HAWKE'S BAY DISTRICT HEALTH BOARD

Statement of Intent
2015 – 2019
and
Statement of Performance Expectations
2015/16

HAWKE'S BAY
District Health Board
Whakawāteatia

Presented to the House of Representatives pursuant to section 150(3) of the CE Act.

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OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

OUR VALUES / BEHAVIOURS

TAUWHIRO - delivering high quality care to patients and Consumers

RARANGA TE TIRA – working together in partnership across the Community

HE KAUANUANU – showing respect for each other, our staff, patients and consumers

AKINA – continuously improving everything we do

Hawke's Bay District Health Board
Annual Plan 2015/16

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1. INTRODUCTION & STRATEGIC INTENTIONS

1.1 EXECUTIVE SUMMARY

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our vision is simple - we want everyone in Hawke's Bay district to be healthy. The funding and provision of services is guided by our statutory obligations and by priorities established at the national, regional and local levels. As an integrated health system, we rely on networks of suppliers across the spectrum of care and across New Zealand. Our organisation is the district's largest single employer making us a significant contributor to the local economy. The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges.

Locally, we are guided by a health-sector strategic framework and our five year strategic programme - Transform and Sustain, which was launched in December 2013. Our three priority goals for Transform and Sustain are: responding to our population; delivering consistent high-quality care; and being more efficient at what we do. Through the programme we will contribute to the Government's priorities for the health system, which include fiscal discipline, strong clinical leadership, integration between Primary and Secondary care, achieving the National Health Targets, and tackling the key drivers of morbidity. We also work collaboratively for optimal arrangements by aligning our work to a Regional Services Plan developed on behalf of the six Central Region DHBs - Whanganui, Mid-Central, Wairarapa, Hutt Valley, Capital & Coast, and Hawke's Bay. Fiscal responsibility means that we plan for modest annual operating surpluses that enable us to invest in programmes that will deliver the necessary transformational change for ongoing quality improvement.

Our Statement of Intent outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes. The health system outcomes are defined by the Ministry of Health as New Zealanders living longer, healthier and more independent lives, and a cost effective health system supporting a productive economy. Over time, we will measure progress towards our vision by considering patient and whānau experiences of care, resource sustainability and life expectancy gap as headline system outcomes plus a suite of eighteen key supporting dimensions that will be evidence of impact.

Targets for service performance standards for the 2015/16 year are aligned to the New Zealand Triple Aim, which is part of our strategic framework, and are set out in the Statement of Performance Expectations grouped according to four reportable classes of outputs: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. A set of financial statements for the 2015 to 2019 period is also included. Actual results will be audited against those forecasts by Audit New Zealand after the end of each financial year.

X_____

Board Member

X _____

Board Member

1.2 CONTEXT

Hawke's Bay District Health Board (HBDHB) is one of 20 District Health Boards (DHBs) that were established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). HBDHB is the Government's funder and provider of public health services for the 159,600[1] people resident in the Hawke's Bay district. A map of the district, which is defined by the NZPHD Act is shown in Figure 1. In 2015/16, HBDHB's allocation of public health funds will be $482 million, including 3.96%[2] of the total health funding that the Government allocates directly to all DHBs.

Our objectives[3] are to improve, promote and protect the health, well-being and independence of our population and to ensure effective and efficient care of people in need of health services or disability support services. To achieve this, HBDHB works with consumers, stakeholder communities and other health and disability organisations to plan and coordinate activities, develop collaborative and cooperative arrangements, monitor and report on health status and health system performance, participate in training of the health workforce, foster health promotion and disease prevention, promote reduction of adverse social and environmental effects, and ensure provision of health and disability services.

Funding and Provision of Services

Each DHB has a statutory responsibility for the health outcomes of its district population as well as an objective under law to seek optimum arrangements for the most effective and efficient delivery of health services. This requires the health system to be integrated at local, regional and national levels.

As a funder, HBDHB buys health and disability services from various organisations right across New Zealand for the benefit of our population.

We fund and work very closely with Health Hawke's Bay – Te Oranga Hawke's Bay Primary Healthcare Organisation (the PHO) who coordinate and support primary health care services across the district. The PHO brings together General Practitioners (GPs), Nurses and other health professionals in the community to serve the needs of their enrolled populations. Other organisations we fund may be community-based private entities, such as residential care providers or individual pharmacists, or may be public entities, such as other DHBs. In 2015/16 we will fund over $222 million worth of services from other providers. 76.5% (2014/15 75%) of those services will be from primary care and private providers mostly based in Hawke's Bay communities and the other 23.4% will be from other DHBs for more specialised care than is provided locally. The local component is projected to grow by $8.4 million.

