
# Annual Report 2018

## CONTENTS



## ACRONYMS USED IN THIS REPORT

| | |
|---|---|
| CCDM | Care Capacity Demand Management |
| CE | Chief Executive |
| DHB | District Health Board |
| DMFT | Decayed, missing or filled teeth |
| DNA | Did Not Attend |
| FSA | First Specialist Assessment |
| FTE | Full time equivalent |
| GP | General Practitioner |
| GST | Goods and services tax |
| HBDHB | Hawke's Bay District Health Board |
| HHB | Health Hawke's Bay |
| HR | Human Resources |
| KPI | Key Performance Indicator |
| MECA | Multi-Employer Collective Agreement |
| MoH | Ministry of Health |
| NGO | Non Government Organisation |
| NZNO | New Zealand Nurses Organisation |
| PHO | Primary Health Organisation |
| The Board | Hawke's Bay District Health Board's governing body |
| The CE Act | Crown Entities Act 2004 |
| The NZPHD Act | New Zealand Public Health and Disability Act 2000 |

# Message from the Chair and Chief Executive

While the 2017/18 year has posed some challenges in terms of patient demand, particularly on hospital services, much has been achieved.

The year has seen us bring 12 months of workshops and consultation with the health sector together to form a draft Clinical Services Plan.

This plan is now out for public consultation. Once finalised this plan will provide a road-map of health services, what is needed and where they should be delivered from, for the next 10-15 years.

Greater investment in nursing and midwifery has been achieved through the Care Capacity Demand Management (CCDM) programme with $0.3m invested in 2017/18 and a further $1.3m included in 2018/19. In addition to this, in 2018/19, the DHB has invested an extra $1.0m in non-CCDM staffing to support critical areas and $1.5m for immediate relief and CCDM implementation support from the NZNO MECA settlement.

Once fully recruited this will have seen our nursing workforce grow by 56 full time equivalent positions. We are nearing completion of “Ruakopito” our $13.1 million Gastroenterology and Endoscopy building.

This significant investment will enable us to deliver the national bowel screening programme to the Hawke’s Bay community. The incidence of bowel cancer in Hawke’s Bay is very high so the introduction of this screening programme is welcomed by our clinicians and our community.

Our Population Health team has been busy addressing the issue alcohol harm has on our community. This is an on-going and important piece of work for the Population Health team as we work to address violence and other harms the high rates of hazardous drinking are having on our community.

During the year we undertook a significant staff survey called the Big Listen which has enabled us to implement a strategic plan to address work life issues for staff.

Other significant developments have been the:

- continued success of the Go Well Travel Plan that as seen improved public and staff travel options to and from Hawke’s Bay Hospital
- Significant investment in Information technology and solutions to help us provide better technology solutions to help staff do their jobs
- Celebrated the 90 year anniversary of Hawke’s Bay Fallen Soldiers Memorial Hospital on ANZAC day
- Population Health study into the long term health effects from the campylobacter outbreak
- New state-of-the art radiology equipment installed in Central Hawke’s Bay’s medical centre
- New playground for paediatric inpatients installed.

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

While we have been unable to report an operating surplus we are pleased with our steps to improve and develop our services throughout the year.

We would like to thank our staff and colleagues across the sector for their significant contribution throughout a challenging year.

**Kevin Snee**
Chief Executive

**Kevin Atkinson**
Chair

# Organisation profile

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

**PUBLIC HOSPITAL AND HEALTH FACILITIES**

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

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

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

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

# Hawke's Bay DHB vision, values and structure

## Board Chair: Kevin Atkinson

Finance Risk and Audit Committee

Māori Relationship Board

Community and Public Health Advisory Committee (Inactive)

- Pasifika Health Leadership Group

Disability Support Advisory Committee (Inactive)

Hospital Advisory Committee (Inactive)

Hawke's Bay Clinical Council

- Clinical Governance Committees

Hawke's Bay Health Consumer Council

- Youth Consumer Council

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

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

**HE KAUANUANU RESPECT**
**ĀKINA IMPROVEMENT**
**RARANGA TE TIRA PARTNERSHIP**
**TAUWHIRO CARE**

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

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

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

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

## Chief Executive: Dr Kevin Snee

Chief Medical and Dental Officer (Hospital)

Chief Allied Health Professions Officer

Chief Medical Officer (Primary)

Chief Nursing and Midwifery Officer

Executive Director Corporate Services

Executive Director People & Quality

Executive Director Primary Care

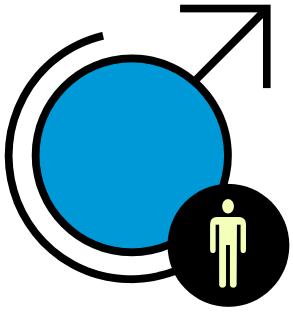
Executive Director of Provider Services

Executive Director Strategy and Health Improvement

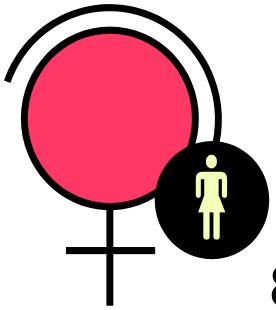
Chief Executive Health Hawke's Bay Ltd – Te Oranga Hawke's Bay

# About Hawke's Bay District Health Board

The DHB currently employs **2926** people, a number of whom are multi-jobbed; with **3233** positions held throughout the organisation. Of these **3233** positions:



17.0%



83.0%

| WORKFORCE PROFILE – by age bands | |
|---|---|
| <25 | 4.5% |
| 25 - 34 | 19.3% |
| 35 - 45 | 18.5% |
| 45 - 55 | 27.0% |
| 55 - 64 | 24.3% |
| 65+ | 6.4% |

| WORKFORCE PROFILE – by occupational group | |
|---|---|
| Medical staff | 9.7% |
| Nursing staff | 51.0% |
| Allied Health staff | 18.2% |
| Non-clinical support staff | 6.1% |
| Management & admin staff | 15.0% |

| | Positions filled | % of Total |
|---|---|---|
| NZ & European | 2118 | 72.4 |
| Māori | 426 | 14.6 |
| Pacific Islands | 45 | 1.5 |
| Asian | 193 | 6.6 |
| Other | 95 | 3.2 |
| Not known | 49 | 1.7 |
| **Total** | **2926** | **100.0** |

| EMPLOYEE STATUS | | |
|---|---|---|
| **Casual** | 14% |  |
| **Full time** | 34% |  |
| **Part time** | 52% |  |

# Report on good employer obligations

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

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

Underpinning our Transform and Sustain agenda is a newly developed People Plan which puts the values and behaviours of the organisation at the centre of the way we do things around here. This People Plan will ensure that our workforce is cared for, well supported, highly skilled, empowered and have joy in their work.

The focus of the People Plan:

- Transformational management and leadership capability
- Building capability – developing individuals, talent, succession planning and recruitment
- Increasing Māori and Pacific staff representation
- Embedding the values and behaviours of the organisation
- Ensuring the health and wellbeing of our workforce

### Leadership, Accountability and Culture:

Investing in its people and developing leadership capability, remains a priority for Hawke's Bay DHB, as does increasing the capability of our whole workforce. Our Transformational Leadership programme has continued to develop our Managers and Clinical Leaders across the health sector and have been very well received. As an organisation we endeavour to engage with our staff and have this year undertaken a significant engagement programme called The Big Listen to understand what it's like to work in the health sector – this has helped inform the key priorities within our new People Plan.

The Hawke's Bay Consumer Council (established June 2013) continues to meet monthly and ensures health consumers have an effective voice in health planning and how it is delivered in Hawke's Bay. The Consumer Council and the DHB's sector-wide Clinical Council has a leadership role in monitoring quality of health services delivered throughout Hawke's Bay. The DHB is adopting principles of co-design in service planning, project development and strategy to ensure the consumer voice is heard with the development and this year the implementation of a Consumer Engagement Strategy. Our service directorate partnerships support medical, nursing and allied health leaders to lead and drive clinical quality and improve patient safety.

The DHB runs an annual Talent Mapping programme to identify high performing and high potential individuals to further develop and invest in. This programme has focused on the third and fourth tier of talent but will be extended to identify emerging talent and to the primary sector. This programme will align to the State Services Commission Leadership Success Profile.

### Recruitment, Selection and Induction:

The DHB has centralised recruitment functions ensuring robust recruitment processes are consistently managed across the DHB. The Taleo applicant management system ensures consistent candidate care. Hawke's Bay DHB has a

particular concern focus on increasing Māori and Pacific uptake into health careers. There will be continued focus in the coming year with the development of both a Maori and Pacific Workforce development action plan.

Hiring managers are supported through the recruitment process to ensure efficiency and consistency of recruitment and this coming year we will be prioritising recruitment of individuals who not only have the technical competence but also are aligned to the values of the organisation.

### Employee Development, Promotion and Exit:

HBDHB has a fair and equitable performance appraisal system in place which will undergo a full review in the coming 12 months. Whilst the process is well documented and available to all staff the system does enable strength based conversations to occur on a more regular basis, where the staff member is able to identify personal development needs and document career aspirations.

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

The Employment Relations Act, and Health and Safety in Employment Amendment Act 2015 continues to reinforce the need to maintain strong relationships with employees and unions. The Bipartite Union Committee continues to be the forum for Union delegates to be engaged on the Transform and Sustain agenda and to discuss common issues. HBDHB has an agreed Health & Safety strategy to ensure that as an organisation we are meeting our obligations and create a Safe Place, Safe People and Safe Care.

### 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 on being equitable.

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

### Harassment and Bullying Prevention:

HBDHB has a zero tolerance to bullying policy which is supported with resources such as clearly defined process supported by policy, manager and staff training, posters throughout the organisation which emphasise respect and

acceptable and unacceptable behaviours, and intranet resources provide a centralised information resource for all staff to access. In the coming year there will be a full review and refresh of our approach and support to dealing with unacceptable and bullying behaviours.

### Safe and Healthy Environment:

The DHB is continuing to make changes to our policies and procedures to reflect the new Health and Safety legislation.

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

HBDHB maintains its ACC partnership programme at tertiary level which recognises that appropriate systems support a safe environment and are implemented throughout the organisation. HBDHB retained this tertiary status as an outcome of the last audit. A Wellbeing Steering group has been established and will continue to be refined in the next 12 months ensuring that all our staff wellbeing is prioritised.

### Staff Ethnicity

Increasing the number of Māori employees is a priority for HBDHB. A KPI measuring the number of positions where incumbents identify as Māori is reported the DHB's Board on a quarterly basis. The target is set at 10% improvement on previous year with the ultimate aim that the workforce reflects the Hawke's Bay population mix.
As at the end of the 2017/18 year the target of 15.68 percent of staff identifying as Māori was not reached:

| | |
|---|---|
| Target 2017/18 | 15.68% (459) |
| Actual at 30 June 2018 | 14.55% (426) |
| Gap | 33 positions |

| | Headcount | % of Total |
|---|---|---|
| Māori | 426 | 14.55 |
| Pacific | 45 | 1.54 |
| Asian | 193 | 6.60 |
| NZ & European | 2,118 | 72.39 |
| Other | 95 | 3.25 |
| Not known | 49 | 1.67 |
| **Total** | **2926** | **100.00** |

Ethnicity breakdown at June 2018

### Staff Disability

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

# Hawke's Bay District Health Board Governance

## Role of the Board

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

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

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

## Role of the CEO

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

## Advisory Committees

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

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

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

**Finance Risk and Audit Committee:**

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

**Māori Relationship Board (MRB):**

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

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

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

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

**Note:**

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

## Meeting Information & Disclosure of Interests

Number of Board Meetings held 11

**KEVIN ATKINSON – Chair**
**Meetings attended 10 of 11**
Chairman, Unison Networks Limited *(to 31 July 2017)*
Director, Unison Fibre Limited *(to 31 July 2017)*
Trustee, Te Matau ā Māui Health Trust
Director, New Zealand Health Partnerships Ltd
Trustee Hawke's Bay Power Consumers Trust (*from 26 October 2017)*

**NGAHIWI TOMOANA - Deputy Chair**
**Meetings attended 9 of 11**
Chairman, Ngāti Kahungunu Iwi Inc
Member, Treaty Tribes Coalition
Brother of employee of HBDHB *(to 11 April 2018)*
Brother is employee of Cranford Hospice
Two nephews are employees of HBDHB
Waitangi Claim #2687 relating to Napier Hospital land *(from 28 March 2018)*

**BARBARA ARNOTT**
**Meetings attended 10 of 11**
Trustee of the Hawke's Bay Air Ambulance Trust
Trustee Hawke's Bay Power Consumers' Trust *(from 26 October 2017)*

**PETER DUNKERLEY**
**Meetings attended 11 of 11**
Trustee, Hawke's Bay Rescue Helicopter Trust
Shareholder of Need a Nerd (*from 13 December 2017)*
Shareholder of NZ Technologies (*from 13 December 2017)*

**DIANA KIRTON**
**Meetings attended 11 of 11**
Brother is a surgeon for HBDHB
Practicum Manager – EIT School of Health and Sport Science
Trustee, Hawke's Bay Power Consumers' Trust
Member HB Law Society Standards Committee
Renew Counselling Services *(from 17 July 2017)*

**DAN DRUZIANIC**
**Meetings attended 10 of 11**
Director, Markhams Hawke's Bay Limited

**DR HELEN FRANCIS**
**Meetings attended 9 of 11**
Patron and Lifetime member of Alzheimer's Society Napier *(to 26 February 2018)*
Employee of Hastings Health Centre *(to 24 January 2018)*
Contractor Hastings Health Centre *(from 24 January 2018 to 26 February 2018)*

Trustee, Hawke's Bay Power Consumers' Trust
Trustee, HB Medical Research Foundation
Independent Consultant to a variety of health organisations *(from 26 February 2018)*

**JACOBY POULAIN**
**Meetings attended 10 of 11**
Board Member of Eastern Institute of Technology
Councillor, Hastings District Council

**HEATHER SKIPWORTH**
**Meetings attended 9 of 11**
Mother is a Kaumatua – Kaupapa Māori HBDHB
Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB
Director of Kahungunu Asset Holding Company Ltd

**ANA APATU**
**Meetings attended 11 of 11**
CEO of U-Turn Trust renamed "Whararaki Trust" *(from 30 August 2017)*
Chair of Directions *(to 30 June 2018)*
Chair, Health Promotion Forum *(to 11 April 2018)*

**HINE FLOOD**
**Meetings attended 10 of 11**
Member, Health Hawke's Bay Priority Population Committee
Councillor for the Wairoa District Council

## Membership of Advisory Committees – statutory

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

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

Refer Board interests disclosed.

**Diana Kirton – Chairperson of DSAC**

**Barbara Arnott – Chairperson of CPHAC**

**Peter Dunkerley – Chairperson of HAC**

**Kevin Atkinson**

**Ngahiwi Tomoana**

**Dan Druzianic**

**Helen Francis**

**Jacoby Poulain**

**Heather Skipworth**

**Ana Apatu**

**Hine Flood**

## FINANCE RISK AND AUDIT COMMITTEE (FRAC)

Number of FRAC Meetings held 11

Refer Board interests disclosed

**Dan Druzianic - Chairperson**
**Meetings attended 10 of 11**

**Kevin Atkinson**
**Meetings attended 10 of 11**

**Ngahiwi Tomoana**
**Meetings attended 6 of 7** *(from November 2017)*

**Barbara Arnott**
**Meetings attended 10 of 11**

**Peter Dunkerley**
**Meetings attended 11 of 11**

**Jacoby Poulain**
**Meetings attended 11 of 11**

**Helen Francis**
**Meetings attended 10 of 11**

**Diana Kirton**
**Meetings attended 11 of 11**

**Heather Skipworth**
**Meetings attended 7 of 7** *(from November 2017)*

**Ana Apatu**
**Meetings attended 7 of 7** *(from November 2017)*

**Hine Flood**
**Meetings attended 6 of 7** *(from November 2017)*

## MĀORI RELATIONSHIP BOARD (MRB)

Number of MRB Meetings held 10.

**Ngahiwi Tomoana – Chair**
**Meetings attended 7 of 10**
Refer Board interests disclosed

**Heather Skipworth – Deputy Chair**
**Meetings attended 9 of 10**
Refer Board interests disclosed

**Ana Apatu**
**Meetings attended 9 of 10**
Refer Board interests disclosed

**Hine Flood**
**Meetings attended 7 of 10**
Refer Board interests disclosed

**Tatiana Cowan-Greening** *(to 26 September 2017)*
**Meetings attended 1 of 3**
Ngāti Kahungunu Iwi Inc representative
Trustee, Te Matau a Maui Health Trust
Husband is Manager of Te Kupenga Hauora

**Beverly TeHuia** *(from October 2017)*
**Meetings attended 4 of 7**
Ngāti Kahungunu Iwi Inc representative
Trustee and employee of Kahungunu Health Services *(from 7 November 2017)*
Employee of Totara Health *(from 7 November 2017)*
Member of the Priority Population Health Committee *(from 7 November 2017)*
Ngā Maia O Aotearoa Chairperson *(from 7 November 2017)*
Iwi Rep on Te Matua ā Māui Health Trust (*from 28 May 2018)*
Claimant of Treaty Health Claim currently with the Tribunal; WAI #2575 *(from 28 May 2018)*

**Kerri Nuku**
**Meetings attended 6 of 10**
Ngāti Kahungunu Iwi Inc representative
Kaiwhakahaere New Zealand Nurses Association
Trustee of Maunga Haruru Tangitu Trust

**Dr Fiona Cram**
**Meetings attended 9 of 10**
Board Member, Ahuriri District Health (Wai 692)
Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington
Director and Shareholder of Katoa Limited *(from 11 April 2018)*
Research work in relation to WAI2575 (MoH) *(from 16 June 2018)*

**Trish Giddens**

**Meetings attended 9 of 10**

Ngati Kahungunu Iwi Inc representative

Trustee, HB Air Ambulance Trust

Assistant Director Rotary District 9930

Manager, Taruna College

Member of the Lotteries Board

**Na Raihania**

**Meetings attended 10 of 10**

Ngati Kahungunu Iwi Inc representative

Wife employed at Te Taiwhenua o Heretaunga

Member Tairawhiti DHB Maori Relationship Board

Employed as a Corrections Officer

Mother in law, Chaplain at Te Matau a Maui *(since 14 February 2018)*

Niece attending NeSP program *(from 14 February 2018)*

**George Mackey**

**Meetings attended 6 of 10**

Ngati Kahungunu Iwi Inc representative

Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB

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

Director and Shareholder of Iron Māori Ltd

Employee of Te Puni Kokiri

**Lynlee Aitcheson-Johnson**

**Meetings attended 5 of 10**

Ngāti Kahungunu Iwi Inc representative

Chair of Māori Party, Heretaunga Branch

Chair of Te Whare Whānau Purotu Inc. Māori Women's Refuge *(to July 2017)*

Treasurer Ikaroa Rawhiti Māori Party Electorate *(from 4 July 2017)*

# Statement of Responsibility

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

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

The board and management of Hawke's Bay District Health Board are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting, and;

In the opinion of the board and management of Hawke's Bay District Health Board the financial statements and statement of service performance for the year ended 30 June 2018, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

**Kevin Atkinson**
*Chair*

**Dan Druzianic**
*Board Member*

31 October 2018

# Independent Auditor's Report

**To the readers of Hawke's Bay District Health Board's financial statements and performance information for the year ended 30 June 2018**

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

**Opinion**

We have audited:

- the financial statements of the Health Board on pages 51 to 87, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 25 to 49 and pages 88 to 111.

In our opinion:

- the financial statements of the Health Board on pages 51 to 87:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2018; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 25 to 49 and 88 to 111:
  - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2018, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2018. This is the date at which our opinion is expressed.

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

**Compliance with the Holidays Act 2003**

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 5.5 on page 84. Our opinion is not modified in respect of this matter.

**Basis for our opinion**

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

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

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

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

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

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

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

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

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

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

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

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

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

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

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

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

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the Health Board audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

**Other information**

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 111, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

**Independence**

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

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

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

# Statement of Service Performance 2017/18

This section outlines Hawke's Bay District Health Board's achievement against the 2017/18 Statement of Performance Expectations. Service performance is grouped into four Output Classes:

- Prevention Services;
- Early Detection and Management Services;
- Intensive Assessment and Treatment Services; and,
- Rehabilitation and Support Services.

Across the output classes, we strive to maintain a balance across the three dimensions of the New Zealand Triple Aim **(Figure 1),** in line with the Health Quality and Safety Commission's drive for quality improvement across the health sector.

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

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

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


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

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

## Prevention services

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

**Statement of Service Performance Output Class 1**

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

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

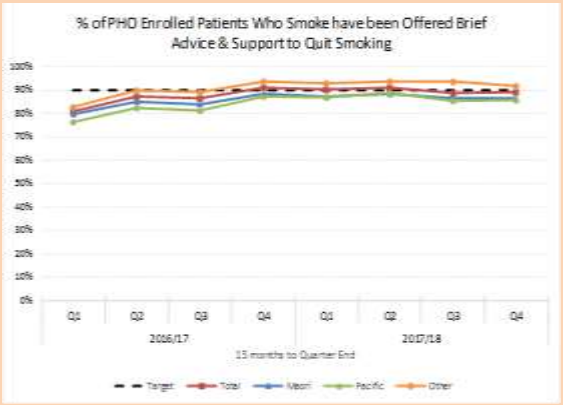
Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly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


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

In Hawke's Bay, we are committed to reducing smoking rates with the vision of a Smokefree Aotearoa by 2025. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care. The National Health Target: Better Help for Smokers to Quit is designed to prompt providers to give brief advice and offer quit support to current smokers. Evidence shows that brief advice is effective at prompting quit attempts and long-term quit success.

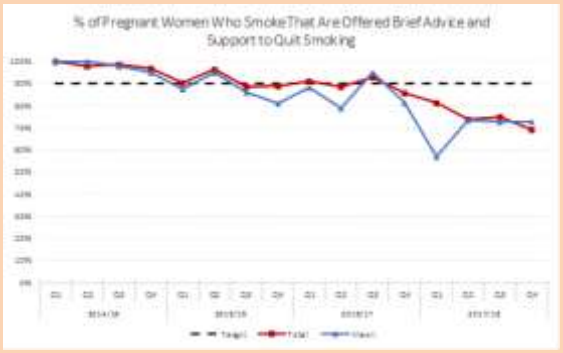
**Smokers are offered advice to quit when seen in General Practice**

Health Hawke's Bay has been working across the health sector on a number of initiatives to increase the number of smokers who are offered smoking brief advice and cessation support. They have continued to fund a number of independent nurses to contact patients on behalf of the practices. Health Hawke's Bay fell just short of the Better Help for Smoker to Quit target with a Smoking Brief Advice coverage rate of 89.1% for the 15 month period ending June 2018. This is compared to 91% for the previous year.



