax. This amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on assets, but otherwise the assumptions and methodology are consistent with the requirements of NZ IAS 19 *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.

26. Related party transactions

Hawke's Bay District Health Board has a related party relationship with its associates, board members and executive officers. The District Health Board has no subsidiaries. All related party transactions have been entered into on an arms' length basis.

Hawke's Bay District Health Board is a wholly owned entity of the Crown. The Government significantly influences the role of the District Health Board as well as being its major source of revenue.

Significant transactions with government-related entities
Hawke's Bay District Health Board has been provided with funding from the Crown of $459.1 million (2013: $450.3 million) for specific purposes as set out in the New Zealand Health and Disability Act 2000 and the Crown Funding Agreement entered into with the Ministry of Health. The District Health Board provides services to, and receives revenue of $5.9 million (2013: $6.1 million) from the Accident Compensation Corporation (ACC), which is also a wholly owned entity of the Crown.

in thousands of New Zealand Dollars

The Ministry of Health administers the inter-district flows regime on behalf of the all the District Health Boards in New Zealand. The regime compensates each district health board for the treatment of patients domiciled in other districts. The Hawke's Bay District Health Board received $8.6 million (2013: $7.8 million) and paid $50.0 million (2013: $52.8 million) under the regime.

Collectively, but not individually, significant, transactions with government related entities

In conducting its activities, Hawke's Bay District Health Board is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The District Health Board is exempt from paying income tax.

The District Health Board also purchase goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government related entities for the year ended 30 June 2014 totalled $6.2 million (2013: $6.1 million). These purchases include blood products from the New Zealand Blood Service, operational costs of Health Benefits Limited, air travel from Air New Zealand, educational courses from the Eastern Institute of Technology, electricity from Genesis Energy, and operational costs of Pharmac and contributions to their discretionary pharmaceutical fund.

Related party transactions with associated entities and joint ventures

	30 June 2014		30 June 2013	
	Transaction amount Payments/(Receipts)	**Outstanding amount** Owed/(Owing)	**Transaction amount** Payments/(Receipts)	**Outstanding amount** Owed/(Owing)
Allied Laundry Services Limited				
Laundry services	1,730	-	1,485	-
Negotiation costs for sale	(21)	-	-	-
Director Fees	(15)	(1)	(15)	1
Consumables	(1)	-	(1)	-
Te Matau a Maui Health Trust				
Primary health services	34,943	-	32,748	-
Primary health services	(791)	(85)	(532)	(546)
Central Region's Technical Advisory Services Limited				
Health information, service planning and external service audits	1,203		2,956	
Meeting facilitation	(2)	-	-	-

Allied Laundry Services Limited and the Te Matau a Maui Health Trust are associate entities of the District Health Board. Central Region Technical Advisory Services is a joint venture with other district health boards. Te Matau a Maui Health Trust operates through Health Hawke's Bay – Te Oranga Hawke's Bay which is a Primary Health Organisation.

The outstanding amount for the Te Matau a Maui Health Trust is owing to the District Health Board as it relates to refunds from Health Hawke's Bay Limited for services the PHO does not provide.

Identity of related parties involving key management personnel (or their close family members)

- Kevin Atkinson (Chair) is chairman of electricity lines company Unison Networks Limited.
- Ngahiwi Tomoana (Deputy Chair) is chairman of Ngati Kahungunu Iwi Incorporated. Ngati Kahungunu Iwi Incorporated is the titular head of Te Taiwhenua o Heretaunga.

in thousands of New Zealand Dollars

- Barbara Arnott (Board Member) was mayor of the Napier City until her retirement at the October 2013 local body elections.
- Peter Dunkerley (Board Member) is a trustee of the Hawke's Bay Helicopter Rescue Trust.
- Denise Eaglesome (Board Member) is deputy mayor of the Wairoa District, and a trustee of Te Matau a Maui Health Trust.
- Helen Francis (Board Member) is a trustee of the Hawke's Bay Power Consumers Trust which holds all the shares in Unison Networks Limited. She is also a committee member of Alzheimers Society Napier Incorporated.
- Diana Kirton (Board Member) is assistant head of school for health recreation and sports science at the Eastern Institute of Technology.
- Jacoby Poulain (Board Member) is a member of the council of the Eastern Institute of Technology and a member of the Hastings District Council.
- Heather Skipworth (Board Member) is a trustee of Te Timatanga Ararau Trust
- Ken Foote (Company Secretary) is a trustee of the Hawke's Bay Helicopter Rescue Trust. He is also the District Health Board's representative on a management committee making recommendations to the Board of Little Elms operated by Trucking for Hawke's Bay Child Cancer Charitable Trust.
- Tracee TeHuia (General Manager, Maori Health) is a member of the council of the Eastern Institute of Technology.
- There are close family members of key management personnel employed by Hawke's Bay District Health Board. The terms and conditions of these arrangements are no more favourable than the District Health Board would have adopted if there were no relationship to key management personnel.
- No provision has been required, nor any expense recognised for the impairment of any loans or other receivables to related parties (2013: Nil).

The following transactions were entered into during the year with key management personnel:

Sales to related parties (figures are in dollars)

Related party	Nature of the transaction	30 June 2014	30 June 2013
Te Taiwhenua o Heretaunga	Training services and staff secondment	$106,082	$26,998
Hawke's Bay Helicopter Rescue Trust	Patient escorts for ACC patients, electricity, telecommunications services, a defibrillator and a ventilator	$17,716	$17,572
Alzheimers Society Napier Incorporated	Meals & staff vaccinations	$22,504	$16,904
Alzheimers Society Napier Incorporated	Gifted the proceeds of a property sale, subject to a specific trust	-	$250,548
Hastings District Council	Health & Safety seminar	$417	-
Eastern Institute of Technology	Acceptance of clinical placements, and supply of clinical goods	$180,927	$136,086

Notes to the financial statements (continued)

For the year ended 30 June 2014
in New Zealand Dollars

Purchases from related parties (figures are in dollars)

Related party	Nature of the transaction	30 June 2014	30 June 2013
Unison Networks Limited	Generator lease	$59,584	$58,854
Unison Networks Limited	Procurement and building of switchgear	-	$30,198
Ngati Kahungunu Iwi Inc.	Support for a number of health related programmes	$55,848	$59,191
Te Taiwhenua o Heretaunga	Health services	$5,634,537	$5,287,543
Napier City Council	Rates, aquatic centre concession cards, training workshops, building concents and building warrants of fitness	$9,516	$6,348
Hawke's Bay Helicopter Rescue Trust	Helicopter transfer services	$281,448	$363,420
Hawke's Bay Helicopter Rescue Trust	Forgiveness of an advance towards the construction of the helicopter hanger on the hospital campus	$15,790	$15,790
Wairoa District Council	Water, rates and various regulatory functions	$31,495	$48,376
Alzheimers Society Napier Incorporated	Dementia specific day care and restorative home based support	$364,395	$292,640
Eastern Institute of Technology	Study courses	$459,454	$237,371
Te Timatanga Ararau Trust	Health services, fitness equipment, and scholarship costs	$44,000	-
Hastings District Council	Share of election costs & fees Rates, building application fees, rubbish disposal fees and health checks	$156,136 $56,221	- -
Little Elms	Rental accommodation	$41,200	$34,256