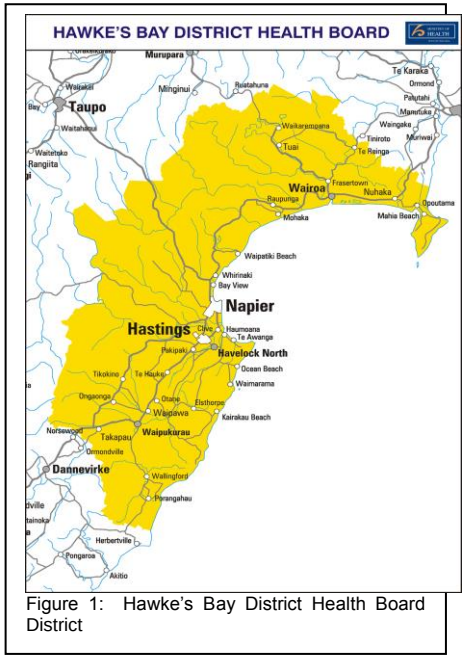

Figure 1: Hawke's Bay District Health Board District

As a provider, we supply health and disability programmes and services for the benefit of our population and on referral for other DHBs' patients. This includes a full range of services from prevention through to end-of-life care that are provided through resources owned or employed directly by us. Where we cannot provide the necessary level of care locally, we refer patients to other DHBs and larger centres with more specialised capability.

[1] Estimated by Statistics New Zealand based on assumptions specified by Ministry of Health

[2] HBDHB share has increased from 3.89% in 2014/15.

[3] DHB performance objectives are specified in section 22 of the NZPHD Act.

Because population numbers are too small to justify a full range of service provision in every district, each DHB is also part of a regional grouping that is coordinated to optimise service delivery. HBDHB is part of the Central Region along with Whanganui, Mid-Central (Manawatu), Capital and Coast (Wellington & Kapiti), Hutt Valley and Wairarapa DHBs. There are approximately 884,000 people living in the Central Region - around 19% of the total New Zealand population.

Despite this larger grouping, a small number of specialised services cannot be efficiently provided even at the regional level and these are, therefore, arranged as national services located at one or two provider hospitals for the whole of New Zealand. Examples are clinical genetics and paediatric cardiology. These services are planned and funded centrally by the National Health Board with all DHBs having access.

Organisational Overview

HBDHB has ...

- 267 doctors
- 1,419 nurses
- 531 allied health professionals
- A 400-bed secondary hospital
- An 11-bed rural hospital
- 2 community health centres

With over 2,800 employees, HBDHB is the district's largest employer. Our provider arm is known as Health Services and our frontline services are delivered to patients and consumers across the district in a number of settings. For example, we provide public health programmes in schools and community centres, inpatient and outpatient services in leased and owned health facilities, and mobile nursing services in people's homes. The main health facilities include Hawke's Bay Hospital, (Hastings Memorial), Wairoa Hospital and Health Centre, Napier Health Centre and Central Hawke's Bay Health Centre. In addition, we have significant investment in clinical equipment, information technology and other (non-clinical) moveable assets.
Corporate and clinical support services are located appropriately to provide effective back-up to our frontline services.

Our organisation is governed by a Board with eleven members, seven of whom are elected every three years (last election in 2013) and four of whom are appointed by the Minister of Health. The Board is advised by four committees that include clinical, community and consumer representation. The Board employs the Chief Executive Officer to lead an executive management team, who oversee the day-to-day operations of the organisation.

Our population

In 2015/16, the Hawke's Bay district population will grow slightly to over 159,000 people. Most of our population live in Napier or Hastings - two cities located within 20 kilometres of each other that together account for more than 80% of the total numbers. About 10% of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 10% live in rural and remote locations.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (25% *vs* 16%), more people aged over 65 years (18% *vs* 15%) and more people living in areas with relatively high material deprivation (27% *vs* 20%). The 2013 New Zealand Index of Deprivation (NZDep13)[4] explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms of people's opportunity to access and use the health system.