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

In 2017/18, 75% of pregnant women who smoke (70% of pregnant Māori women who smoke) were offered advice and support. Data from 2014/15 showed that 43% of pregnant Māori women giving birth in Hawke's Bay were smokers[1] identifying the advice and support measure as a leading marker for the DHB in addressing health inequity. It is noted that the data shows steadily declining rate for all populations in this area. After an internal audit, it was found that this is primarily due to the way data is collected, rather than a reduction in activity. Further work is underway to improve data integrity.




Tobacco use during pregnancy increases the risk of miscarriage, premature birth and low birth rate, as well as their children's risk of asthma and sudden unexplained death of infant. The maternity component of the health target is aimed at offering brief advice and support to quit smoking for pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer.

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

**Smoke free Māori women at two weeks postnatal**

This indicator was historically reported in the Māori Health Plan and was included to ensure there was continued focus on smoke-free health. During the year this indicator has year been replaced with the SLM 'Number of Babies who live in a smoke-free household at 6 weeks post-natal', as a result no new data has been supplied.

**Number of babies who live in a smoke-free household at 6 weeks post-natal**

Most recent rates, from July to December 2017, show Total at 66.1% and Māori at 41.2%.

Incentivised programmes continue for pregnant women, women with babies up to six months and their whānau. Tame Your Taniwha Challenges have been operating with further initiatives planned.

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

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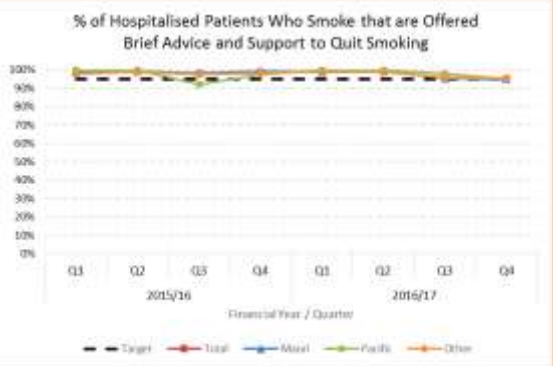
### Hospitalised smokers are offered advice to quit

In 2017/18, 96.5% of hospitalised patients were offered brief advice and support to quit smoking by a health practitioner. The target of 95% continues to be achieved for Māori and total population with a business as usual approach for the hospital staff.



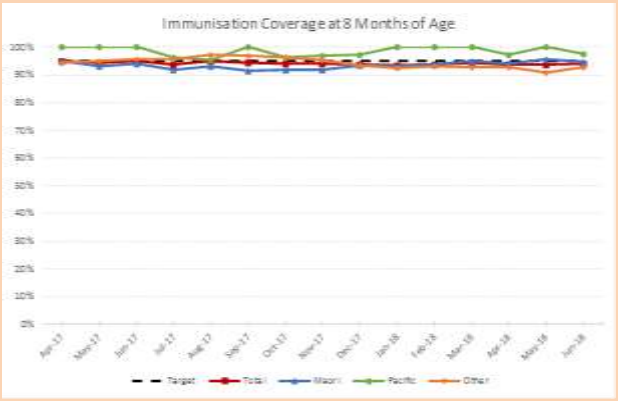


### National Health Target: Increased Immunisation

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

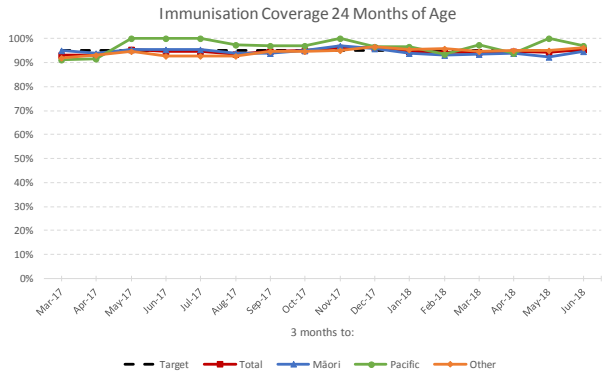
### Eight month olds have received their complete primary course of immunisations

Hawke's Bay DHB has fallen behind this year, not reaching the target of 95% coverage for eight month olds. The average yearly figures came in at 93% for total population, 93% for Māori and 98% for Pacific. The Q4 result was 94% for total population.



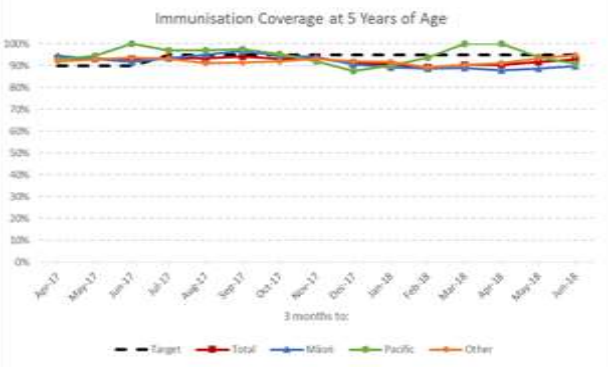

### Children are fully immunised at 2 years of age

Hawke's Bay DHB is consistently reaching 94% (national target is 95%) for 2 year coverage with good equity achieved.




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

The number of children fully immunised by 5 years is averaging 92% for the financial year. This coverage is slowly improving and Q4 is higher than the national coverage of 92%.



**Girls receive all three HPV immunisations**

Human Papillomavirus (HPV) immunisation is a primary preventative intervention to help reduce the incidence of cervical cancer. In June 2018, 75.7% of eligible girls had received all three doses of the HPV immunisation. The national target is 70%. Māori girls had a higher rate of immunisation at 84.9% and Pacific were at 88.3%.

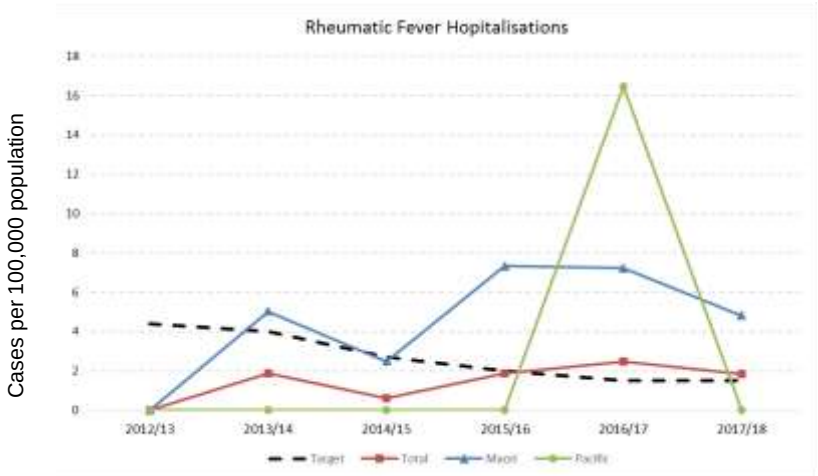
**Vulnerable elderly receive an influenza vaccine**

Seasonal influenza is a contributory factor in the high number of preventable hospitalisations amongst older people, particularly Māori. The National Immunisation Register shows a coverage of 60% for the 2016 calendar year. For the 6 months to September 2018 the result was 58%. This is not a true reflection of coverage for this group as not all influenza immunisations given are on this register. The coverage would be higher than what we see reflected here.

Hawke's Bay DHB and Health Hawke's Bay Immunisation teams are working alongside Māori providers and primary care providers to improve their capability through education and support with authorised vaccines and cold chain protocols.

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

Hawke's Bay is categorised as a high incidence DHB for Rheumatic Fever, a preventable disease which has serious consequences. The rate of first time hospitalisations for Rheumatic Fever is at 1.86 per 100,000 populations; a decrease from last year's rate of 2.48 per 100,000. This was still below target of ≤1.5 in the first half of the year however in the second half of the year there were no notified cases which is a good achievement. Of note, we have a small at-risk population with high variance which results in unstable rate estimates.

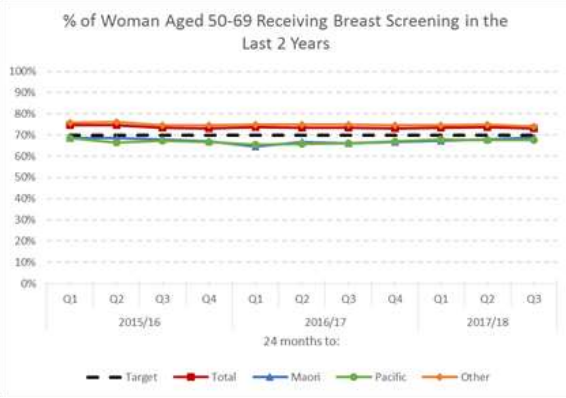


### More women are screened for cancer

Primary prevention of health includes screening those at risk and is a key strategy in effective management of long-term conditions. Screening programmes help to detect health problems early and result in better options for treatment and improved survivability. Reducing inequities continues to be an ongoing priority for the screening sector and service providers continue to take a collaborative approach to improving Māori participation in both screening programmes.

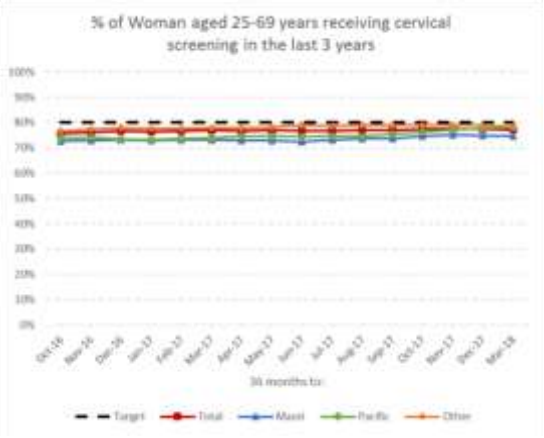
### Women aged 50-69 years received breast screening in the last 2 years

Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 50 and 69. Overall our rate at the end of Q3 was 73% which is favourable to the national target of ≥70%. Both Māori and Pacific results are slightly below the target at 69% and 68% respectively. Of note, in April 2018 the rate for Māori reached target for the first time.




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

Screening for cervical cancer is offered every three years to all women between the ages of 25 and 69 years. In an attempt to reduce inequities, this is offered free for priority group women i.e. Māori, Pacific and Asian women and other women aged 30-69 years who have never had a smear or have not had a smear in the past five years. Overall our rate is 77.1% which has not achieved the target of ≥80%. Māori rates were 74.6% and Pacific 78.1%. The DHB Population Screening team, Te Taiwhenua o Heretaunga and Choices are working together in the community offering smears to Māori and Pacific in the home. We continue to work closely with Health Hawke's Bay to identify primary care solutions to increase screening for Māori and Pacific.




### Breastfeeding

| Key Performance Measures | Infants are exclusively of fully breastfed at 6 weeks | | | Infants are exclusively of fully breastfed at 3 months | | |
|---|---|---|---|---|---|---|
| | Target | Previous Jun 2016 | Actual Dec 17 | Target | Previous Jun 2016 | Actual Dec 2017 |
| Māori | ≥75% | 67% (U) | - | ≥60% | 39% (U) | 41% (U) |
| Total | | 73% (U) | - | | 51% (U) | 51% (U) |
| | | | | | | |

Breastfeeding provides the optimum nutrition from birth, and is a foundation for later health and well-being. The measures used to track progress for improving breastfeeding rates include: exclusive breastfeeding at 6 weeks [2] (Target ≥75%) and 3 months (Target ≥60%).

At the 3 month measure there has been an increase for Māori. The total result has remained the same over the 2 periods, at 51%. The equity gap remains with Pacific at 43%, High Deprivation groups at 44% and Non-Māori at 58%.

The six week breastfeeding data for well child tamariki ora is not available through the Well Child Tamariki Ora Quality Improvement Framework.

Breastfeeding rates amongst Māori mothers remains a focus for HBDHB. To help eliminate disparities in breastfeeding and improve access to breastfeeding support, HBDHB funds a specialised breastfeeding support service for Māori mothers and their whānau who are experiencing difficulties establishing and maintaining breastfeeding in the home. An important feature of this programme are linkages with support services such as smoking cessation, safe sleep practices, and healthy homes programmes etc.

| Prevention Services | | | |
|---|---|---|---|
| *$'millions* | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
| Ministry of Health | *9.3* | *10.2* | *8.7* |
| Other sources | *0.4* | *0.2* | *0.2* |
| **Income by Source** | ***9.7*** | ***10.4*** | ***8.9*** |
| *Less:* | | | |
| Personnel | *1.3* | *1.4* | *1.6* |
| Clinical supplies | - | - | *0.1* |
| Infrastructure and non clinical supplies | *0.3* | *0.3* | *0.4* |
| Payments to other providers | *6.9* | *7.8* | *5.9* |
| **Expenditure by type** | ***8.5*** | ***9.5*** | ***8.0*** |
| **Net Result** | ***1.2*** | ***0.9*** | ***0.9*** |

[2] Data for breastfeeding at 6 weeks has previously been provided in the Tamariki Ora Quality Improvement Framework however no updated data has been provided

# Early Detection and Management

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

**Statement of Service Performance Output Class 2**

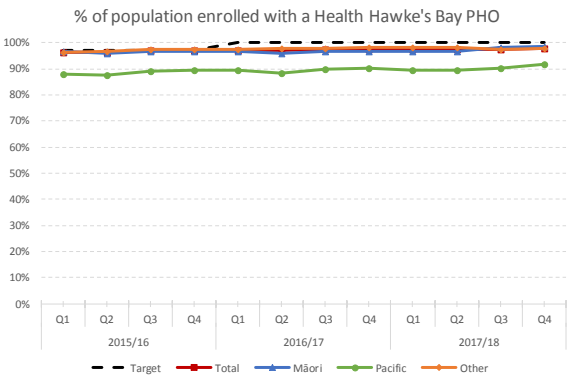
Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes,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

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

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

**Proportion of the population enrolled in the PHO**

Across New Zealand, people are required and encouraged to enrol with a general practice that is affiliated to a Primary Health Organisation (PHO). Health Hawke's Bay coordinates and manages the targeting of many services to those populations who are known to have a poor health status such as Māori, Pacific peoples and those living in the most deprived areas. Being enrolled in a PHO and having access to care in the right place at the right time allows for early detection and management of health issues and risks. As at June 2018, 97.9% of people are enrolled with the PHO which is just below the target of 100%.There has been a steady increase in Māori enrolled with the PHO, reaching 98.8% in Q4. Pacific has also been increasing over recent years reaching 91.9% in Q4. Health Hawkes Bay continues to work closely with Hawke's Bay DHB and general practice to promote enrolments and offer resources to facilitate the process.



**Ambulatory sensitive hospitalisations**

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

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

**0-4 year olds**

**A**SH rates 0-4 years have increased for both Māori and total populations.

The total population rate was 6,360 per 100,000 for the 12 months to March 2018. No target was set for total population as the emphasis was on reducing inequity. The Māori rate for the same period was 7,259 per 100,000, favourable to a target for Māori of <7,388. Note that the target for Māori was set based on improved equity between Māori and other.

Work needs to continue to keep children out of hospital and eliminate the inequity. The conditions that have the highest ASH rates are respiratory and ear nose and throat infections severe dental decay and skin conditions. We continue to focus on these areas to bring down ASH rates and reduce inequities. Work on the dental project has been positive this year with a decrease in ASH 0-4 for dental conditions.

**45-64 years**

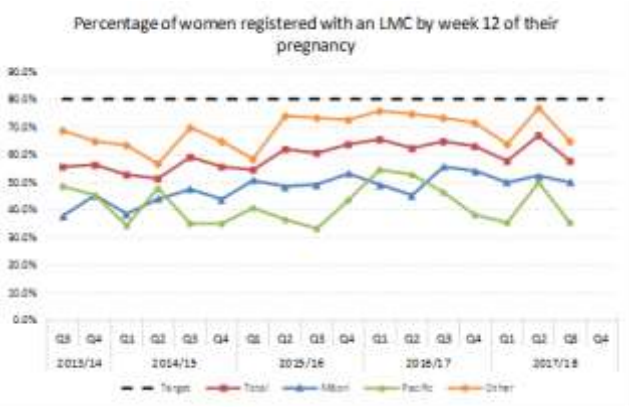
The ASH rate for 45-65 years has been slowly increasing since 2015. A large inequity is observed for both Māori and Pasifika.

For the 12 months to June 2018 the total population rate was 4,414 per 100,000, but the Māori rate was 8,302 and Pasifika 7,954. Our focus remains on reducing inequities which are mainly evident in heart disease, skin infections and respiratory infections. Over the year attention has been focussed on clinical pathways for both cellulitis and congestive heart failure. Practice nurses have been provided with specialist respiratory training.

**Early Engagement with Lead Maternity Carers (LMC) - Women booked with an LMC by week 12 of their pregnancy**

The percentage of women registered with an LMC by week 12 has decreased from 65% in Q3 2016/17 to 58% Q3 2017/18. Both Māori and Pacific have decreased over the year from 56% to 50% and 47% to 35% respectively. This is a concern for Hawke's Bay and needs to continue to be a priority area to address.

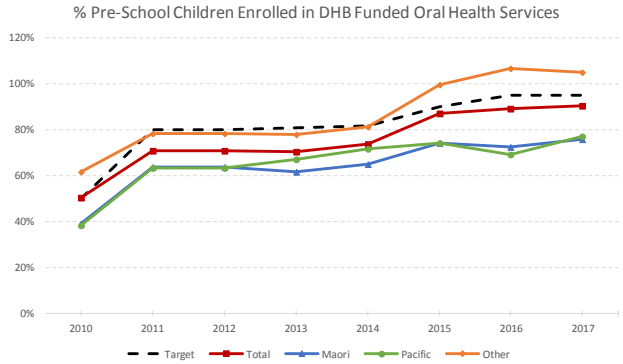
Lack of available LMC has become problematic with investigation going into this area. A Kaupapa Māori maternal programme has been developed led by Māori Health in partnership with Maternity and Population Health teams.



## Oral Health

### Pre-school enrolments with oral health services

Due to the poor oral health status of Hawke's Bay children, especially Māori and Pacific, we have a focus on improving early enrolment with dental services. Those identified as needing further examination or treatments are scheduled for a recall. In the last year, 90.5% of pre-school children were enrolled in DHB funded oral health services (76.1% Māori and 77.1% Pacific) which is below the target of 95%.




### Children and youth attending oral health services

2017 calendar year figures show that 8% of children were not examined according to planned recall which is above the target of <10%.

The percentage of adolescents using DHB funded dental services in the 2017 calendar year was 66.6% being below the target of ≥85%. A continued effort is being undertaken to increase use of dental services by adolescents by providing a smooth transition of information from the Community Oral Health Service to dentists at Year 8, by creating a strong continued awareness of free dental care, particularly among 17-year-olds and by working with schools and dental practices with lower levels of attendance.

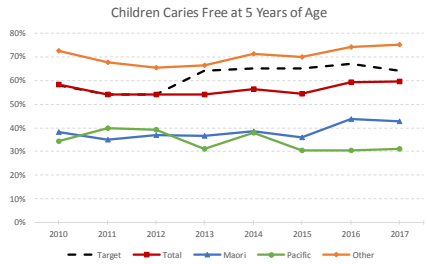
| Percentage of children not examined according to planned recall | | |
|---|---|---|
| **Baseline** 2016 | **Target** 2017 | **Actual** 2017 |
| 2.8% | <10% | 8% (F) |

| Percentage of adolescents using DHB funded dental services | | |
|---|---|---|
| **Baseline** 2016 | **Target** 2017 | **Actual** 2017 |
| 75.9% | ≥85% | 66.6% (U) |

### Children without decay

59.5% of five year olds were caries free in 2017, similar to 2016, and is still below the target of ≥64%.

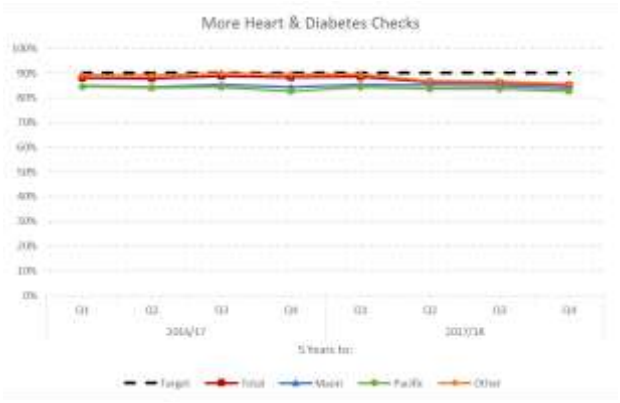
Children are also checked at year 8 for decayed, missing or filled teeth (DMFT). The mean rate of DMFT has reduced from 0.8 to 0.7 over the last year measured, with Māori decreasing from 1.1 to 1.04. At 5 years, there are large inequity gaps between Māori, Pacific, and Other ethnicities which need to be eliminated. At 8 years, both Māori and Pacific have reduced but so has Other hence the equity gap continues. The dental project continues to work to improve access to oral health services for Māori tamariki.



**More Heart and Diabetes Checks**

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

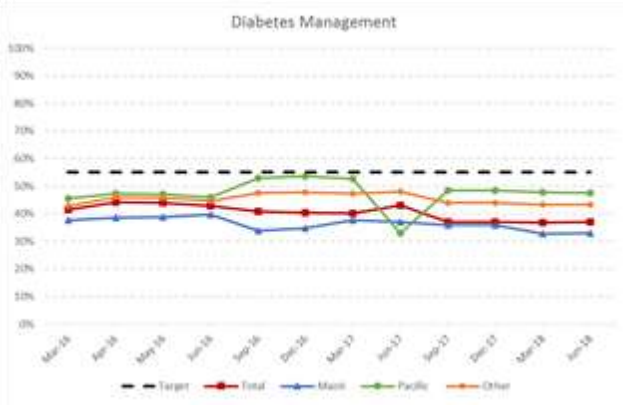
The More Heart and Diabetes Checks indicator monitors the proportion of the eligible population who have had blood tests for Cardiovascular disease (CVD) risk assessment in the preceding five year period. CVD disproportionately affects Māori and is preventable with lifestyle advice and treatment for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




Q4 figures shows this indicator sitting at 85% compared to 88% in Q4 last year. A similar profile has occurred for all ethnicities. This indicator has been removed as a Health target for 2017/18 but Health Hawkes Bay will continue to put emphasis on this area through the System Level Measures framework.