Outstanding balances from related parties (figures are in dollars)

Related party	Nature of the transaction	30 June 2014	30 June 2013
Hawke's Bay Helicopter Rescue Trust	Patient escorts for ACC patients, electricity and telecommunications services	$1,875	$3,709
Te Taiwhenua o Heretaunga	Training services and staff secondment	$12,726	-
Alzheimers Society Napier Incorporated	Meals & staff vaccinations	-	$2,416
Eastern Institute of Technology	Acceptance of clinical placements, and supply of clinical goods	$887	$34,982

Outstanding balances to related parties (figures are in dollars)

Related party	Nature of the transaction	30 June 2014	30 June 2013
Napier City Council	Water usage	$136	-
Alzheimers Society Napier Incorporated	Day care services	$10,945	-
Hawke's Bay Helicopter Rescue Trust	Advance towards the construction of the helicopter hanger on the hospital campus	$94,730	$110,520

in thousands of New Zealand Dollars unless stated otherwise

Key management personnel compensation

	30 June 2014	30 June 2013
Salaries and other short term employment benefits	2,981	2,931
Post-employment benefits	-	-
Other long term benefits	-	9
Termination benefits	-	101
	2,981	**3,041**

Key management personnel includes board members, the Chief Executive Officer, and the 11 (2013: 13) senior management staff and advisors who were members of the executive management team during the year.

27. Remuneration

Remuneration – Board members

	30 June 2014		30 June 2013	
	Board	**Committees**	**Board**	**Committees**
Kevin Atkinson *Chair*	42,000	2,750	40,000	3,500
Ngahiwi Tomoana *Deputy Chair (appointed member)*	25,500	1,250	25,000	1,937
Barbara Arnott *(appointed member)*	20,400	3,500	20,000	4,125
David Barry *(retired November 2013)*	8,500	1,250	20,000	4,125
Andrew Blair *(appointed October 2013)*	11,900	1,250	-	-
David Davidson *(retired November 2013)*	8,500	250	20,000	1,500
Dan Druzianic *(appointed member/elected October 2013)*	20,400	3,684	20,000	4,125
Peter Dunkerley	20,400	4,000	20,000	4,063
Denise Eaglesome *(appointed member)*	20,400	1,000	20,000	1,250
Helen Francis	20,400	1,500	20,000	2,062
Diana Kirton	20,400	750	20,000	1,374
Jacoby Poulain *(elected October 2013)*	11,900	1,000	-	-
Heather Skipworth *(elected October 2013)*	11,900	500	-	-
Kirsten Wise *(retired November 2013)*	8,500	1,000	20,000	3,250

During the year directors fees of $7,500 were paid to ex-board member David Ritchie (2013: $7,500) as one of the District Health Board's representatives on the Board of Allied Laundry Services Limited.

in New Zealand Dollars

Remuneration – Committee members who are not board members or employees

	30 June 2014	30 June 2013
Mabel Aiolupotea	750	-
Lynlee Aitcheson	750	-
Bayden Barber	-	1,250
Heather Campbell	250	1,000
Iakopo Faafuata	500	-
Tevita Fakaosi	750	-
Patricia Giddens	750	-
Tatiana Greening	4,650	4,250
Leslie Hokianga	500	750
Ngatai Huata	-	2,500
Terry Kingston	-	1,500
Amber Logan-Riley	-	1,750
Patrick Legeyt	500	-
George Mackey	750	-
Vaun McCormick	-	250

	30 June 2014	30 June 2013
John Newland	-	1,000
Graeme Norton	250	1,750
Kerri Nuku	1000	750
Eileen Page	250	1,250
Diana Peterson	250	750
Na Raihania	750	-
Caren Rangi	750	-
Desma Ratima	750	2,000
Heather Robertson	-	-
Frances Smiler-Edwards	-	1,000
Laureen Sutherland	-	1,000
Joan Sye	250	1,000
Panu TeWhaiti	750	-
Diane Walsh	250	1,250
Evangelene Wong	750	-

During the year no additional payments (2013: $6,345) were paid to Ngatai Huata for additional work resulting from her membership of advisory committees.

Employee Remuneration

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

	30 June 2014	30 June 2013
100,000-109,999	22	42
110,000-119,999	28	27
120,000-129,999	18	19
130,000-139,999	8	9
140,000-149,999	4	11
150,000-159,999	6	6
160,000-169,999	5	9
170,000-179,999	7	7
180,000-189,999	7	10
190,000-199,999	11	9
200,000-209,999	9	6
210,000-219,999	8	6
220,000-229,999	12	8
230,000-239,999	11	5
240,000-249,999	8	5
250,000-259,999	11	2
260,000-269,999	5	6
270,000-279,999	9	4

	30 June 2014	30 June 2013
280,000-289,999	5	4
290,000-299,999	6	4
300,000-309,999	4	1
310,000-319,999	5	5
320,000-329,999	4	1
330,000-339,999	2	1
340,000-349,999	2	2
350,000-359,999	2	-
360,000-369,999	-	1
370,000-379,999	3	-
380,000-389,999	1	-
390,000-399,999	-	-
400,000-409,999	-	-
410,000-419,999	-	-
420,000-429,999	-	-
430,000-439,999	1	1
440,000-449,999	-	-
450,000-459,999	1	1

During the year, eleven (30 June 2013: 11) employees received compensation and other benefits in relation to cessation totalling $173,041 (30 June 2013: $246,164).

in New Zealand Dollars

Compensations

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

The Hawke's Bay District Health Board has affected 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.

28. Subsequent events

There are no significant events subsequent to balance date.

29. Output class summary

	30 June 2014	Budget 30 June 2014	30 June 2013
Income			
Prevention services	10.3	7.0	4.5
Early detection and management	149.8	141.3	146.3
Intensive assessment and treatment	263.2	272.3	261.6
Rehabilitation and support	62.9	65.1	62.5
Total income	486.2	485.7	474.,9
Expenditure			
Prevention services	8.6	6.6	6.6
Early detection and management	128.7	139.9	143.6
Intensive assessment and treatment	281.7	271.4	259.4
Rehabilitation and support	64.0	64.8	63.2
Total expenses	483.0	482.7	472.8
Surplus/(deficit) for the year	**3.2**	**3.0**	**2.1**

Direct income and costs are attributed directly to output classes. Indirect income and costs are allocated to output classes using appropriate cost drivers.