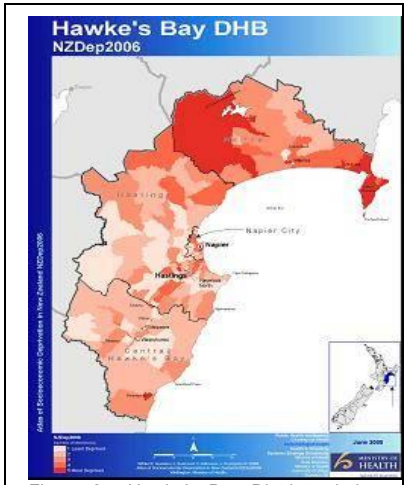

Figure 2: Hawke's Bay District relative deprivation

[4] NZDep2013 is a measure of the average level of deprivation of people living in an area at a particular point in time relative to the whole of New Zealand. The 2013 index was based on nine variables: - 2 related to income plus home ownership, family support, employment status, qualifications, living space, communications, transport. Result quoted is based on mesh-block data.

Figure 2, shows the pattern across Hawke's Bay DHB according to NZDep2006 – this is not expected to be markedly different to NZDep2013.

Health Status

In 2014 we produced an analysis and report on health status in Hawke's Bay[5]. The focus of the report was on equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

The report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifika and people living in more-deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

Key findings:

- More deaths at younger ages. More Māori, more Pasifika and more people living in the most deprived parts of Hawke's Bay are dying at younger ages
- Socioeconomic conditions. Social inequity in Hawke's Bay is widening. The health impacts on children are more immediate and rates of admission to hospital for 0-14 year olds for conditions known to be strongly linked to social conditions are increasing, particularly for Pasifika and Māori children
- Tobacco use. The leading cause of avoidable deaths amongst Māori women is now lung cancer. High smoking rates amongst pregnant Māori women is a significant health issue.
- Obesity. One in three adults in Hawke's Bay is obese. Hawke's Bay men and women are less active in all age groups than their New Zealand average counterparts
- Alcohol use. One in every four adults in Hawke's Bay is likely to be harming their own health or causing harm to others through their alcohol use.
- Access to primary care. High self-reported unmet need and higher rates of avoidable hospital admissions, especially amongst 45-64 year olds, show that there continue to be access issues to primary care.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been presented to a range of groups and organisations - the DHB and PHO Boards and staff, local government bodies, Ministry of Social Development, the National Health Committee, Māori providers, clinicians, etc. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum[6] taking a role in putting together an action plan, with nominated sector leads, to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

The full Health Equity Report can be accessed from our website: www.hawkesbay.health.nz. Health status reviews rely on up-to-date population information and HBDHB conducts periodic updates with full reviews following the release of Census data. The next full review is likely to be conducted following the 2018 Census.

[5] Health Equity in Hawke's Bay, Hawke's Bay District Health Board. 2014. Available from www.Hawke'sbay.health.nz

[6] Includes Mayors, Members of Parliament, Iwi, Local and Regional Councils, Business HB, EIT, Government agencies – Housing NZ; Police, Corrections, Ministry of Social Development, Ministry of Education, Te Puni Kokiri, DHB

1.3 STRATEGIC INTENTIONS

Integrating the funding and provision of health and disability services across national, regional and local levels necessitates alignment of strategic direction in the same manner.

National

The driving goals for Government and the State Sector are that New Zealanders have greater opportunities, enjoy greater security, and experience greater prosperity. The health system contributes to these goals by working towards New Zealanders living longer, healthier and more independent lives, and by supporting New Zealand's economic growth.

Government's priorities for the health system are communicated to all DHBs through the Minister of Health's annual "Letter of Expectations"[7]. For 2015/16 the Government's investment of an extra $3.8 billion in health since 2008/09 is highlighted alongside a requirement that DHBs operate within allocated funding and drive efficiency in back-office processes and collaboration national, regional and sub-regional levels. Fostering strong clinical leadership remains a focus for DHB as well as continuing to focus on integration between primary and secondary care. There is an ongoing focus on the national health targets and the Better Public Services initiatives along with a new emphasis on tackling the drivers of morbidity with particular reference to what DHBs can do to help reduce the incidence of obesity in New Zealand. In an effort to focus DHBs on strategic direction, the Minister has promised the sector an update and refresh of the New Zealand Health Strategy while requiring all DHBs to submit refreshed Statements of Intent.