**Management of Diabetes**

A measure of good long term diabetes management is monitoring of glycaemic control. The number of people with good or acceptable glycaemic control remains unfavourable to the target of 55% with Q4 performance at 37%. Collective work with Health Hawke's Bay on identifying patients at risk and reviewing specialist nursing roles is ongoing. Stanford self-management programmes, "Feel Good' and Whānau Wellness programmes are all targeting Māori and Pacific.



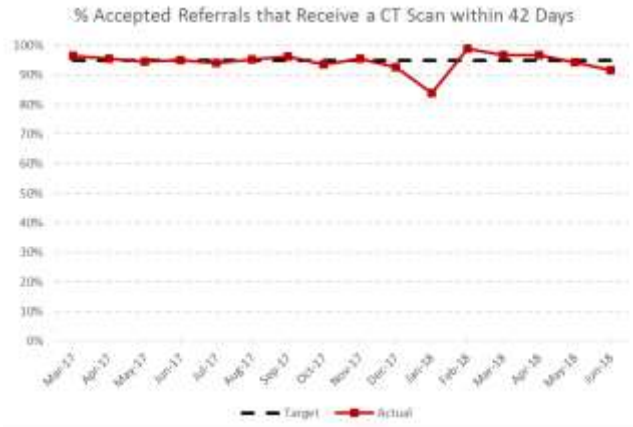

**Less Waiting for Diagnostic Services**

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

**Computed Tomography**

For Computed Tomography (CT), the standard is that 95% of 'routine' referrals receive a CT scan within 42 days.

Over the year, we have met target for two quarters out of four with Q4 sitting unfavourable to target.



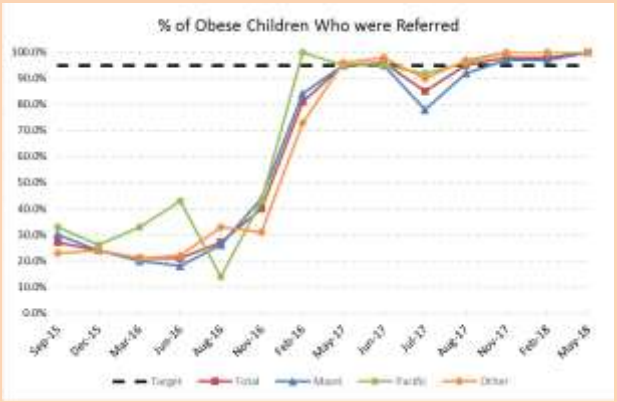
### Magnetic Resonance Imaging

For Magnetic Resonance Imaging (MRI) the target is that 90% of referrals receive an MRI within 42 days. Figures over the year have been slowly rising due to a seven day MRI service being implemented early in the year. The dip in Q4 was due to an increase in acute demand which meant that routine MRIs had to be put back.


### National Health Target: Raising Healthy Kids

100% of obese children identified in the Before School Check (B4SC) programme were offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

We are meeting target for all ethnicities with 100% achieved over the last two quarters.




We also monitor the percentage of 4 year olds who receive a B4SC. This has a target of >100%. As at June 2018, we have reached 102% for total population, 100% for Māori and 101% for Pacific. The figures are over 100% due to movement of people throughout NZ and coming into the country from overseas whilst working with a birth cohort established by the Ministry of Health.

| Early Detection and Management | | | |
|---|---|---|---|
| $'millions | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
| Ministry of Health | *112.6* | *116.5* | *129.9* |
| Other District Health Boards (IDF) | *3.0* | *3.0* | *2.1* |
| Other sources | *2.6* | *2.2* | *3.4* |
| **Income by Source** | ***118.2*** | ***121.7*** | ***135.4*** |
| *Less:* | | | |
| Personnel | *18.7* | *18.9* | *26.9* |
| Outsourced services | *2.6* | *1.2* | *5.3* |
| Clinical supplies | *1.2* | *0.4* | *3.0* |
| Infrastructure and non clinical supplies | *3.3* | *3.4* | *8.1* |
| Payments to other District Health Boards | *2.7* | *2.6* | *2.6* |
| Payments to other providers | *91.4* | *95.7* | *87.6* |
| **Expenditure by type** | ***119.9*** | ***122.2*** | ***133.5*** |
| **Net Result** | ***(1.7)*** | ***(0.5)*** | ***1.9*** |

## Intensive Assessment and Treatment Services

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

**Statement of Service Performance Output Class 3**

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

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

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

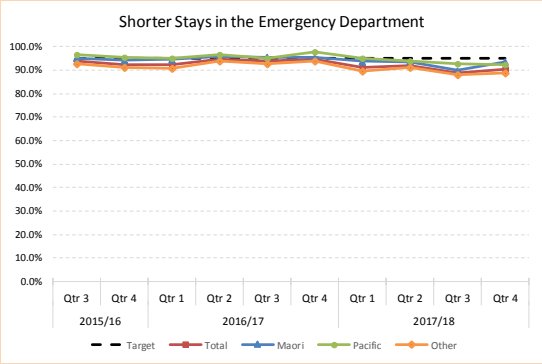

**National Health Target: Shorter Stays in the Emergency Department**

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

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

The target for the percentage of people waiting less than six hours in ED is 95%. Monthly figures have fluctuated over the year with the yearly average of 90.8%, lower than the previous year's result of 93.9%. Q4 result was 90.5%.

Growth in acute demand has put significant pressure on ED and flow on into hospital services which is reflected in the deteriorating performance despite the work in the FLOW and Fit for Winter programmes to mitigate this..

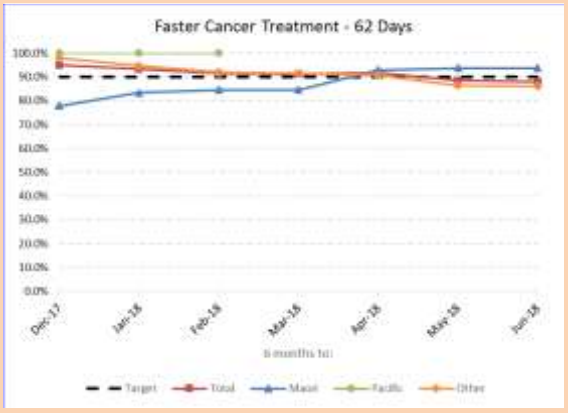


## Faster Cancer Treatment (FCT)

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

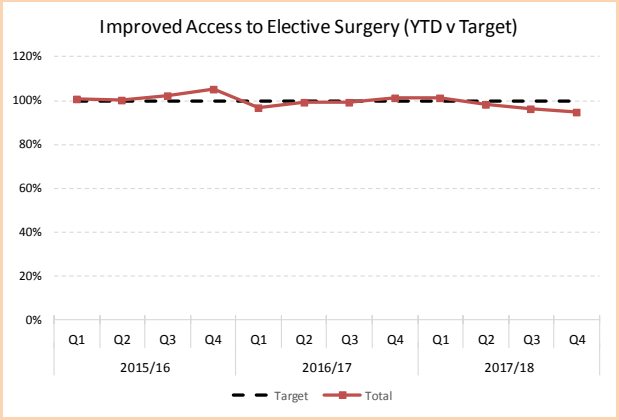
The yearly average for people referred with a high suspicion of cancer receiving their first cancer treatment within 62 days was 90.8%, favourable to the target of 90%. Māori rates have been increasing over the year, now meeting target. The Pasifika line reflects no referrals in some months.

Weekly case meetings and surgical capacity discussion plans continue. Regular reporting to the Finance Risk and Audit Committee is also in place identifying barriers in access to diagnostics and treatments.




## National Health Target: Improved Access to Elective Surgery

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




### More people have access to Surgery

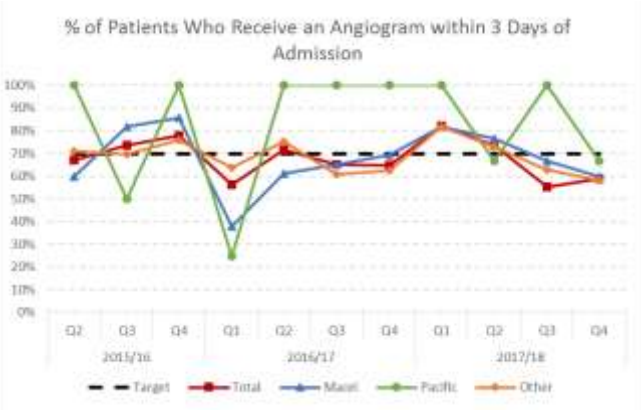
A number of initiatives to improve productivity and throughput have been successfully implemented this year resulting in HBDHB achieving 7,159 elective surgery discharges, but not meeting our target of 7,574.

**Better Management of Long Term Conditions (LTC)**

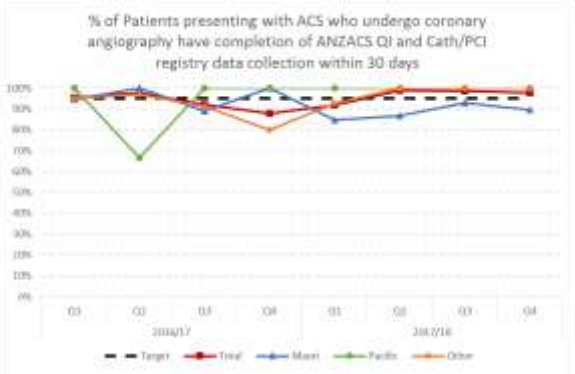
Across the Central Region there is a commitment to improved timelier access to cardiac services. HBDHB supports the regional programme outlined in the Regional Service Plan and also works locally to:

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

In 2017/18, 68% of high risk patients received an angiogram within 3 days (target 70%). For Māori we achieved 69% Performance throughout the year has been inconsistent which largely reflects delays in accessing tertiary services in Wellington and provision of only twice weekly angiography services at Hawke's Bay Hospital.




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



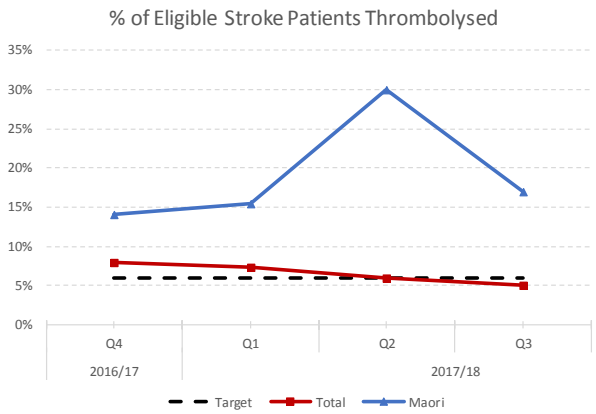

Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

The 2017/18 result was 97%, favourable against the target of 95%.

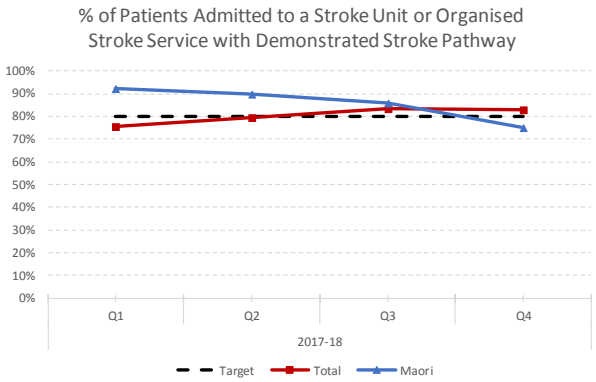
**Stroke thrombolysis and stroke pathway**

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

In 2017/18, 6.5% of eligible patients were thrombolysed, favourable against a target of 6%.



The percentage of patients admitted to the acute stroke unit or managed through the approved stroke pathway was 80% for 2017/18 which is favourable against the target of ≥80%.




The target for percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services, who are transferred within 7 days of acute admission is >80%. Results over the year have fluctuated with the average being 67%.

### Standardised Intervention Rates

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

For Major Joint Replacements we achieved 21.8 per 10,000 which is above the target and an improvement from 21.5 per 10,000 in December 2016.

Cardiac surgery intervention rates were unfavourable against the target rate of 6.5 per 10,000 reaching 5.4 per 10,000, a decrease from 6.6 in December 2016.

There has been a decrease in percutaneous revascularization rates from 12.5 per 10,000 in December 2016 to 11.6 which comes in under the target of 12.5.

Intervention rates for cataracts procedure and coronary angiography are above the target intervention rates at 47.5 and 35.9 per 10,000 respectively.

Coronary angiography services were favourable against the target of ≥34.7 per 10,000, reaching 35.9 per 10,000, an increase from 34.7 in December 2016.

| Elective Services Standardised Intervention Rates (per 10,000 population) | | | |
|---|---|---|---|
| Key Performance Measures | Baseline December 2016 | Actual March 2018 | Target 2017/18 |
| Major joint replacement | 21.5 | 21.8 (F) | ≥21.0 |
| Cataract procedures | 58.7 | 47.5 (F) | ≥27.0 |
| Cardiac procedures | 6.6 | 5.4 (U) | ≥6.5 |
| Percutaneous revascularization | 12.4 | 11.64 (U) | ≥12.5 |
| Coronary angiography services | 39.5 | 35.9 (F) | ≥34.7 |

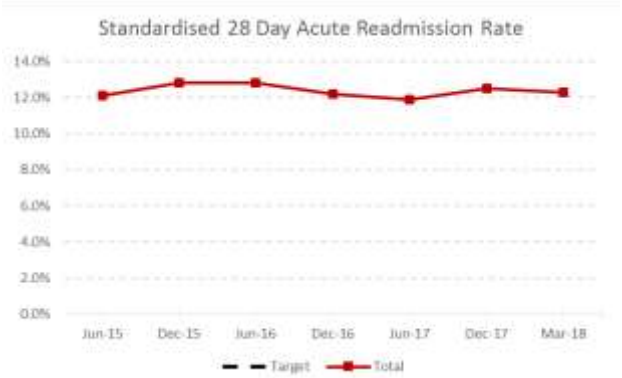
### Average Length of Stay (ALOS)

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

By delivering a more patient-centred elective service we expected to reduce the ALOS for elective inpatients. The target was set at ≤1.47 days. Over the year results have fluctuated between 1.52 and 1.58 days.

Acute ALOS has reduced over the year from 2.48 to 2.39 however not meeting the target of < 2.3. We continue to focus on work to improve patient flow through the hospital to ensure good hospital productivity.

| Average Length of Stay | | | |
|---|---|---|---|
| | Baseline December 2016 | Target 2017/18 | Actual March 2018 |
| Elective | 1.56 | ≤1.47 days | 1.55 (U) |
| Acute | 2.48 | ≤2.3 days | 2.39 (U) |




**Acute Readmission to Hospital**

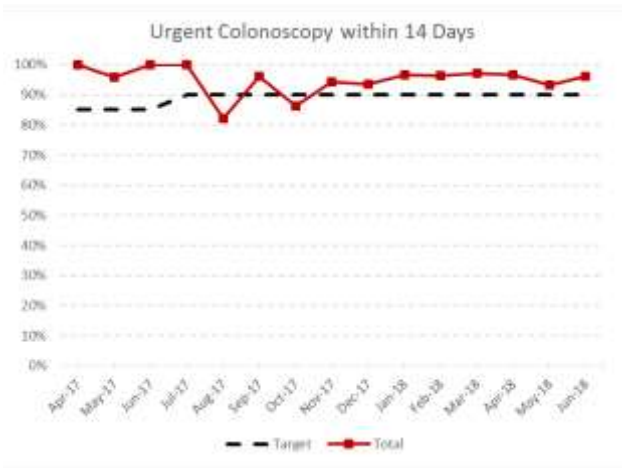
In our quest to increase hospital throughput it is important that we measure acute unplanned readmission rates. These occur when treatment, either in hospital or in the 28 days following discharge, has not been effective and a readmission is required urgently. A low rate is an indication of effective support services in the community (e.g. primary care) and hospital reliability. The result for 2017/18 was 12.3%. We will continue to target a reduction in readmission rates through better integration with primary and community services.

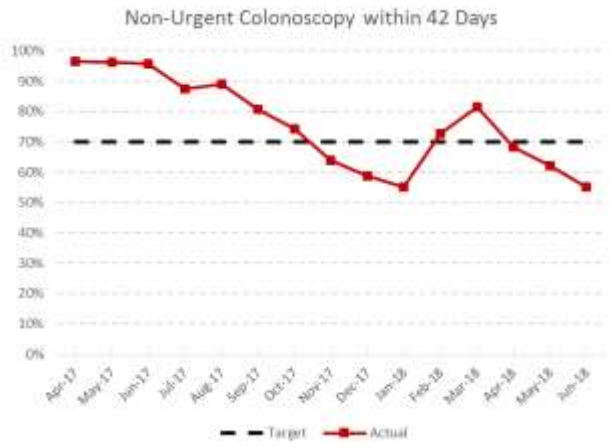
## Quicker access to diagnostics

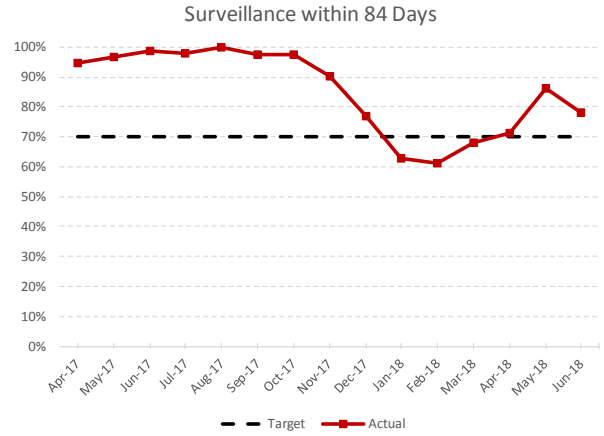
Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care, and therefore improve patient outcomes in a range of areas.

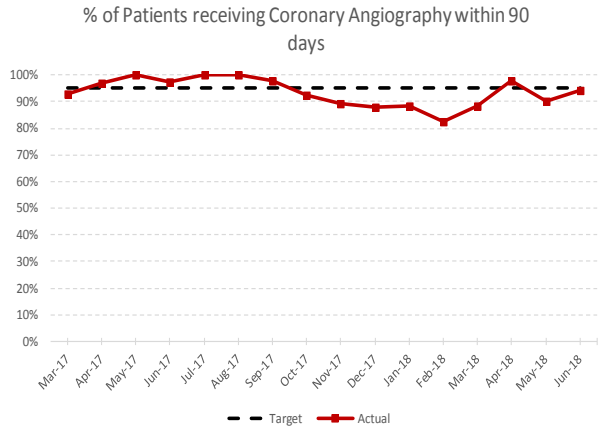
In June 2018, 96% of urgent diagnostic colonoscopies were performed within 14 days and 55% of routine cases performed within 42 days. These are above the targets of 85% and 70% respectively. The target for surveillance colonoscopy was achieved with 78% of people waiting less than 84 days beyond planned date (target ≥70%).

The percentage of patients receiving coronary angiography within 90 days has fluctuated throughout the year. We ended the year achieving 94 %, unfavourable to the target of ≥95%.



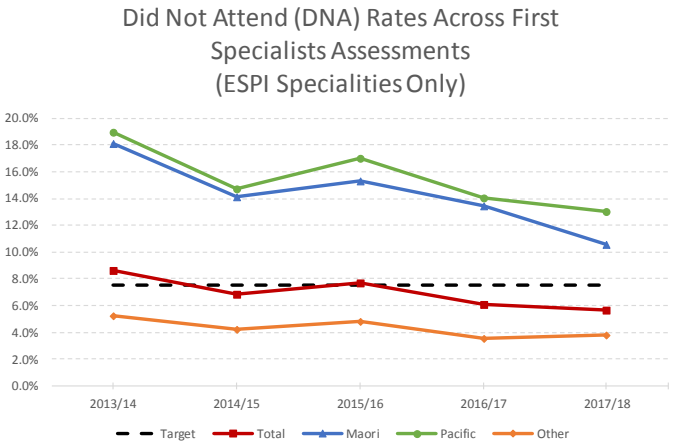




## Attendance at First Specialist Appointment

Low 'did not attend' (DNA) rates to specialist outpatient appointments are an indicator of good communication between patient, referrer and specialist services. It is a measure of the rate of scheduled first specialist appointments (FSAs) that do not proceed due to patient non-attendance. DNA rates are targeted because high rates result in significant waste and rework. High rates also indicate unnecessary delays in treatment and could, in some cases, be avoided by a more customer focused booking system and improved patient experience.

The overall DNA rate in 2017/18 was 5.7% which is favourable against the target. However, the Māori DNA rate is 10.6% and Pacific 13.0% indicating significant inequity gaps. Of note, all three indicators have decreased from the previous year. Customer focussed booking has moved from project mode to business as usual. Preventative pathways have been put in place via strong relationships with Māori and Pacific Health teams.



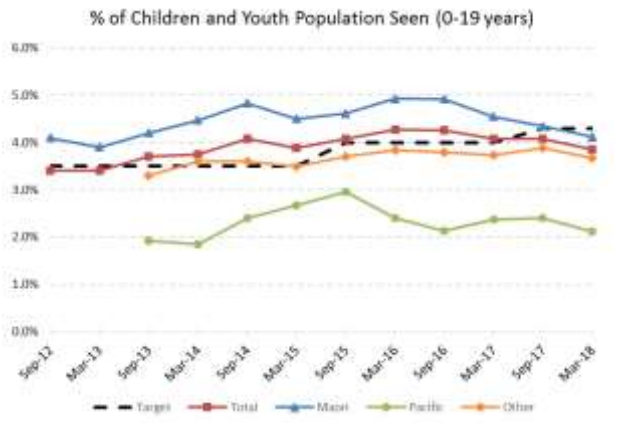

## Mental Health and Addiction Services

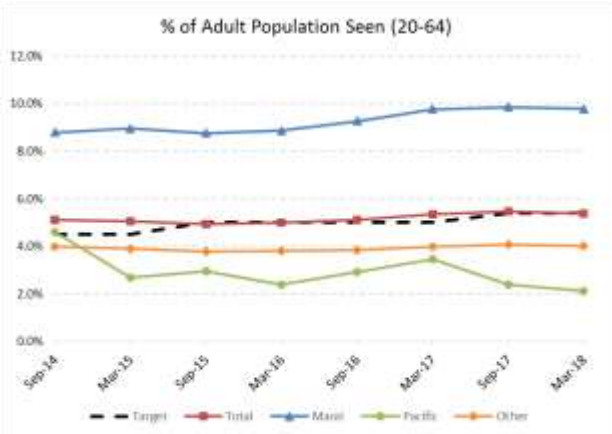
Specialist mental health and addiction services are funded for people who are severely affected by mental illness or addictions. Better and timelier access to a broad range of services improves people's mental health and wellbeing and contributes to better outcomes and recovery.