30. Explanation of financial variances from budget

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

Notes to the financial statements (continued)

For the year ended 30 June 2014

in millions of New Zealand Dollars

Financial Performance

Income for the year is $0.5 million higher than plan reflecting:

- income of $3.2 million for additional services for the Ministry of Health, including $1 million for providing an additional 200 elective surgery discharges;
- additional income from other DHBs of $0.5 million, including $0.4 million from Mid Central DHB for oncology clinics and $0.1 million from Tairawhiti DHB for cytotoxic drugs;
- interest on working capital invested of $0.4 million;
- additional revenue of $1.2 million, including donations, bequests and clinical trial income of $0.7 million, and increases in a other income across a number of departments such as, community nurse training and laboratory tests;
- one off income of $0.8 million, including the elective surgery wash-up for 2012/13 from the Ministry of Health, the PHO funding contribution to Wairoa Integrated Family Centre and funding for Pharmac medical devices set up costs;

offset by;

- the decision not to drawdown the revenue banking of $5 million; and
- lower than budgeted income from ACC of $0.7 million.

Financial Position

The table below adjusts the projections for assets, liabilities and equity in the 2013/14 Annual Plan, by the difference between the forecasts used for 2012/13 in the Plan, and the results for 2012/13 reported in the 2012/13 Annual Report.

	2013/14 Annual Plan 2012/13 Forecast Result	***2012/13 Annual Report*** 2012/13 Reported Result	Adjustment required to the 2012/13 Result	***2013/14 Annual Plan*** 2013/14 Projected Result	***2013/14 Annual Plan*** Adjusted for 2012/13 Result	***2013/14 Annual Report*** Reported 2013/14 Result	***2013/14 Annual Plan*** to Annual Report Variance
	A	B	C=B-A	D	E=D+C	F	G=F-E
Assets	149,440	150,947	(1,507)	153,732	152,225	161,791	9,566
Liabilities	(103,442)	(104,669)	1,227	(105,091)	(103,864)	(112,650)	(8,786)
Equity	(45,998)	(46,278)	280	(48,641)	(48,361)	(49,141)	(780)

Equity is $0.8 million higher than the adjusted plan, reflecting the higher than planned surplus. Assets are $9.6 million higher than the adjusted plan, reflecting the effect on cash holdings of lower than planned capital expenditure and un-invoiced services from providers pending contract negotiations. Liabilities are $8.8 million higher than the adjusted plan reflecting growth in trade payables and employee entitlements, including the un-invoiced services from providers.

Cash Flow

Cash flow from operating activities was $6.2 million higher than plan reflecting the higher surplus and increases in payables. Cash flow from investing activities was $5.9 million lower than plan, resulting from lower than planned expenditure on property, plant and equipment and lower investment in intangibles including Health Benefits Limited and the Central Region Information Systems Plan (CRISP). Cash flow from financing activities was in line with budget.

Appendix one: Technical Results Report

Key for technical results report

Baseline	Latest available data for planning purpose
Target 2013/14	Target 2013/14
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target (if the actual result is less than or equal to -0.5% of the target then the result is classified as Favourable)
U (Unfavourable)	Actual to date is unfavourable to target

OUTPUT CLASS 1: PREVENTION SERVICES

HEALTH PROMOTION AND EDUCATION SERVICES

Health Target: Better help for smokers to quit - Percentage of hospitalised smokers offered advice to quit			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*92.6%* *October – December 2011*	*≥95%*	*97% (F) - July to September 2012*
			99.4% (F) – October to December 2012
			98.7% (F) – January to March 2013
			98.5% (F) - April to June 2013
2013/14	*99.5%* *October – December 2012*	*≥95%*	*99.2% (F) - July to September 2013*
			98.6% (F) – October to December 2013
			98.2% (F) – January to March 2014
			97.7% (F) - April to June 2014

Health Target: Better help for smokers to quit - Percentage of PHO enrolled smokers offered advice to quit			
Financial Year *Source: Ministry of Health*	**Baseline**	**Target**	**Actual to Date**
2012/13	*30.8%* *12 months to December 2011* *(Source: DHBNZ)*	*≥90%*	*51.8% (U) - 12 months to September 2012*
			56.3% (U) – 12 months to December 2012
			91.2% (F) - 12 months to March 2013
			79.6% (U) - 12 months to June 2013
2013/14	*56.3%* *October – December 2012* *(Source: DHBNZ)*	*≥90%*	*80.5% (U) - 12 months to September 2013*
			80.2% (U) – 12 months to December 2013
			73.5% (U) - 12 months to March 2014
			77.0% (U) - 12 months to June 2014

Health Target: Better help for smokers to quit - % of pregnant women offered advice and support to quit			
Financial Year *Source: Ministry of Health*	**Baseline**	**Target**	**Actual to Date**
2012/13	-	-	-
2013/14	*New*	*≥90%*	93.2% (F) - *12 months to September 2013*
			96.3% (F) - *12 months to December 2013*
			87.9% (U) - *12 months to March 2014*
			94.5% (F) - *12 months to June 2014*

The number of people participating in GRx (Green Prescription) programmes in primary, secondary care or community settings			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2012/13	*1,836* *2010 calendar year*	*≥1,741*	*1,625 (U) - July 2012 to June 2013*
2013/14	*2,030* *2012 financial year*	*≥1,741*	*1,740(F) - July 2013 to June 2014*
MAORI/PACIFIC			
2012/13	*NEW*	*≥696*	*670 (U) - July 2012 to June 2013*
2013/14	*16%*	*50%*	*51.2% (F) - July 2013 to June 2014*

Percentage of people waiting more than 5 days for treatment following a positive swab *(this indicator relates to Rheumatic Fever)*			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*0%* *3 months to December 2012*	*≤5%*	*1.2% (F) - July to September 2012*
			0.0% (F) – October to December 2012
			0.0% (F) – January to March 2013
			0.0% (F) - April to June 2013
2013/14	*0%* *3 months to December 2012*	*≤5%*	*0.0% (F) - July to September 2013*
			0.0% (F) – October to December 2013
			0.0% (F) – January to March 2014
			0.0% (F) - April to June 2014

STATUTORY AND REGULATORY SERVICES

100% of tobacco retailers are visited for smokefree health promotion and regulatory compliance			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	-	-	-
2013/14	*New*	*100%*	*100%*

