HAWKE'S BAY
District Health Board
Whakawāteatia

ANNUAL REPORT 2016

CONTENTS

ACRONYMS USED IN THIS REPORT

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

Message from the Chair and Chief Executive

We continue to make progress in making transformational change in the Hawke's Bay health system in some key areas.

Mental health services have been transformed through a new model of care that has seen more programmes delivered in the community that are better designed and easier for people to access. This and the opening of the new inpatient unit Ngā Rau Rakāu earlier this year now provide the Hawke's Bay community with more mental health services and a more robust service designed to meet these patients needs.

Other examples of transformational change are the older peoples engAGE service, which now links up with many more GPs helping to identify and support at risk older people so they don't end up as an emergency hospital admission.

District Nurses are now much better aligned with GPs and have direct communication with them. This change has made a difference to patient care with more coordinated care and communication with general practice and the district nursing teams.

Hawke's Bay Hospital for the first time has a new Integrated Operations Centre giving us a better overview of what's happening in the hospital on a daily basis, and providing early identification of pressure points so we can do something about them.

This year we also opened our new maternity low risk birthing centre Waioha. This new birthing centre is already adding benefit to our maternity service and has received many positive comments from birthing mothers.

We have also refurbished and improved our family accommodation at the Māori Health Centre, Mihiroa Whānau accommodation, known as "The Whare"

The district health board's Health Equity report, fundamental to delivering better health outcomes for our community has been updated.

We have developed a plan, the Go Well strategy which is about improving access to the hospital and giving staff alternative ways to get to work through better facilities and improved public transport opportunities.

In organisational development we have invested in talent management, Māori Cultural Awareness, consumer awareness for staff, and consumer engagement and we continue to work on Operation Productivity to improve the workflow of our theatres so more people have access to elective surgery. In our structures we have further developed the size of the Quality Improvement and Patient Safety team.

We are working hard on developing our partnerships with other agencies and now meet regularly with the Ministry of Social Development developing a joint programme of action. We work closely with Health Hawke's Bay (PHO) and highly value the relationship we have. This year a number of people in the organisation have also been involved in the Intersectoral Group of CEOs, Mayors and Chairs to develop a work plan that will help to improve health and social outcomes for Hawke's Bay people.

In the year ahead we will be looking to refresh Transform and Sustain, which will lead in to the development of a Clinical Services Plan, a Palliative Care plan and a Social Inclusion Strategy across sectors.

Financially we are pleased to report a $4.4 million surplus which we will continue to invest in improving our services, our buildings, developing staff competencies and encouraging clinical leadership.

Our consistent financial and annual service performance highlights the commitment of our staff and the health system working together to contribute to a quality health service for our community.

We take this opportunity to thank our staff and our health and social sector partners for another great year.

Naku te rourou nau te raurau ka ora ai te Iwi
With my contribution and yours we assist our people toward better health.

Kevin Snee
Chief Executive

Kevin Atkinson
Chair

Organisation profile

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

PUBLIC HOSPITAL AND HEALTH FACILITIES

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

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

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

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

Hawke's Bay DHB vision, values and structure

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

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

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RĀRANGA 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.

RĀRANGA TE TIRA PARTNERSHIP

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

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.

Hawke's Bay District Health Board

Board Chair Kevin Atkinson

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

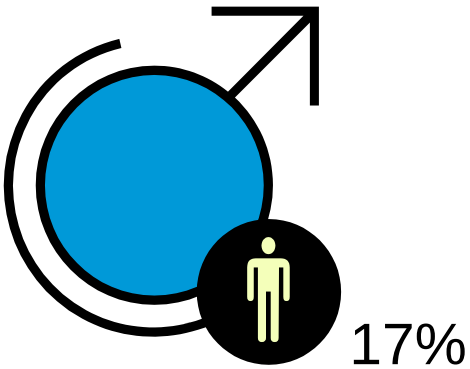
Hawke's Bay District Health Board

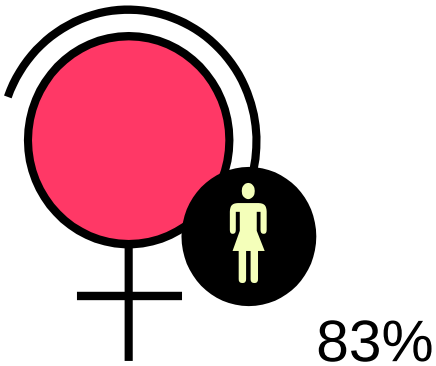
Chief Executive Dr Kevin Snee

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

About Hawke's Bay District Health Board

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





WORKFORCE PROFILE – by age bands	
<25	4.7%
25 - 35	16.2%
35 - 45	19.5%
45 - 55	29.5%
55 - 64	23.3%
65+	6.8%

WORKFORCE PROFILE – by occupational group	
Medical staff	9.4%
Nursing staff	50.4%
Allied Health staff	18.6%
Non-clinical support staff	6.3%
Management & admin staff	15.3%

WORKFORCE PROFILE – by ethnicity	
NZ European	64.2%
NZ Māori	12.5%
Pacific Island	1.2%
British & Irish	7.1%
Other ethnicities	21.6%
Not known	2.4%

EMPLOYEE STATUS		
Casual	13%	
Full time	36%	
Part time	51%	

Report on good employer obligations

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

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

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

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

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

Leadership, Accountability and Culture:

Investing in its people and developing leadership capability, remains a priority for Hawke's Bay DHB. Leadership is visible, and celebrated, through monthly executive briefings, monthly CEO newsletter to all staff, annual Hawke's Bay health sector awards and the annual people publication. Our Transformational Leadership and Basics Management programmes have continued to develop our Managers and Clinical Leaders across the health sector and have been very well received.

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

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

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

Recruitment, Selection and Induction:

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

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

Employee Development, Promotion and Exit:

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

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

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

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

Flexibility and Work Design:

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

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

Remuneration, Recognition and Conditions:

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

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

Harassment and Bullying Prevention:

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

acceptable and unacceptable behaviours, and intranet resources provide a centralised information resource for all staff to access.

Safe and Healthy Environment:

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

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

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

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

Staff Ethnicity:

Increasing the number of Māori employees is a priority for HBDHB. A KPI measuring the number of positions where incumbents identify as Māori is reported the DHB's Board on a quarterly basis. The target is set at 10% improvement on previous year with the ultimate aim that the percent Māori more closely reflect the overall Hawke's Bay population mix where it is estimated the Māori population for Hawke's Bay is 25.9 percent.

As at the end of the 2015/16 year the target of 14.30 percent of staff identifying as Māori was not reached although there had been a slight improvement on the previous year:
30 June 2016 = 12.47 percent Māori
30 June 2015 = 12.27 percent Māori

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

June 2016 breakdown

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

Hawke's Bay District Health Board Governance

Role of the Board

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

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

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

Role of the CEO

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

Advisory Committees

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

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

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

Finance Risk and Audit Committee:

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

Māori Relationship Board (MRB):

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

Other components of HBDHB's governance structures include:

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

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

Note:

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

Meeting Information & Disclosure of Interests

Number of Board Meetings held 11

KEVIN ATKINSON – Chair
Meetings attended 11 of 11
Chairman, Unison Networks Limited
Director, Unison Fibre Limited
Director, Hawke's Bay Rugby Football Union
Trustee Te Matau ā Māui Health Trust

NGAHIWI TOMOANA - Deputy Chair
Meetings attended 10 of 11
Chairman – Ngāti Kahungunu Iwi Inc
Member – Treaty Tribes Coalition
Brother of employee of HBDHB
Brother is employee of Cranford Hospice
Two nephews are employees of HBDHB

BARBARA ARNOTT
Meetings attended 10 of 11
Trustee of the Hawke's Bay Air Ambulance Trust
Daughter, Commercial Manager Food for Health Benefits Limited (to 24 February 2016)

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

HELEN FRANCIS
Meetings attended 8 of 11
Patron and Lifetime member of Alzheimer's Society Napier
Employee of Hastings Health Centre
Trustee Hawke's Bay Power Consumers' Trust
Trustee of HB Medical Research Foundation

DIANA KIRTON
Meetings attended 11 of 11
Brother is a surgeon for HBDHB
Practicum Manager – EIT School of Health and Sport Science
Trustee Hawke's Bay Power Consumers' Trust
Son is a GP in Wairoa
Daughter-in-law is a Paediatric Registrar at HBDHB
Daughter-in-law at Starship Hospital undertaking Paediatrics Training (14 Dec 2015 to 30 Mar 2016)

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

DENISE EAGLESOME

Meetings attended 9 of 11

Deputy Mayor of Wairoa District Council

Trustee Te Matau ā Māui Health Trust

Co-ordinator of health contract with Wairoa Rugby

ANDREW BLAIR

Meetings attended 10 of 11

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

Owner of Andrew Blair Consulting Limited

Advisor to Chelsea Hospital Trust

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

Chair of Southern Partnership Group (from 19 September 2015)

Director of Breastscreen Auckland Limited (from 17 December 2015)

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

JACOBY POULAIN

Meetings attended 11 of 11

Board Member of Eastern Institute of Technology

Councillor Hastings District Council

HEATHER SKIPWORTH

Meetings attended 9 of 11

Mother is a Kaumatua – Kaupapa Māori HBDHB

Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB

Membership of Advisory Committees – statutory

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

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

Diana Kirton – Chairperson of DSAC

Barbara Arnott – Chairperson of CPAC

Peter Dunkerley – Chairperson of HAC

Helen Francis

Denise Eaglesome

Kevin Atkinson

Ngahiwi Tomoana

Dan Druzianic

Andrew Blair

Jacoby Poulain

Heather Skipworth

FINANCE RISK AND AUDIT COMMITTEE (FRAC)

Number of FRAC Meetings held 11

Dan Druzianic - Chairperson
Meetings attended 10 of 11
Refer Board interests disclosed

Kevin Atkinson
Meetings attended 11 of 11
Refer Board interests disclosed

Barbara Arnott
Meetings attended 10 of 11
Refer Board interests disclosed

Peter Dunkerley
Meetings attended 11 of 11
Refer Board interests disclosed

Andrew Blair
Meetings attended 10 of 11
Refer Board interests disclosed

Jacoby Poulain
Meetings attended 10 of 11

MĀORI RELATIONSHIP BOARD (MRB)

Number of MRB and Annual Planning Meetings held 10.

Ngahiwi Tomoana – Chairperson
Meetings attended 6 of 10
Refer Board interests disclosed

Denise Eaglesome
Meetings attended 5 of 10
Refer Board interests disclosed

Helen Francis
Meetings attended 6 of 10
Refer Board interests disclosed

Diana Kirton
Meetings attended 8 of 10
Refer Board interests disclosed

Heather Skipworth
Meetings attended 7 of 10
Refer Board interests disclosed

Tatiana Cowan-Greening
Meetings attended 6 of 10
Ngāti Kahungunu Iwi Inc representative
Trustee, Te Matau ā Māui Health Trust
Husband is Manager of Te Kupenga Hauora

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

Des Ratima
Meetings attended 8 of 10
Representative of Ahuriri District Health (Wai 692)
Chairperson, Ahuriri District Health Trust
Chairperson, Te Whanantahi Charitable Trust
Deputy Chair, Māori Wardens NZ Maori Council
Chair Kaupapa Māori Committee
Chair Takatimu Māori District Council
Chair Whakatu Kohanga Reo

Trish Giddens

Meetings attended 9 of 10

Ngāti Kahungunu Iwi Inc representative

Trustee, HB Air Ambulance Trust

Assistant Director Rotary District 9930

Manager, Taruna College

Member of the Lotteries Board

Na Raihania

Meetings attended 10 of 10

Ngāti Kahungunu Iwi Inc representative

Wife employed at Te Taiwhenua o Heretaunga

Member Tairawhiti DHB Māori Relationship Board

George Mackey

Meetings attended 6 of 10

Ngāti Kahungunu Iwi Inc representative

Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB

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

Employee of Te Puni Kokiri (from 19 June 2014)

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

Meetings attended 7 of 10

Ngāti Kahungunu Iwi Inc representative

Chair of Māori Party, Heretaunga Branch

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

Ana Apatu

Meetings attended 8 of 9

Ngāti Kahungunu Iwi Inc representative

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

Chairperson of Directions (from August 2015)

Member of the Heart Foundation (from August 2015)

Deputy Chair Health Promotion Forum (from August 2015)

Statement of Responsibility

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

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

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

In the opinion of the board and management of Hawke's Bay District Health Board the financial statements and statement of service performance for the year ended 30 June 2016, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

Kevin Atkinson
Chair

Dan Druzianic
Board Member

31 October 2016

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 2016

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

We have audited:

- the financial statements of the District Health Board on pages 50 to 88, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the District Health Board on pages 26 to 47 and 89 to 107.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the District Health Board:
    - o present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended; and
    - o comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

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

In respect of the 30 June 2015 comparative information only, some significant performance measures of the District Health Board, including some of the national health targets, relied on information from third-party health providers, such as primary health organisations. The District Health Board's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2015 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2016 year, however, the limitation cannot be resolved for the 30 June 2015 year. This means that the District Health Board's performance information reported in the statement of performance for the 30 June 2016 year, may not be directly comparable to the 30 June 2015 performance information.

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

- presents fairly, in all material respects, the District Health Board's performance for the year ended 30 June 2016,Including:
    - o for each class of reportable outputs:

- its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included In the statement of performance expectations for the financial year;

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

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2016. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;

- the reasonableness of the significant accounting estimates and judgements made by the Board;

- the appropriateness of the reported performance information within the District Health Board's framework for reporting performance;

- the adequacy of the disclosures in the financial statements and the performance information; and

- the overall presentation of the financial statements and the performance information.