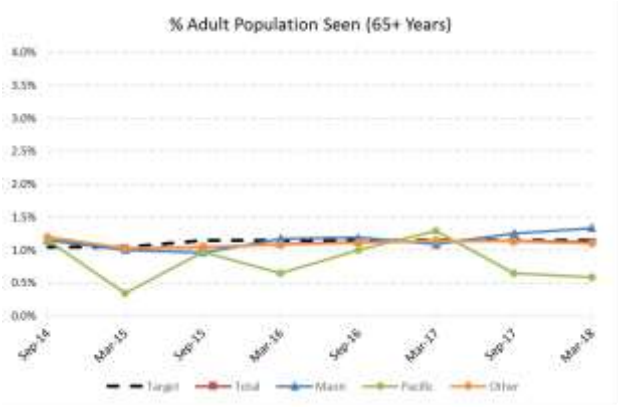
***Improved access to services:***

In the year ending March 2018, 3.86% of 0-19 year old (target ≥4.3%), 5.39% of 20-64 year olds (target ≥5.4%) and 1.12% of 65+ year olds (target ≥1.15%) accessed mental health services.

Māori rates remain favourable to target in the 20-64 and 65+ age groups. Pacific are unfavourable to all three targets.



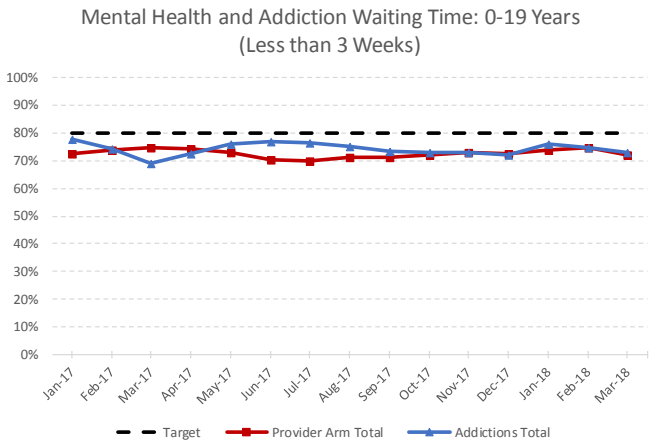



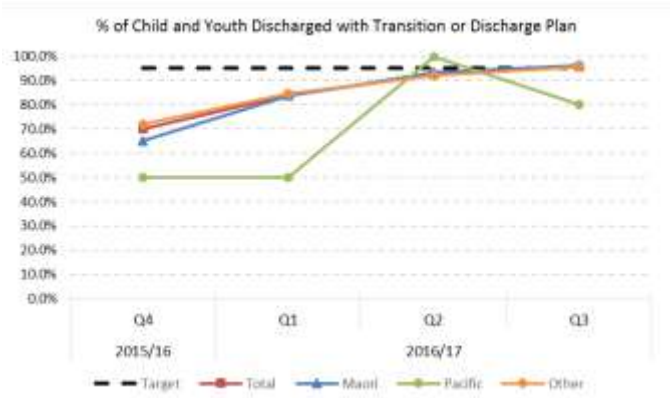

***Improved Waiting Times:*** Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. We differentiate the targets in 2 ways: firstly, between the mental health services that are delivered by our provider arm and the addiction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

For mental health services, the waiting time expectation of 3 weeks was achieved in 72.2% of cases and the 8 week result was 92.2%. Both of these results are below the targets of 80% and 95% respectively.

For addictions services with a range of providers, 73.2% were seen within 3 weeks and 92.9% seen within 8 weeks. The services maintain clear focus on referral response and turnaround time.




***Improved Discharge Planning:*** Maintaining and improving patient engagement through the use of a transition/discharge plan will ensure that services are responsive to patients needs and that people are better able to manage their own health condition. Improving discharge planning in the Children & Family Service (CAFS) has continued to be a real focus over the last year. The result for Q3 was 96% against a target of 95%, up from last year.




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

There is a disproportionately high rate of Māori placed under the s29 compulsory treatment order (CTO) and HBDHB aims to reduce this inequity. For the 12 month period ending March 2018, the rate of s29 orders per 100,000 was 130 which is higher than the target of ≤81.5 per 100,000. The rate for Māori was high at 398 per 100,000. This is not a straightforward matter as all the social and health inequities which Māori experience contribute to increased use of the Mental Health (Compulsory Assessment and Treatment) Act 1992. We continue to work on services to provide early interventions for people with mental health problems and as alternatives to hospitalisation. These include; Home based Treatment; NGO provided recovery orientated short term day programmes; resilience focussed community group programmes; and the Harekeke acute day programme based in Ngā Rau Rākau as well as partnership with police.

| Intensive Assessment and Treatment | | | |
|---|---|---|---|
| $'millions | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
| Ministry of Health | *328.5* | *322.6* | *294.4* |
| Other District Health Boards (IDF) | *2.2* | *6.2* | *4.2* |
| Other sources | *14.6* | *9.6* | *12.9* |
| **Income by Source** | ***345.3*** | ***338.4*** | ***311.5*** |
| *Less:* | | | |
| Personnel | *182.0* | *185.0* | *160.3* |
| Outsourced services | *16.7* | *13.3* | *12.9* |
| Clinical supplies | *47.6* | *35.6* | *44.1* |
| Infrastructure and non clinical supplies | *46.8* | *45.9* | *35.6* |
| Payments to other District Health Boards | *50.3* | *47.5* | *48.0* |
| Payments to other providers | *10.0* | *10.3* | *11.5* |
| **Expenditure by type** | ***353.4*** | ***337.6*** | ***312.4*** |
| **Net Result** | ***(8.1)*** | ***0.8*** | ***(0.9)*** |

## Rehabilitation and support services

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

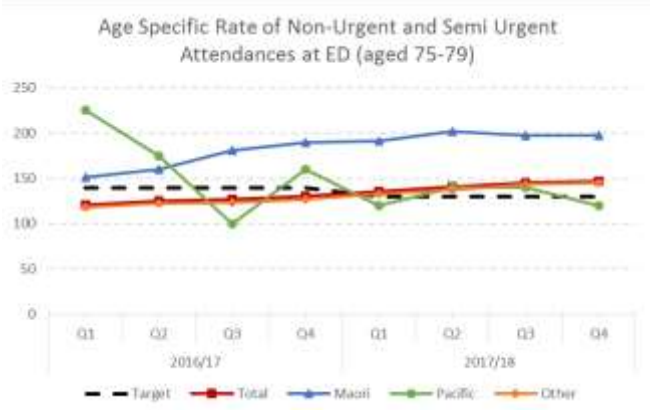
**Statement of Service Performance Output Class 4**

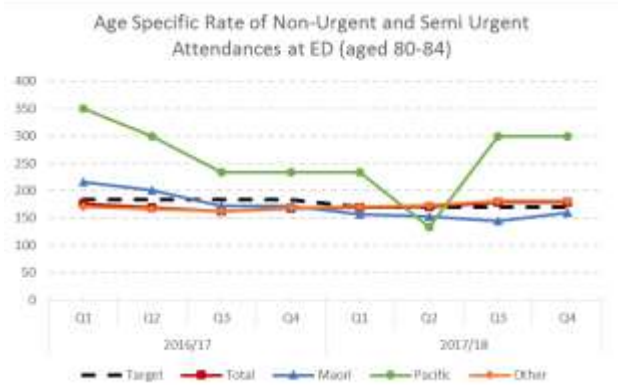
This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input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

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

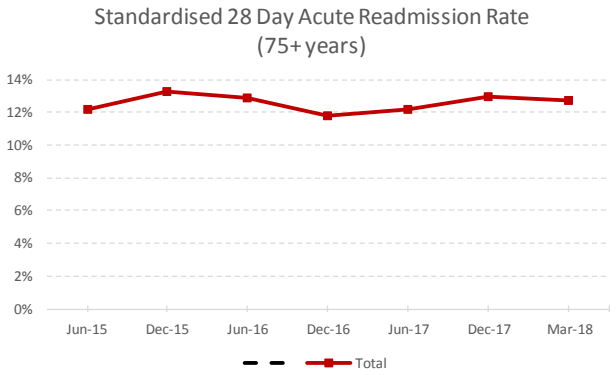
**Better access to care for older people**

Age specific rate of non-urgent and semi urgent attendances at the Emergency Department are monitored for ages 75-79, 80-84 and 85+. A decrease in these rates is an indicator of the services available to keep elderly safe and independent in their own homes. For the 75-79 group, the Q4 result was 147.0, unfavourable to target of 130. The 80-84 group result was 178.8, unfavourable to a target of 170. The 85+ result also came in favourably at 237.1 against a target of 225. An equity gap remains visible for Māori in the 75-79 age bracket and for Pacific in the 80-84 bracket. The engAGE model whereby the ORBIT interprofessional allied health team and engAGE community teams support frail older people to remain independent at home, continues to work in this area. whilst the ageing population increases.



The rate of acute readmission, as discussed above in output class 3, is a measure of effective support services and treatment. Reducing the readmission rate in this age group is especially important for sustainability as the over 75 population continues to grow. At March 2018 our rate was 12.7%.




**Better community support for older people**

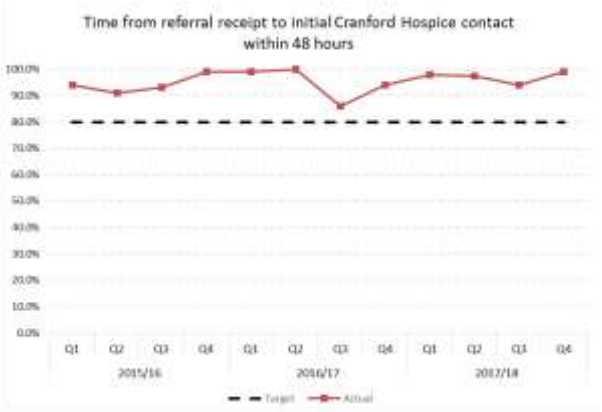
Delivering coordinated high quality services to older people supports New Zealanders to live longer, healthier and more independent lives. By providing better community support for elderly, we would expect that they are able to maintain independence and function in their own homes, therefore reducing rest home bed utilisation for the growing population. Comprehensive clinical assessments and completed care plans are an important component of keeping people safe in their own homes and maintaining their independence. In 2017/18 100% of the people using long term home support received a comprehensive clinical assessment and completed care plan.

The CHESS scale is designed to identify individuals at serious risk of decline. There are 6 levels (0 – 5) where 0 is stable and 5 is unstable. The target for percentage of total first assessments showing a 4 or 5 score is <13.8. In Q4 we were favourable to target, at 11%. This tells us that a reasonably low proportion of older people living independently in the community were at risk of decline when they were assessed. We want to keep decreasing this proportion so that we can be sure we are recognising emerging instability in a timely way.

**Prompt response to Palliative referrals**

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

Ensuring that most referrals to our district's community-based provider, Cranford Hospice, are responded to within 48 hours will improve service access, affirm that the service is responding in a timely way and show that capacity constraints are being appropriately managed. The target response standard of 48 hours was met in 99% of cases in Q4 and the target of 80% was well exceeded all year.



### More Day Services

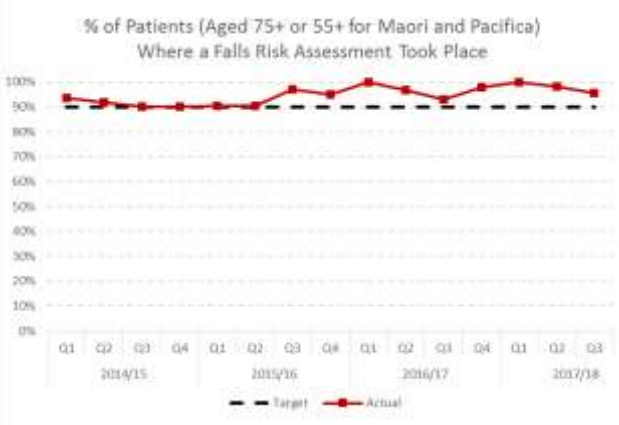
Improved management and integration of services in the community along with enhanced capability, enables early intervention to maintain function so that clients remain at home for longer. We commit extra resources to increase day services to give better support to people with specialised or high needs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

| Number of Day Services | |
|---|---|
| Target | Actual |
| 21,791 | 21,830 (F) |

### Reducing harm from falls

Reducing harm from falls is one of our priority Quality and Safety Markers. In 2017/18, a falls risk assessment was completed for 96.1% of elderly patients which is well above the target of 90%.

If assessed to be at risk of falling, a patient needs an individualised care plan to minimise the risk. We ended the year at 93.4% favourable to target of 90%.




| Rehabilitation and Support | | | |
|---|---|---|---|
| *$'millions* | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
| Ministry of Health | *80.5* | *80.4* | *76.5* |
| Other District Health Boards (IDF) | *3.0* | *3.1* | *2.3* |
| Other sources | *0.1* | *0.2* | *0.2* |
| **Income by Source** | ***83.6*** | ***83.7*** | ***79.0*** |
| *Less:* | | | |
| Personnel | *6.2* | *6.2* | *7.1* |
| Clinical supplies | *0.8* | *0.6* | *0.8* |
| Infrastructure and non clinical supplies | *1.8* | *1.8* | *1.9* |
| Payments to other District Health Boards | *4.2* | *4.0* | *3.9* |
| Payments to other providers | *70.6* | *70.8* | *63.6* |
| **Expenditure by type** | ***83.6*** | ***83.4*** | ***77.3*** |
| **Net Result** | **-** | ***0.3*** | ***1.7*** |

## 2017/18 Financial Performance

### Result

The result for 2017/18 is an operating deficit of $8.6 million on revenue of $556.9 million. This is in comparison to the $3.6 million surplus reported last year.

The deficit is $10.1 million less than the $1.5 million surplus projected in the 2017/18 Annual Plan, and mainly reflects the cost of higher than projected patient volumes in the second half of the year, including difficulties achieving planned efficiencies with increased patient numbers and high acuity.

### Cash flow

The operating cash surplus of $13.0 million, and a reduction in cash holdings of $8.9 million, were used to fund the $21.5 million spend on property, plant and equipment, intangible assets and investments, and repay equity of $0.4 million.

### Auditors

The Auditor-General is required under section 15 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements and performance information presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2017/18 annual report, amount to $128,670.

### Ministerial directions

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

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

The DHB has given effect to the December 2018 milestones for the implementation of the NZBN Directive. Planning is underway to identify the key changes and the actions required for the DHB to give regard to the remaining requirements by the December 2020 milestone date.

## 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 | 2018 | 2017 | 2016 | 2015 | 2014 |
|---|---|---|---|---|---|---|
| Return on net funds employed | 7.1% | -0.1% | 7.3% | 9.8% | 8.3% | 11.2% |
| Operating margin to revenue | 1.8% | 0.0% | 1.8% | 2.2% | 1.4% | 1.4% |
| Revenue to net funds employed | 3.9 | 3.8 | 3.8 | 3.8 | 4.5 | 5.7 |
| Net result before financing & abnormals | 10.0m | (0.2)m | 10.3m | 13.2m | 9.1m | 9.5m |
| Net result | 1.5m | (8.6)m | 3.6m | 4.4m | 3.1m | 3.2m |
| Ratio of earnings to revenue | 4.3% | 2.4% | 4.5% | 5.2% | 4.7% | 4.8% |
| Average cost per paid FTE | $90,356 | $89,090 | $87,731 | $86,563 | $84,085 | $81,948 |
| Average revenue per paid FTE | $236,765 | $238,336 | $239,610 | $238,939 | $232,975 | $233,937 |

# Statement of comprehensive revenue and expense

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
|---|---|---|---|---|
| Patient care revenue | 2.5 | 550,792 | 548,998 | 529,121 |
| Interest revenue | | 876 | 885 | 912 |
| Other operating revenue | 2.6 | 5,228 | 4,360 | 4,680 |
| Total revenue | | 556,896 | 554,243 | 534,713 |
| | | | | |
| Personnel costs | 2.7 | 208,167 | 211,514 | 195,883 |
| Outsourced services | | 19,291 | 14,469 | 18,236 |
| Clinical supplies | | 46,432 | 33,234 | 44,605 |
| Infrastructure and non-clinical expenses | | 26,238 | 27,329 | 23,152 |
| Payments to other DHBs | | 57,228 | 54,100 | 54,542 |
| Payments to non-health board providers | | 178,873 | 184,624 | 168,579 |
| Other operating expenses | 2.8 | 7,014 | 5,299 | 5,704 |
| Depreciation and amortisation expense | 3.6, 3.7 | 13,639 | 13,625 | 13,883 |
| Financing costs | 2.9 | - | - | 777 |
| Capital charge | 2.10 | 8,378 | 8,549 | 5,906 |
| Impairment losses | | 212 | - | - |
| Total expenses | | 565,472 | 552,743 | 531,267 |
| | | | | |
| Share of associate surplus/(deficit) | 3.9 | - | - | 121 |
| | | | | |
| **Surplus/(deficit)** | | **(8,576)** | 1,500 | **3,567** |
| | | | | |
| **Other comprehensive revenue and expense** | | | | |
| Revaluation of land and buildings | | 15,312 | - | - |
| | | | | |
| **Total comprehensive revenue and expense** | | **6,736** | 1,500 | **3,567** |

Explanations of major variance against budget are provided in note 2.2.

DHBs are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2018 was overspent by $0.2 million (2017: underspent by $0.6 million). Mental health payments are $0.1 million less than funding over the seventeen years since 1 July 2001 (30 June 2017: $0.1 million in excess of funding).

*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 2018**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
|---|---|---|---|---|
| Balance at 1 July | | 142,345 | 142,378 | 91,637 |
| | | | | |
| Total comprehensive revenue and expense | | 6,736 | 1,500 | 3,567 |
| Owner transactions | | | | |
| Equity injections from the Crown | | - | - | 47,500 |
| Equity repayments to the Crown | | (357) | (357) | (359) |
| | | | | |
| **Balance at 30 June** | 4.5 | **148,724** | **143,521** | **142,345** |

Explanations of major variance against budget are provided in note 2.2.

*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 2018**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
|---|---|---|---|---|
| **Assets** | | | | |
| *Current assets* | | | | |
| Cash and cash equivalents | 3.1 | 7,685 | 17,365 | 16,592 |
| Short term investments | 3.1 | 1,645 | 3,026 | 1,638 |
| Receivables and prepayments | 3.2 | 25,460 | 22,940 | 26,722 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 3.3 | 14 | 11 | 13 |
| Inventories | 3.4 | 3,907 | 4,419 | 4,435 |
| Non-current assets held for sale | 3.5 | - | - | 625 |
| **Total current assets** | | 38,711 | 47,761 | 50,025 |
| | | | | |
| *Non-current assets* | | | | |
| Property, plant and equipment | 3.6 | 173,641 | 154,692 | 152,216 |
| Intangible assets *(see note below)* | 3.7 | 12,736 | 13,465 | 11,464 |
| Investment property | 3.8 | 960 | 131 | 131 |
| Investment in associate *(see note below)* | 3.9 | 1,160 | 1,339 | 1,092 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 3.3 | 15 | 15 | 29 |
| **Total non-current assets** | | 188,512 | 169,642 | 164,932 |
| **Total assets** | | **227,223** | **217,402** | **214,957** |
| | | | | |
| **Liabilities** | | | | |
| *Current liabilities* | | | | |
| Payables and deferred revenue | 4.2 | 36,973 | 35,761 | 35,635 |
| Employee entitlements | 4.3 | 37,971 | 35,381 | 34,138 |
| Provisions | 4.4 | 936 | - | 334 |
| **Total current liabilities** | | 75,880 | 71,142 | 70,107 |
| | | | | |
| *Non-current liabilities* | | | | |
| Employee entitlements | 4.3 | 2,619 | 2,739 | 2,505 |
| **Total non-current liabilities** | | 2,619 | 2,739 | 2,505 |
| **Total liabilities** | | **78,499** | **73,881** | **72,612** |
| **Net assets** | | **148,724** | **143,521** | **142,345** |
| | | | | |
| **Equity** | | | | |
| Contributed capital | 4.5 | 82,002 | 82,002 | 82,357 |
| Property revaluation reserves | 4.5 | 82,704 | 67,392 | 67,392 |
| Restricted funds | 4.5 | 2,841 | 3,026 | 3,516 |
| Accumulated surpluses/(deficits) | 4.5 | (18,823) | (8,899) | (10,920) |
| **Total equity** | | **148,724** | **143,521** | **142,345** |

Explanations of major variance against budget are provided in note 2.2.

*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 2018**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Receipts from patient care | | 551,188 | 552,877 | 521,886 |
| Receipts from donations, bequests and clinical trials | | 574 | - | 453 |
| Other receipts | | 3,167 | - | 9,399 |
| Payments to suppliers | | (328,255) | (318,349) | (318,774) |
| Payments to employees | | (204,727) | (210,693) | (195,465) |
| Goods and services tax (net) | | (1,436) | - | (180) |
| Cash generated from operations | | **20,511** | **23,835** | **17,319** |
| Interest received | | 876 | 885 | 912 |
| Interest paid | | - | (164) | (1,558) |
| Capital charge paid | | (8,378) | (8,549) | (5,906) |
| Net cash inflow/(outflow) from operating activities | | **13,009** | **16,007** | **10,767** |
| | | | | |
| **Cash flows from investing activities** | | | | |
| Proceeds from sale of property, plant and equipment | | 660 | 625 | 38 |
| Acquisition of property, plant and equipment | | (19,364) | (16,320) | (13,255) |
| Acquisition of intangible assets | | (920) | (1,600) | (197) |
| Acquisition of investments | | (1,928) | (982) | (1,040) |
| Net cash inflow/(outflow) to investing activities | | **(21,552)** | **(18,277)** | **(14,454)** |
| | | | | |
| **Cash flows from financing activities** | | | | |
| Proceeds from equity injections by the Crown | | - | - | 5,000 |
| Proceeds from movement in short term investments (net) | | (7) | - | 101 |
| Repayment of equity to the Crown | | (357) | (357) | (359) |
| Net cash inflow/(outflow) from financing activities | | **(364)** | **(357)** | **4,742** |
| | | | | |
| Net increase/(decrease) in cash and cash equivalents | | (8,907) | (2,627) | 1,055 |
| Add: opening cash | | 16,592 | 21,263 | 15,537 |
| **Cash and cash equivalents at end of year** | 3.1 | **7,685** | **18,636** | **16,592** |

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

Explanations of major variance against budget are provided in note 2.2.