POPULATION BASED SCREENING SERVICES

Percentage 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			
2012/13	*69.4%* *24 months to November 2011*	*≥70%*	*74.1% (F) - 24 months to 31 May 2013*
2013/14	*73.6%* *24 months to November 2012*	*≥70%*	*75.7% (F) - 24 months to 30 April 2014*
MAORI			
2012/13	*55.6%* *24 months to November 2011*	*≥70%*	*66.1% (U) - 24 months to 31 May 2013*
2013/14	*62.7%* *24 months to November 2012*	*≥70%*	*65.6% (U) - 24 months to 30 April 2014*
PACIFIC			
2012/13	*64.9%* *24 months to November 2011*	*≥70%*	*69.4% (U) - 24 months to 31 May 2013*
2013/14	*70.1%* *24 months to November 2012*	*≥70%*	*73.8% (F) - 24 months to 30 April 2014*

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years			
Financial Year *Source: Breast Screen Coast to Coast*	**Baseline**	**Target**	**Actual to Date**
OVERALL RATE			
2012/13	*78.9%* *36 months to December 2011*	*≥80%*	*81.7% (F) - 36 months to 31 March 2013*
2013/14	*81.2%* *36 months to 30 September 2012*	*≥80%*	*80.7% (F) - 36 months to 31 March 2014*
MAORI			
2012/13	*66.4%* *36 months to December 2011*	*≥80%*	*74.1% (U) - 36 months to 31 March 2013*
2013/14	*72.6%* *36 months to 30 September 2012*	*≥80%*	*74.2% (U) - 36 months to 31 March 2014*
PACIFIC			
2012/13	*69.5%* *36 months to December 2011*	*≥80%*	*81.9% (F) - 36 months to 31 March 2013*
2013/14	*82.7%* *36 months to 30 September 2012*	*≥80%*	*83.9% (F) - 36 months to 31 March 2014*

IMMUNISATION SERVICES

Health Target: Increased immunisation - Percentage of 8 month who complete their primary course of immunisations			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2012/13	*NEW*	*≥85%*	*87.0% (F) – 3 months to September2012*
			91.8% (F) – 3 months to December 2012
			93.6% (F) – 3 months to March 2013
			94.8% (F) - 3 months to June 2013
2013/14	*91.8%* *3 months to December 2012*	*≥90%*	*92.0% (F) – 3 months to September2013*
			94.7% (F) – 3 months to December 2013
			93.7% (F) – 3 months to March 2014
			93.8% (F) - 3 months to June 2014
MAORI			
2012/13	*NEW*	*≥85%*	*86.8% (F) – 3 months to September2012*
			90.3% (F) – 3 months to December 2012
			94.0% (F) – 3 months to March 2013
			95.7% (F) - 3 months to June 2013
2013/14	*90.3%* *3 months to December 2012*	*≥90%*	*92.2% (F) – 3 months to September2013*
			96.4% (F) – 3 months to December 2013
			91.6% (F) – 3 months to March 2014
			92.7% (F) - 3 months to June 2014

Increased immunisation - Percentage of 2 year olds fully immunised:			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2012/13	*93.9%* *3 months to December 2011*	*≥95%*	*93.8% (U) – 3 months to September2012*
			94.9% (U) – 3 months to December 2012
			93.6% (U) – 3 months to March 2013
			96.1% (F) - 3 months to June 2013
2013/14	*94.9%* *3 months to December 2012*	*≥95%*	*93.8% (U) – 3 months to September2013*
			95.5% (F) – 3 months to December 2013
			92.3% (U) – 3 months to March 2014
			94.6% (F) - 3 months to June 2014
MAORI			
2012/13	*94.3%* *3 months to December 2011*	*≥95%*	*95.8% (F) – 3 months to September2012*
			97.2% (F) – 3 months to December 2012
			95.2% (F) – 3 months to March 2013
			97.8% (F) - 3 months to June 2013
2013/14	*97.2%* *3 months to December 2012*	*≥95%*	*96.0% (F) – 3 months to September2013*
			97.7% (F) – 3 months to December 2013
			95.6% (F) – 3 months to March 2014
			94.5% (F) - 3 months to June 2014

Percentage of high needs 65 years olds and over influenza immunisation rate			
Financial Year *Source: DHB Shared Services*	**Baseline**	**Target**	**Actual to Date**
2012/13	*67.1%* *January to December 2011*	*≥70%*	*66.5% (U) - January to December 2012*
2013/14	*66.5%* *January to December 2012*	*≥75%*	*69.0% (U) - January to December 2013*

WELL CHILD AND SCHOOL HEALTH SERVICES

Number of Children receiving a B4 school check - Overall			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*2,012* *2010/11*	*≥1,887*	*1,932 (F) - July 2012 to June 2013*
2013/14	*2,045* *2011/12*	*≥1,971*	*2,307 (F) - July 2013 to June 2014*

Number of Children receiving a B4 school check – Quintile 5			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*667* *2010/11*	*≥514*	*709(F) - July 2012 to June 2013*
2013/14	*660* *2011/12*	*≥667*	*755 (F) - July 2013 to June 2014*

Percentage of eligible population receiving a B4 school check			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*86%* *2010/11*	*≥80%*	*101% (F) - July 2012 to June 2013*
2013/14	*87%* *2011/12*	*≥80%*	*94% (F) - July 2013 to June 2014*

The number of clients (5 to18 year olds) seen by public health nurses			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	-	-	-
2013/14	*NEW*	*≥5,050*	*5,963 (F) - July 2013 to June 2014*

Percentage of year 9's in low decile schools who have a HEADSSS assessment completed			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*92.4%* *2011 calendar year*	*≥91%*	*102.5% (F) - July 2012 to June 2013*
2013/14	*98.3%* *2012 financial year*	*≥91%*	*95.5% (F) - July 2013 to June 2014*

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

PRIMARY HEALTH CARE SERVICES

GP utilisation: ratio of high needs enrolees vs others			
Financial Year *Source: DHB Shared Services*	**Baseline**	**Target**	**Actual to Date**
2012/13	*1.09* *July – September 2011*	*≥1.12*	*1.15 (F) - April to June 2012*
			1.16 (F) - July to September 2012
			1.14 (F) - October to December 2012
			1.23 (F) - January to March 2013
2013/14	*1.14* *3 months to December 2012*	*≥1.23*	*1.18 (U) - April to June 2013*
			1.40 (F) - July to September 2013
			1.15 (U) - October to December 2013
			1.21 (U) - January to March 2014

Of patients seen at the hospital emergency department between 6pm and 10pm, percentage who are triaged as lower urgency.			
Financial Year	**Baseline**	**Target**	**Actual to Date**

2012/13	*54.8%* *October - December 2011*	*≤56%*	*53.1% (F) - July to September 2012*
			55.7% (F) - October to December 2012
			55.7% (F) - January to March 2013
			52.3% (F) - April to June 2013
2013/14	*55.7%* *3 months to December 2012*	*≤55%*	*50.6% (F) - July to September 2013*
			54.0% (F) - October to December 2013
			52.4% (F) - January to March 2014
			47.7% (F) - April to June 2014