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

Statement of Service Performance 2015/16

This section outlines Hawke's Bay District Health Board's achievement against the 2015/16 Statement of Performance Expectations. Service performance is grouped into four Output Classes: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and, Rehabilitation and Support Services. Across the output classes, we strive to maintain a balance across the three dimensions of the New Zealand Triple Aim **(Figure 1),** in line with the Health Quality and Safety Commission's drive for quality improvement across the health sector.

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

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

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

Figure 1: The New Zealand Triple Aim

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

Prevention services

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

Statement of Service Performance Output Class 1

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

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

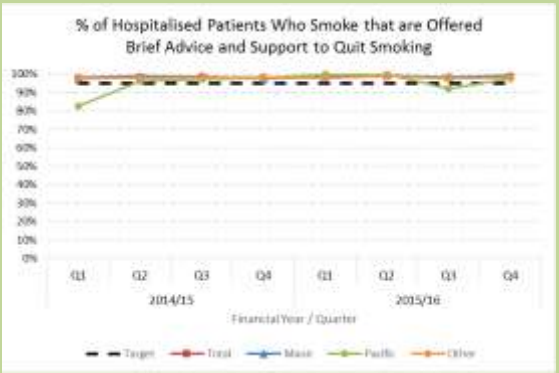
Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly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

National Health Target: Better Help for Smokers to Quit

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

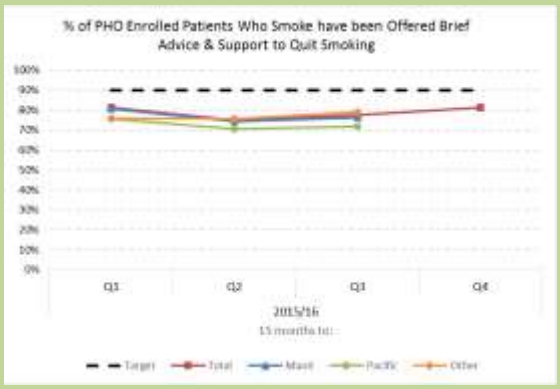
Hospitalised smokers are offered advice to quit

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



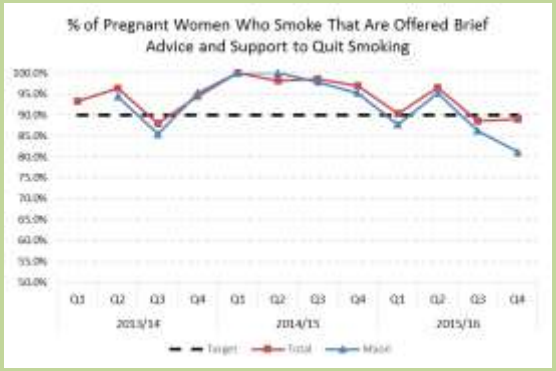
Smokers are offered advice to quit when seen in General Practice

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



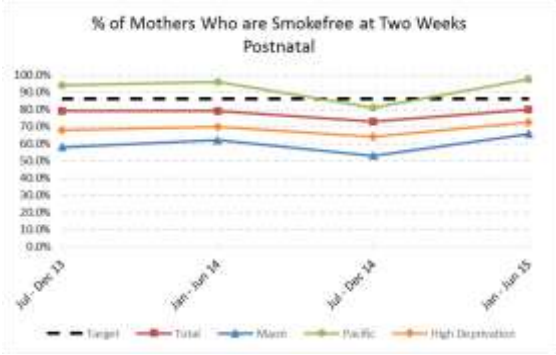
Pregnant women are offered advice and support to quit

Of pregnant women who smoke, 89% were offered advice and support to quit in Q4. This result was lower for Māori at 81%. The latest data from 2014/15 showed that 43% of pregnant Māori women giving birth in Hawke's Bay were smokers[1]. This rate is alarmingly high. Tobacco use during pregnancy increases the risk of miscarriage, premature birth and low birth rate, as well as their children's risk of asthma and sudden unexplained death of infant. The maternity component of the health target is aimed at offering brief advice and support to quit smoking for pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer.



Smokefree Māori women at two weeks postnatal

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



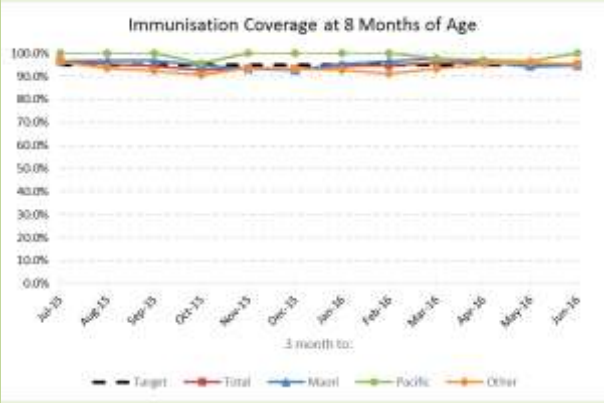
[1] Health Equity in Hawke's Bay Update 2016

National Health Target: Increased Immunisation

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

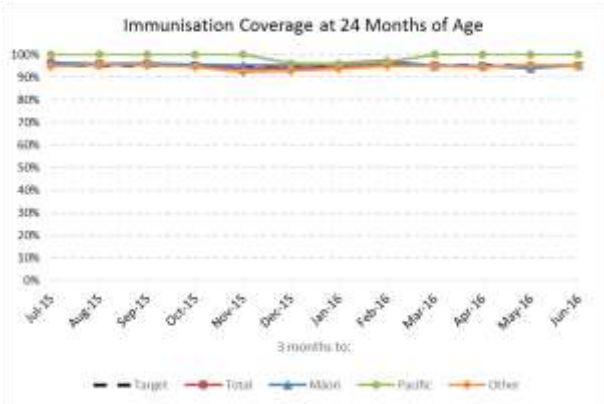
Eight month olds have received their complete primary course of immunisations

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



Children are fully immunised at 2 years of age

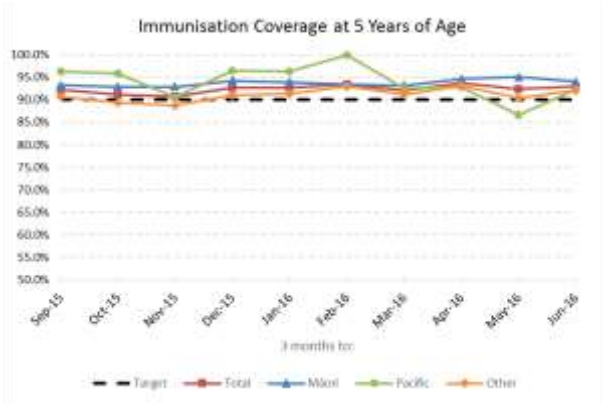
95% immunisation coverage in 2 year olds was achieved in Māori, Pacific and total population. There was a short period of time where the total population rate dropped to 94% but this was quickly recovered.



Children are fully immunised by 5 years of age

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

The consistently high rate of coverage at multiple milestones is seen across all ethnicities and is indicative of well-coordinated and targeted services across multiple providers with good systems and processes for identifying issues and early intervention.



Girls receive all three HPV immunisations

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

Vulnerable elderly receive an influenza vaccine

Hawkes Bay immunisation services also focus on the older population offering influenza vaccinations for high needs people aged 65 years and over. Seasonal influenza is a contributory factor in the high number of preventable hospitalisations amongst older people, particularly Māori. Data for this period is unavailable but the DHB and Health Hawke's Bay Immunisation teams are working alongside Māori providers to improve their capability through education and support with authorised vaccines and cold chain protocols.

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

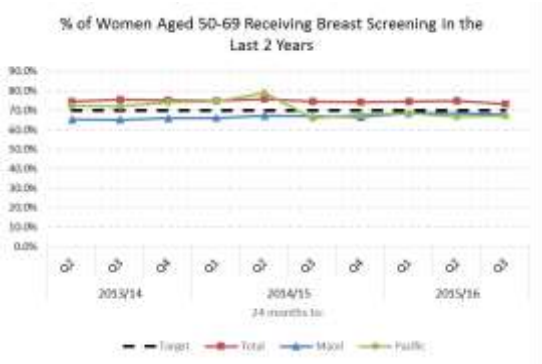
Hawke's Bay has high rates of Rheumatic Fever, a preventable diseases that has serious consequences. Ongoing implementation and review of the Rheumatic Fever Prevention Plan is proving to be effective as rates continue to decline in Hawkes Bay. The latest results show that the first time hospitalisation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

More women are screened for cancer

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

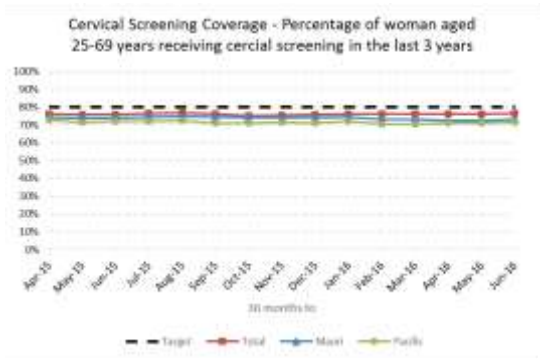
Women aged 50-69 years received breast screening in the last 2 years

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



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

Screening for cervical cancer is offered every three years to all women between the ages of 25 and 69 years. In an attempt to reduce inequities, this is offered free for National Cervical Screening programme priority group women i.e. Māori, Pacific and Asian women and other women aged 30-69 years who have never had a smear or have not had a smear in the past five years. Overall our rate is 76.6% which is below the target of ≥80% for all ethnicities. The DHB Population Screening, Health Hawke's Bay and Māori providers are working together to promote a mobile visit to the Cook Island Community Centre and offering support services to priority women.



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

Reduced rate of Sudden Unexplained Death of Infant in HB

Another area of focus in Hawke's Bay is reducing sudden unexplained death of infant (SUDI). HBDHB is committed to reducing risk factors associated with SUDI such as smoking during pregnancy and increasing breastfeeding rates. HBDHB run a safe sleep programme to educate parents on safe sleep, related risk factors and provide safe sleep devices. The SUDI rate has reduced from 1.77 per 1,000 live births in 2011 to 1.16 per 1,000. This is a good result but it is still higher than the target of <0.5 per 1,000 live births and rate for Māori is higher than the total population rate. In 2016/17 there will continue to be a focus on eliminating the inequity by continuing to target at risk populations through allocation of ongoing sustainable funding to the programme.

Breastfeeding

High rates of breastfeeding not only reduce the risk of SUDI but also lay a foundation for good health in infancy, childhood and into adult life. The measures include exclusive breastfeeding at 6 weeks (Target ≥75%) and 3 months (Target 60%) as well as receiving breast milk either exclusively, fully or partially at 6 months (Target 65%).

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

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

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

Sexual Health Services

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

Prevention Services			
$'millions	30 June 2016	Budget 30 June 2016	30 June 2015
Ministry of Health	10.3	14.6	10.4
Other sources	0.2	0.1	0.4
Income by source	**10.5**	**14.7**	**10.8**
Less:			
Personnel	1.3	1.3	1.2
Clinical supplies	0.1	0.1	0.1
Infrastructure and non-clinical supplies	0.3	0.3	0.3
Payments to other providers	8.4	9.1	8.4
Expenditure by type	**10.1**	**10.8**	**10.0**
Net Result	**0.4**	**3.9**	**0.8**

Budget and prior period amounts have been reclassified using the same allocation methodology used for the current year.

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

Early Detection and Management

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

Statement of Service Performance Output Class 2

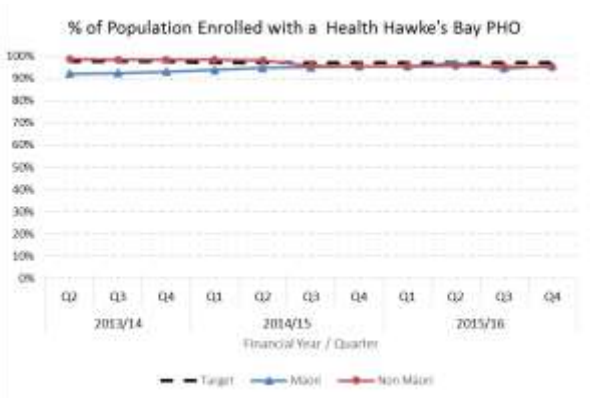
Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes,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

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

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

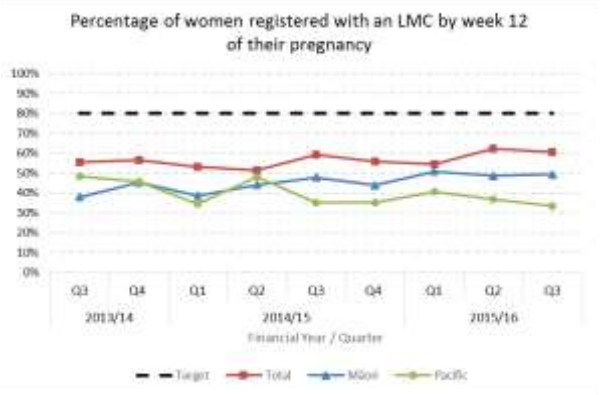
Proportion of the population enrolled in the PHO

Across New Zealand, people are required and encouraged to enrol with a general practice that is affiliated to a Primary Health Organisation (PHO). Health Hawke's Bay coordinates and manages the targeting of many services to those populations who are known to have a poor health status such as Māori, Pacific peoples and those living in the most deprived areas. Being enrolled in a PHO and having access to care in the right place at the right time allows for early detection and management of health issues and risks. 95.9% of people are enrolled with the PHO which is just below the target of 97%. There has been a steady increase in Māori enrolled with the PHO, reaching 95.6% in Q4. Health Hawkes Bay continues to work closely with Hawke's Bay DHB and general practice to promote enrolments and offer resources to facilitate the process.