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

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

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

| | Notes | 30 June 2018 | Budget 30 June 2018 | 30 June 2017 |
|---|---|---|---|---|
| **Surplus/(deficit) for the year** | | **(8,576)** | **1,500** | **3,567** |
| **Add back non-cash items:** | | | | |
| Share of associate surplus | | - | - | (121) |
| Depreciation and amortisation | | 13,639 | 13,625 | 13,883 |
| Impairment of investment in the National Oracle Solution | | 212 | - | - |
| **Add back items classified as investing activity:** | | | | |
| Net loss/(gain) on disposal of property, plant and equipment | | 42 | - | 103 |
| Debt forgiven (Hawke's Bay Helicopter Rescue Trust) | | 13 | 13 | 13 |
| **Movement in working capital:** | | | | |
| (Increase)/decrease in receivables and prepayments | | 1,262 | (612) | (4,371) |
| (Increase)/decrease in inventories | | 527 | (87) | (142) |
| Increase/(decrease) in payables and deferred revenue | | 372 | 760 | (2,729) |
| Increase/(decrease) in employee entitlements | | 4,902 | 762 | 391 |
| Increase/(decrease) in provisions | | 635 | (13) | 40 |
| Net movement in working capital | | 7,698 | 810 | (6,811) |
| **Other movements not in working capital** | | | | |
| Increase/(decrease) in employee entitlements | | (19) | 59 | 133 |
| **Net cash inflow/(outflow) from operating activities** | | **13,009** | **16,007** | **10,767** |

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

# Notes to the financial statements

**For the year ended 30 June 2018**

In preparing the 2018 financial statements, the notes have been grouped into sections under five key categories which are considered to be the most relevant for stakeholders and other users.

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

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

## 1. Reporting entity and basis of preparation

### 1.1 Reporting Entity

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

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

The financial statements of HBDHB comprise the DHB, its 17.4% interest in Allied Laundry Services Limited, its 16.7% interest in Central Region's Technical Advisory Services Limited, and its 3.7% interest in New Zealand Health Partnerships Limited.

The financial statements for HBDHB are for the year ended 30 June 2018, and were approved by the Board on 31 October 2018.

### 1.2 Basis of preparation

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

#### Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 PBE accounting standards, and comply with those standards.

#### Presentation currency and rounding

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

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

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

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

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

The DHB will apply the new standards in preparing its 30 June 2019 financial statements. The DHB expects there will be minimal or no change in applying the new standards.

In May 2017, the External Reporting Board issued PBE IPSAS 39 Employee Benefits for reporting periods beginning on or after 1 January 2019. The DHB will apply the new standard in preparing its 30 June 2019 financial statements. The DHB expects there will be minimal or no change in applying the new standards.

In November 2017, the External Reporting Board issued PBE FRS 48 Service Performance Reporting for reporting periods beginning on or after 1 January 2021. The DHB has yet to review the new accounting standard to determine its impact, and consequently has yet to set the date from when it will apply the new standard.

## 2. Result for the year

### 2.1 Performance by Arm

HBDHB's annual plan includes separate operating statements for funding, governance and funding administration and providing health services. The table below compares performance against the plan for the 2017/18 year.

| | Achieved $'millions | Plan $'millions | Variance $'millions |
|---|---|---|---|
| **Revenue** | | | |
| Funding health services | 524.9 | 524.1 | 0.8 |
| Governance and funding administration | 3.5 | 3.3 | 0.2 |
| Providing health services | 314.2 | 310.7 | 3.5 |
| Eliminations | (285.7) | (283.9) | (1.8) |
| | 556.9 | 554.2 | 2.7 |
| **Surplus/(Deficit)** | | | |
| Funding health services | (3.1) | 1.5 | (4.6) |
| Governance and funding administration | 0.6 | - | 0.6 |
| Providing health services | (6.1) | - | (6.1) |
| | (8.6) | 1.5 | (10.1) |

*Notes:*

*Providing health services includes $7.0 million (2017: $6.0 million) of claims for pharmaceutical expenditure through sector services (MOH) that are ultimately paid for from the funding health services category. These claims are eliminated in the financial statements, but are included in the above table to provide a more useful comparison.*

*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.*

The funding health services deficit largely arises from additional costs for Hawke's Bay residents treated in other Health Districts.

The governance and funding administration surplus relates to funding administration vacancies during a restructuring process, and Health and Social Care Networks positions unfilled through a strategic review.

Higher patient volumes than projected and increased patient acuity, made it a difficult environment to achieve the efficiencies planned for providing health services. Capacity constraints and radiologist vacancies requiring the outsourcing of elective surgery and radiology reads also contributed to the adverse result. The costs of additional nursing resources were offset by allied health vacancies.

## 2.2 Performance against budget

*Accounting Policy*

The budget figures are those approved by HBDHB in its annual plan. The budget figures are prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the DHB for the preparation of the financial statements.

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

**Financial Performance**

The result for the year is $10.1 million adverse to plan. Drivers include increased patient volumes resulting in higher costs for the DHB and for the treatment of Hawke's Bay domiciled patients in other DHB districts, and a shortfall of $5.9 million in the savings plan, reflecting the difficult environment for achieving efficiencies due to the increased volumes.

**Financial Position**

Equity ended the year higher than budget by $5.2 million, being the difference between the $15.3 million property revaluation, and the $10.1 million adverse variance from the planned surplus. Current assets were $9.1 million lower than budget reflecting the use of cash to fund the deficit and for capital expenditure. Non-current assets were $18.9 million higher than budget comprising the effect of the property revaluation, and capital expenditure net of depreciation expense. Liabilities were $4.6 million higher than plan reflecting provisions for IDF wash-ups, employee claims and back pays, and ACC work accident claims.

**Cash Flow**

Cash from operating activities was $3.0 million lower than plan, reflecting unachieved efficiencies offset by provisions that have not yet required cash out flows. Purchases of property, plant and equipment are $3.3 million ahead of plan and relates to retention payments for work completed in prior years.

## 2.3 Critical accounting estimates and assumptions

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

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

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

### Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $5.339 million (2017: $4.995 million). Refer note 4.3.

### Workplace accident self-insurance

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

## 2.4 Critical judgements in applying accounting policies

In the process of applying HBDHB's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. Management has exercised the following critical judgements in applying accounting policies for the year ended 30 June 2018.

### Impairment of intangible assets with indefinite lives

Investment in the National Oracle Solution (NOS), and the Regional Health Information Project (RHIP, formally CRISP) will provide the DHB's main financial, procurement and clinical systems. New Zealand Health Partnerships (NZHP) has identified some assets that will not be part of the NOS system, and the investment in NZHP has been reduced by $211 thousand as a result (refer Note 3.6). No other impairments are considered to be necessary to either investment.

## 2.5 Patient care revenue

*Accounting policy*

### Ministry of Health population-based revenue

HBDHB receives annual funding from the Ministry of Health based on Hawke's Bay's share of the national population. Revenue for the financial year is recognised based on the funding entitlement for that year.

### Ministry of Health contract revenue

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

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

### Revenue from other DHBs

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

### Other Crown entity contracted revenue

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Ministry of Health population-based revenue | 484,591 | 473,987 |
| Ministry of Health contract revenue | 46,327 | 35,477 |
| Revenue from other DHBs | 12,710 | 12,592 |
| Other Crown entity contracted revenue | 6,046 | 5,861 |
| Other patient care related revenue | 1,118 | 1,204 |
| | **550,792** | **529,121** |

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

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Appropriation | 482.4 | 470.2 |
| Transferred from 2015/16 | - | 4.2 |
| Appropriation not attributed to population-based revenue | 2.2 | (0.4) |
| Ministry of Health population-based revenue | 484.6 | 474.0 |

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

*in thousands of New Zealand Dollars*

## 2.6 Other operating revenue

*Accounting policy*

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

### Interest revenue

Interest revenue is recognised using the effective interest rate method.

### Rental revenue

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

### Sale of goods

Revenue from goods sold is recognised when HBDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

### Provision of services

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

### Vested assets

Where a physical asset is gifted to or acquired by HBDHB for nil or nominal cost, the fair value of the asset received is recognised as revenue when control over the asset is obtained.

### Donated services

The activities of HBDHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB.

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Donations and bequests received | 288 | 280 |
| Rental revenue | 605 | 680 |
| Cafeteria and food sales | 1,017 | 963 |
| Other operating revenue | 3,260 | 2,693 |
| Gain on sale of property, plant and equipment | 57 | 64 |
| | **5,227** | **4,680** |

## 2.7 Personnel costs

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Salaries and wages | 198,116 | 189,847 |
| Employer contributions to defined contribution plans | 6,104 | 5,619 |
| Increase/(decrease) in employee entitlements | 3,947 | 417 |
| | **208,167** | **195,883** |

*in thousands of New Zealand Dollars*

## 2.8 Other operating expenses

*Accounting policy*

**Operating lease payments**

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Impairment of receivables (bad and doubtful debts) | 47 | 147 |
| Loss on disposal of property, plant and equipment | 67 | 133 |
| Fees to auditor for the audit of the financial statements | 129 | 125 |
| Fees to board members | 251 | 251 |
| Operating lease expenses | 5,074 | 4,501 |
| Increase/(decrease) in provisions | 1,444 | 544 |
| Koha | 2 | 3 |
| | **7,014** | **5,704** |

## 2.9 Financing Costs

*Accounting Policy*

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

Attributed interest on finance leases are charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Interest on Crown loans | - | 777 |
| Attributed interest on finance leases | - | - |
| | **-** | **777** |

Borrowings from the Ministry of Health converted into equity on 15 February 2017. The DHB had no borrowings or finance leases at balance date.

## 2.10 Capital charge

*Accounting policy*

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

DHBs pay a capital charge to the Crown on their taxpayers' funds as at 30 June and 31 December each year. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2018 was 6% (2017: 7% for the first half of the year and 6% for the second half).

*in thousands of New Zealand Dollars*

## 3. Resourcing the DHB's activities

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

*Accounting policy*

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

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

| **Cash and cash equivalents** | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Cash | 4 | 4 |
| Bank balances | 12 | 1 |
| Credit balance (NZ Health Partnerships Limited) | 6,473 | 15,254 |
| Call deposits – special funds | 777 | 459 |
| Call deposits – clinical trials | 419 | 874 |
| Cash and cash equivalents | **7,685** | **16,592** |

| **Short term investments** | | |
|---|---|---|
| Term deposits – special funds | 942 | 1,419 |
| Term deposits – clinical trials | 703 | 219 |
| | **1,645** | **1,638** |

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

*Financial assets recognised subject to restrictions*

Included in cash and cash equivalents and short term investments are unspent funds with restrictions that relate to the delivery of health services (special funds) and participation in clinical trials by the DHB. The delivery of health services is usually restricted by specialty, location or patient type.

| **Special funds** | | |
|---|---|---|
| Opening balance | 1,878 | 1,820 |
| Donations and bequests | 261 | 210 |
| Interest received | 49 | 52 |
| Expenditure during the year | (469) | (204) |
| | **1,719** | **1,878** |

Special funds include funding from the Ministry of Education for early childhood education purposes. Receipts in 2018 amounted to $163 thousand (2017: Nil), and the balance of funds as at 30 June 2018 amounted to $63 thousand (30 June 2017: $362 thousand).

*in thousands of New Zealand Dollars*

| Clinical Trials | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Opening balance | 1,093 | 1,193 |
| Receipts | 348 | 254 |
| Interest received | 23 | 21 |
| Expenditure during the year | (342) | (375) |
| | **1,122** | **1,093** |

**DHB Treasury Services Agreement**

HBDHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships (NZHP) and all DHBs. This agreement enables NZHP to sweep DHB bank account balances and invest the pool of surplus funds on their behalf. The agreement also allows individual DHBs to borrow from the pool of surplus funds at the on-call interest rate earned on the pool plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's provider arm funding plus GST. As at 30 June 2018 this limit for HBDHB was $26.9 million (2017: $26.1 million), and has not been utilised.

The DHBs have appointed BNZ as their preferred supplier of the banking arrangements. The DHB has undertaken as follows:

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

**Credit card facility**

HBDHB has a $200 thousand BNZ Business Visa Card facility.

## 3.2 Receivables and prepayments

*Accounting policy*

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Ministry of Health receivables | 1,754 | 1,754 |
| Trade receivables | 1,656 | 3,185 |
| Ministry of Health accrued revenue | 11,012 | 12,833 |
| Other accrued revenue | 10,486 | 6,495 |
| Prepayments | 552 | 2,455 |
| | **25,460** | **26,722** |

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 $306 thousand (2017: $274 thousand)

Receivables are shown net of impairments amounting to $334 thousand (2017: $329 thousand) recognised in the current year and arising from non-resident fees and small service charges that can be uneconomic to collect.

*in thousands of New Zealand Dollars*

As at 30 June 2018 and 2017, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

| | Gross 30 June 2018 | Impairment 30 June 2018 | Net 30 June 2018 | Gross 30 June 2017 | Impairment 30 June 2017 | Net 30 June 2017 |
|---|---|---|---|---|---|---|
| Not past due/past due<30days | 2,344 | (13) | 2,331 | 2,265 | (17) | 2,248 |
| Past due 31-60 days | 411 | (6) | 405 | 353 | (2) | 351 |
| Past due 61-90 days | 113 | (4) | 109 | 1,940 | (9) | 1,931 |
| Past due >90 days | 876 | (311) | 565 | 710 | (301) | 409 |
| | **3,744** | **(334)** | **3,410** | **5,268** | **(329)** | **4,939** |

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Balance at beginning of year | 329 | 215 |
| Additional provisions made during the year | 51 | 153 |
| Receivables written-off during period | (46) | (39) |
| Balance at end of year | 334 | 329 |

## 3.3 Loans

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

| **Loan to Hawke's Bay Helicopter Rescue Trust** | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Non-current | 15 | 29 |
| Current | 14 | 13 |
| | **29** | **42** |

The fair value of loans receivable is $31 thousand (2017 $45 thousand). Fair value has been determined using contractual cash flows discounted using a rate based on market quoted Government stock at balance date plus an adequate constant credit spread totalling 2.35% ( 2017 2.60%).

## 3.4 Inventories

*Accounting Policy*

**Inventories held for distribution**

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

**Inventories held for sale**

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

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

*in thousands of New Zealand Dollars*

| Inventories held for distribution | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Pharmaceuticals | 792 | 939 |
| Surgical and medical supplies | 2,041 | 2,361 |
| Other supplies | 1,074 | 1,135 |
| | **3,907** | **4,435** |

Write-down of inventories amounted to $10 thousand (2017: $11 thousand). No reversal of previously recognised write-downs was made in the current year. The amount of inventories recognised as an expense during the year was $40.6 million (2017: $41.2 million). No inventories were held at current replacement cost at 30 June 2018 (30 June 2017: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

## 3.5 Non-current assets held for sale

*Accounting policy*

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

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

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Land | - | 330 |
| Buildings | - | 295 |
| | **-** | **625** |

Changes and improvements to the mental health service delivery model, resulted in three properties being declared surplus in October 2013, their transfer at their book values from property, plant and equipment to non-current assets held for sale, and their write-down by $518 thousand to fair value less costs to sell. One property has subsequently been transferred back to property, plant and equipment. The sale date of the remaining properties is uncertain as both properties are leased to other health providers, and the properties have consequently been reclassified to investment properties.

## 3.6 Property, plant and equipment

*Accounting policy*

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

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

### Revaluations

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

*in thousands of New Zealand Dollars*

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

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense. Surplus property is carried at the book value on the date the property was declared surplus less impairment losses until it is disposed of.

### Additions

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

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

### Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in the revaluation reserve are transferred to accumulated surpluses/(deficits).

### Subsequent costs

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

### Depreciation

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

| Class of asset | Estimated life | Depreciation rate |
|---|---|---|
| Buildings | 2 to 50 years | 2% to 50% |
| Clinical equipment | 2 to 20 years | 5% to 50% |
| Information technology | 3 to 10 years | 10% to 33% |
| Motor vehicles | 7 to 20 years | 5% to 14% |
| Other equipment | 3 to 30 years | 3% to 33% |

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

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

## Impairment of property, plant and equipment

HBDHB does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

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

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

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

# Notes to the financial statements (continued)

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

| | 1 July 2017 | | | | | | | | | 30 June 2018 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2018** | Cost/ Valuation | Accumulated Depreciation | Carrying Amount | Acquisitions | Transfers from work in progress | Revaluation of land and buildings | Disposals | Depreciation expense | Depreciation write back on disposal/ revaluation | Cost/ valuation | Accumulated Depreciation | Carrying Amount |
| **Owned assets** | | | | | | | | | | | | |
| Land | 8,530 | - | 8,530 | - | - | 1,215 | - | - | - | 9,745 | - | 9,745 |
| Buildings | 135,576 | (15,979) | 119,597 | - | 5,140 | (10,406) | (3) | (8,526) | 24,505 | 130,307 | - | 130,307 |
| Clinical equipment | 34,039 | (21,405) | 12,634 | - | 3,775 | - | (1,562) | (3,169) | 1,488 | 36,252 | (23,086) | 13,166 |
| Information tech. | 7,524 | (5,793) | 1,731 | - | 701 | - | (892) | (875) | 893 | 7,333 | (5,775) | 1,558 |
| Motor vehicles | 1,824 | (1,167) | 657 | - | 38 | - | (18) | (155) | 18 | 1,844 | (1,304) | 540 |
| Other equipment | 3,428 | (1,672) | 1,756 | - | 187 | - | (73) | (307) | 69 | 3,542 | (1,910) | 1,632 |
| | 190,921 | (46,016) | 144,905 | - | 9,841 | (9,191) | (2,548) | (13,032) | 26,973 | 189,023 | (32,075) | 156,948 |
| **Leased assets** | | | | | | | | | | | | |
| Alterations | 1,501 | (341) | 1,160 | - | 157 | - | - | (142) | - | 1,658 | (483) | 1,175 |
| | 1,501 | (341) | 1,160 | - | 157 | - | - | (142) | - | 1,658 | (483) | 1,175 |
| **Work in Progress** | | | | | | | | | | | | |
| Buildings | 5,269 | - | 5,269 | 14,122 | (5,297) | - | - | - | - | 14,094 | - | 14,094 |
| Clinical equipment | 783 | - | 783 | 3,269 | (3,775) | - | - | - | - | 277 | - | 277 |
| Information tech. | 99 | - | 99 | 1,749 | (701) | - | - | - | - | 1,147 | - | 1,147 |
| Motor vehicles | - | - | - | 38 | (38) | - | - | - | - | - | - | - |
| Other equipment | - | - | - | 187 | (187) | - | - | - | - | - | - | - |
| | 6,151 | - | 6,151 | 19,365 | (9,998) | - | - | - | - | 15,518 | - | 15,518 |
| | 198,573 | (46,357) | 152,216 | 19,365 | | (9,191) | (2,548) | (13,174) | 26,973 | 206,199 | (32,558) | 173,641 |

**Valuation**

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid MPropertyStudies BCom FNZIV FPINZ of Added Valuation Limited. The valuation is effective as at 30 June 2018. The valuation of buildings was subsequently reduced by $4 million in recognition of the cost of additional structural work to be undertaken within the theatre block to improve seismic performance for this importance level 4 building, in line with the latest building regulations

*Land*

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

*Buildings*

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

- Cost is based on replacement with modern equivalent assets, adjusted where appropriate for physical deterioration and optimisation due to over-design or surplus capacity.
- Cost is derived from historical cost records plus other construction data including: Rawlinsons 2007 Construction handbook; Rider Levett Bucknall Costings; Maltbys (Quantity Surveyors and Construction Cost Managers) cost data and indices; Opus International Consultants (Quantity Surveyor Advice), and other data collected by Added Valuation Limited.
- In determining obsolescence and physical depreciation regard has been given to the period that the DHB expects to make use of each asset.
- The estimated remaining life has been applied in determining depreciated replacement cost, using recent asset management plans.

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

The board believes that the net book value of plant and equipment is the fair value at 30 June 2018.

**Restrictions**

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

# Notes to the financial statements (continued)

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

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

# Notes to the financial statements (continued)

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

## 3.7 Intangible assets

*Accounting policy*

**Software acquisition and development**

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

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

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

**Amortisation**

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

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

| Type of asset | Estimated life | Amortisation rate |
|---|---|---|
| Acquired computer software | 2 to 15 years | 7% to 50% |
| Developed computer software | 3 to 15 years | 7% to 33% |
| NOS rights | Indefinite | Nil |
| RHIP assets (PACS Archive) | 10 years | 10% |

**Impairment of intangible assets**

HBDHB does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

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

# Notes to the financial statements (continued)

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

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

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

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

| | 1 July 2017 | | | | | | | | 30 June 2018 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2018 Owned assets** | Cost/ Valuation | Accumulated Amortisation | Carrying Amount | Acquisitions | Transfers | Disposals/ Impairment | Amortisation Expense | Amortisation written back | Cost/ Valuation | Accumulated Amortisation | Carrying Amount |
| Software | 11,322 | (9,504) | 1,818 | - | 124 | (77) | (465) | 79 | 11,369 | (9,890) | 1,479 |
| | 11,322 | (9,504) | 1,818 | - | 124 | (77) | (465) | 79 | 11,369 | (9,890) | 1,479 |
| **Work in Progress** | | | | | | | | | | | |
| Software | 65 | - | 65 | 918 | (124) | - | - | - | 859 | - | 859 |
| NOS rights | 2,504 | - | 2,504 | - | - | (211) | - | - | 2,293 | - | 2,293 |
| RHIP assets | 7,077 | - | 7,077 | 1,028 | - | - | - | - | 8,105 | - | 8,105 |
| | 9,646 | - | 9,646 | 1,946 | (124) | (211) | - | - | 11,257 | - | 11,257 |
| | 20,968 | (9,504) | 11,464 | 1,946 | | (288) | (465) | 79 | 22,626 | (9,890) | 12,736 |

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

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. The fund established by NZHP through the on-charging of depreciation on the NOS assets to the DHB s will be used to, and is sufficient to maintain the NOS assets standard of performance or service potential indefinitely. The date from which the DHB will beginning using the new system has not yet been determined.

# Notes to the financial statements (continued)

**For the year ended 30 June 2018**

*in thousands of New Zealand Dollars*

The RHIP assets are the DHB's share of the assets comprising the Regional Health Informatics Programme (RHIP) facilitated by Central Region's Technical Advisory Services Limited (CRTAS). The intangible asset recognises the DHB's right to use the RHIP clinical information systems, and its ownership of a proportion of the systems assets. During the year ended 30 June 2015 RHIP was reclassified into the four clinical systems and the supporting regional infrastructure it comprises, and will be amortised or depreciated when these assets are complete. The RHIP work in progress at 30 June 2018 is considered to be fit for purpose, and the DHBs in the central region continue to support the project. HBDHB considers the carrying amount of the assets (the cost of the system build), is equivalent to the recoverable service amount using depreciated replacement cost, and consequently no impairment of the assets is necessary.