PRIMARY AND COMMUNITY CARE PROGRAMMES

Health Target: More heart and diabetes checks: **% of the eligible population will have had their cardiovascular disease risk assessed in the last 5 years**			
Financial Year *Source: DHB Shared Services*	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2012/13	*47.9%* *As at 30th June 2011*	*≥75%*	*61.4% (U) - July to September 2012*
			64.7% (U) – October to December 2012
			67.1% (U) – January to March 2013
			72.4% (U) - April to June 2013
2013/14	*57.5%* *As at 30th June 2012*	*≥90%*	*73.1% (U) - July to September 2013*
			73.7% (U) – October to December 2013
			79.1% (U) – January to March 2014
			84.1% (U) - April to June 2014
MAORI			
2012/13	*48.8%* *As at 30th June 2011*	*≥75%*	*62.2% (U) - July to September 2012*
			63.8% (U) – October to December 2012
			65.8% (U) – January to March 2013
			69.7% (U) - April to June 2013
2013/14	*59.5%* *As at 30th June 2012*	*≥90%*	*70.4% (U) - July to September 2013*
			69.8% (U) – October to December 2013
			75.3% (U) – January to March 2014
			79.8% (U) - April to June 2014
PACIFIC			
2012/13	*49.1%* *As at 30th June 2011*	*≥75%*	*61.5% (U) - July to September 2012*
			63.4% (U) – October to December 2012
			65.3% (U) – January to March 2013
			69.1% (U) - April to June 2013
2013/14	*59.4%* *As at 30th June 2011*	*≥90%*	*70.4% (U) - July to September 2013*
			70.9% (U) – October to December 2013
			74.1% (U) – January to March 2014
			79.0% (U) - April to June 2014

More heart and diabetes checks - Better management of long-term conditions: Diabetes detection and follow up			
Financial Year *Source: DHB Shared Services*	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2012/13	*NEW*	*≥80%*	*80.6% (F) - July 2012 to June 2013*
2013/14	*78.2%* *July to December 2012*	*≥80%*	*73.4% (U) - July 2012 to June 2013*

More heart and diabetes checks - Better management of long-term conditions: Diabetes Case management			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2012/13	-	-	-
2013/14	*NEW**	*≥80%*	*54.1% (U) – July 2013 to September 2013*
			54.0% (U) – July 2013 to December 2013
			52.5% (U) – July 2013 to March 2014
			51.7% (U) - July 2013 to June 2014
MAORI:			
2012/13	-	-	-
2013/14	*NEW**	*≥80%*	*50.5% (U) – July 2013 to September 2013*
			49.0% (U) – July 2013 to December 2013
			49.3% (U) – July 2013 to March 2014
			50.2% (U) - July 2013 to June 2014
PACIFIC:			
2012/13	-	-	-
2013/14	*NEW**	*≥80%*	*45.8% (U) – July 2013 to September 2013*
			43.0% (U) – July 2013 to December 2013
			45.3% (U) – July 2013 to March 2014
			45.4% (U) - July 2013 to June 2014

**Although this indicator was included in the previous year (2012/13) the denominator changed for the 2013/14 period. Previously the denominator was all those people who had attend a Diabetes Annual Review (DAR) within 12 months, the new denominator is the Virtual Diabetes Register (VDR) provided by the Ministry of Health and is an estimated number of people in the DHB who have diabetes. This change had a dramatic affect on the results and meant we could not compare with previous years.*

Sub-acute Community Support (Volumes)			
Financial Year *Please note this data is subject to change over time*	**Baseline**	**Target**	**Actual to Date**
2012/13	*29* *July 2011 – March 2012*	*≥ 30*	*60 (F) - July 2012 to June 2013*
2013/14	*25* *July to December 2012*	*≥ 35*	*54 (F) - July 2013 to June 2014*

% of primary mental health packages targeted to young people (0 to 24 years)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	-	-	-
2013/14	*26%* *July to December 2012*	*≥ 26%*	*26.7 (F) - July 2013 to June 2014*

ORAL HEALTH SERVICES

Percentage of enrolled preschool and primary school children not examined according to planned recall			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*3.2%* *2010 calendar year*	*<5%*	*4% (F) - 2012 calendar year*
2013/14	*4%* *2012 calendar year*	*<5%*	*4.2% (F) - 2013 calendar year*

Percentage of eligible preschool enrolments in DHB-funded oral health services			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2012/13	*50.4%* *2010 calendar year*	*≥80%*	*71.1% (U) - 2012 calendar year*
2013/14	*71.1%* *2012 calendar year*	*≥81%*	*70.4% (U) - 2013 calendar year*
MAORI:			
2012/13	*39.2%* *2010 calendar year*	*≥80%*	*63.8% (U) - 2012 calendar year*
2013/14	*63.8%* *2012 calendar year*	*≥81%*	*61.9% (U) - 2013 calendar year*
PACIFIC:			
2012/13	*38.3%* *2010 calendar year*	*≥80%*	*63.3% (U) - 2012 calendar year*
2013/14	*63.3%* *2012 calendar year*	*≥81%*	*67.4% (U) - 2013 calendar year*

COMMUNITY REFERRED TESTS/DIAGNOSTIC SERVICES AND PHARMACIST SERVICES

Percentage of routine laboratory tests[6] (by volume) completed and communicated to referring practitioners within 48 hours from time of receipt			
Financial Year *Source: Southern Community Laboratories and HBDHB Laboratory*	**Baseline**	**Target**	**Actual to Date**
2012/13	*97.2%* *October – December 2011*	*≥90%*	*97.3% (F) - July to September 2012*
			97.0% (F) – October to December 2012
			97.2% (F) – January to March 2013
			97.2% (F) - April to June 2013
2013/14	*97.0%* *October – December 2012*	*≥90%*	*99.2% (F) - July to September 2013*
			99.7% (F) – October to December 2013
			99.9% (F) – January to March 2014
			99.8% (F) - April to June 2014

Percentage of accepted referrals that receive MRI or CT scans within 42 days			
Financial Year	**Baseline**	**Target**	**Actual to Date**
CT			
2012/13	*NEW*	*≥75%*	*74.2% (U) - July to September 2012*
			85.8% (F) – October to December 2012
			90.2% (F) – January to March 2013
			92.3% (F) - April to June 2013
2013/14	*N/A*	*≥85%*	*81.1% (U) - July to September 2013*
			88.0% (F) – October to December 2013
			94.1% (F) – January to March 2014
			80.5% (U) - April to June 2014
MRI			
2012/13	*NEW*	*≥75%*	*47.6% (U) - July to September 2012*
			53.1% (U) – October to December 2012
			61.6% (U) – January to March 2013
			63.5% (U) - April to June 2013
2013/14	*N/A*	*≥75%*	*52.2% (U) - July to September 2013*
			54.1% (U) – October to December 2013
			60.1% (U) – January to March 2014
			60.2% (U) - April to June 2014