Early Engagement with Lead Maternity Carers (LMC)

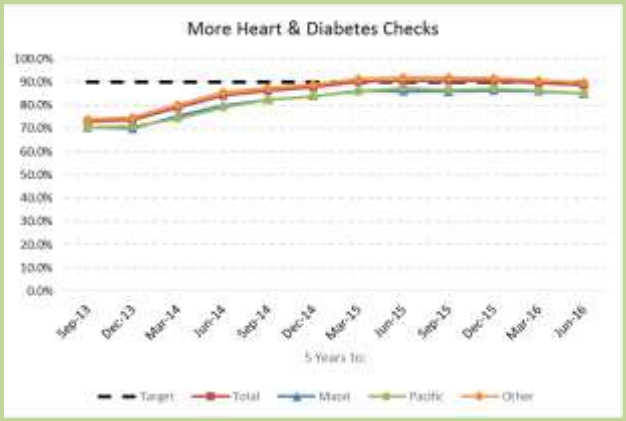
Women booked with an LMC by week 12 of their pregnancy



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

National Health Target: More Heart and Diabetes Checks

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

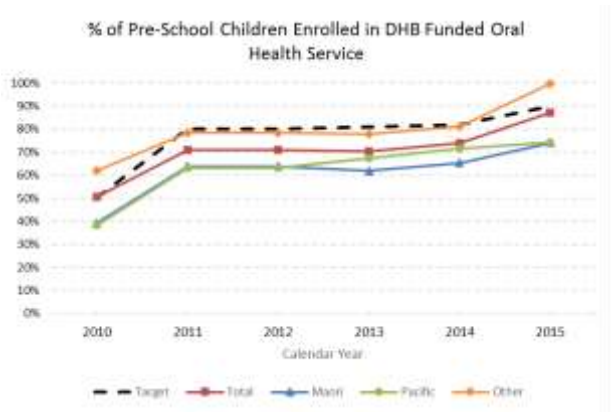


The More Heart and Diabetes Checks indicator monitors the proportion of the eligible population who have had blood tests for Cardiovascular disease (CVD) risk assessment in the preceding five year period. CVD disproportionately affects Māori and is preventable with lifestyle advice and treatment for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

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

Oral Health

Pre-school enrolments with oral health services



Due to the poor oral health status of Hawke's Bay children, especially Māori and Pacific, we have a focus on improving early enrolment with dental services. Those identified as needing further examination or treatments are scheduled for a recall. In the last year, 87.1% of pre-school children were enrolled in DHB funded oral health services (74.1% Māori and 74.2% Pacific). All ethnicities have improved remarkably since 2014 due to the quadruple enrolment initiative which involved babies being enrolled with oral health services at birth.

Children and youth attending oral health services

3.7% of children were not examined according to planned recall which is favourable against a target of less than 5% and an improvement on last year (4.0%).

The percentage of adolescents using DHB funded dental services in 2015 was 75.9% which is unfavourable against a target of ≥85% A continued effort is being undertaken to increase use of dental services by adolescents by providing a smooth transition of information from the Community Oral Health Service to dentists at Year 8 and by creating a strong continued awareness of free dental care, particularly among 17-year-olds

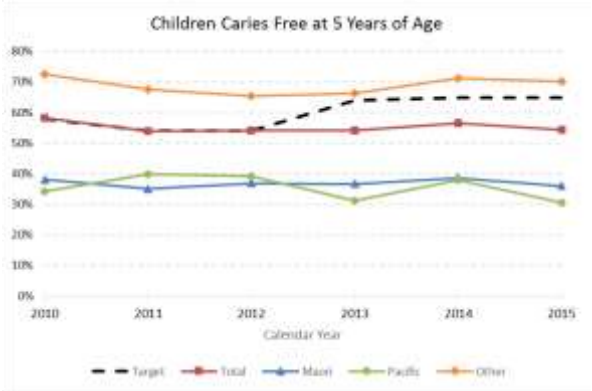
Percentage of children not examined according to planned recall		
Baseline 2014	**Target** 2015	**Actual** 2015
4.0%	*<5%*	*3.7% (F)*

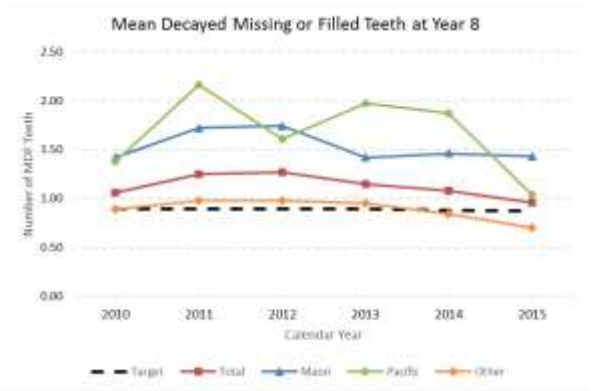
Percentage of adolescents using DHB funded dental services		
Baseline 2013	**Target** 2015	**Actual** 2015
84.5%	*≥85%*	*75.9% (U)*

Children without decay

54.4% of five year olds were carries free in 2015 which is unfavourable against a target of ≥66%.

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

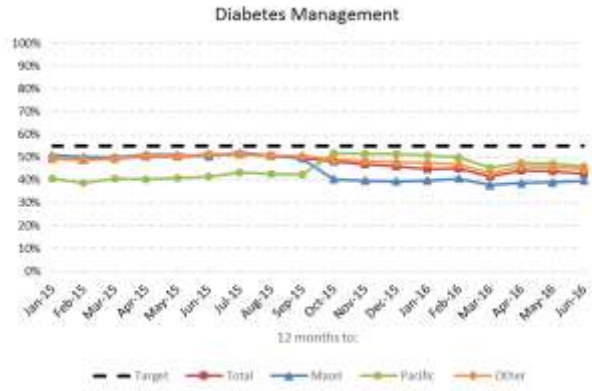




Management of Diabetes

People with good glycaemic control

Good glycaemic control reduces the risk of CVD and is an indicator of long term conditions management. The number of people with good or acceptable glycaemic control remains below the target of 55% with Q4 performance dropping to 42.8%. A consumer-led governance group is being established and an integrated work plan developed to progress initiatives to improve diabetes management in the population.



Less Waiting for Diagnostic Services

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

Computed Tomography

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

Magnetic Resonance Imaging

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

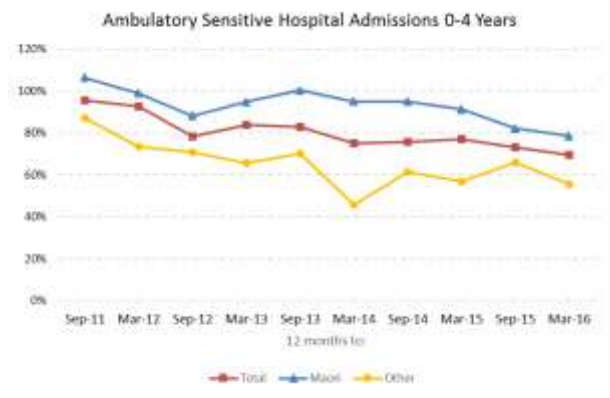
Ambulatory sensitive hospitalisations

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

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

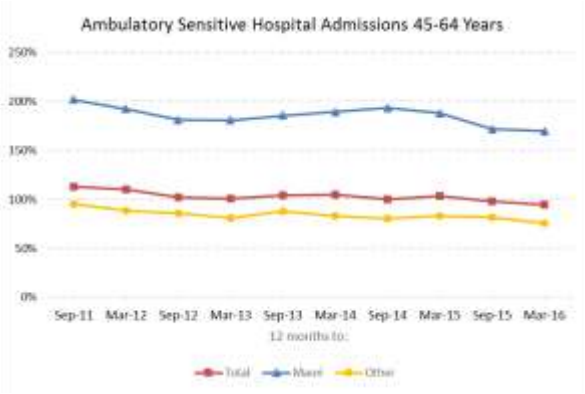
0-4 year olds

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



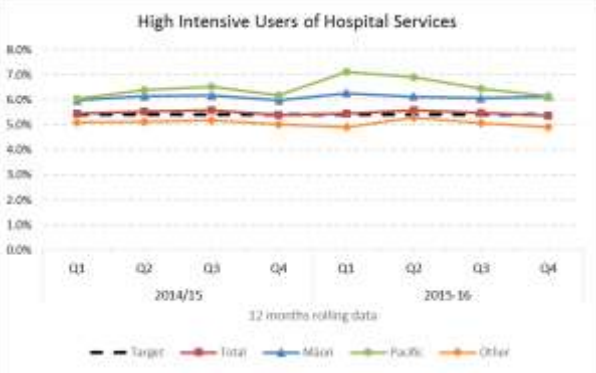
45-64 years

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



High intensive users of hospital services

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



B4 School Checks

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

Early Detection and Management			
$'millions	**30 June 2016**	**Budget 30 June 2016**	**30 June 2015**
Ministry of Health	106.5	110.1	104.4
Other District Health Boards	2.8	2.8	2.9
Other sources	3.4	3.6	4.5
Income by source	**112.7**	**116.5**	**111.8**
Less:			
Personnel	16.7	16.8	16.0
Outsourced services	0.3	0.2	0.2
Clinical supplies	0.5	0.5	0.5
Infrastructure and non-clinical supplies	3.0	2.7	2.9
Payments to other District Health Boards	2.5	2.5	2.4
Payments to other providers	87.5	89.5	83.9
Expenditure by type	**110.5**	**112.2**	**105.9**
Net Result	**2.2**	**4.3**	**5.9**

Budget and prior period amounts have been reclassified using the same allocation methodology used for the current year.

Intensive Assessment and Treatment Services

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

Statement of Service Performance Output Class 3

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

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

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

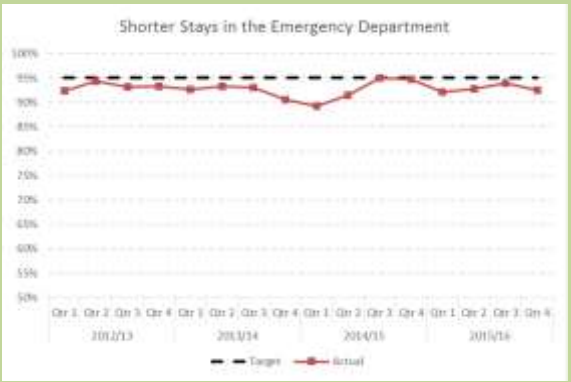
National health Target: Shorter Stays in the Emergency Department

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

People presenting at ED wait less than six hours

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

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



Faster Cancer Treatment (FCT)

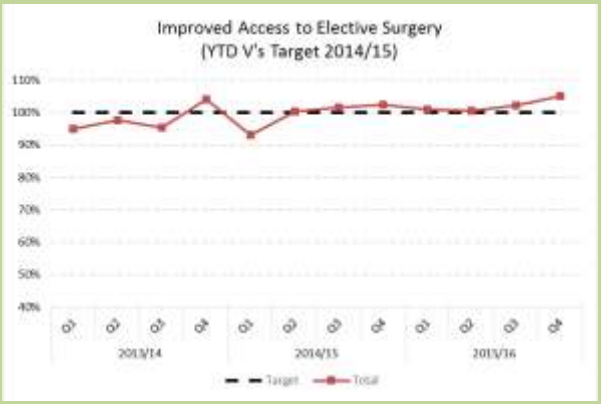
FCT takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. The target aims to reduce the time from referral to treatment for those with a high suspicion of cancer.

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

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

National Health Target: Improved Access to Elective Surgery

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



More people have access to Surgery

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

Standardised Intervention Rates

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

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

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

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

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

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

Average Length of Stay (ALOS)

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

By delivering a more patient-centred elective service we expected to reduce the ALOS for elective inpatients. The target was set at ≤1.59 days and although we have not quite managed to meet the target, we have reduced the ALOS from 1.74 to 1.61.