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

*in thousands of New Zealand Dollars*

## 3.8 Investment property

*Accounting policy*

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

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

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

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Balance at beginning of year | 131 | 131 |
| Transfers from non-current assets held for sale | 625 | |
| Fair value adjustments | 204 | - |
| Balance at end of year | **960** | **131** |

The properties were revalued as at 30 June 2018 by John Reid MPropertyStudies BCom FNZIV FPINV of Added Valuation, who holds an annual practicing certificate and has held registration since 1985. The fair value of the investment properties was determined using market based evidence.

## 3.9 Investments in associates

*Accounting policy*

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

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

HBDHB has an investment in one associate entity, Allied Laundry Services Limited (ALSL), whose principal activity is the provision of laundry services. The interest held at 30 June 2018 was 17.42% (30 June 2017: 18.25%). ALSL has six DHB shareholders holding 1,150,000 shares each, all fully paid except for Hutt Valley DHB (HVDHB) whose shares are paid to $850,000, with the remainder to be paid by January 2019. The associates balance date is 30 June. There are no significant restrictions on the ability of the associate to transfer funds to HBDHB in the form of cash dividends.

*in thousands of New Zealand Dollars*

| Summarised financial information of Allied Laundry Services Limited | 30 June 2018 | 30 June 2017 |
|---|---|---|
| *Presented on a gross basis* | | |
| Assets | 10,014 | 10,497 |
| Liabilities | 3,177 | 4,112 |
| Revenue | 10,590 | 10,432 |
| Surplus/(deficit) | 543 | 542 |
| HBDHB ownership interest | 17.42% | 18.25% |
| Share of ALSL's contingent liabilities incurred jointly with other investors | - | - |
| Other contracted commitments (operating leases) | - | - |

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited draft accounts as at 30 June 2018, and their audited financial statements as at 30 June 2017.

## 4. Financing the DHB's activities

### 4.1 Borrowings and finance leases

Borrowings from the Ministry of Health converted into equity on 15 February 2017. The DHB had no borrowings or finance leases at balance date.

### 4.2 Payables and deferred revenue

*Accounting policy*

Payables and deferred revenue are recorded at their face value.

| Payables and deferred revenue under exchange transactions | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Trade payables | 3,717 | 5,034 |
| Income in advance relating to contracts with specific performance obligations | 2,835 | 3,307 |
| Other non-trade payables and accrued expenses | 26,940 | 23,142 |
| | 33,492 | 31,483 |
| **Payables and deferred revenue under non exchange transactions** | | |
| ACC levy payable | 1,157 | 188 |
| Goods and services tax | 2,324 | 3,964 |
| | 3,481 | 4,152 |
| **Total payables and deferred revenue** | **36,973** | **35,635** |

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

*in thousands of New Zealand Dollars*

## 4.3 Employee entitlements

*Accounting policy*

### Short-term employee entitlements

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

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

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

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

### Long-term employee entitlements

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

### Superannuation schemes

### Defined contribution schemes

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

### Defined benefit schemes

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

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

| **Non-current liabilities** | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Long service leave | 2,524 | 2,413 |
| Retirement gratuities | 95 | 92 |
| | **2,619** | **2,505** |

| **Current liabilities** | | |
|---|---|---|
| Accrued salaries and wages | 9,067 | 7,852 |
| Annual leave | 20,955 | 19,474 |
| Sick leave | 393 | 345 |
| Continuing medical education leave and expenses | 5,229 | 4,322 |
| Sabbatical leave | 716 | 546 |
| Long service leave | 1,530 | 1,521 |
| Retirement gratuities | 81 | 78 |
| | **37,971** | **34,138** |

*in thousands of New Zealand Dollars*

**Key assumptions in measuring employee entitlements**

The present value of sick leave, sabbatical leave, long service leave, and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis by external independent actuary, Paul Dalebroux BSc(Hons), FIA, FNZSA. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any change in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 1.78% in year one to 4.75% after 37 years. The salary inflation factor is the DHB's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates are 1% lower, or salary increases 1% higher, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $237 thousand higher. Conversely if the discount rates are 1% higher, or salary increases 1% lower, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $214 thousand lower.

Issues relating to Holidays Act compliance are discussed in Note 5.5 Contingent Liabilities.

## 4.4 Provisions (ACC Partnership Programme)

*Accounting policy*

### Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in financing costs.

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Balance at beginning of year | 334 | 300 |
| Additional provisions made | 1,444 | 544 |
| Amounts used | (842) | (510) |
| Unused amounts reversed | - | - |
| Balance at end of year | **936** | **334** |

All provisions are classified as current.

**ACC Accredited Employers Programme**

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

*Liability valuation*

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

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

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

HBDHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will carry the total cost of claims up to $2.0 million for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceed the stop loss limit, the DHB will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

The DHB is not exposed to any significant concentrations of insurance risk, as work-related injuries generally are the result of an isolated event involving an individual employee.

An independent consulting actuary, Peter Davies B.Bus.Sc, FIA, FNZSA has calculated the DHB's liability, and the valuation is effective 30 June 2018. The actuary has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the consulting actuary's report.

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

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

*in thousands of New Zealand Dollars*

## 4.5 Equity

| | Crown Equity | Property Revaluation Reserves | Restricted Funds | Accumulated Deficit | Total Equity |
|---|---|---|---|---|---|
| Balance at 1 July 2017 | 82,357 | 67,392 | 3,516 | (10,920) | 142,345 |
| Surplus/(deficit) for the year | - | - | - | (8,576) | (8,576) |
| Revaluation of land and buildings | - | 15,312 | - | - | 15,312 |
| Transfers between reserves | 2 | - | (675) | 673 | - |
| Repayment to the Crown | (357) | - | - | - | (357) |
| **Balance at 30 June 2018** | **82,002** | **82,704** | **2,841** | **(18,823)** | **148,724** |

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

### Property Revaluation Reserves

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Land | 8,275 | 7,060 |
| Buildings | 74,429 | 60,332 |
| | **82,704** | **67,392** |

### Restricted Funds

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

*in thousands of New Zealand Dollars*

## 5. Other disclosures

### 5.1 Taxes

*Accounting policy*

**Goods and services tax**

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

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position.

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

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

Commitments and contingencies are disclosed exclusive of GST.

**Income tax**

HBDHB is a public authority and consequently is exempt from the payment of income tax under section CB3 of the Income Tax Act 2007.

### 5.2 Capital commitments and operating leases

| **Capital commitments** | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Property, plant and equipment | | |
| Buildings | 4,800 | 8,399 |
| Clinical equipment | 163 | 582 |
| Plant | 693 | 4 |
| Information technology | 199 | 3 |
| Intangible assets | | |
| Software | 23 | 3 |
| Regional Health Information Project (RHIP) | 263 | 1,288 |
| New Zealand Health Partnerships | 440 | - |
| | 6,581 | 10,279 |

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

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

| **Non-cancellable commitments – operating leases** | 30 June 2018 | 30 June 2017 |
|---|---|---|
| Not more than one year | 2,632 | 2,898 |
| One to five years | 6,664 | 7,162 |
| Later than five years | 504 | 2,754 |
| | **9,800** | **12,814** |

*in thousands of New Zealand Dollars*

HBDHB leases a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The main property leases are listed below.

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

## 5.3 Financial instruments

### a. Financial instrument categories

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| **Financial Assets** | | |
| Loans and receivables | | |
| Cash and cash equivalents | 7,685 | 16,592 |
| Short term investments | 1,645 | 1,638 |
| Loans | 29 | 42 |
| Trade and other receivables | 25,460 | 26,722 |
| | **34,819** | **44,994** |
| **Financial Liabilities** | | |
| Financial liabilities measured at amortised cost | | |
| Trade and other payables | 36,973 | 35,635 |
| | **36,973** | **35,635** |

### b. Fair value hierarchy disclosures

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

### c. Financial instrument risks

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

**Market risk**

*Fair value interest rate risk*

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. HBDHB's exposure to fair value interest rate risk is to bank deposits which were at fixed rates of interest at balance date.

*Cash flow interest rate risk*

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable interest rates expose HBDHB to cash flow interest rate risk.

*in thousands of New Zealand Dollars*

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

HBDHB's borrowing policy requires a spread of interest rate re-pricing dates on borrowings to limit the exposure to short-term interest rate movements.

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

| 30 June 2018 | Effective Interest Rates | Total | 6 months or less |
|---|---|---|---|
| Cash and cash equivalents | | | |
| Cash | - | 4 | 4 |
| Bank balances | - | 12 | 12 |
| Credit balance (NZHP) | 2.37% | 6,473 | 6,473 |
| Short term deposits | 1.32% | 1,196 | 1,196 |
| Short term investments | 3.28% | 1,645 | 1,645 |
| Repricing gap | | **9,330** | **9,330** |

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

*Currency risk*

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

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

*Sensitivity analysis*

The effect of a general increase of one percentage point in the value of NZD against other foreign currencies would reduce earnings dependent on how New Zealand based suppliers reflect the increase through the prices they charge. Direct import of goods from overseas is restricted to major capital investment, usually with the price fixed in NZD.

*in thousands of New Zealand Dollars*

### Credit risk

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

Financial instruments, which potentially subject the DHB to concentrations of risk consist principally of cash, short-term deposits and accounts receivable. The DHB places its cash with New Zealand Health Partnerships, a low risk and high quality entity due to its status as a Crown Entity which among other activities, invests surplus cash on behalf of the DHBs.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 95% (30 June 2017: 95%) of the DHB's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

*Sensitivity analysis*

At 30 June 2018, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2018/19, as the DHB has no term debt, and only the net interest from cash holdings would be affected.

*Credit quality of financial assets*

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

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| **Counterparties with credit ratings** | | |
| **Cash, cash equivalents and investments** | | |
| AA- | 2,841 | 2,972 |
| *Total cash and cash equivalents* | 2,841 | 2,972 |
| | | |
| **Counterparties without credit ratings** | | |
| **Cash and cash equivalents** | | |
| NZ Health Partnerships Limited – no defaults in the past | 6,473 | 15,254 |
| **Receivables and prepayments** | | |
| Receivables and prepayments with no defaults in the past | 25,154 | 26,448 |
| Receivables and prepayments with defaults in the past | 306 | 274 |
| Total Receivables and prepayments | 25,460 | 26,722 |
| **Loans** | | |
| Hawke's Bay Helicopter Rescue Trust - no defaults in the past | 29 | 42 |

### Liquidity risk

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

### Contractual maturity analysis of financial liabilities

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

**Forecasted transactions**
HBDHB does not hedge forecasted transactions.

## 5.4 Contingent assets

There are no contingent assets at 30 June 2018.

## 5.5 Contingent liabilities

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

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

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 deficit will affect future contributions by employers, as there is no prescribed basis for allocation.

No employer contributions to the Scheme are expected for the next annual reporting period.

The actuarial review as at 31 March 2018 indicated that the scheme had a past service surplus of $6.6 million (6.1% of the liabilities). This amount was exclusive of employer superannuation contribution tax. Employers are not expected to contribute in the future provided the experience of the Scheme is in line with the valuation assumptions used for that actuarial review.

The Scheme had 180 members at 31 March 2018, five of whom are employees of the DHB.

**Holidays Act compliance**

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements. For employers such as the DHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability. Until the baseline document is agreed, no assessment of the financial effect can be made.

*in thousands of New Zealand Dollars*

## 5.6 Related party transactions

HBDHB is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier and/or client/recipient relationship, on terms and conditions no more or less favourable than those that it is reasonable to expect HBDHB would have adopted, in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies, and undertaken on the normal terms and conditions for such transactions.

**Key management personnel compensation**

| | 30 June 2018 | 30 June 2017 |
|---|---|---|
| **Board Members** | | |
| Remuneration | 284 | 277 |
| *Full time equivalent members* | *1.3* | *1.3* |
| **Executive management team** | | |
| Remuneration | 2,932 | 2,886 |
| *Full time equivalent members* | *11.0* | *11.2* |
| **Total key management personnel remuneration** | **3,216** | **3,163** |
| ***Total full time equivalent personnel*** | ***12.3*** | ***12.5*** |

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

## 5.7 Remuneration

**Remuneration – Board members**

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

| | 30 June 2018 | | 30 June 2017 | |
|---|---|---|---|---|
| | **Board** | **Committees** | **Board** | **Committees** |
| Kevin Atkinson *Chair* | 42,000 | 2,500 | 42,000 | 2,500 |
| Ngahiwi Tomoana *Deputy Chair* | 25,500 | 2,125 | 25,500 | 2,000 |
| Ana Apatu *(elected October 2016)* | 20,400 | 4,000 | 11,900 | 2,000 |
| Barbara Arnott | 20,400 | 3,250 | 20,400 | 3,250 |
| Andrew Blair *(retired October 2016)* | - | - | 8,500 | 1,312 |
| Dan Druzianic | 20,825 | 3,120 | 20,400 | 2,808 |
| Peter Dunkerley | 20,400 | 2,562 | 20,400 | 2,562 |
| Denise Eaglesome *(retired October 2016)* | - | - | 8,500 | 750 |
| Hine Flood *(appointed October 2016)* | 20,400 | 3,250 | 11,900 | 250 |
| Helen Francis | 20,400 | 2,500 | 20,400 | 1,500 |
| Diana Kirton | 20,400 | 2,500 | 20,400 | 2,250 |
| Jacoby Poulain | 20,400 | 2,500 | 20,400 | 2,750 |
| Heather Skipworth | 20,400 | 4,188 | 20,400 | 1,750 |
| | 251,525 | 32,495 | 251,100 | 25,682 |

*in thousands of New Zealand Dollars*

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

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

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

**Employee Remuneration**

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

| | 30 June 2018 | 30 June 2017 | | 30 June 2018 | 30 June 2017 |
|---|---|---|---|---|---|
| 100,000-109,999 | 78 | 67 | 340,000-349,999 | 1 | 3 |
| 110,000-119,999 | 33 | 32 | 350,000-359,999 | 3 | 3 |
| 120,000-129,999 | 31 | 31 | 360,000-369,999 | 3 | - |
| 130,000-139,999 | 21 | 19 | 370,000-379,999 | 1 | 1 |
| 140,000-149,999 | 14 | 18 | 380,000-389,999 | - | - |
| 150,000-159,999 | 10 | 9 | 390,000-399,999 | 1 | 2 |
| 160,000-169,999 | 12 | 9 | 400,000-409,999 | 1 | - |
| 170,000-179,999 | 8 | 6 | 410,000-419,999 | - | - |
| 180,000-189,999 | 12 | 11 | 420,000-429,999 | - | - |
| 190,000-199,999 | 8 | 9 | 430,000-439,999 | 1 | 1 |
| 200,000-209,999 | 11 | 12 | 440,000-449,999 | 1 | - |
| 210,000-219,999 | 10 | 6 | 450,000-459,999 | - | - |
| 220,000-229,999 | 7 | 8 | 460,000-469,999 | - | - |
| 230,000-239,999 | 4 | 5 | 470,000-479,999 | - | - |
| 240,000-249,999 | 6 | 4 | 480,000-489,999 | - | 2 |
| 250,000-259,999 | 5 | 11 | 490,000-499,999 | 1 | - |
| 260,000-269,999 | 6 | 5 | 500,000-509,999 | - | - |
| 270,000-279,999 | 3 | 8 | 510,000-519,999 | - | - |
| 280,000-289,999 | 10 | 6 | 520,000-529,999 | - | - |
| 290,000-299,999 | 7 | 6 | 530,000-539,999 | - | - |
| 300,000-309,999 | 4 | 3 | 540,000-549,999 | - | - |
| 310,000-319,999 | 7 | 1 | 550,000-559,999 | - | - |
| 320,000-329,999 | 3 | 5 | 560,000-569,999 | 1 | - |
| 330,000-339,999 | 1 | 1 | | | |

During the year, six (30 June 2017: 11) employees received compensation and other benefits in relation to cessation totalling $275,586 (30 June 2017: $428,595).

**Compensations**

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

HBDHB has taken out Directors' and Officers' Liability and Professional Indemnity Insurance cover during the financial year in respect of the liability or costs of Board members and employees.

## 5.8. Capital management

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

## 5.9. Events after balance date

There are no significant events after balance date.

## 5.10. Statement of Performance Expectations 2018/19

The DHB is required to complete its final Statement of Performance Expectations by the start of the financial year, under section 149C of the Crown Entities Act 2004. This requirement has not been met for the 2018/19 year. The 2018/19 Statement of Performance Expectations was signed by the Board on 31 October 2018.

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# Appendix one: Technical Results Report

**Key for technical results report**

| | |
|---|---|
| **Baseline** | Latest available data for planning purpose |
| **Target 2016/17** | Target 2017/18 |
| **Actual to date** | Actual to date |
| **F (Favourable)** | Actual to date is favourable to target (above or within 0.5% of target) |
| **U (Unfavourable)** | Actual to date is unfavourable to target |

## OUTPUT CLASS 1: PREVENTION SERVICES

### Population and Individual Dimensions

**Better help for smokers to quit -** % of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking

| Financial Year | Baseline | Target | Actual to Date |
|---|---|---|---|
| 2016/17 | 99.1% – October to December 2015 | ≥95% | 99.1% (F) – July to September 2016 |
| | | | 99.0% (F) – October to December 2016 |
| | | | 95.6% (F) – January to March 2017 |
| | | | 95.2% (F) – April to June 2017 |
| 2017/18 | 99.0% – October to December 2016 | ≥95% | 97.4% (F) – July to September 2017 |
| | | | 95.5% (F) – October to December 2017 |
| | | | 95.7% (F) – January to March 2018 |
| | | | 97.1% (F) – April to June 2018 |

**Better help for smokers to quit -** % of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

| Financial Year<br>Source: Ministry of Health | Baseline | Target | Actual to Date |
|---|---|---|---|
| 2016/17 | 81.2%<br>July to September 2015<br>(Source: DHBNZ) | ≥90% | 80.9% (U) – July to September 2016 |
| | | | 87.4% (U) – October to December 2016 |
| | | | 86.4% (U) – January to March 2017 |
| | | | 91.0% (F) – April to June 2017 |
| 2017/18 | 87.4%<br>October to December 2016 (Source: DHBNZ) | ≥90% | 90.2% (F) – July to September 2017 |
| | | | 90.9% (F) – October to December 2017 |
| | | | 88.9% (U) – January to March 2018 |
| | | | 89.0% (U) – April to June 2018 |

**Better help for smokers to quit -** % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

| Financial Year<br>Source: Ministry of Health | Baseline | Target | Actual to Date |
|---|---|---|---|
| 2016/17 | 96.5%<br>October - December 2015 | ≥90% | 91.2% (F) – July to September 2016 |
| | | | 88.5% (U) – October to December 2016 |
| | | | 92.8% (F) – January to March 2017 |
| | | | 85.7% (U) – April to June 2017 |
| 2017/18 | 88.5%<br>October - December 2016 | ≥90% | 81.3% (U) – July to September 2017 |
| | | | 73.9% (U) – October to December 2017 |
| | | | 75.0% (U) – January to March 2018 |
| | | | 69.0% (U) – April to June 2018 |

| **Better help for smokers to quit** Number of babies who live in a smoke-free household at six weeks post-natal | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 73.0%<br>July to December 2014 | ≥95% | 80% (U) July to December 2016 |
| 2017/18 | 80.0%<br>July to December 2015 | ≥95% | 66.1% (U) July to December 2017 |

| **Better help for smokers to quit** % of pregnant women who are smokefree at 2 weeks postnatal | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 73.0%<br>July to December 2014 | ≥95% | 80% (U) July to December 2016 |
| 2017/18 | 80.0%<br>July to December 2015 | ≥95% | No New Data |

*This indicator was replaced during the year with the SLM 'Number of Babies who live in a smoke-free household at 6 weeks post-natal'. As a result, no new data has been collected.