[6] Hematology (routine) – complete blood count (CBC). Prothrombin time (INR – International Normalised Ratio)
Biochemistry (routine) – Electrolytes (Sodium), Liver functions tests (LFT), Lipids, Beta gonadotropin hormone (BHCG)
Microbiology (routine) – Urine microscopy and culture

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

MENTAL HEALTH SERVICES

Percentage of people with enduring severe mental illness who have an up to date relapse prevention plan			
Financial Year	**Baseline**	**Target**	**Actual to Date**
0-19 YEARS CHILD AND YOUTH			
TOTAL			
2012/13	*47.3%* *As January 2012*	≥95%	*85.5% (U) – As at 25th October 2012*
			82.1% (U) – As at 5th January 2013
			87.4% (U) – As at 7th April 2013
			87.5% (U) – As at 9th July 2013
2013/14	*82.1%* *As January 2013*	≥95%	*90.7% (U) – As at 6th October 2013*
			81.8% (U) – As at 12th January 2014
			90.8% (U) – As at 7th April 2014
			92.4% (U) – As at 10th July 2014
MAORI			
2012/13	*40%* *As January 2012*	≥95%	*75.8% (U) – As at 25th October 2012*
			64.0% (U) – As at 5th January 2013
			85.7% (U) – As at 7th April 2013
			75.8% (U) – As at 9th July 2013
2013/14	*64%* *As January 2013*	≥95%	*85.7% (U) – As at 6th October 2013*
			81.0% (U) – As at 12th January 2014
			89.5% (U) – As at 7th April 2014
			85.0% (U) – As at 10th July 2014
20 YEARS AND OVER ADULTS (EXCLUDING ADDICITONS)			
TOTAL			
2012/13	*77.7%* *As January 2012*	≥95%	*82.5% (U) – As at 25th October 2012*
			83.6% (U) – As at 5th January 2013
			94.8% (U) – As at 7th April 2013
			93.1% (U) – As at 9th July 2013
2013/14	83.6% *As January 2013*	≥95%	*94.6% (F) – As at 6th October 2013*
			87.1% (U) – As at 12th January 2014
			96.7% (F) – As at 7th April 2014
			94.7% (U) – As at 10th July 2014
MAORI			
2012/13	*60.1%* *As January 2012*	≥95%	*68.9% (U) – As at 25th October 2012*
			62.9% (U) – As at 5th January 2013
			93.0% (U) – As at 7th April 2013
			87.1% (U) – As at 9th July 2013
2013/14	*62.9%* *As January 2013*	≥95%	*96.4% (F) – As at 25th October 2013*
			85.7% (U) – As at 5th January 2014
			95.3% (F) – As at 7th April 2014
			92.5% (U) – As at 9th July 2014

Shorter waits for non-urgent drug and alcohol services

Financial Year *Please note data is subject to change over time*	Baseline	Target	Actual to Date
PERCENTAGE OF PEOPLE SEEN WITHIN 3 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
2012/13	*NEW*	*≥60%*	*64.6% (F) - October 2011 to September 2012* *66.0% (F) – April 2012 to March 2013*
2013/14	*64.6%* *12 months to September 2012*	*≥80%*	*74.1% (U) - October 2012 to September 2013* *74.9% (U) - January 2012 to December 2013* *75.3% (U) - April 2013 to March 2014*
ADDICTIONS (PROVIDER ARM AND NGO)			
2012/13	*NEW*	*≥60%*	*61.3% (F) – October 2011 to September 2012* *57.7% (U) – April 2012 to March 2013*
2013/14	*61.3%* *12 months to September 2012*	*≥70%*	*61.3% (U) - October 2012 to September 2013* *67.2% (U) - January 2012 to December 2013* *74.8% (F) - April 2013 to March 2014*
PERCENTAGE OF PEOPLE SEEN WITHIN 8 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
2012/13	*NEW*	*≥90%*	*87.7% (U) – October 2011 to September 2012* *83.7% (U) – April 2012 to March 2013*
2013/14	*87.7%* *12 months to September 2012*	*≥92.5%*	*90.4% (U) - October 2012 to September 2013* *91.3% (U) - January 2012 to December 2013* *91.4% (U) - April 2013 to March 2014*
ADDICTIONS (PROVIDER ARM AND NGO)			
2012/13	*NEW*	*≥90%*	*88.6% (U) - October to September 2012* *83.0% (U) – April 2012 to March 2013*
2013/14	*88.6%* *12 months to September 2012*	*≥92.5%*	*85.8% (U) - October 2012 to September 2013* *90.3% (U) - January 2012 to December 2013* *93.4% (F) - April 2013 to March 2014*

ELECTIVE SERVICES (inpatient, outpatient and cancer treatment)

Health target: Improved access to elective surgery (discharges)[7]			
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)*			
2012/13	*5,860 2010/2011*	*≥5,729*	*6,678 (F) - July 2012 to June 2013*
2013/14	*5,729 2012/2013*	*≥5,866*	*6,103 (F) - July 2012 to June 2013*

(ESPI2) Percentage patients waiting longer than 5 months for their First Specialist Assessment (FSA)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13 (See note)	-	-	-
2013/14	*NEW*	*0%*	*0.3% (U) – September 2013*
			0.2% (U) – December 2013
			0.0% (F) – March 2014
			0.0% (F) - June 2014

(ESPI5) Percentage of patients given a commitment but not treated within 5 months			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13 (See note)	-	-	-
2013/14	*NEW*	*0%*	*0.7% (U) – September 2013*
			1.0% (U) – December 2013
			0.0% (F) – March 2014
			0.0% (F) - June 2014

Note: ESPI 2 and ESPI 5 went from being a target of 'waiting no longer than 6 months' in 2012/13 to a target of 'waiting no longer than 5 months' in 2013/14 and therefore a comparison cannot be drawn.