Regional:

A Regional Services Plan (RSP)[8] has been developed by the six central region DHBs to provide an overall framework for future planning around optimum arrangements and regionalisation. In the short-term, the RSP focuses on short to medium-term coordination of regional programmes, integration of vulnerable services and financial sustainability.

Local

In 2013, we published Transform & Sustain[9], our strategic plan for 2014 – 2018. Transform & Sustain provides common understanding of our direction and began with sector-wide agreement on a common vision:

"Excellent health services working in partnership
to improve the health and well-being of our people
and to reduce health inequities within our community."

Underpinning that vision are values, principles, aims, goals and strategies that are summarised in Appendix 1.

The logic that links the impact of our work locally to local, regional and national strategic intentions is shown in Figure 3 below.

[7] Minister of Health's Letter of Expectations, December 17th 2014.

[8] Regional Services Plan 2015-2016, Central Region District Health Boards, 2015. Available from www.centraltas.co.nz

[9] Available from our website: www.hawkebay.health.nz

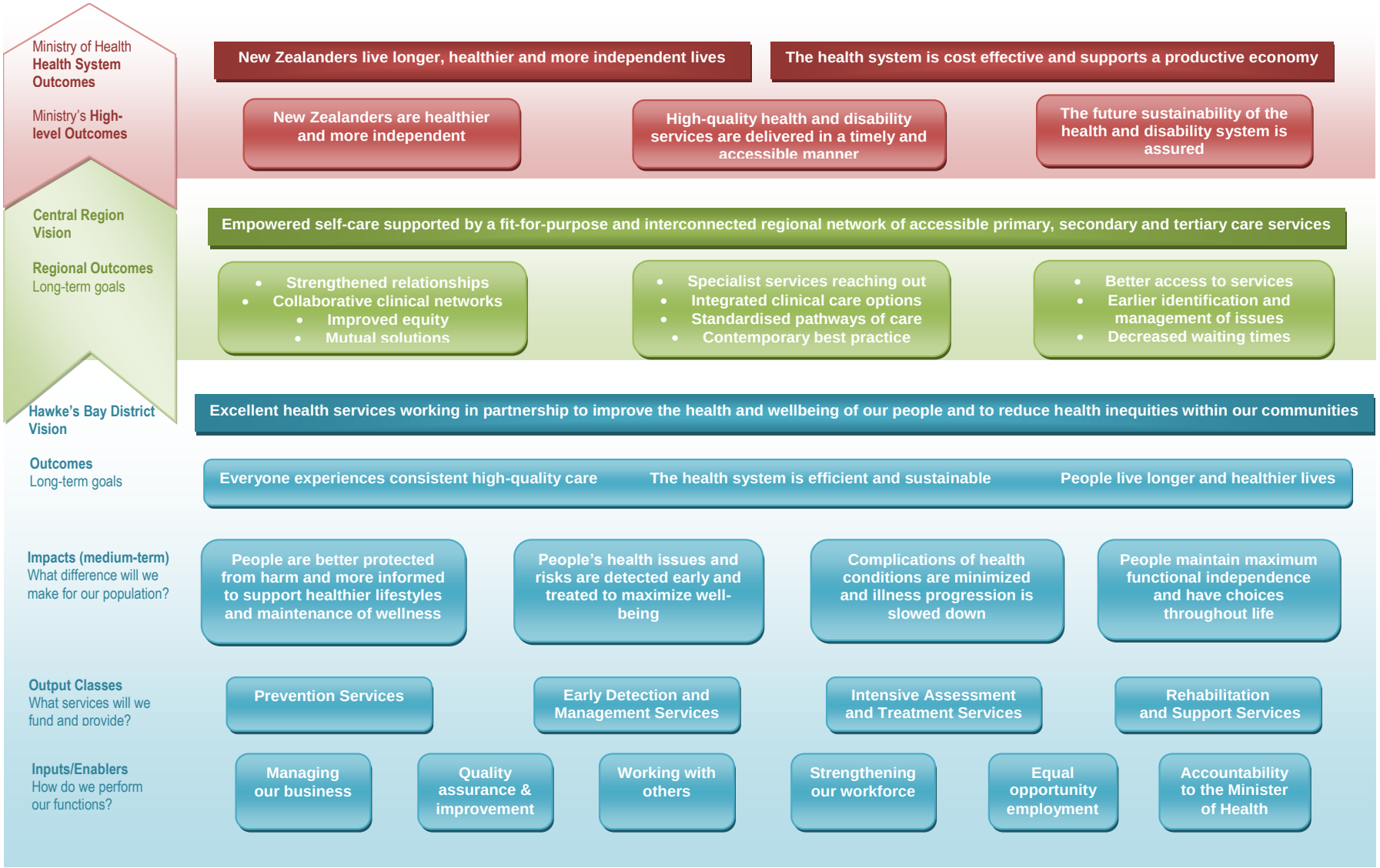

Figure 3: Connecting local activity to local, regional and national objectives

Despite the significant progress made in the recent past, our vision will remain a series of words unless we deal with the more challenging issues, such as the growth in chronic illness, our ageing population and vulnerability in a large sector of our community.

Our Challenges

Locally, our population profile is changing. Despite population growth[10] being modest, at about 2.7% in the next 10 years, we will see significant changes in age groups. In our population the over 65s will grow by 16% and the over 85s will increase by 12%. The same age group of Māori and Pasifika people will grow even faster at 51% and 106% respectively.

MĀORI & PASIFIKA	2016	2025	Growth
0-14	15,770	16,450	4.3%
15-64	28,220	30,790	9.1%
65yrs +	3,010	4,550	51.2%
85 yrs +	160	330	106.3%

Growth in the population is being driven by a younger age profile in the Māori and Pasifika population, which results in a higher birth rate, plus increased life expectancy across our whole population.

TOTAL	2016	2025	Growth
0-14	34,150	33,170	-2.9%
15-64	97,960	96,070	-1.9%
65yrs +	29,190	33,960	16.3%
85 yrs +	3,480	3,930	12.9%

[10] Statistics New Zealand, Projections prepared for Ministry of Health, October 2014.

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues.