| **Increased immunisation -** % of 8 month olds will have their primary course of immunisation (six weeks, three months and five month events) on time | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 93.3%<br>3 months to December 2015 | ≥95% | 95.4% (F) – July to September 2016 |
| | | | 95.3% (F) – October to December 2016 |
| | | | 94.4% (U) – January to March 2017 |
| | | | 95.0% (F) – April to June 2017 |
| 2017/18 | 95.3%<br>October to December 2016 | ≥95% | 94.5% (F) – July to September 2017 |
| | | | 93.6% (U) – October to December 2017 |
| | | | 94.3% (U) – January to March 2018 |
| | | | 94.0% (U) – April to June 2018 |
| **MAORI** | | | |
| 2016/17 | 92.6%<br>3 months to December 2015 | ≥95% | 94.4% (U) – July to September 2016 |
| | | | 94.4% (U) – October to December 2016 |
| | | | 95.4% (F) – January to March 2017 |
| | | | 94.0% (U) – April to June 2017 |
| 2017/18 | 94.4%<br>October to December 2016 | ≥95% | 91.5% (U) – July to September 2017 |
| | | | 93.4% (U) – October to December 2017 |
| | | | 95.0% (F) – January to March 2018 |
| | | | 94.7% (F) – April to June 2018 |

| **Increased immunisation -** % of 2 year olds fully immunised | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 93.9%<br>3 months to December 2015 | ≥95% | 95.6% (F) – July to September 2016 |
| | | | 94.7% (F) – October to December 2016 |
| | | | 93.2% (U) – January to March 2017 |
| | | | 94.7% (F) – April to June 2017 |
| 2017/18 | 94.7%<br>October to December 2016 | ≥95% | 94.6% (F) – July to September 2017 |
| | | | 96.4% (F) – October to December 2017 |
| | | | 94.5% (F) – January to March 2016 |
| | | | 95.7% (F) – April to June 2016 |
| **MAORI** | | | |
| 2016/17 | 95.1%<br>3 months to December 2015 | ≥95% | 96.3% (F) – July to September 2016 |
| | | | 95.4% (F) – October to December 2016 |
| | | | 95.1% (F) – January to March 2017 |
| | | | 95.7% (F) – April to June 2017 |
| 2017/18 | 95.4%<br>October to December 2016 | ≥95% | 94.1% (U) – July to September 2017 |
| | | | 95.8% (F) – October to December 2017 |
| | | | 93.8% (U) – January to March 2018 |
| | | | 94.8% (F) – April to June 2018 |

| **Increased immunisation -** % of 5 year olds fully immunised | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 92.7%<br>3 months to December 2015 | ≥90% | 92.1% (F) – July to September 2016 |
| | | | 93.5% (F) – October to December 2016 |
| | | | 92.6% (F) – January to March 2017 |
| | | | 93.2% (F) – April to June 2017 |
| 2017/18 | 93.5%<br>October to December 2016 | ≥95% | 94.2% (U) – July to September 2017 |
| | | | 91.3% (U) – October to December 2017 |
| | | | 90.3% (U) – January to March 2018 |
| | | | 93.0% (U) – April to June 2018 |
| **MAORI** | | | |
| 2016/17 | 94.2%<br>3 months to December 2016 | ≥90% | 93.4% (F) – July to September 2015 |
| | | | 95.8% (F) – October to December 2015 |
| | | | 94.9% (F) – January to March 2016 |
| | | | 91.8% (F) – April to June 2016 |
| 2017/18 | 95.8%<br>October to December 2016 | ≥95% | 96.7% (F) – July to September 2016 |
| | | | 90.7% (U) – October to December 2016 |
| | | | 89.1% (U) – January to March 2017 |
| | | | 89.8% (U) – April to June 2017 |

| **Increased immunisation -** % of girls fully immunised – HPV vaccine | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 68.4%<br>2002 – June 2016 | ≥70% | 70.4% (F) 2003 – June 2017 |
| 2017/18 | 68.4%<br>2002 – June 2016 | ≥75% | 75.7% (F) 2004 – June 2018 |
| **MAORI** | | | |
| 2016/17 | 87.8%<br>2002 – June 2016 | ≥70% | 76.9% (F) 2003 – June 2017 |
| 2017/18 | 87.8%<br>2002 – June 2016 | ≥75% | 84.9% (F) 2004 – June 2018 |

| **Increased immunisation** % of 65+ year olds immunised – flu vaccine | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 67.9% - January to December 2014 | ≥70% | 60% January 2016 – December 2016 |
| 2017/18 | 60.0% - January to December 2016 | ≥75% | 58% March 2018 – September 2018 |

| **Reduced incidence of first episode Rheumatic Fever** Acute rheumatic fever initial hospitalisation rate per 100,000 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 0.6 per 100,000<br>July 2014 – June 2015 | ≤1.5 | 2.48 per 100,000<br>July 2016 – June 2017 |
| 2017/18 | 2.48 per 100,000<br>July 2016 – June 2017 | ≤1.5 | 1.86 per 100,000<br>July 2017 – June 2018 |

| **Improve breast screening rates** % of women aged 50-69 years receiving breast screening in the last 2 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Breast Screen Aotearoa | **Baseline** | **Target** | **Actual to Date** |
| **OVERALL RATE** | | | |
| 2016/17 | 74.7%<br>24 months to December 2015 | ≥70% | 73.4% (F) - 24 months to 31 March 2017 |
| 2017/18 | 73.6%<br>24 months to December 2016 | ≥70% | 71.8% (F) - 24 months to 31 March 2018 |
| **MAORI** | | | |
| 2016/17 | 68.4%<br>24 months to December 2015 | ≥70% | 66.2% (U) - 24 months to 31 March 2017 |
| 2017/18 | 64.7%<br>24 months to December 2016 | ≥70% | 64.6% (U) - 24 months to 31 March 2018 |
| **PACIFIC** | | | |
| 2016/17 | 70.7%<br>24 months to December 2015 | ≥70% | 66.1% (U) - 24 months to 31 March 2017 |
| 2017/18 | 65.4%<br>24 months to December 2016 | ≥70% | 72.8% (F) - 24 months to 31 March 2018 |

| **Improve cervical screening coverage** % of women aged 25–69 years who have had a cervical screening event in the past 36 months | | | |
|---|---|---|---|
| **Financial Year**<br>Source: National Screening Unit | **Baseline** | **Target** | **Actual to Date** |
| **OVERALL RATE** | | | |
| 2016/17 | 75.8%<br>36 months to 31 December 2015 | ≥80% | 79.6% (F) - 36 months to May 2017 |
| 2017/18 | 76.7%<br>36 months to 31 December 2016 | ≥80% | 77.1% (U) - 36 months to May 2018 |
| **MAORI** | | | |
| 2016/17 | 74.1%<br>36 months to 31 December 2015 | ≥80% | 73.0% (U) - 36 months to May 2017 |
| 2017/18 | 72.8%<br>36 months to 31 December 2016 | ≥80% | 74.6% (U) - 36 months to May 2018 |
| **PACIFIC** | | | |
| 2016/17 | 71.2%<br>36 months to 31 December 2015 | ≥80% | 74.8% (U) - 36 months to May 2017 |
| 2017/18 | 74.8%<br>36 months to 31 December 2016 | ≥80% | 78.1% (U) - 36 months to May 2018 |

| **Better rates of breastfeeding** % of infants that are exclusively or fully breastfed | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **At 6 Weeks Total:** | | | |
| 2017/18 | 72% 6 months to December 2015 | ≥75% | No New Data |
| **At 6 Weeks Maori:** | | | |
| 2017/18 | 66% 6 months to December 2015 | ≥75% | No New Data |
| **At 3 Months Total** | | | |
| 2016/17 | 54%<br>January 2015 to June 2015 | ≥60% | 51% (U) – January 2016 to June 2016 |
| 2017/18 | 51%<br>January 2016 to June 2016 | ≥60% | 51% (U) – July 2017 to December 2017 |
| **At 3 Months Maori:** | | | |
| 2016/17 | 46%<br>January 2015 to June 2015 | ≥60% | 39% (U) - January 2016 to June 2016 |
| 2017/18 | 39%<br>January 2016 to June 2016 | ≥60% | 41% (U) - July 2017 to December 2017 |

* The six week breast feeding data for Well Child Tamariki Ora was not made available through the Well Child Tamariki Ora Quality Improvement Framework. Going forward we will only be reporting Breastfeeding rates at 3 months.

# OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

| **Improved access primary care -** % of the population enrolled in the PHO | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 96.4%<br>December 2015 | ≥100% | 97.0% (U) - July to September 2016 |
| | | | 97.1% (U) – October to December 2016 |
| | | | 97.3% (U) – January to March 2017 |
| | | | 97.8% (U) - April to June 2017 |
| 2017/18 | 97.1%<br>October 2016 | ≥100% | 97.4% (U) - July to September 2017 |
| | | | 97.6% (U) – October to December 2017 |
| | | | 97.5% (U) – January to March 2018 |
| | | | 97.9% (U) - April to June 2018 |
| **MĀORI:** | | | |
| 2016/17 | 97.2%<br>December 2015 | ≥100% | 96.6% (U) - July to September 2016 |
| | | | 96.8% (U) – October to December 2016 |
| | | | 97.5% (U) – January to March 2017 |
| | | | 97.9% (U) - April to June 2017 |
| 2017/18 | 96.8%<br>October 2016 | ≥100% | 96.6% (U) - July to September 2017 |
| | | | 96.6% (U) – October to December 2017 |
| | | | 98.3% (U) – January to March 2018 |
| | | | 98.8% (U) - April to June 2018 |

| **Reduce the difference between Māori and other rate for ASH 0-4** - Ambulatory sensitive hospitalisation rate per 100,000 0-4 years | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 4,725<br>October 2014 to September 2015 | NA | 5,272 - 12 months to September 2016 |
| | | | 4,892 -12 months to March 2017 |
| 2017/18 | 5,272<br>October 2015 to September 2016 | NA | 5,794 - 12 months to September 2018 |
| | | | 6,360 -12 months to March 2018 |
| **MĀORI:** | | | |
| 2015/16 | New | NA | 6,092 - 12 months to September 2016 |
| | | | 5,150 - 12 months to March 2017 |
| 2017/18 | 5,755<br>October 2015 to September 2016 | Gap Māori and other ≤1,028 | 6,434 - 12 months to September 2017 |
| | | | 7,259 - 12 months to March 2018 |

| **Reduce ASH 45-64** - Ambulatory sensitive hospitalisation rate per 100,000 45-64 years | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 3,510<br>October 2014 to September 2015 | <3,510 | 4,063 - 12 months to September 2016<br>3,399 -12 months to March 2017 |
| 2017/18 | 4,129<br>October 2015 to September 2016 | <4,129 | 4,373 - 12 months to September 2017<br>4,414 -12 months to June 2018 |
| **MĀORI:** | | | |
| 2016/17 | 6,310<br>October 2014 to September 2015 | <3,510 | 7,801 - 12 months to September 2016<br>6,802 - 12 months to March 2017 |
| 2017/18 | 7,636<br>October 2015 to September 2016 | <4,129 | 8,165 - 12 months to September 2017<br>8,302 - 12 months to June 2018 |
| **Pacific** | | | |
| 2016/17 | New | New | New<br>New |
| 2017/18 | 7,636<br>October 2015 to September 2016 | <4,129 | 7,168 - 12 months to September 2017<br>7,954 - 12 months to June 2018 |

| **More pregnant women under the care of a Lead Maternity Carer (LMC)** % of women booked with an LMC by week 12 of their pregnancy | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 55.4%<br>October to December 2015 | ≥80% | 63.7% (U) – April to June 2016<br>65.7% (U) – July to September 2016<br>62.5% (U) – October to December 2016<br>64.8% (U) – January to March 2017 |
| 2017/18 | 65.7%<br>July to September 2016 | ≥80% | 63.0% (U) – April to June 2017<br>57.9% (U) – July to September 2017<br>67.1% (U) – October to December 2017<br>57.9% (U) – January to March 2018 |
| **MĀORI:** | | | |
| 2016/17 | 50.7%<br>October to December 2015 | ≥80% | 53.3% (U) – April to June 2016<br>49.2% (U) – July to September 2016<br>45.3% (U) – October to December 2016<br>55.7% (U) – January to March 2017 |
| 2017/18 | 49.2%<br>July to September 2016 | ≥80% | 54.1% (U) – April to June 2017<br>50.0% (U) – July to September 2017<br>52.4% (U) – October to December 2017<br>50.0% (U) – January to March 2018 |

| **Better oral health -** % of eligible pre-school enrolments in DHB-funded oral health services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 73.9%<br>2014 calendar year | ≥90% | 89.2% (U) - 2016 calendar year |
| 2017/18 | 89.2%<br>2016 calendar year | ≥95% | 90.5% (U) - 2017 calendar year |
| **MAORI:** | | | |
| 2016/17 | 65.3%<br>2014 calendar year | ≥90% | 72.7% (U) - 2016 calendar year |
| 2017/18 | 72.7%<br>2016 calendar year | ≥95% | 76.1% (U) - 2017 calendar year |
| **PACIFIC:** | | | |
| 2016/17 | 71.7%<br>2014 calendar year | ≥90% | 69.1% (U) - 2016 calendar year |
| 2017/18 | 69.1%<br>2016 calendar year | ≥95% | 77.1% (U) - 2017 calendar year |

| **Better oral health** % of children who are carries free at 5 years of age | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 54.4% 2014 calendar year | ≥67% | 59.0% (U) – 2016 calendar year |
| 2017/18 | 59.0% 2016 calendar year | ≥64% | 59.5% (U) – 2017 calendar year |

| **Better oral health** % of enrolled preschool and primary school children not examined according to planned recall | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 4.0%<br>2014 calendar year | <4.8% | 2.8% (F) - 2016 calendar year |
| 2017/18 | 2.8%<br>2015 calendar year | <10% | 8.0% (F) - 2017 calendar year |

| **Better oral health** % of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 78.3%<br>2014 calendar year | ≥85% | 68.8% (U) – 2016 calendar year |
| 2017/18 | 75.9%<br>2015 calendar year | ≥85% | 66.6% (U) – 2017 calendar year |

| **Better oral health** Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 0.96<br>2015 calendar year | <0.92 | 0.81 (F) – 2016 calendar year |
| 2017/18 | 0.81<br>2016 calendar year | <0.96 | 0.72 (F) – 2017 calendar year |

| **Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke)** Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 41.4%<br>12 months to December 2015 | ≥55% | 40.8% (U) – July to September 2016 |
| | | | 40.3% (U) – October to December 2016 |
| | | | 40.1% (U) – January to March 2017 |
| | | | 43.0% (U) – April to June 2017 |
| 2017/18 | 65.4%<br>12 months to December 2016 | ≥65.4% | 34.8% (U) – July to September 2017 |
| | | | 31.4% (U) – October to December 2017 |
| | | | 34.7% (U) – January to March 2018 |
| | | | 34.9% (U) – April to June 2018 |
| **MAORI:** | | | |
| 2016/17 | 37.8%<br>12 months to December 2015 | ≥55% | 33.8% (U) – July to September 2016 |
| | | | 34.8% (U) – October to December 2016 |
| | | | 37.6% (U) – January to March 2017 |
| | | | 37.0% (U) – April to June 2017 |
| 2017/18 | 46.2%<br>12 months to December 2016 | ≥65.4% | 33.3% (U) – July to September 2017 |
| | | | 27.8% (U) – October to December 2017 |
| | | | 30.4% (U) – January to March 2018 |
| | | | 30.6% (U) – April to June 2018 |
| **PACIFIC:** | | | |
| 2016/17 | 45.5%<br>12 months to December 2015 | ≥55% | 52.9% (U) – July to September 2016 |
| | | | 53.6% (U) – October to December 2016 |
| | | | 52.7% (U) – January to March 2017 |
| | | | 33.0% (U) – April to June 2017 |
| 2017/18 | 39.3%<br>12 months to December 2016 | ≥65.4% | 49.8% (U) – July to September 2017 |
| | | | 44.6% (U) – October to December 2017 |
| | | | 49.0% (U) – January to March 2018 |
| | | | 48.8% (U) – April to June 2018 |

| **Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke)** % of the eligible population will have had a CVD risk assessment in the last 5 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 90.3%<br>5 years to December 2015 | ≥90% | 88.1% (U) – 5 years to September 2016 |
| | | | 87.8% (U) – 5 years to December 2016 |
| | | | 88.7% (U) – 5 years to March 2017 |
| | | | 88.2% (U) – 5 years to June 2017 |
| 2017/18 | 87.8<br>5 years to December 2016 | ≥90% | 88.4% (U) – 5 years to September 2017 |
| | | | 86.3% (U) – 5 years to December 2017 |
| | | | 86.1% (U) – 5 years to March 2018 |
| | | | 85.2% (U) – 5 years to June 2018 |
| **MAORI** | | | |
| 2016/17 | 86.3%<br>5 years to December 2015 | ≥90% | 84.9% (U) – 5 years to September 2016 |
| | | | 84.5% (U) – 5 years to December 2016 |
| | | | 85.3% (U) – 5 years to March 2017 |
| | | | 84.4% (U) – 5 years to June 2017 |
| 2017/18 | 84.5%<br>5 years to December 2016 | ≥90% | 85.4% (U) – 5 years to September 2017 |
| | | | 85.0% (U) – 5 years to December 2017 |
| | | | 84.8% (U) – 5 years to March 2018 |
| | | | 83.8% (U) – 5 years to June 2018 |
| **PACIFIC** | | | |
| 2016/17 | 87.0%<br>5 years to December 2015 | ≥90% | 84.6% (U) – 5 years to September 2016 |
| | | | 84.0% (U) – 5 years to December 2016 |
| | | | 84.3% (U) – 5 years to March 2017 |
| | | | 82.7% (U) – 5 years to June 2017 |
| 2017/18 | 84.0%<br>5 years to December 2016 | ≥90% | 84.3% (U) – 5 years to September 2017 |
| | | | 83.6% (U) – 5 years to December 2017 |
| | | | 83.5% (U) – 5 years to March 2018 |
| | | | 82.7% (U) – 5 years to June 2018 |

| **Less waiting for diagnostic services** % of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 84.4% December 2015 | ≥95% | 87.4% (U) September 2016 |
| | | | 95.1% (F) December 2016 |
| | | | 96.4% (F) March 2017 |
| | | | 95.1% (F) June 2017 |
| 2017/18 | 95.1% December 2016 | ≥95% | 96.1% (F) September 2017 |
| | | | 92.5% (U) December 2017 |
| | | | 96.7% (F) March 2018 |
| | | | 91.6% (U) June 2018 |

| **Less waiting for diagnostic services** % of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 31.0% December 2015 | ≥85% | 52.8% (U) September 2016 |
| | | | 48.0 % (U) December 2016 |
| | | | 59.0% (U) March 2017 |
| | | | 69.7% (U) June 2017 |
| 2017/18 | 48.0% December 2016 | ≥90% | 91.7% (F) September 2017 |
| | | | 93.8 % (F) December 2017 |
| | | | 97.3% (F) March 2018 |
| | | | 80.0% (U) June 2018 |

| **Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions** - % of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | New | ≥95% | 27% (U) – March to August 2016 |
| | | | 40% (U) – June to November 2016 |
| | | | 81% (U) – August to February 2017 |
| | | | 95% (F) – December to May 2017 |
| 2017/18 | 40% - June to November 2016 | ≥95% | 95.0% (F) – March to August 2017 |
| | | | 98.0% (F) – June to November 2017 |
| | | | 98.0% (F) – August to February 2018 |
| | | | 100% (F) – December to May 2018 |

# OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

| **Less waiting for ED treatment** - % of patients admitted, discharged or transferred from an ED within 6 hours | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 94.7% – October to December 2015 | ≥95% | 92.4% (U) – July to September 2016 |
| | | | 94.7% (F) – October to December 2016 |
| | | | 93.8% (U) – January to March 2017 |
| | | | 94.7% (F) – April to June 2017 |
| 2017/18 | 94.7% – October to December 2016 | ≥95% | 91.4% (U) – July to September 2017 |
| | | | 92.2% (U) – October to December 2017 |
| | | | 89.0% (U) – January to March 2018 |
| | | | 90.5% (U) – April to June 2018 |

| **Faster cancer treatment** - % of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 77.6 % October to December 2015 | 85% | 65.1% (U) - April to September 2016 |
| | | | 63.6% (U) – July to December 2016 |
| | | | 71.8% (U) – October 2015 to March 2017 |
| | | | 77.1% (U) – January to June 2017 |
| 2017/18 | 65.4 % October to December 2016 | 90% | 88.1% (U) - April to September 2017 |
| | | | 95.0% (F) – July to December 2017 |
| | | | 91.2% (F) – October 2015 to March 2018 |
| | | | 88.0% (U) – January to June 2018 |

| **More elective surgery** - Number of elective surgery discharges | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **NUMBER OF ELECTIVE DISCHARGES (VOLUMES)**(Source: Ministry of Health) | | | |
| 2016/17 | 6,154<br>2014/2015 | ≥7,374 | 7,467 (F) - July 2016 to June 2017 |
| 2017/18 | 7,469<br>2015/2016 | ≥7,574 | 7,159 (U) - July 2017 to June 2018 |

| Patients with ACS receive seamless, coordinated care across the clinical pathway | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| % of high-risk patients will receiving an angiogram within 3 days of admission. | | | |
| **TOTAL** | | | |
| 2016/17 | 68.7%<br>October to December 2015 | ≥70% | 56.4% (U)- July to September 2016 |
| | | | 71.6% (F)– October to December 2016 |
| | | | 64.9% (U) – January to March 2017 |
| | | | 65.4% (U) - April to June 2017 |
| 2017/18 | 73.1%<br>October to December 2016 | ≥70% | 82.1% (F)- July to September 2017 |
| | | | 73.5% (F)– October to December 2017 |
| | | | 55.2% (U) – January to March 2018 |
| | | | 58.9% (U) - April to June 2018 |
| **MAORI** | | | |
| 2016/17 | 60.0%<br>October to December 2015 | ≥70% | 38.1% (U)- July to September 2016 |
| | | | 61.1% (U)– October to December 2016 |
| | | | 65.0% (U) – January to March 2017 |
| | | | 69.2% (U) - April to June 2017 |
| 2017/18 | 61.1%<br>October to December 2016 | ≥70% | 81.8% (F)- July to September 2017 |
| | | | 76.5% (F)– October to December 2017 |
| | | | 66.7% (U) – January to March 2018 |
| | | | 60.0% (U) - April to June 2018 |
| % of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge | | | |
| 2016/17 | 84.1%<br>October to December 2015 | ≥95% | 95.5% (F) - July to September 2016 |
| | | | 97.7% (F) – October to December 2016 |
| | | | 90% (U) – January to March 2017 |
| | | | 85.2% (U) - April to June 2017 |
| 2017/18 | 95.5%<br>October to December 2016 | ≥95% | 92.0% (U) - June to August 2017 |
| | | | 98.8% (F) – September to November 2017 |
| | | | 98.5% (F) – December to February 2018 |
| | | | 97.7% (F) - March to May 2018 |
| **MAORI** | | | |
| 2016/17 | 71.4%<br>October to December 2015 | ≥95% | 94.7% (F) - July to September 2016 |
| | | | 100% (F) – October to December 2016 |
| | | | 88.9% (U) – January to March 2017 |
| | | | 100% (F) - April to June 2017 |
| 2017/18 | 95.0%<br>October to December 2016 | ≥95% | 84.6% (U) - June to August 2017 |
| | | | 86.7% (U) – September to November 2017 |
| | | | 92.9% (U) – December to February 2018 |
| | | | 89.5% (U) - March to May 2018 |

| **Equitable access to care for stroke patients** - % of potentially eligible stroke patients who are thrombolysed 24/7 | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 4.1%<br>October to December 2015 | ≥6% | 4.5% (U) - April to June 2016 |
| | | | 5.7% (U) - July to September 2016 |
| | | | 8.2% (F) – October to December 2016 |
| | | | 8.0% (F) – January to March 2017 |
| 2017/18 | 10.2%<br>October to December 2016 | ≥6% | 7.9% (F) - April to June 2017 |
| | | | 7.3% (F) - July to September 2017 |
| | | | 5.9% (U) – October to December 2017 |
| | | | 5.0% (U) – January to March 2018 |

| **Equitable access to care for stroke patients** - % of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 78.4%<br>October to December 2015 | ≥80% | 90.9% (F) - April to June 2016 |
| | | | 84.9% (F) - July to September 2016 |
| | | | 83.6% (F) – October to December 2016 |
| | | | 82.0% (F) – January to March 2017 |
| 2017/18 | 88.1%<br>October to December 2016 | ≥80% | 84.2% (F) - April to June 2017 |
| | | | 75.6% (U) - July to September 2017 |
| | | | 79.4% (F) – October to December 2017 |
| | | | 93.8 % (F) – January to March 2018 |

| **Equitable access to care for stroke patients** - % of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 77.4%<br>October to December 2015 | ≥80% | 90.9% (F) - April to June 2016 |
| | | | 79.0% (U) - July to September 2016 |
| | | | 58% (U) – October to December 2016 |
| | | | 71% (U) – January to March 2017 |
| 2017/18 | 58.0%<br>October to December 2016 | ≥80% | 71.4% (U) - April to June 2017 |
| | | | 57.9% (U) - July to September 2017 |
| | | | 37.5% (U) – October to December 2017 |
| | | | 95.2% (F) – January to March 2018 |