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

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

Acute Readmission to Hospital

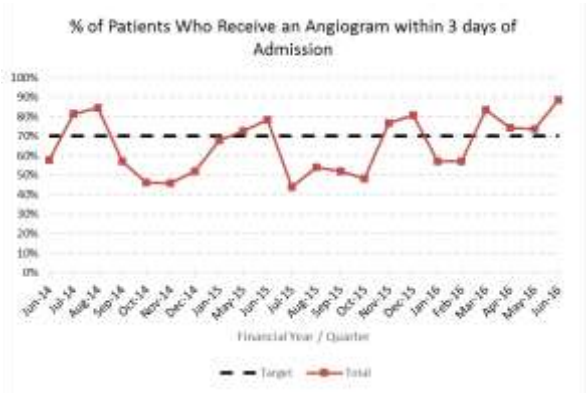
In our quest to increase hospital throughput it is important that we measure acute unplanned readmission rates. These occur when treatment, either in hospital or in the 28 days following discharge, has not been effective and a readmission is required urgently. A low rate is an indication of effective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

Better Management of Long Term Conditions (LTC)

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

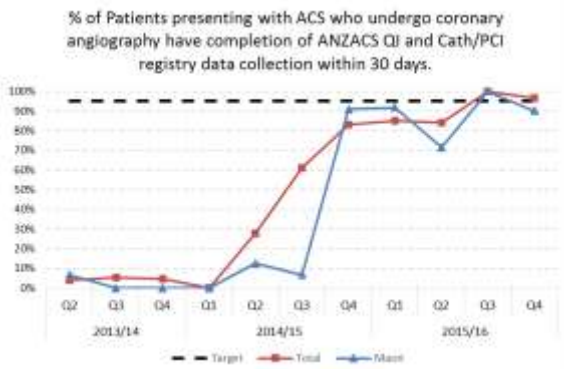
- Improve access to cardiac diagnostics and specialist assessments
- Reduce waiting times for people requiring cardiac services
- Improve prioritisation and selection of cardiac surgical patients
- Increase cardiac surgical discharges
- Reduce variations in access across the region

In Q4, 77.6% of high risk patients received an angiogram within 3 days (target 70%). For Māori we achieved 84.6%. Performance throughout the year has been inconsistent which largely reflects delays in accessing tertiary services in Wellington and provision of only twice weekly angiography services at Hawke's Bay Hospital. However, overall this is a commendable achievement with a significant improvement in performance on last year.



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

Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days. Near the end of 2014/15 we introduced a more robust system to support data capture and data entry. In Q4 we achieved 96.6% against a target of ≥95%. We fell just short of the target in Q4 with our Māori population, achieving 90%.

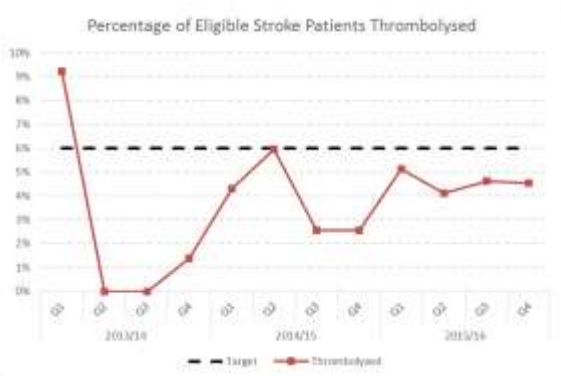


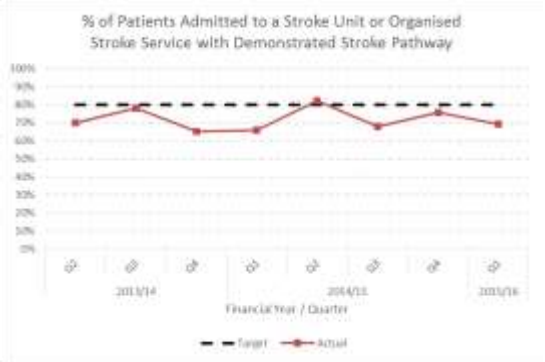
Stroke thrombolysis and stroke pathway

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

In Q4, 4.5% of eligible patients were thrombolysed against a target of 6%. Although the target has not been met this year, performance has been consistently better than last year.

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



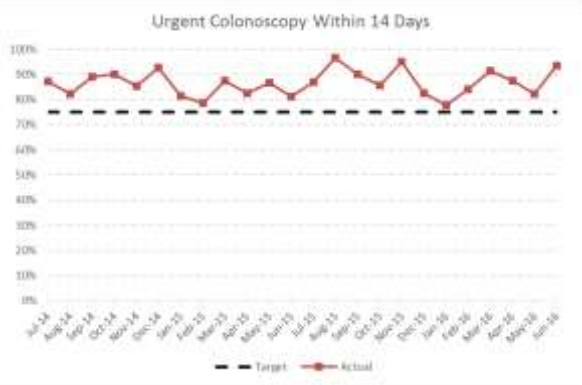


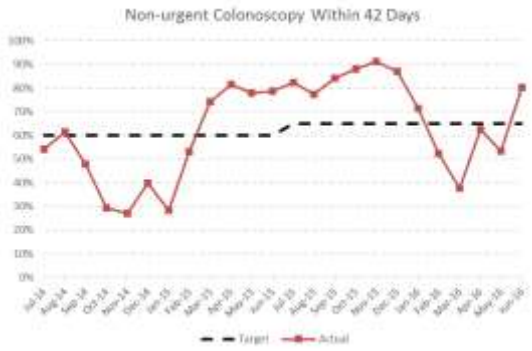
Quicker access to diagnostics

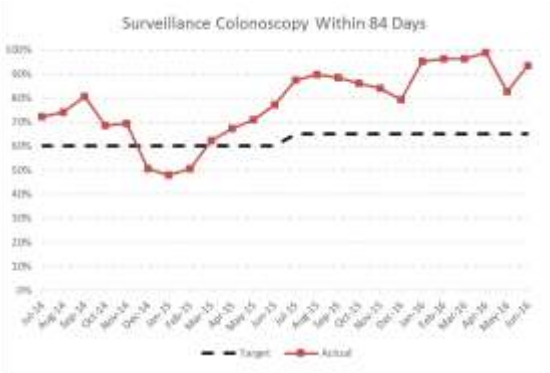
Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care, and therefore improve patient outcomes in a range of areas.

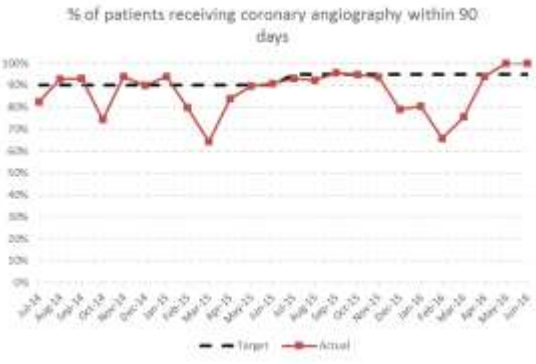
In June 2016, 93.5% of Urgent diagnostic colonoscopys were performed within 14 days and 80.4% of routine cases performed within 42 days. These are above the targets of 75% and 65% respectively. The target for surveillance colonoscopy was also achieved with 93.5% of people waiting less than 84 days beyond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

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





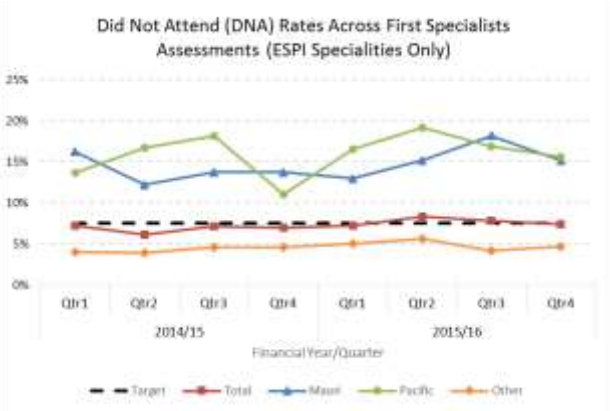




Attendance at First Specialist Appointment

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

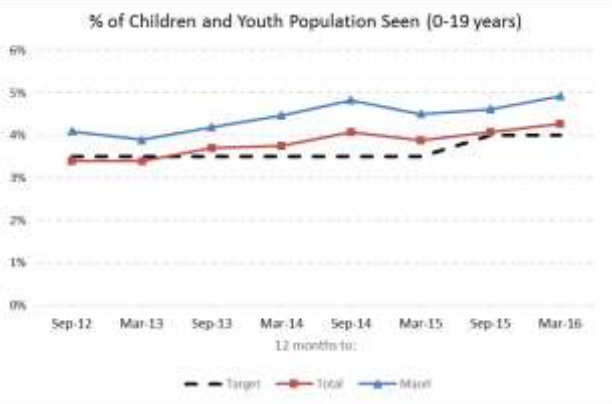
The overall DNA rate is 7.4% which is favourable against the target. However, the Māori DNA rate is 15.2% indicating a significant inequity gap. The customer focussed booking project has developed better DNA reporting and have launched a new initiative focussing on the three specialties with the highest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

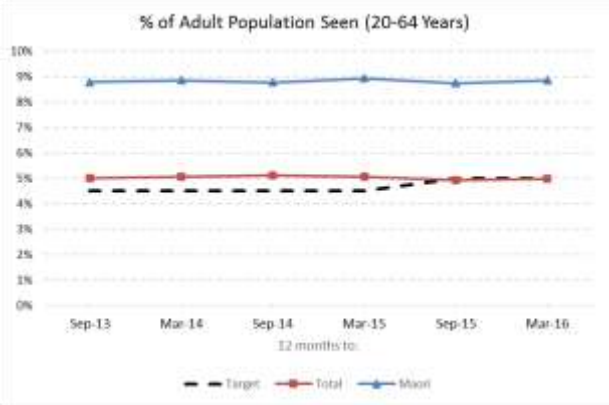


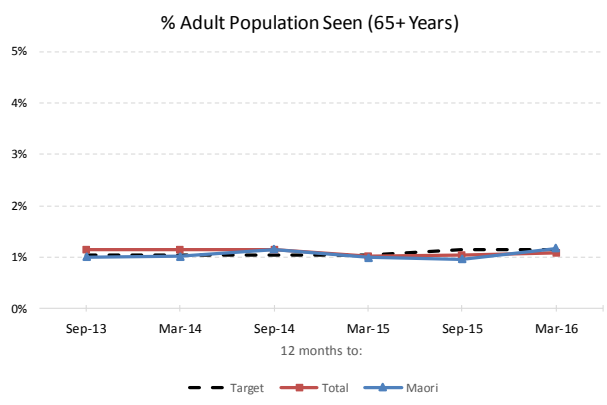
Mental Health and Addiction Services

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

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



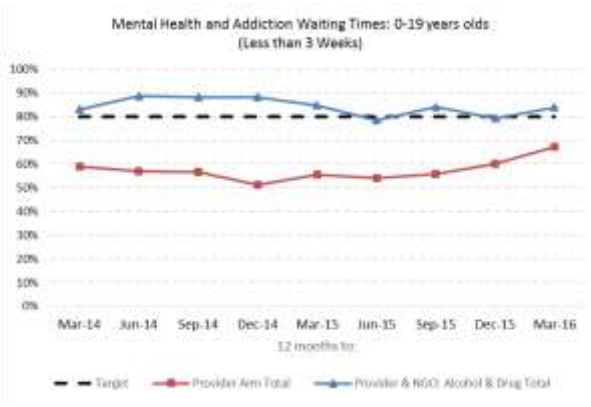


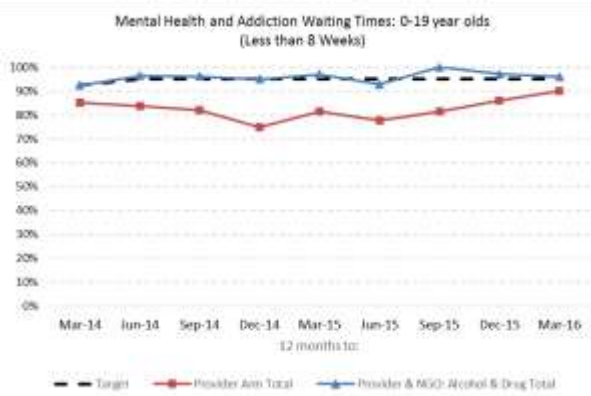


Improved Waiting Times: Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. We differentiate the targets in 2 ways: firstly, between the mental health services that are delivered by our provider arm and the addiction services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

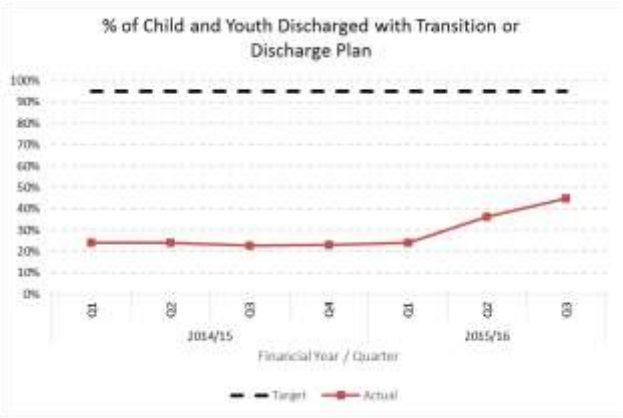
For mental health services, the waiting time expectation of 3 weeks was achieved in 67.4% of cases and the 8 week result was 90.2%. Both of these results are below the targets of 80% and 95% respectively however, considerable efforts have resulted in improved performance and we anticipate this trend will continue.

For addictions services with a range of providers, the waiting times expectations have been exceeded with 84.0% of people seen within 3 weeks and 96.0% seen within 8 weeks The services maintain clear focus on referral response and turnaround time.





Improved Discharge Planning: Maintaining and improving patient engagement through the use of a transition/discharge plan will ensure that services are responsive to patients needs and that people are better able to manage their own health condition. Improving discharge planning has been a real focus over the past six months which is reflected in the improved performance. The end of year result of 44.83% for the 12 months to March 2016, it will take a while for our current performance to be fully reflected in the data.



Mental Health (Compulsory Assessment and Treatment) Act 1992

There is a disproportionately high rate of Māori placed under the s29 compulsory treatment order (CTO) and HBDHB aims to reduce this inequity. In Q4, The rate of s29 orders per 100,000 Māori was 97.3 which is higher than the target of ≤80 per 100,000. This is not a straightforward matter as all the social and health inequities which Māori experience contribute to increased use of the Mental Health (Compulsory Assessment and Treatment) Act 1992. We have put in place new services to provide early interventions for people with mental health problems and as alternatives to hospitalisation. These include; Home based Treatment; NGO provided recovery orientated short term day programmes; resilience focussed community group programmes; and later this year the Harekeke acute day programme based in Ngā Rau Rākau. We are also carrying out an audit of cases locally to see if any of these factors particularly stand out as contributing towards the inequity.