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

Did not attend (DNA) rate across first specialist assessments[8]			
Financial Year *Please note data is subject to change over time*	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2012/13	*9.8% October to December 2011*	*≤7.5%*	*7.9% (U) - July to September 2012*
			8.8% (U) – October to December 2012
			10.2% (U) – January to March 2013
			9.5% (U) - April to June 2013
2013/14	*8.8% October to December 2012*	*≤7.5%*	*9.8% (U) - July to September 2013*
			9.1% (U) – October to December 2013
			8.4% (U) – January to March 2014
			7.4% (F) - April to June 2014
MAORI			
2012/13	*19.4% October to December 2011*	*≤7.5%*	*16.1% (U) - July to September 2012*
			18.5% (U) – October to December 2012
			20.9% (U) – January to March 2013
			17.9% (U) - April to June 2013
2013/14	*18.5% October to December 2012*	*≤7.5%*	*19.7% (U) - July to September 2013*
			17.9% (U) – October to December 2013
			18.3% (U) – January to March 2014
			16.5% (U) - April to June 2014

Percentage of cancelled elective cases as a result of prioritised acute demand			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*NEW*	*≤6%*	*11.1% (U) - July to September 2012*
			14.4% (U) – October to December 2012
			13.6% (U) – January to March 2013
			19.8% (U) - April to June 2013
2013/14	*14.4% October to December 2012*	*≤6%*	*14.8% (U) - July to September 2013*
			12.1% (U) – October to December 2013
			7.8% (U) – January to March 2014
			15.5% (U) - April to June 2014

Elective inpatient ALOS			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13 (See note)	-	-	-
			-
			-
			-
2013/14	*3.49 days January to December 2012*	*≤3.21 days*	*3.4 (U) - April to June 2013*
			3.4 (U) – July to September 2013
			3.3 (U) – October to December 2013
			3.4 (U) – January to March 2014

Note: In 2013 'Elective and Arranged Inpatient Length of Stay' was changed from being reported as 1 total figure and is now reported separately for Elective and Acute, therefore a comparison cannot be drawn with previous data.

[8] ESPI specialities only

Health Target: Shorter waits for cancer treatment - Radiation Oncology Treatment Waiting Times less than 4 weeks			
Financial Year *Source: MidCentral DHB*	**Baseline**	**Target**	**Actual to Date**
2012/13	*100%* *October – December 2011*	*100%*	*100% (F) - July to September 2012*
			100% (F) – October to December 2012
			100% (F) – January to March 2013
			100% (F) - April to June 2013
2013/14	*100%* *January – December 2012*	*100%*	*100% (F) - July to September 2013*
			100% (F) – October to December 2013
			100% (F) – January to March 2014
			100% (F) - April to June 2014

Chemotherapy Treatment waiting times less than 4 weeks			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*100%* *October – December 2011*	*100%*	*100% (F) - July to September 2012*
			100% (F) - October to December 2012
			100% (F) - January to March 2013
			100% (F) - April to June 2013
2013/14	*100%* *January – December 2012*	*100%*	*100% (F) - July to September 2013*
			100% (F) - October to December 2013
			100% (F) - January to March 2014
			100% (F) - April to June 2014

Initial contact by District Nursing Service within 48 hours of receipt of referral			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*NEW*	*≥80%*	*61.9% (U) - July to September 2012*
			78.1% (U) – October to December 2012
			81.0% (F) – January to March 2013
			82.7% (F) - April to June 2013
2013/14	*78.1%* *January – December 2012*	*≥80%*	*82.9% (F) - July to September 2013*
			77.3% (U) – October to December 2013
			86.2% (F) – January to March 2014
			87.8% (F) - April to June 2014

ACUTE SERVICES (emergency department, inpatient, outpatient)

Health Target: Shorter stays in Emergency Departments - Percentage of patients admitted, discharged or transferred from an emergency department within 6 hours			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*94.5%* *October to December 2011*	*≥95%*	*94.0% (U) - July to September 2012*
			94.3% (U) – October to December 2012
			93.1% (U) – January to March 2013
			93.3% (U) - April to June 2013
2013/14	*94.3%* *October to December 2012*	*≥95%*	*92.6% (U) - July to September 2013*
			93.3% (U) – October to December 2013
			93.0% (U) – January to March 2014
			90.6% (U) - April to June 2014

Emergency Department Triage compliance rates			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TRIAGE 1[9]			
2012/13	*100.0% October to December 2011*	*100%*	*100% (F) - July to September 2012*
			100% (F) – October to December 2012
			100% (F) – January to March 2013
			100% (F) - April to June 2013
2013/14	*100.0% October to December 2012*	*100%*	*100% (F) - July to September 2013*
			100% (F) – October to December 2013
			100% (F) – January to March 2014
			100% (F) - April to June 2014
TRIAGE 2[10]			
2012/13	*68.5% October to December 2011*	*≥80%*	*64.5% (U) - July to September 2012*
			59.8% (U) – October to December 2012
			62.4% (U) – January to March 2013
			66.4% (U) - April to June 2013
2013/14	*59.8% October to December 2012*	*≥80%*	*75.1% (U) - July to September 2013*
			72.6% (U) – October to December 2013
			63.4% (U) – January to March 2014
			60.0% (U) - April to June 2014
TRIAGE 3[11]			
2012/13	*58.3% October to December 2011*	*≥75%*	*45.4% (U) - July to September 2012*
			43.3% (U) – October to December 2012
			43.8% (U) – January to March 2013
			51.5% (U) - April to June 2013
2013/14	*43.3% October to December 2012*	*≥75%*	*49.2% (U) - July to September 2013*
			49.5% (U) – October to December 2013
			45.0% (U) – January to March 2014
			43.4% (U) - April to June 2014

[9] Definition of Triage 1: seen immediately
[10] Definition of Triage 2: seen within 10 minutes
[11] Definition of Triage 3: seen within 30 minutes

Standardised 28 day acute readmission rate			
Financial Year *Source: Ministry of Health*	**Baseline**	**Target**	**Actual to Date**
Total Population			
2012/13	*11.3%* *2010/2011*	*≤11.2%*	*10.96% (F) - 12 months to June 2012*
			10.98% (F) - 12 months to September 2012
			10.81% (F) - 12 months to December 2012
			10.5% (F) - 12 months to March 2013
2013/14	*7.7%* *January to December 2012*	*≤7.7%*	*7.2% (F) - 12 months to June 2013*
			7.3% (F) - 12 months to September 2013
			7.5% (F) - 12 months to December 2013
			7.8% (U) - 12 months to March 2014
75+			
2012/13	-	-	-
2013/14	*NEW*	*≤12.2%*	*11.8% (F) - 12 months to June 2013*
			11.6% (F) - 12 months to September 2013
			11.9% (F) - 12 months to December 2013
			12.4% (U) - 12 months to March 2014

day acute readmission but linked to events outside of the 28 day period. The data quality issues make it difficult to get a true understanding of our Acute Readmission rate. However results from Quarter 1, 2, 3 & 4 (with data quality issues) are stable.