| **Equitable access to surgery** - Standardised intervention rates for surgery per 10,000 population for: | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| Major joint replacement | | | |
| 2016/17 | 17.6<br>12 months to December 2015 | ≥21.0 | 20.3 (U) – July 2015 to June 2016 |
| | | | 21.5 (F) – October 2015 to September 2016 |
| | | | 20.0 (U) – January 2016 to December 2016 |
| | | | 20.6 (U) - April 2016 to March 2017 |
| 2017/18 | 21.5<br>12 months to September 2016 | ≥21.0 | 21.8 (F) – July 2015 to June 2017 |
| | | | 22.9 (F) – October 2015 to September 2017 |
| | | | 22.4 (F) – January 2016 to December 2017 |
| | | | 21.8 (F) - April 2016 to March 2018 |
| Cataract procedures | | | |
| 2016/17 | 51.2<br>12 months to December 2015 | ≥27.0 | 53.5 (F) – July 2015 to June 2016 |
| | | | 58.7 (F) – October 2015 to September 2016 |
| | | | 56.6 (F) – January 2016 to December 2016 |
| | | | 52.5 (F) - April 2016 to March 2017 |
| 2017/18 | 58.7<br>12 months to September 2016 | ≥27.0 | 46.4 (F) – July 2015 to June 2017 |
| | | | 49.7 (F) – October 2015 to September 2017 |
| | | | 46.6 (F) – January 2016 to December 2017 |
| | | | 47.5 (F) - April 2016 to March 2018 |
| Cardiac surgery | | | |
| 2016/17 | 6.3<br>12 months to December 2015 | ≥6.5 | 6.4 (U) – July 2015 to June 2016 |
| | | | 6.6 (F) – October 2015 to September 2016 |
| | | | 6.3 (U) – January 2016 to December 2016 |
| | | | 5.9 (U) - April 2016 to March 2017 |
| 2017/18 | 6.6<br>12 months to September 2016 | ≥6.5 | 5.2 (U) – July 2015 to June 2017 |
| | | | 4.7 (U) – October 2015 to September 2017 |
| | | | 4.8 (U) – January 2016 to December 2017 |
| | | | 5.4 (U) - April 2016 to March 2018 |
| Percutaneous revascularisation | | | |
| 2016/17 | 12.4<br>12 months to December 2015 | ≥12.5 | 13.0 (F) – July 2015 to June 2016 |
| | | | 13.1 (F) – October 2015 to September 2016 |
| | | | 13.1 (F) – January 2016 to December 2016 |
| | | | 12.4 (F) - April 2016 to March 2017 |
| 2017/18 | 12.4<br>12 months to September 2016 | ≥12.5 | 12.2 (U) – July 2015 to June 2017 |
| | | | 11.96 (U) – October 2015 to September 2017 |
| | | | 11.85 (U) – January 2016 to December 2017 |
| | | | 11.64 (U) - April 2016 to March 2018 |
| Coronary angiography services | | | |
| 2016/17 | 39.5<br>12 months to December 2015 | ≥34.7 | 38.4 (F) – July 2015 to June 2016 |
| | | | 39.0 (F) – October 2015 to September 2016 |
| | | | 37.5 (F) – January 2016 to December 2016 |
| | | | 35.1 (F) - April 2016 to March 2017 |
| 2017/18 | 39.5<br>12 months to September 2016 | ≥34.7 | 35.5 (F) – July 2015 to June 2017 |
| | | | 36.55 (F) – October 2015 to September 2017 |
| | | | 36.4 (F) – January 2016 to December 2017 |
| | | | 35.9 (F) - April 2016 to March 2018 |

| **Shorter stays in hospital** - Length of stay Elective (days) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 1.66 days<br>12 months to December 2015 | ≤1.55 days | 1.58 (F) – July 2015 to June 2016 |
| | | | 1.56 (F) – October 2015 to September 2016 |
| | | | 1.57 (F) – January 2016 to December 2016 |
| | | | 1.61 (U) – April 2016 to March 2017 |
| 2017/18 | 1.56 days<br>12 months to September 2016 | ≤1.47 days | 1.58 (U) – July 2016 to June 2017 |
| | | | 1.55 (U) – October 2016 to September 2017 |
| | | | 1.52 (U) – January 2017 to December 2017 |
| | | | 1.55 (U) – April 2017 to March 2018 |

*****The target agreed in the Annual Plan is for quarter 4 with staggered targets for each quarter throughout the year. U or F refers to the result against the staggered target at the end of each quarter.

| **Shorter stays in hospital** - Length of stay Acute (days) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 2.55<br>12 months to December 2015 | ≤2.35 days | 2.49 (F) – July 2015 to June 2016 |
| | | | 2.48 (U) – October 2015 to September 2016 |
| | | | 2.42 (U) – January 2016 to December 2016 |
| | | | 2.5 (U) – April 2016 to March 2017 |
| 2017/18 | 2.48<br>12 months to September 2016 | ≤2.3 days | 2.46 (U) – July 2016 to June 2017 |
| | | | 2.41 (U) – October 2016 to September 2017 |
| | | | 2.39 (U) – January 2017 to December 2017 |
| | | | 2.39 (U) – April 2017 to March 2018 |

***** The target agreed in the Annual Plan is for quarter 4 with staggered targets for each quarter throughout the year. U or F refers to the result against the staggered target at the end of each quarter.

| **Fewer readmissions** - Acute readmissions to hospital | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | NA | NA | NA |
| | | | NA |
| | | | NA |
| | | | NA |
| 2017/18 | 7.3%<br>January to December 2016 | TBC | 12.2% January 2016 to December 2016 |
| | | | 11.9% July 2016 to June 2017 |
| | | | 12.5% January 2017 to December 2017 |
| | | | 12.3% April 2017 to March 2018 |

***for 2016/17 the ministry reported data for information purposes only in line with the new definition.**

| **Quicker access to diagnostics** - % accepted referrals for elective coronary angiography completed within 90 days | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 78.9%<br>December 2015 | 95% | 100.0% (F) - September 2016 |
| | | | 97.7% (F) –December 2016 |
| | | | 92.9% (U) – March 2017 |
| | | | 97.2% (F) - June 2017 |
| 2017/18 | 97.7%<br>December 2016 | 95% | 98.0% (F) - September 2017 |
| | | | 87.8% (U) –December 2017 |
| | | | 88.5% (U) – March 2018 |
| | | | 94.4% (U) - June 2018 |

| **Quicker access to diagnostics** - % of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 82.4% December 2015 | ≥85% | 93.0% (F) - September 2016 |
| | | | 91.7% (F) –December 2016 |
| | | | 84.8% (F) – March 2017 |
| | | | 100% (F) - June 2017 |
| 2017/18 | 91.7% December 2016 | ≥90% | 96.2% (F) - September 2017 |
| | | | 93.5% (F) –December 2017 |
| | | | 97.1% (F) – March 2018 |
| | | | 96.0% (F) - June 2018 |

| **Quicker access to diagnostics** - % of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 87.1% December 2015 | ≥70% | 97.6% (F) - September 2016 |
| | | | 93.9% (F) –December 2016 |
| | | | 84.9% (F) – March 2017 |
| | | | 95.7% (F) - June 2017 |
| 2017/18 | 93.9% December 2016 | ≥70% | 80.7% (F) - September 2017 |
| | | | 58.6% (U) –December 2017 |
| | | | 81.6% (F) – March 2018 |
| | | | 55% (U) - June 2018 |

| **Quicker access to diagnostics** - % of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 79.3% December 2015 | ≥65% | 94.6% (F) - September 2016 |
| | | | 98.1% (F) –December 2016 |
| | | | 98.1% (F) – March 2017 |
| | | | 98.6% (F) - June 2017 |
| 2017/18 | 98.1% December 2016 | ≥70% | 97.4% (F) - September 2017 |
| | | | 76.9% (F) –December 2017 |
| | | | 68.0% (U) – March 2018 |
| | | | 78.0% (F) - June 2018 |

| **Fewer missed outpatient appointments** - Did not attend (DNA) rate across first specialist assessments | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2016/17 | 8.1%<br>October to December 2015 | ≤7.5% | 7.5% (F) - July to September 2016 |
| | | | 6.7% (F) – October to December 2016 |
| | | | 5.1% (F) – January to March 2017 |
| | | | 5.2% (F) - April to June 2017 |
| 2017/18 | 6.7%<br>October to December 2016 | ≤7.5% | 5.2% (F) - July to September 2017 |
| | | | 5.3% (F) – October to December 2017 |
| | | | 5.7% (F) – January to March 2018 |
| | | | 6.5% (F) - April to June 2018 |
| **MAORI** | | | |
| 2016/17 | 14.9%<br>October to December 2015 | ≤7.5% | 15.4% (U) - July to September 2016 |
| | | | 14.2% (U) – October to December 2016 |
| | | | 11.8% (U) – January to March 2017 |
| | | | 12.3% (U) - April to June 2017 |
| 2017/18 | 14.2%<br>October to December 2016 | ≤7.5% | 10.4% (U) - July to September 2017 |
| | | | 9.2% (U) – October to December 2017 |
| | | | 10.2% (U) – January to March 2018 |
| | | | 12.3% (U) - April to June 2018 |

| **Better mental health services Improving access Better access to mental health and addiction services** - Proportion of the) population seen by mental health and addiction services | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **Child and Youth (0-19)** | | | |
| **TOTAL** | | | |
| 2016/17 | 4.07% October 2014 to September 2015 | ≥4.0% | 4.26% (F) – October 2015 to September 2016<br>4.08% (F) - April 2016 to March 2017 |
| 2017/18 | 4.26% October 2015 to September 2016 | ≥4.3% | 4.07% (U) – October 2016 to September 2017<br>3.86% (U) - April 2017 to March 2018 |
| **MAORI** | | | |
| 2016/17 | 4.62% October 2014 to September 2015 | ≥4.0% | 4.92% (F) – October 2015 to September 2016<br>4.55% (F) - April 2016 to March 2017 |
| 2017/18 | 4.92% October 2015 to September 2016 | ≥4.3% | 4.34% (F) – October 2016 to September 2017<br>4.12% (U) - April 2017 to March 2018 |
| **Adult (20-64)** | | | |
| **TOTAL** | | | |
| 2017/18 | 4.94% October 2014 to September 2015 | ≥5.0% | 5.11% (F) – October 2015 to September 2016<br>5.35% (F) - April 2016 to March 2017 |
| 2017/18 | 5.11% October 2015 to September 2016 | ≥5.4% | 5.46% (F) – October 2016 to September 2017<br>5.39% (U) - April 2017 to March 2018 |
| **MAORI** | | | |
| 2016/17 | 8.75% October 2014 to September 2015 | ≥5.0% | 9.26% (F) – October 2015 to September 2016<br>9.76% (F) - April 2016 to March 2017 |
| 2017/18 | 9.26% October 2015 to September 2016 | ≥5.4% | 9.85% (F) – October 2016 to September 2017<br>9.78% (F) - April 2017 to March 2018 |
| **Older Adult (65+)** | | | |
| **TOTAL** | | | |
| 2016/17 | 1.04% October 2014 to September 2015 | ≥1.15% | 1.12% (U) – October 2015 to September 2016<br>1.13% (U) - April 2016 to March 2017 |
| 2017/18 | 1.12% October 2015 to September 2016 | ≥1.15% | 1.14% (U) – October 2016 to September 2017<br>1.12% (U) - April 2017 to March 2018 |
| **MAORI** | | | |
| 2016/17 | 0.96% October 2014 to September 2015 | ≥1.15% | 1.19% (F) – October 2015 to September 2016<br>1.09% (U) - April 2016 to March 2017 |
| 2017/18 | 1.19% October 2015 to September 2016 | ≥1.15% | 1.25% (F) – October 2016 to September 2017<br>1.33% (F) - April 2017 to March 2018 |

| Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| % of 0-19 year olds seen within 3 weeks of referral | | | |
| MENTAL HEALTH PROVIDER ARM | | | |
| 2016/17 | 60.1%<br>12 months to December 2015 | ≥80% | 71.2% (U) - July 2015 to June 2016 |
| | | | 72.3% (U) - October 2015 to September 2016 |
| | | | 73.2% (U) – January 2016 to December 2016 |
| | | | 74.8% (U) - April 2016 to March 2017 |
| 2017/18 | 73.2%<br>12 months to December 2016 | ≥80% | 70.5% (U) - July 2016 to June 2017 |
| | | | 71.3% (U) - October 2016 to September 2017 |
| | | | 72.5% (U) – January 2017 to December 2017 |
| | | | 72.2% (U) - April 2017 to March 2018 |
| ADDICTIONS (PROVIDER ARM AND NGO) | | | |
| 2016/17 | 84.2%<br>12 months to September 2015 | ≥80% | 81.2% (F) - July 2015 to June 2016 |
| | | | 81.1% (F) - October 2015 to September 2016 |
| | | | 81.4% (F) – January 2016 to December 2016 |
| | | | 69.2% (U) - April 2016 to March 2017 |
| 2017/18 | 81.1%<br>12 months to September 2016 | ≥80% | 76.8% (U) - July 2016 to June 2017 |
| | | | 73.4% (U) - October 2016 to September 2017 |
| | | | 72.1% (U) – January 2017 to December 2017 |
| | | | 73.2% (U) - April 2017 to March 2018 |
| % of 0-19 year olds seen within 8 weeks of referral | | | |
| MENTAL HEALTH PROVIDER ARM | | | |
| 2016/17 | 81.5%<br>12 months to September 2015 | ≥95% | 91.2% (U) - July 2015 to June 2016 |
| | | | 91.7% (U) - October 2015 to September 2016 |
| | | | 91.9% (U) – January 2016 to December 2016 |
| | | | 90.9% (U) - April 2016 to March 2017 |
| 2017/18 | 91.7%<br>12 months to September 2016 | ≥95% | 91.4% (U) - July 2016 to June 2017 |
| | | | 90.9% (U) - October 2016 to September 2017 |
| | | | 91.2% (U) – January 2017 to December 2017 |
| | | | 92.2% (U) - April 2017 to March 2018 |
| ADDICTIONS (PROVIDER ARM AND NGO) | | | |
| 2016/17 | 99.5%<br>12 months to September 2015 | ≥95% | 92.8% (U) - July 2015 to June 2016 |
| | | | 94.6% (U) - October 2015 to September 2016 |
| | | | 95.7% (F) – January 2016 to December 2016 |
| | | | 90.8% (U) - April 2016 to March 2017 |
| 2017/18 | 94.6%<br>12 months to September 2016 | ≥95% | 94.6% (U) - July 2016 to June 2017 |
| | | | 92.2% (U) - October 2016 to September 2017 |
| | | | 95.6% (F) – January 2017 to December 2017 |
| | | | 92.9% (U) - April 2017 to March 2018 |

| **Improving mental health services using discharge planning** - % of clients discharged will have a quality transition or wellness plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 36.2%<br>January 2015 to December 2015 | ≥95% | 70.0% (U) - July to June 2016 |
| | | | 84.0% (U) – October 2014 to September 2016 |
| | | | 93.0% (U) – January 2015 to December 2016 |
| | | | 96.0% (F) – April 2015 to March 2017 |
| 2017/18 | 92.5%<br>January 2015 to December 2016 | ≥95% | 59.5% (U) - July to June 2017 |
| | | | 75.9% (U) – October 2014 to September 2017 |
| | | | 75.3% (U) – January 2015 to December 2017 |
| | | | 61.1% (F) – April 2015 to March 2018 |

| **Increasing consumer focus More equitable use of Mental Health Act:** Section 29 community treatment orders - Rate of s29 orders per 100,000 population | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2016/17 | 97.0<br>October to December 2015 | ≤81.5 | 89.7 (U) - July to September 2016 |
| | | | 89.3 (U) – October to December 2016 |
| | | | 93.2 (U) – January to March 2017 |
| | | | 90.7 (U) - April to June 2017 |
| 2017/18 | 90.1<br>October to December 2016 | ≤81.5 | 117 (U) – July 2016 to June 2017 |
| | | | 124 (U) – October 2016 to September 2017 |
| | | | 129 (U) – January 2017 to December 2017 |
| | | | 130 (U) – April 2017 to March 2018 |
| **MAORI** | | | |
| 2016/17 | New | New | NA |
| | | | NA |
| | | | NA |
| | | | NA |
| 2017/18 | 179.9<br>October to December 2016 | ≤81.5 | 382 (U) – July 2016 to June 2017 |
| | | | 384 (U) – October 2016 to September 2017 |
| | | | 398 (U) – January 2017 to December 2017 |
| | | | 398 (U) – April 2017 to March 2018 |

# OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

| **Better access to acute care for older people** - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 75-79 Years | | | |
| 2016/17 | 136.5 January 2015 to December 2015 | ≤139.5 | 120.1 (F) - October 2015 to September 2016 |
| | | | 124.0 (F) – January 2015 to December 2016 |
| | | | 135.1 (F) – April 2016 to March 2017 |
| | | | 139.4 (F) - July 2016 to June 2017 |
| 2017/18 | 124.0 January 2016 to December 2016 | ≤130 | 135.6 (U) - October 2016 to September 2017 |
| | | | 140.7 (U) – January 2017 to December 2017 |
| | | | 145.1 (U) – April 2017 to March 2018 |
| | | | 147.0 (U) - July 2017 to June 2018 |
| 80-84 Years | | | |
| 2016/17 | 178.9 October to December 2015 | ≤183.1 | 176.8 (F) - October 2015 to September 2016 |
| | | | 167.8 (F) – January 2016 to December 2016 |
| | | | 164.9 (F) – April 2016 to March 2017 |
| | | | 170.6 (F) - July 2016 to June 2017 |
| 2017/18 | 167.8 October to December 2016 | ≤170 | 168.9 (F) - October 2016 to September 2017 |
| | | | 170.8 (U) – January 2017 to December 2017 |
| | | | 178.3 (U) – April 2017 to March 2018 |
| | | | 178.8 (U) - July 2017 to June 2018 |
| 85+ Years | | | |
| 2016/17 | 229.2 October to December 2015 | ≤231.0 | 216.3 (F) - October 2015 to September 2016 |
| | | | 216.6 (F) – January 2016 to December 2016 |
| | | | 218.3 (F) – April 2016 to March 2017 |
| | | | 216.9 (F) - July 2016 to June 2017 |
| 2017/18 | 216.6 October to December 2016 | ≤225 | 223.6 (U) - October 2016 to September 2017 |
| | | | 235.9 (U) – January 2017 to December 2017 |
| | | | 228.7 (U) – April 2017 to March 2018 |
| | | | 237.1 (U) - July 2017 to June 2018 |

| **Better community support for older people** Acute readmissions to hospital 75 Years + | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | NA | NA | NA |
| | | | NA |
| | | | NA |
| | | | NA |
| 2017/18 | 10.2% 12 months to December 2016 | <10% | 11.8% - January 2016 to December 2016 |
| | | | 12.2% - October 2016 to September 2017 |
| | | | 13.0% - January 2017 to December 2017 |
| | | | 12.7% - April 2017 to March 2018 |

*for 2016/17 the ministry reported data for information purposes only in line with the new definition.

| **Better community support for older people** - % of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 100%<br>October to December 2015 | ≥95% | 100% (F) April to June 2016 |
| | | | 100% (F) July to September 2016 |
| | | | 100% (F) October to December 2017 |
| | | | 100% (F) January to March 2017 |
| 2017/18 | 100%<br>October to December 2016 | ≥95% | 100% (F) April to June 2017 |
| | | | 100% (F) July to September 2017 |
| | | | 100% (F) October to December 2018 |
| | | | 100% (F) January to March 2018 |

| **Increased capacity and efficiency in needs assessment and service coordination services** - Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 13.8%<br>October 2015 to December 2015 | <13.8% | 11% (F) - July to September 2016 |
| | | | 10% (F) - October to December 2016 |
| | | | 7.0% (F) - January to March 2017 |
| | | | 9% (F) - April to June 2017 |
| 2017/18 | 13.8%<br>July to September 2016 | <14% | 10% (F) - July to September 2017 |
| | | | 12% (F) - October to December 2017 |
| | | | 7.0% (F) - January to March 2018 |
| | | | 11% (F) - April to June 2018 |

| **Prompt response to palliative care referrals** - Time from referral receipt to initial Cranford Hospice contact within 48 hours | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 91.0%<br>October to December 2015 | ≥80% | 99.0% (F) – July to September 2016 |
| | | | 100% (F) - October to December 2016 |
| | | | 86.0% (F) – January to March 2017 |
| | | | 94.0% (F) – April to June 2017 |
| 2017/18 | 100%<br>October to December 2016 | ≥80% | 98.0% (F) – July to September 2017 |
| | | | 97.5% (F) - October to December 2017 |
| | | | 94.0% (F) – January to March 2018 |
| | | | 99.0% (F) – April to June 2018 |

| **More day services** - Number of day services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 21,546<br>July 2015 to June 2016 | ≥21,791 | 13,264 – July 2016 to March 2017 |
| 2017/18 | * | ≥21,791 | 21,830 – July 2017 to June 2018 |

*no baseline data available

| **More older patients receive falls risk assessment and care plan** - % of older patients given a falls risk assessment | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 90.5%<br>October to December 2015 | ≥90% | 100% (F) – July to September 2016 |
| | | | 96.7% (F) - October to December 2016 |
| | | | 93.0% (F) – January to March 2017 |
| | | | 97.9% (F) – April to June 2017 |
| 2017/18 | 96.7%<br>October to December 2016 | ≥90% | 100% (F) – July to September 2017 |
| | | | 98.3% (F) - October to December 2017 |
| | | | 95.8% (F) – January to March 2018 |
| | | | 92.1% (F) – April to June 2018 |

| **More older patients receive falls risk assessment and care plan** - % of older patients assessed as at risk of falling receive an individualised care plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2016/17 | 78.4%<br>October to December 2015 | ≥98% | 99.3% (F) – July to September 2016 |
| | | | 98.0% (F) - October to December 2016 |
| | | | 93.9% (U) – January to March 2017 |
| | | | 88.9% (U) – April to June 2017 |
| 2017/18 | 98.0%<br>October to December 2015 | ≥98% | 99.3% (F) – July to September 2017 |
| | | | 95.5% (U) - October to December 2017 |
| | | | 90.6% (U) – January to March 2018 |
| | | | 88.2% (U) – April to June 2018 |


HAWKE'S BAY
District Health Board
Whakawāteatia