Intensive Assessment and Treatment			
$'millions	30 June 2016	Budget 30 June 2016	30 June 2015
Ministry of Health	305.7	295.0	286.6
Other District Health Boards	5.7	5.7	5.8
Other sources	10.0	9.2	10.6
Income by source	**321.4**	**309.9**	**303.0**
Less:			
Personnel	163.8	164.8	156.6
Outsourced services	14.7	10.4	12.9
Clinical supplies	43.2	42.1	44.7
Infrastructure and non-clinical supplies	41.0	37.3	40.2
Payments to other District Health Boards	45.7	45.8	44.5
Payments to other providers	12.0	12.2	8.7
Expenditure by type	**320.4**	**312.6**	**307.6**
Net Result	**1.0**	**(2.7)**	**(4.6)**

Budget and prior period amounts have been reclassified using the same allocation methodology used for the current year.

Rehabilitation and support services

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

Statement of Service Performance Output Class 4

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

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

Better access to care for older people

Age specific rate of non-urgent and semi urgent attendances at the Emergency Department are monitored for ages 75-79, 80-84 and 85+. These rates are an indicator of the services available to keep elderly safe and independent in their own homes. For 75-79 the rate has increased slightly from 139.5 per 1,000 to 153.3 per 100. For both 80-84 and 85+ year olds, the rate has decreased. This data will continue to be used to assess community services.

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

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

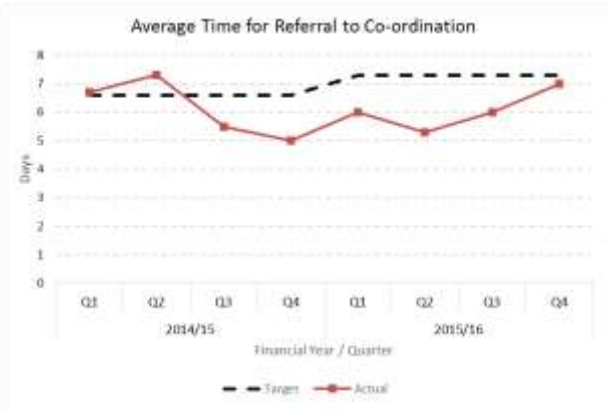
Better community support for older people

Delivering coordinated high quality services to older people supports New Zealanders to live longer, healthier and more independent lives. By providing better community support for elderly, we would expect that they are able to maintain independence and function in their own homes, therefore reducing rest home bed utilisation for the growing population. Comprehensive clinical assessments and completed care plans are an important component of keeping people safe in their own homes and maintaining their independence. In 2015/16, 100% of the people using home support received a comprehensive clinical assessment and completed care plan.

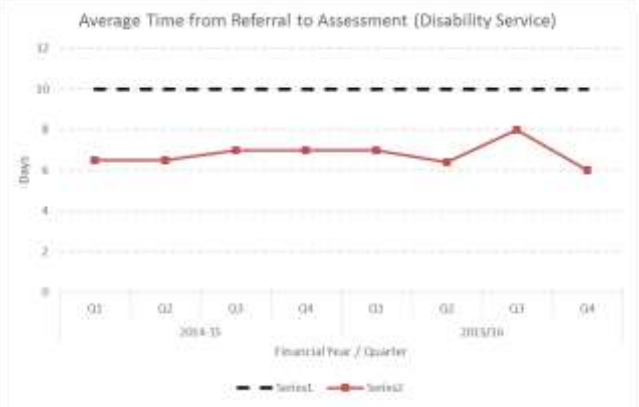
Increased capacity and efficiency in Needs Assessment and Service Coordination services

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

The elderly population of Hawke's Bay is increasing and to confirm that we are coping with the increase and providing a prompt service, we expect to reduce or maintain time from referral to co-ordination. The average time from referral to assessment in Q4 was 7.0 days against a target of ≤7.3 days.



As well as age-related disability, NASC services also provide disability services for people under 65 years of age. The average time from referral to assessment for this service in Q4 was 6.0 days which is favourable against the target of ≤10 days.



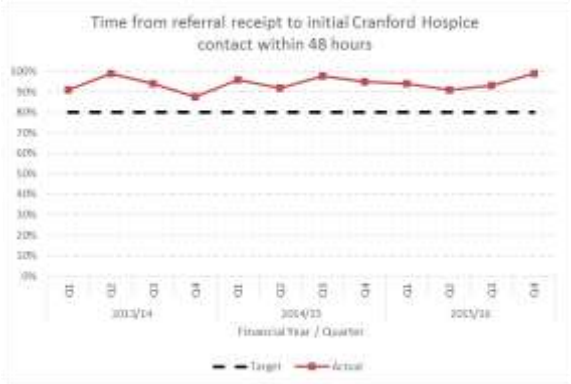
Number of needs assessments completed (disability service)		
Previous Year (2012/13)	**Target** (2015/16)	**Actual** (2015/16)
618	≥600	508

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

Prompt response to Palliative referrals

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

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



More Day Services

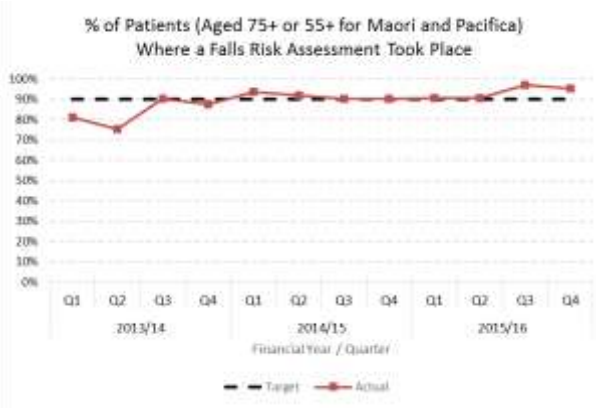
Improved management and integration of services in the community along with enhanced capability, enables early intervention to maintain function so that clients remain at home for longer. We commit extra resources to increase day services to give better support to people with specialised or high needs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

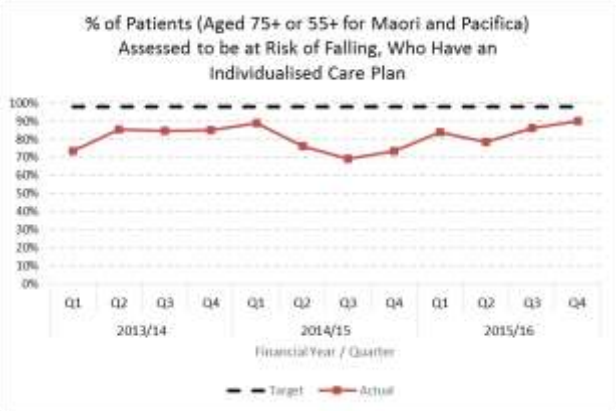
Number of Day Services	
Target	**Actual**
21,791	21,546

Reducing harm from falls

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

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





Rehabilitation and Support			
$'millions	**30 June 2016**	**Budget 30 June 2016**	**30 June 2015**
Ministry of Health	69.3	66.0	67.6
Other District Health Boards	3.0	3.0	3.1
Other sources	0.2	0.3	0.1
Income by source	**72.5**	**69.3**	**70.8**
Less:			
Personnel	5.5	5.5	5.3
Outsourced services	0.1	0.1	0.1
Clinical supplies	0.7	0.7	0.7
Infrastructure and non-clinical supplies	1.6	1.4	1.5
Payments to other District Health Boards	3.9	3.9	3.8
Payments to other providers	59.9	59.2	58.4
Expenditure by type	**71.7**	**70.8**	**69.8**
Net Result	**0.8**	**(1.5)**	**1.0**

Budget and prior period amounts have been reclassified using the same allocation methodology used for the current year.

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

Reconciliation (in $'millions) of the appropriation to Ministry of Health population-based revenue in Note 2.6 of the financial statements.

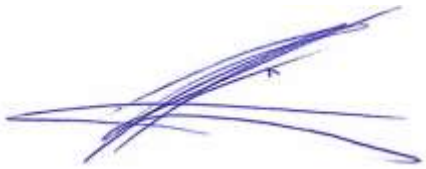
Appropriation	461.3
Transferred to 2016/17	(4.2)
MOH population based revenue	457.1

MOH 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.

Financial Report for the year ended 30 June 2016

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

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



Kevin Atkinson
Chair

Dan Druzianic
Board Member

31 October 2016

2015/16 Financial Performance

Result

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

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

Cash flow

The operating cash surplus of $20.4 million was used to fund the $19.4 million spend on property, plant and equipment, intangible assets and investments, repay equity of $0.4 million, and increase cash holdings by $0.6 million.

Auditors

The Auditor-General is required under section 15 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements and performance information presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2015/16 annual report, amount to $122,608.

Ministerial directions

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

Five year financial performance summary

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

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

Statement of comprehensive revenue and expense

For the year ended 30 June 2016

in thousands of New Zealand Dollars

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

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

DHBs are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2016 was overspent by $0.4 million (2015: underspent $0.8 million). Mental health payments in excess of funding since 1 July 2001 is $0.7 million (30 June 2015: $0.3 million).

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

Statement of changes in equity

For the year ended 30 June 2016

in thousands of New Zealand Dollars

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

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

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

Statement of financial position

As at 30 June 2016

in thousands of New Zealand Dollars

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

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

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

Statement of cash flows

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

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

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

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

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

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

For the year ended 30 June 2016

in thousands of New Zealand Dollars

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

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

Notes to the financial statements

For the year ended 30 June 2016

In preparing the 2016 financial statements, the notes have been grouped into sections under five key categories which are considered to be the most relevant for stakeholders and other users.

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

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

1. Reporting entity and basis of preparation

1.1 Reporting Entity

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

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

The financial statements of HBDHB comprise the DHB, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited which is controlled by the six DHB's in the central region.

The financial statements for HBDHB are for the year ended 30 June 2016, and were approved by the Board on 31 October 2016.

1.2 Basis of preparation

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

Statement of compliance

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

Presentation currency and rounding

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

Standards issued and not yet effective and not early adopted

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

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

2. Result for the year

2.1 Performance by Arm

HBDHB's annual plan includes separate operating statements for funding, governance and funding administration and providing health services. The table below compares performance against the plan for the 2015/16 year.

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

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

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

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

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

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

2.2 Output classes

Accounting Policy – cost allocation

Revenue and expenditure for each output class funded or provided by HBDHB and reported in the statement of service performance, has been derived using the allocation system outlined below.

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

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

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

HBDHB's annual plan includes projections of revenue and expenditure by output class. The table below compares performance by output class against planned and prior period amounts that have been reclassified using the same allocation methodology used for the current year.

	30 June 2016	Budget 30 June 2016	30 June 2015
Revenue			
Prevention services	10.5	14.7	10.8
Early detection and management	112.7	116.5	111.8
Intensive assessment and treatment	321.4	309.9	303.0
Rehabilitation and support	72.5	69.3	70.8
Total revenue	517.1	510.4	496.4
Expenditure			
Prevention services	10.1	10.8	10.0
Early detection and management	110.5	112.2	105.9
Intensive assessment and treatment	320.4	312.6	307.6
Rehabilitation and support	71.7	70.8	69.8
Total expenses	512.7	506.4	493.3
Surplus/(deficit) for the year	**4.4**	**4.0**	**3.1**

Comparison to 2014/15

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

Comparison to budget

The increase in intensive assessment and treatment reflects the same medical, outsourcing and investment factors mentioned above. Rehabilitation and support costs includes demographic impacts on the health of older people.

2.3 Performance against budget

Accounting Policy

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

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

Financial Performance

Revenue for the year is $6.7 million higher than plan. This reflects:

- additional funding of $3.5 million from MOH, including $3.0 million to compensate for additional capital charges resulting from land and building revaluations in June 2015, and the remainder for palliative assessment care coordination and cancer nurse coordinator funding.
- sundry income of $1.1 million including $0.5 million from donations, bequests and clinical trials;

- reduced ACC levies of $1 million due mainly to the removal of the residual claims levy; and
- interest on working capital invested of $0.4 million;

partly offset by:

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

Financial Position

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

Cash Flow

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

2.4 Critical accounting estimates and assumptions

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

Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $5.225 million (2015: $4.796 million). Refer note 4.3.

Workplace accident self-insurance

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

2.5 Critical judgements in applying accounting policies

In the process of applying HBDHB's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. Management has exercised the following critical judgements in applying accounting policies for the year ended 30 June 2016.

Impairment of intangible assets with indefinite lives

The DHB has invested in the National Oracle Solution (NOS) facilitated by New Zealand Health Partnerships Limited, a company collectively owned by the 20 DHBs, to provide a finance, procurement and supply chain (FPSC) system and return significant procurement savings to the sector.

in thousands of New Zealand Dollars

The investment is considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. The fund established by NZHPL through the on-charging of depreciation on the FPCS assets to the DHB s will be used to, and is sufficient to maintain the FPSC assets standard of performance or service potential indefinitely. The DHB is expecting to be using the new system at some point between 2017 and 2019.