Rate[12] of hospital-acquired bloodstream infections[13]			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*0.12 per 1000 occupied bed days* *2011calendar year*	*≤0.29*	*0.19 per 1000 occupied bed days (F) – July to September 2012*
			0.17 per 1000 occupied bed days (F) – October to December 2012
			0.17 per 1000 occupied bed days (F) – January to March 2013
			0.08 per 1000 occupied bed days (F) – April to June 2013
2013/14	*0.17 per 1,000 occupied bed days* *October to December 2012*	*≤0.29*	*0.11 per 1000 occupied bed days (F) – July to September 2013*
			0.08 per 1000 occupied bed days (F) – October to December 2013
			0.04 per 1000 occupied bed days (F) – January to March 2014
			0.19 per 1000 occupied bed days (F) – April to June 2014

[12] Per 1000 occupied bed days
[13] Only those with an Acute admission type

MATERNITY SERVICES

Post natal Average length of stay (days)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*2.1 days* *October – December 2011*	*≤2.1 days*	*2.2% (U) - July to September 2012*
			2.3% (U) – October to December 2012
			2.2% (U) – January to March 2013
			2.3% (U) - April to June 2013
2013/14	*2.3 days* *October – December 2012*	*≤2.1 days*	*2.2% (U) - July to September 2013*
			2.1% (F) – October to December 2013
			2.3% (U) – January to March 2014
			2.3% (U) - April to June 2014

Percentage of first time mothers delivering who are breastfeeding (Full or exclusive) at the time of discharge			
Financial Year *Please note this data is subject to change over time*	**Baseline**	**Target**	**Actual to Date**
2012/13	*83.3%* *October – December 2011*	*≥75%*	*80.2% (F) - July to September 2012*
			81.5% (F) – October to December 2012
			80.1% (F) – January to March 2013
			83.6% (F) - April to June 2013
2013/14	*81.5%* *October – December 2012*	*≥80%*	*76.6% (U) - July to September 2012*
			84.2% (F) – October to December 2012
			85.9% (F) – January to March 2013
			79.8% (F) - April to June 2013

ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)

Percentage of AT&R patients discharged home			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*59.3%* *12 months to December 2011*	*≥60%*	*61.0% (F) - 12 months to June 2013*
2013/14	*58.2%* *January to December 2012*	*≥60%*	*62.5% (F) - 12 months to June 2014*

Inpatient falls per 100 bed days AT&R			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*1.2* *October – December 2011*	*≤1.1*	*0.9 per 100 bed days (F) - July to September 2012*
			0.6 per 100 bed days (F) – October to December 2012
			0.8 per 100 bed days (F) – January to March 2013
			0.7 per 100 bed days (F) - April to June 2013
2013/14	*0.6* *October – December 2012*	*≤1.0*	*0.6 per 100 bed days (F) - July to September 2013*

			0.4 per 100 bed days (F) – October to December 2013
			0.6 per 100 bed days (F) – January to March 2014
			0.9 per 100 bed days (F) - April to June 2014

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

NEEDS ASSESSMENT AND SERVICE COORDINATION (NASC) SERVICES

Number of referrals processed (65 years and over)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*5,787* *2010/11*	*≥5,787*	*6,888 (F) - July 2012 to June 2013*
2013/14	*6,098* *2011/12*	*≥5,500*	*7,215 (F) - July 2013 to June 2014*

Average time from referral to allocation (65 years and over)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*12 days* *January – March 2012*	*≤10 days*	*11 days (U) - July to September 2012*
			5 days (F) - October to December 2012
			7 days (F) - January to March 2013
			5 days (F) - April to June 2013
2013/14	*5 days* *October - December 2012*	*≤10 days*	*11 days (U) - July to September 2013*
			9 days (F) - October to December 2013
			14 days (U) - January to March 2014
			14 days (U) - April to June 2014

Number of needs assessments completed (Disability Services)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*522* *2010/11*	*≥300*	*463 (F) July 2012 to June2013*
2013/14	*415* *2011/12*	*≥300*	*618 (F) July 2013 to June2014*

Average time from referral to assessment (Disability Services)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*13 days* *2010/11*	*≤13 days*	*12 days (F) - July to September 2012*
			4 days (F) - October to December 2012
			6 days (F) - January to March 2013
			3 days (F) - April to June 2013
2013/14	*4 days* *October - December 2012*	*≤13 days*	*2 days (F) - July to September 2012*
			3 days (F) - October to December 2012
			2.5 days (F) - January to March 2013
			2 days (F) - April to June 2013

REHABILITATION SERVICES AND PALLIATIVE CARE SERVICES

Utilisation of restorative care (packages of care) funding[14]			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*100%* *July – September 2011*	*≥97.0%*	*111.7% (F) – April to June 2012*
			106.7% (F) – July to September 2012
			127.5% (F) – October to December 2012
			111.7% (F) - January to March 2013

[14] Percentage of high level clients

2013/14	*106.7%* *October to December 2012*	*≥97.0%*	*98%% (F) – July to September 2013*
			93% (U) – October to December 2013
			91% (U – January to March 2014
			79% (U) - April to June 2014

Time from referral receipt to initial Cranford Hospice contact within 48 hours			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*47%* *January to March 2011*	*≥80%*	*90% (F) - April to June 2013*
2013/14	*92.0%* *October to December 2012*	*≥80%*	*91.0% (F) - July to September 2013*
			99.0% (F) – October to December 2013
			94.0% (F) – January to March 2014
			87.5% (F) - April to June 2014

HOME BASED SUPPORT SERVICES AND AGED RESIDENTIAL CARE BED SERVICES

Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*NEW*	*≥90%*	*93.8% (F) - July to September 2012*
			93.3% (F) – October to December 2012
			95.7% (F) – January to March 2013
			95.2% (F) - April to June 2013
2013/14	*93.8%* *October to December 2012*	*≥95%*	*95.8% (F) - July to September 2013*
			94.4% (F) – October to December 2013
			97.0% (F) – January to March 2014
			100% (F) - April to June 2014

Vitamin D prescribing			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*53.6%* *October – December 2011*	*≥75%*	*57.3% (U) - July to September 2012*
			61.0% (U) – October to December 2012
			61.0% (U) – January to March 2013
			61.0% (U) - April to June 2013
2013/14	*61.0%* *Sep 2012*	*≥75%*	*75.8% (U) - July to September 2013*
			80.0% (U) – October to December 2013
			82.0% (U) – January to March 2014
			84.0% (U) - April to June 2014

RESPITE CARE AND DAY SERVICES

Number of respite days			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*4,919* *July 2010 – June 2011*	*≥7,274*	*4,514 (U) - July 2012 to June 2013*
2013/14	*4,242* *2011/12*	*≥5,577*	*4,765(U) - July 2013 to June 2014*

Number of day services			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2012/13	*9,600* *July 2010 – June 2011*	*≥13,837*	*15,696 (F) - July 2012 to June 2013*
2013/14	*13,510* *2011/12*	*≥17,374*	*20,754 (F) - July 2013 to June 2014*

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