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

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

2.6 Patient care revenue

Accounting policy

Ministry of Health population-based revenue

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

Ministry of Health contract revenue

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

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

Revenue from other DHBs

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

Other Crown entity contracted revenue

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

	30 June 2016	30 June 2015
Ministry of Health population-based revenue	457,148	431,817
Ministry of Health contract revenue	34,647	37,186
Revenue from other DHBs	11,455	12,137
Other Crown entity contracted revenue	5,933	6,421
Other patient care related revenue	1,313	1,483
	510,496	**489,044**

Ministry of Health population-based and contract revenue includes appropriations from the Crown of $461,348 thousand. Performance against the appropriations is reported in the statement of service performance.

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

2.7 Other operating revenue

Accounting policy

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

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Rental revenue

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

Sale of goods

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

Provision of services

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

Vested assets

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

Donated services

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

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

2.8 Personnel costs

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

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

2.9 Other operating expenses

Accounting policy

Operating lease payments

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

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

2.10 Financing Costs

Accounting Policy

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

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

	30 June 2016	30 June 2015
Interest on Crown loans	2,018	2,281
Attributed interest on finance leases	-	8
	2,018	**2,289**

2.11 Capital charge

Accounting policy

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

DHBs pay a capital charge to the Crown on their taxpayers' funds as at 30 June and 31 December each year. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2016 was 8% (2015: 8%).

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

Short term investments		
Term deposits – special funds	1,397	1,368
Term deposits – clinical trials	342	335
	1,739	**1,703**

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

Financial assets recognised subject to restrictions

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

Special funds		
Opening balance	1,804	1,805
Donations and bequests	233	299
Interest received	61	70
Expenditure during the year	(278)	(370)
	1,820	**1,804**

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

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

DHB Treasury Services Agreement

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

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

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

Credit card facility

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

3.2 Receivables and prepayments

Accounting policy

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

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

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

The carrying value of receivables that would otherwise be past due, but not impaired, whose terms have been renegotiated is $33 thousand (2015: $27 thousand)

Receivables are shown net of impairments amounting to $216 thousand (2015: $139 thousand) recognised in the current year and arising from non-resident fees and small service charges which can be uneconomic to collect.

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

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

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

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 2016	30 June 2015
Non-current	42	55
Current	13	12
	55	**67**

The fair value of loans receivable is $60 thousand (2015 $73 thousand). Fair value has been determined using contractual cash flows discounted using a rate based on market quoted Government stock at balance date plus an adequate constant credit spread totalling 2.14% (2015 3.23%).

3.4 Inventories

Accounting Policy

Inventories held for distribution

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

Inventories held for sale

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

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

For the year ended 30 June 2016
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Inventories held for distribution	30 June 2016	30 June 2015
Pharmaceuticals	775	738
Surgical and medical supplies	2,432	2,058
Other supplies	1,086	1,085
	4,293	**3,881**

Write-down of inventories amounted to $28 thousand (2015: $44 thousand). No reversal of previously recognised write-downs was made in the current year. The amount of inventories recognised as an expense during the year ended 30 June 2016 was $34.2 million (2015: $39.6 million). No inventories were held at current replacement cost at 30 June 2016 (30 June 2015: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

3.5 Non-current assets held for sale

Accounting policy

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

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

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

	30 June 2016	30 June 2015
Land	730	730
Buildings	490	490
	1,220	**1,220**

Changes and improvements to the mental health service delivery model, resulted in three properties being declared surplus in October 2013. Subsequently the three properties were transferred at their book values from property, plant and equipment to non-current assets held for sale. The properties were expected to be sold prior to 30 June 2016, however the disposal process through the Treaty of Waitangi protection mechanism took longer than anticipated. All three properties are now expected to be sold within the next twelve months. At 30 June 2015 the three properties were measured at fair value less costs to sell, resulting in a write-down of $518 thousand within other operating expenses.

3.6 Property, plant and equipment

Accounting policy

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

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

Revaluations

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

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

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

Additions

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

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

Disposals

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

Subsequent costs

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

Depreciation

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

Class of asset	Estimated life	Depreciation rate
Buildings	2 to 50 years	2% to 50%
Clinical equipment	2 to 20 years	5% to 50%
Information technology	3 to 10 years	10% to 33%
Motor vehicles	8.5 to 20 years	5% to 12%
Other equipment	10 to 30 years	3.3% to 10%

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

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

Impairment of property, plant and equipment

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

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

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

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

Notes to the financial statements (continued)

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

Notes to the financial statements (continued)

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Valuation

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

Land

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

Buildings

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

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

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

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

Restrictions

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

Notes to the financial statements (continued)

For the year ended 30 June 2016
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	1 July 2014									30 June 2015		
30 June 2015	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions	Transfers	Revaluations	Disposals/ transfer/ reclassification to operating lease (Note 3)	Depreciation expense	Depreciation write back on disposal, transfer, or revaluation (Note 1,2,3)	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Owned assets					(Note 1)	(Note 2)						
Land	5,868	-	5,868	-	-	2,432	(170)	-	-	8,130	-	8,130
Buildings	95,108	(19,322)	75,786	-	8,513	5,649	(1,350)	(7,450)	26,772	107,920	-	107,920
Clinical equipment	32,278	(16,989)	15,289	-	3,502	-	(3,026)	(3,546)	2,832	32,754	(17,703)	15,051
Information tech.	7,716	(4,869)	2,847	-	665	-	(295)	(1,045)	291	8,086	(5,623)	2,463
Motor vehicles	1,774	(782)	992	-	52	-	(38)	(162)	37	1,788	(907)	881
Other equipment	9,032	(3,619)	5,413	-	(5,940)	-	(215)	(669)	2,909	2,877	(1,379)	1,498
	151,776	(45,581)	106,195	-	6,792	8,081	(5,094)	(12,872)	32,841	161,555	(25,612)	135,943
Leased assets												
Buildings	3,565	(3,375)	190	-	-	-	(3,565)	(157)	3,532	-	-	-
Alterations	-	-	-	-	1,347	-	-	-	(153)	1,347	(153)	1,194
	3,565	(3,375)	190	-	1,347	-	(3,565)	(157)	3,379	1,347	(153)	1,194
Work in Progress												
Buildings	3,384	-	3,384	11,101	(3,742)	-	-	-	-	10,743	-	10,743
Clinical equipment	62	-	62	3,671	(3,532)	-	-	-	-	201	-	201
Information tech.	169	-	169	633	(680)	-	-	-	-	122	-	122
Motor vehicles	-	-	-	52	(52)	-	-	-	-	-	-	-
Other equipment	44	-	44	118	(133)	-	-	-	-	29	-	29
	3,659	-	3,659	15,575	(8,139)	-	-	-	-	11,095	-	11,095
	159,000	(48,956)	110,044	15,575		8,081	(8,659)	(13,029)	36,220	173,997	(25,765)	148,232

Notes to the financial statements (continued)

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Note 1: Classification changes

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

Note 2: Revaluations

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

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

Responsibility for the provision of health services in the Chatham Islands transferred from HBDHB to the Canterbury District Health Board on 30 June 2015. The transfer was effected by an order in council and included the transfer of the assets in the Chatham Islands for no consideration. The effect of the transaction on HBDHB is to reduce property, plant and equipment by $1.655 million, and equity by the same amount. Land and buildings reduced by $170 thousand and $1.350 million respectively. Clinical equipment, information technology and other equipment transferred at $135 thousand comprising a cost of $250 thousand, accumulated depreciation of $137 thousand, and a $38 thousand gain on transfer.

Notes to the financial statements (continued)

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3.7 Intangible assets

Accounting policy

Software acquisition and development

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

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

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

Amortisation

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

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

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

Impairment of intangible assets

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

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

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

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

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

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

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

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

Notes to the financial statements (continued)

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The RHIP assets are the DHB's share of the assets comprising the Regional Health Informatics Programme (RHIP) facilitated by Central Region's Technical Advisory Services Limited (CRTAS). The intangible asset recognises the DHB's right to use the RHIP clinical information systems, and its ownership of a proportion of the systems assets. During the year ended 30 June 2015 RHIP was reclassified into the four clinical systems and the supporting regional infrastructure it comprises, and will be amortised or depreciated when these assets are complete. The RHIP work in progress at 30 June 2016 is considered to be fit for purpose, and the DHBs in the central region continue to support the project. HBDHB considers the carrying amount of the assets (the cost of the system build), is equivalent to the recoverable service amount using depreciated replacement cost, and consequently no impairment of the assets is necessary.

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

in thousands of New Zealand Dollars

3.8 Investment property

Accounting policy

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

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

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

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

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

No revaluation was completed for investment properties as at 30 June 2016 due to the minimal value of the properties. The properties were last revalued as at 30 June 2015 by John Reid MPropertyStudies BCom(VPM) ANZIV SNZPI of Logan Stone, who holds an annual practicing certificate and has held registration since 1985. The fair value of the investment properties was determined using market based evidence. One of the properties is leased to an external party for $11 thousand per annum.

3.9 Investments in associates

Accounting policy

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

If the share of deficits of an associate equals or exceeds the DHB's interest in the associate, further deficits are not recognised. After the DHB's interest is reduced to zero, additional deficits are 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 2016 was 19% (30 June 2015: 25%). ALSL issued 400,000 bonus shares to each of the existing shareholders, taking their shareholdings to 1,150,000 each, and Capital and Coast DHB (CCDHB) and Hutt Valley DHB (HVDHB) were each issued 1,150,000 shares for $1 per share in cash. The CCDHB shares are fully paid, and the HVDHB shares are paid to $300,000, with the remainder to be paid over the next three years. The associates balance date is 30 June. There are no significant restrictions on the ability of the associate to transfer funds to HBDHB in the form of cash dividends.

in thousands of New Zealand Dollars

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

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited draft financial statements as at 30 June 2016, and their audited financial statements as at 30 June 2015.

4. Financing the DHB's activities

4.1 Borrowings and finance leases

Accounting policy

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

Finance leases transfer to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance component is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the leased term and its useful life.

Non-current	30 June 2016	30 June 2015
Crown loans	42,500	42,500
	42,500	**42,500**

Crown loans

HBDHB has a secured bank loan with the Crown. The details of terms and conditions are as follows:

Weighted average interest rate		
Crown loans	4.58%	4.58%

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

in thousands of New Zealand Dollars

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

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

The fair value of Crown loan borrowings is $46.803 million (2015 $45.117 million). Fair value has been determined using contractual cash flows discounted using a rate based on market quoted Government stock at balance date plus a margin for DHB risk ranging from 2.10% to 2.35% (2015 3.19% to 3.45%).

Security and Terms

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

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

The Government of New Zealand does not guarantee term loans.

Finance Lease Liabilities

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

in thousands of New Zealand Dollars

4.2 Payables and deferred revenue

Accounting policy

Payables and deferred revenue are recorded at their face value.

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

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

4.3 Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

in thousands of New Zealand Dollars

Defined benefit schemes

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

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

Non-current liabilities	30 June 2016	30 June 2015
Long service leave	2,497	2,194
Retirement gratuities	141	148
	2,638	**2,342**

Current liabilities		
Accrued salaries and wages	7,465	7,919
Annual leave	18,807	19,125
Sick leave	342	257
Continuing medical education leave and expenses	4,729	4,375
Sabbatical leave	619	576
Long service leave	1,470	1,463
Retirement gratuities	156	157
	33,588	**33,872**

Key assumptions in measuring employee entitlements

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 2.12% in year one to 4.75% after 39 years. The salary inflation factor is the DHB's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $228 thousand higher/lower. If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $195 thousand higher/lower.

4.4 Provisions (ACC Partnership Programme)

Accounting policy

Provisions

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

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

in thousands of New Zealand Dollars

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

All provisions are classified as current.

a. ACC Accredited Employers Programme

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

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

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

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

HBDHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will carry the total cost of claims up to $1.5 million for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceed the stop loss limit, the DHB will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

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

An independent actuarial valuer, Peter Davies B.Bus.Sc, FIA, FNZSA, AIAA has calculated the DHB's liability, and the valuation is effective 30 June 2016. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

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

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

b. Other provisions

There are no provisions for site restoration or onerous contracts as at 30 June 2016 (30 June 2015: Nil).

in thousands of New Zealand Dollars

4.5 Equity

	Crown Equity	Property Revaluation Reserves	Restricted Funds	Asset Replace Reserve	Accumulated Deficit	Total Equity
Balance at 1 July 2015	35,572	69,188	3,125	15,253	(35,511)	87,627
Surplus/(deficit) for the year	-	-	-	-	4,366	4,366
Transfers between reserves	-	-	(112)	(15,253)	15,365	-
Repayment to the Crown	(356)	-	-	-	-	(356)
Revaluation of land and buildings	-	(1,796)	-	-	1,796	-
Balance at 30 June 2016	**35,216**	**67,392**	**3,013**	**-**	**(13,984)**	**91,637**

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

Asset Replacement Reserves

The asset replacement reserve included cash proceeds from the sale of the Napier Hill site of $7.850 million, and underspends relating to mental health funding from the Ministry of Health of $7.403 million. These funds were reserved for the development of the mental health intensive care unit, and with the completion of Nga Rau Rakau in February 2016, were transferred to accumulated deficit.

Property Revaluation Reserves

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

	30 June 2016	30 June 2015
Land	7,060	7,842
Buildings	60,332	61,346
	67,392	**69,188**

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

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

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

Non-cancellable commitments – operating leases	30 June 2016	30 June 2015
Not more than one year	2,730	1,994
One to five years	7,524	5,797
Later than five years	3,682	3,556
	13,936	**11,347**

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:

Financial Assets

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

Financial Liabilities

Financial liabilities measured at amortised cost		
Secured bank loans (Ministry of Health)	42,500	42,500
Trade and other payables	38,318	30,823
	80,818	**73,323**

b. Fair value hierarchy disclosures

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

c. Financial instrument risks

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

Market risk

Fair value interest rate risk

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

in thousands of New Zealand Dollars

Cash flow interest rate risk

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

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

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

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

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

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

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

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.

in thousands of New Zealand Dollars

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

Sensitivity analysis

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

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 96% (30 June 2015: 96%) of the DHB's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Sensitivity analysis

At 30 June 2016, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2016/17, as most of the DHB's term debt is at fixed rates, and only the net interest from cash holdings would be affected.

Credit quality of financial assets

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

	30 June 2016	30 June 2015
Counterparties with credit ratings		
Cash, cash equivalents and investments		
AA-	3,053	3,135
Total cash and cash equivalents	3,053	3,135

in thousands of New Zealand Dollars

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

Liquidity risk

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

Contractual maturity analysis of financial liabilities

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

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

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

Forecasted transactions

HBDHB does not hedge forecasted transactions.

5.4 Contingent assets

There are no contingent assets at 30 June 2016.

in thousands of New Zealand Dollars

5.5 Contingent liabilities

Lawsuits against the DHB

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

Superannuation schemes

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

As at March 2016, the scheme had a past service surplus of $11.7 million (7.4% of the liabilities). This amount is exclusive of employer superannuation contribution tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology are consistent with the requirements of PBE IPSAS 25 *Employee Benefits.* The actuary to the scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report the actuary recommended employer contributions remain suspended.

5.6 Related party transactions

HBDHB is a wholly owned entity of the Crown.

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

Key management personnel compensation

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

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

in thousands of New Zealand Dollars

5.7 Remuneration

Remuneration – Board members

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

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

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

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

Remuneration – Committee members who are not board members or employees

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

in New Zealand Dollars

Employee Remuneration

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

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

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

Compensations

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

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

5.8. Capital management

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

5.9. Events after balance date

There are no significant events after balance date.

Appendix one: Technical Results Report

Key for technical results report

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2015/16
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

Health Target: Better help for smokers to quit - Percentage of hospitalised smokers offered advice to quit			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	98.6% October – December 2013	≥95%	97.5% (F) – July to September 2014
			98.2% (F) – October to December 2014
			98.3% (F) – January to March 2015
			97.8% (F) – April to June 2015
2015/16	98.2% October – December 2014	≥95%	98.1% (F) – July to September 2015
			99.1% (F) – October to December 2015
			97.8% (F) – January to March 2016
			98.6% (F) – April to June 2016

Health Target: Better help for smokers to quit - Percentage of PHO enrolled smokers offered advice to quit			
Financial Year Source: Ministry of Health	**Baseline**	**Target**	**Actual to Date**
2014/15	80.2% October – December 2013 (Source: DHBNZ)	≥90%	95.3% (F) – July to September 2014
			96.1% (F) – October to December 2014
			89.5% (F) – January to March 2015
			85.2% (U) – April to June 2015
2015/16	96.0% October – December 2014 (Source: DHBNZ)	≥90%	81.2% (U) – July to September 2015
			75.0% (U) – October to December 2015
			77.6% (U) – January to March 2016
			81.3% (U) – April to June 2016

Health Target: Better help for smokers to quit - % of pregnant women offered advice and support to quit			
Financial Year Source: Ministry of Health	**Baseline**	**Target**	**Actual to Date**
2014/15	New	≥90%	100% (F) - July to September 2014
			98.1% (F) – October to December 2014
			98.6% (F) – January to March 2015
			96.9% (F) - April to June 2015
2015/16	98.1% October – December 2014	≥90%	90.3% (F) – July to September 2015
			96.5% (F) – October to December 2015
			88.6% (U) – January to March 2016
			89.0% (U) – April to June 2016

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

Health Target: Increased immunisation - Percentage of 8 month who complete their primary course of immunisations			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2014/15	94.7% 3 months to December 2013	≥95%	94.3% (U) – 3 months to September 2014
			96.0% (F) – 3 months to December 2014
			95.1% (F) – 3 months to March 2015
			95.5% (F) - 3 months to June 2015
2015/16	96.0% 3 months to December 2014	≥95%	94.5% (F) – July to September 2015
			93.3% (U) – October to December 2015
			98.5% (F) – January to March 2016
			95.2% (F) – April to June 2016
MAORI			
2014/15	96.4% 3 months to December 2013	≥95%	95.1% (F) – 3 months to September2014
			95.9% (F) – 3 months to December 2014
			95.8% (F) – 3 months to March 2015
			95.2% (F) - 3 months to June 2015
2015/16	95.9% 3 months to December 2014	≥95%	96.7% (F) – July to September 2015
			92.6% (U) – October to December 2015
			97.7% (F) – January to March 2016
			94.6% (F) – April to June 2016

Increased immunisation - Percentage of 2 year olds fully immunised:			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2014/15	95.5% 3 months to December 2013	≥95%	95.7% (F) – 3 months to September2014
			94.0% (U) – 3 months to December 2014
			94.3% (U) – 3 months to March 2015
			96.6% (F) - 3 months to June 2015
2015/16	94.0% 3 months to December 2014	≥95%	95.7% (F) – July to September 2015
			93.9% (U) – October to December 2015
			95.1% (F) – January to March 2016
			95.2% (F) – April to June 2016
MAORI			
2014/15	97.7% 3 months to December 2013	≥95%	97.1% (F) – 3 months to September2014
			95.0% (F) – 3 months to December 2014
			96.7% (F) – 3 months to March 2015
			97.4% (F) - 3 months to June 2015
2015/16	95.0% 3 months to December 2014	≥95%	95.9% (F) – July to September 2015
			95.1% (F) – October to December 2015
			94.8% (F) – January to March 2016
			95.1% (F) – April to June 2016

Increased immunisation - Percentage of 4 year olds fully immunised by age 5:

Financial Year	Baseline	Target	Actual to Date
TOTAL			
2014/15	New	New	-
2015/16	90.6% 3 months to December 2014	≥90%	92.2% (F) – July to September 2015
			92.7% (F) – October to December 2015
			92.2% (F) – January to March 2016
			93.0% (F) – April to June 2016
MAORI			
2014/15	New	New	-
2015/16	New	≥90%	93.3% (F) – July to September 2015
			94.2% (F) – October to December 2015
			93.2% (F) – January to March 2016
			94.0% (F) – April to June 2016

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

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

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

POPULATION BASED SCREENING SERVICES

Percentage of women aged 50-69 years receiving breast screening in the last 2 years			
Financial Year Source: Breast Screen Coast to Coast	**Baseline**	**Target**	**Actual to Date**
OVERALL RATE			
2014/15	74.0% 24 months to October 2013	≥70%	74.4% (F) - 24 months to 31 March 2015
2015/16	75.8% 24 months to October 2014	≥70%	73.4% (F) - 24 months to 31 March 2016
MAORI			
2014/15	65.8% 24 months to October 2013	≥70%	66.9% (U) - 24 months to 31 March 2015
2015/16	62.7%	≥70%	67.9% (U) - 24 months to 31 March 2016

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

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years			
Financial Year Source: Breast Screen Coast to Coast	**Baseline**	**Target**	**Actual to Date**
OVERALL RATE			
2014/15	82.2% 36 months to 31 October 2013	≥80%	76.7% (U) - 36 months to 31 March 2015
2015/16	76.9% 36 months to 31 December 2014	≥80%	76.6% (U) - 36 months to 31 June 2016
MAORI			
2014/15	74.1% 36 months to 31 October 2013	≥80%	74.6% (U) - 36 months to 31 March 2015
2015/16	73.8% 36 months to 31 December 2014	≥80%	73.2% (U) - 36 months to 31 June 2016
PACIFIC			
2014/15	84.2% 36 months to 31 October 2013	≥80%	72.6% (U) - 36 months to 31 March 2015
2015/16	72.8% 36 months to 31 December 2014	≥80%	71.4% (U) - 36 months to 31 June 2016

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

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

2014/15	New	New	-
2015/16	New	≥60%	39% (U) - June 2015 to December 2015

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

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

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

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Proportion of the population enrolled in the PHO			
Financial Year Source: DHB Shared Services	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2014/15	96.9% April 2014	≥97%	97.1% (F) - July to September 2014
			97.3% (F) – October to December 2014
			95.5% (U) – January to March 2015
			95.4% (U) - April to June 2015
2015/16	97.3% December 2014	≥97%	95.6% (U) - July to September 2015
			96.0% (U) – October to December 2015
			95.2% (U) – January to March 2016
			95.9% (U) - April to June 2016
MĀORI:			
2014/15	93.1% April 2014	≥97%	93.8% (U) - July to September 2014
			94.7% (U) – October to December 2014
			95.0% (U) – January to March 2015
			95.4% (U) - April to June 2015
2015/16	94.7% December 2014	≥97%	95.9% (U) - July to September 2015
			97.2% (U) – October to December 2015
			97.8% (U) – January to March 2016
			95.6% (U) - April to June 2016

Percentage of Women booked with an LMC by week 12 of their pregnancy			
Financial Year Source: DHB Shared Services	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2014/15	46.9% October to December 2013	≥80%	56.5% (U) – April to June 2014
			52.9% (U) – July to September 2014
			51.4% (U) – October to December 2014
			59.2% (U) – January to March 2015
2015/16	51.4% October to December 2014	≥80%	56.8% (U) – April to June 2015
			54.5% (U) – July to September 2015
			62.1% (U) – October to December 2015
			60.6% (U) – January to March 2016
MĀORI:			
2014/15	37.8% October to December 2013	≥80%	45.3% (U) – April to June 2014
			38.6% (U) – July to September 2014
			44.1% (U) – October to December 2014
			47.7% (U) – January to March 2015
2015/16	44.1% October to December 2014	≥80%	43.9% (U) – April to June 2015
			50.7% (U) – July to September 2015
			48.5% (U) – October to December 2015
			49.2% (U) – January to March 2016

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

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

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

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

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

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

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

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

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

More heart and diabetes checks - Better management of long-term conditions: Proportion of diabetic patients with good or acceptable glycaemic control			
Financial Year	**Baseline**	**Target**	**Actual to Date**
TOTAL:			
2014/15	54.3% July to December 2013	≥55%	50.3% (U) – October 2013 to September 2014
			50.0% (U) – January 2013 to December 2014
			49.2% (U) – April 2014 to March 2015
			50.7% (U) - July 2014 to June 2015
2015/16	49.2% April 2014 to March 2015	≥55%	49.7% (U) – July to September 2015
			42.9% (U) – October to December 2015
			42.6% (U) – January to March 2016
			42.8% (U) – April to June 2016
MAORI:			
2014/15	No baseline	≥55%	50.2% (U) – October 2013 to September 2014
			50.9% (U) – January 2013 to December 2014
			50.0% (U) – April 2014 to March 2015
			50.4% (U) - July 2014 to June 2015
2015/16	50.0% – April 2014 to March 2015	≥55%	49.4% (U) – July to September 2015
			41.4% (U) – October to December 2015
			41.4% (U) – January to March 2016
			39.8% (U) – April to June 2016
PACIFIC:			

2014/15	No baseline	≥55%	42.4% (U) – October 2013 to September 2014
			40.9% (U) – January 2013 to December 2014
			40.5% (U) – April 2014 to March 2015
			41.5% (U) - July 2014 to June 2015
2015/16	40.9% – January 2013 to December 2014	≥55%	42.4% (U) – July to September 2015
			37.8% (U) – October to December 2015
			36.4% (U) – January to March 2016
			46.1% (U) – April to June 2016

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

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

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

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

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

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Health Target: Shorter stays in Emergency Departments - Percentage of patients admitted, discharged or transferred from an emergency department within 6 hours			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	93.3% October to December 2013	≥95%	89.2% (U) - July to September 2014
			91.5% (U) – October to December 2014
			94.9% (F) – January to March 2015
			94.8% (F) - April to June 2015
2015/16	91.5% – October to December 2014	≥95%	92.1% (U) – July to September 2015
			92.7% (U) – October to December 2015
			93.9% (U) – January to March 2016
			92.5% (U) – April to June 2016

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

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

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

Acute coronary syndrome			
Financial Year	**Baseline**	**Target**	**Actual to Date**
PERCENTAGE OF HIGH RISK PATIENTS RECEIVING AN ANGIOGRAM WITHIN 3 DAYS			
TOTAL			
2014/15	68.3% October to December 2013	≥70%	75.7% (F) - July to September 2014
			49.3% (U) – October to December 2014
			62.3% (U) – January to March 2015
			63.4% (U) - April to June 2015
2015/16	50.7% October to December 2014	≥70%	50.7% (U) - July to September 2015
			68.7% (U) – October to December 2015
			71.1% (F) – January to March 2016
			77.6% (F) - April to June 2016
MAORI			
2014/15	81.8% January to March 2014	≥70%	90.9% (F) - July to September 2014
			33.3% (U) – October to December 2014
			66.7% (U) – January to March 2015
			58.3% (U) - April to June 2015
2015/16	33.3% October to December 2014	≥70%	38.5% (U)- July to September 2015
			60.0% (U)– October to December 2015
			80% (F) – January to March 2016
			84.6% (F) - April to June 2016
PERCENTAGE OF ANGIOGRAPHY PATIENTS WHOSE DATA IS RECORDED ON NATIONAL DATABASES			
2014/15	68.3% October to December 2013	≥95%	0% (U) - July to September 2014
			27.8% (U) – October to December 2014
			61.1% (U) – January to March 2015
			83.1% (U) - April to June 2015
2015/16	12.3% October to December 2014	≥95%	85.1% (U) - July to September 2015
			84.1% (U) – October to December 2015
			100% (F) – January to March 2016
			96.6% (U) - April to June 2016
MAORI			
2014/15	6.7% January to March 2014	≥95%	0% (U) - July to September 2014
			12.5% (U) – October to December 2014
			6.7% (U) – January to March 2015
			90.9% (U) - April to June 2015
2015/16	12.5% October to December 2014	≥95%	91.7% (U) - July to September 2015
			71.4% (U) – October to December 2015
			100.0% (F) – January to March 2016
			90.0% (U) - April to June 2015

STROKE – Percentage of potentially eligible patients who are thrombolysed			
Financial Year Please note data is subject to change over time	**Baseline**	**Target**	**Actual to Date**
2014/15	0% October to December 2013	≥6%	4.3% (U) - July to September 2014
			6.0% (F) – October to December 2014
			2.6% (U) – January to March 2015
			2.6% (U) - April to June 2015
2015/16	6.0% October to December 2014	≥6%	5.1% (U) - July to September 2015
			4.1% (U) – October to December 2015
			4.6% (U) – January to March 2016

			4.5% (U) - April to June 2016

STROKE – Percentage of patients admitted to the demonstrated stroke pathway			
Financial Year Please note data is subject to change over time	**Baseline**	**Target**	**Actual to Date**
2014/15	78% October to December 2013	≥80%	65.7% (U) - July to September 2014
			82.1% (F) – October to December 2014
			67.9% (U) – January to March 2015
			75.6% (U) - April to June 2015
2015/16	82.1% October to December 2014	≥80%	69.2% (U) - July to September 2015
			69.9% (F) – October to December 2015
			84.6% (F) – January to March 2016
			90.9% (F) - April to June 2016

Standardised intervention rates for surgery (per 10,000 population)			
Financial Year Please note data is subject to change over time	**Baseline**	**Target**	**Actual to Date**
Major joint replacement			
2014/15	19.6 12 months to September 2013	≥21.0	23.3 (F) – July 2013 to June 2014
			22.5 (F) – October 2013 to September 2014
			21.3 (F) – January 2014 to December 2014
			21.9 (F) - April 2014 to March 2015
2015/16	21.3 12 months to December 2014	≥21.0	16.9 (U) – July 2013 to June 2015
			17.6 (U) – October 2013 to September 2015
			19.4 (U) – January 2014 to December 2015
			19.2 (U) - April 2014 to March 2016
Cataract procedures			
2014/15	32.6 12 months to September 2013	≥27.0	52.7 (F) – July 2013 to June 2014
			54.3 (F) – October 2013 to September 2014
			52.1 (F) – January 2014 to December 2014
			52.6 (F) - April 2014 to March 2015
2015/16	52.1 12 months to December 2014	≥27.0	50.2 (F) – July 2013 to June 2015
			51.2 (F) – October 2013 to September 2015
			47.0 (F) – January 2014 to December 2015
			49.6 (F) - April 2014 to March 2016
Cardiac surgery			
2014/15	5.6 12 months to September 2013	≥6.5	5.49 (U) – July 2013 to June 2014
			6.0 (U) – October 2013 to September 2014
			5.7 (U) – January 2014 to December 2014
			6.0 (U) - April 2014 to March 2015
2015/16	5.7 12 months to December 2014	≥6.5	5.9 (U) – July 2013 to June 2015
			6.3 (U) – October 2013 to September 2015
			6.8 (F) – January 2014 to December 2015
			6.3 (U) - April 2014 to March 2016
Percutaneous revascularisation			
2014/15	11.2 12 months to September 2013	≥12.5	10.88 (U) – July 2013 to June 2014
			11.1 (U) – October 2013 to September 2014
			10.9 (U) – January 2014 to December 2014
			10.8 (U) - April 2014 to March 2015
2015/16	10.9 12 months to December 2014	≥12.5	11.7 (U) – July 2013 to June 2015
			12.4 (U) – October 2013 to September 2015
			12.8 (F) – January 2014 to December 2015
			13.3 (F) - April 2014 to March 2016

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

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

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

Acute readmissions to hospital			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	7.4%	≤7.5%	7.5% (F) – July 2013 to June 2014
			7.5% (F) – October 2013 to September 2014
			7.6% (U) – January 2014 to December 2014
			*
2015/16	7.6%	Reduce	NA
			NA
			NA
			NA

*the Ministry of Health are currently reviewing this measure, no results were published for the period April 2014 to March 2015. For 2015/16 the DHB was supplied results by the Ministry however the DHB was not measured against the data as the measure is still under development.

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

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

Diagnostic Colonoscopy : Percentage of urgent cases performed within 14 days			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	63.0% December 2013	≥75%	89.1% (F) - September 2014
			92.6% (F) –December 2014
			87.5% (F) – March 2015
			81.3% (F) - June 2015
2015/16	92.6% December 2014	≥75%	90.0% (F) - September 2015
			82.4% (F) –December 2015
			91.3% (F) – March 2016
			93.5% (F) - June 2016

Diagnostic Colonoscopy : Percentage of diagnostic cases performed within 42 days			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	51.4% December 2013	≥60%	48.0% (U) - September 2014
			39.7% (U) –December 2014
			74.3% (F) – March 2015
			78.7% (F) - June 2015
2015/16	39.7% December 2014	≥65%	84.1% (F) - September 2015
			87.1% (F) –December 2015
			37..6% (U) – March 2016
			80.4% (F) - June 2016

Surveillance Colonoscopy : Percentage waiting less than 84 days beyond planned date			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	64.3% December 2013	≥60%	80.6% (F) - September 2014
			50.7% (U) –December 2014
			62.2% (F) – March 2015
			77.3% (F) - June 2015
2015/16	50.7% December 2014	≥65%	88.5% (F) - September 2015
			79.3% (U) –December 2015
			96.3% (F) – March 2015
			93.5% (F) - June 2015

Did not attend (DNA) rate across first specialist assessments[4]			
Financial Year Please note data is subject to change over time	**Baseline**	**Target**	**Actual to Date**
TOTAL			
2014/15	9.1% October to December 2013	≤7.5%	7.2% (F) - July to September 2014
			6.1% (F) – October to December 2014
			7.2% (F) – January to March 2015
			6.9% (F) - April to June 2015
2015/16	7.2% October to December 2014	≤7.5%	6.8% (F) - July to September 2014
			8.1% (U) – October to December 2014
			7.8% (U) – January to March 2015
			7.4% (F) - April to June 2015

[4] ESPI specialties only

MAORI			
2014/15	17.9% October to December 2013	≤7.5%	16.2% (U) - July to September 2014
			12.2% (U) – October to December 2014
			13.7% (U) – January to March 2015
			13.7% (U) - April to June 2015
2015/16	12.2% October to December 2014	≤7.5%	11.6% (U) - July to September 2015
			14.9% (U) – October to December 2015
			18.2% (U) – January to March 2016
			15.2% (U) - April to June 2016

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

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

Shorter waits for non-urgent mental health and addiction services for 0-19 year olds			
Financial Year Please note data is subject to change over time	**Baseline**	**Target**	**Actual to Date**
PERCENTAGE OF PEOPLE SEEN WITHIN 3 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
2014/15	56.9% 12 months to September 2013	≥80%	57.0% (U) - July 2013 to June 2014
			56.7% (U) - October 2013 to September 2014
			51.3% (U) – January 2014 to December 2014
			55.6% (U) - April 2014 to March 2015
2015/16	56.7% 12 months to September 2014	≥80%	54.2% (U) - July 2014 to June 2015
			55.8% (U) - October 2014 to September 2015
			60.1% (U) – January 2015 to December 2015
			67.4% (U) - April 2015 to March 2016
ADDICTIONS (PROVIDER ARM AND NGO)			
2014/15	73.5% 12 months to September 2013	≥80%	88.7% (F) - July 2013 to June 2014
			88.3% (F) - October 2013 to September 2014
			88.3% (F) – January 2014 to December 2014
			84.8% (F) - April 2014 to March 2015
2015/16	88.3% 12 months to September 2014	≥80%	78.6% (U) - July 2014 to June 2015
			84.2% (F) - October 2014 to September 2015
			79.4% (U) – January 2015 to December 2015
			84.0% (U) - April 2015 to March 2016
PERCENTAGE OF PEOPLE SEEN WITHIN 8 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
2014/15	85.4% 12 months to September 2013	≥95%	83.7% (U) - July 2013 to June 2014
			82.0% (U) - October 2013 to September 2014
			75.0% (U) – January 2014 to December 2014
			81.5% (U) - April 2014 to March 2015
2015/16	82.0% 12 months to September 2014	≥95%	77.6% (U) - July 2014 to June 2015
			81.5% (U) - October 2014 to September 2015
			86.0% (U) – January 2015 to December 2015
			90.2% (U) - April 2015 to March 2016
ADDICTIONS (PROVIDER ARM AND NGO)			
2014/15	92.0% 12 months to September 2013	≥95%	96.5% (F) - July 2013 to June 2014
			96.1% (F) - October 2013 to September 2014
			95.0% (F) – January 2014 to December 2014
			97.0% (F) - April 2014 to March 2015
2015/16	96.1% 12 months to September 2014	≥95%	92.9% (F) - July 2014 to June 2015
			100.0% (F) - October 2014 to September 2015
			97.1% (F) – January 2015 to December 2015
			96.0% (F) - April 2015 to March 2016

Improving mental health services using discharge planning – Percentage of children and youth with a transition (discharge) plan			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15			24.17% (U) - July 2013 to June 2014

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

More equitable use of Mental Health Act: Section 29 community treatment orders – Rate of section 29 orders per 100,000 population			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	New	Reduce the rate*	74.4 (U) - July to September 2014
			82.0 (U) – October to December 2014
			85.8 (U) – January to March 2015
			85.2 (U) - April to June 2015
2015/16	81.5 October to December 2014	≤80	91.1 (U) - July to September 2015
			97.0 (U) – October to December 2015
			100.7 (U) – January to March 2016
			97.3 (U) - April to June 2016

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital emergency department (per 1,000 population)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
75-79 Years			
2014/15	164.7 July 2012 to June 2013	≤164.7	125.7 (F) - July to September 2014
			139.2 (F) – October to December 2014
			127.2 (F) – January to March 2015
			138.0 (F) - April to June 2015
2015/16	139.2 January 2014 to December 2014	≤139.5	186.7 (U) - October 2014 to September 2015
			160.0 (U) – January 2015 to December 2015
			146.7 (U) – April 2015 to March 2016
			153.3 (U) - July 2015 to June 2016
80-84 Years			
2014/15	222.0 July 2012 to June 2013	≤222.0	172.7 (F) - July to September 2014
			183.1 (F) – October to December 2014
			161.4 (F) – January to March 2015
			176.1 (F) - April to June 2015
2015/16	183.1 October to December 2014	≤183.1	166.9 (F) - October 2014 to September 2015
			175.5 (F) – January 2015 to December 2015
			180.5 (F) – April 2015 to March 2016
			178.1 (F) - July 2015 to June 2016
85+ Years			
2014/15	231.0 July 2012 to June 2013	≤231.0	244.8 (U) - July to September 2014
			254.8 (U) – October to December 2014
			230.8 (F) – January to March 2015
			232.2 (U) - April to June 2015
2015/16	254 October to December 2014	≤231.0	231.5 (U) - October 2014 to September 2015
			233.9 (U) – January 2015 to December 2015
			221.3 (F) – April 2015 to March 2016
			221.8 (F) - July 2015 to June 2016

Acute readmissions to hospital 75 Years +			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	11.1%	≤11.1%	10.9% (F) – July 2013 to June 2014
			10.9% (F) – October 2013 to September 2014
			10.8% (F) – January 2014 to December 2014
			*
2015/16	7.6% 12 months to September 2014	<10%	NA
			NA
			NA
			NA

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

Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	94.4% January to March 2014	≥95%	100% (F) April to June 2014*
			100% (F) July to September 2014
			100% (F) October to December 2014
			93% (U) January to March 2015
2015/16	100% October to December 2014	≥95%	100% (F) April to June 2015
			100% (F) July to September 2015
			100% (F) October to December 2015
			100% (F) January to March 2016

Average time from assessment to coordination (65 years and over)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	6.6 Days	≤6.6 Days	6.7 days (U) - July to September 2014
			7.3 days (U) - October to December 2014
			5.5 days (F) - January to March 2015
			5.0 days (F) - April to June 2015
2015/16	7.3 Days October to December 2014	≤7.3 Days	6.0 days (U) - July to September 2015
			5.3 days (U) - October to December 2015
			6.0 days (F) - January to March 2016
			7.0 days (F) - April to June 2016

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

Average time from referral to assessment (Disability Services)			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	4 days October - December 2012	≤10days	6.5 days (F) - July to September 2014
			6.5 days (F) - October to December 2014
			7.0 days (F) - January to March 2015
			7.0 days (F) - April to June 2015

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

Time from referral receipt to initial Cranford Hospice contact within 48 hours			
Financial Year	**Baseline**	**Target**	**Actual to Date**
2014/15	99% October to December 2013	≥80%	96.0% (F) – July to September 2014
			92.0% (F) - October to December 2014
			97.7% (F) – January to March 2015
			95.0% (F) – April to June 2015
2015/16	92.0% October to December 2014	≥80%	94.0% (F) – July to September 2015
			91.0% (F) - October to December 2015
			93.0% (F) – January to March 2016
			99.0% (F) – April to June 2016

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

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

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

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