Risk and Opportunity

The health of our population can be described using the diagram in Figure 3, where everyone in the population fits within one of these categories. Our focus will be to keep people healthy, to stay well and to require less hospital care.

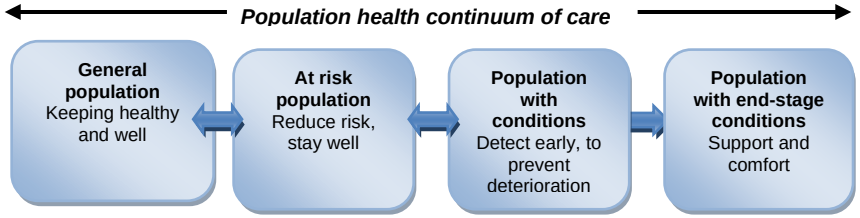

Figure 4 - Population Health Continuum of Care

An increasing burden of long-term conditions is a worldwide issue as modern medicine reduces early death. This is particularly so in places with demographics like Hawke's Bay – an ageing population with areas of significant deprivation and vulnerability. New Zealand research shows that, generally, Māori develop ageing conditions about 10 years younger than non-Māori.

Therefore, due to age-related and other long-term conditions, we need to concentrate on three main themes:

1. Helping people to stay healthy and well and able to live independently in their own home for longer
2. Ensuring that people who have complex long-term illnesses are able to live to their full potential

3. Supporting frail elderly people and their families/whānau.so that they can put in place a better plan for how they want to be cared for as the end of their life approaches (advance care planning).

This needs to be done in an integrated and coordinated way, meaning that all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required. At the same time, by better understanding the changing needs and challenges of our ageing population and their inevitable frailty and dependency towards the end of a long life, we need to put in place better services designed to support the elderly and the changing needs of our population.

We can summarise these challenges into three priority goals:

1. Responding to our population
2. Delivering consistent high-quality health care
3. Being more efficient at what we do.

At the same time it is imperative that we remain financially robust so we are in a position to invest in programmes that will deliver transformational change.

Our Strategic Response

Considering the duties placed on us by the Treaty of Waitangi, the NZPHD Act and the national, regional and local context outlined above, HBDHB will prioritise our funding and provision of health and disability services based on our three priority goals.

Priority Goal 1: Responding to our Population

We have been too focused on the hospital when we could have been taking health services into the community. We have made progress in recent years but it has been slow, and there is still too much focus on meeting demand through secondary (hospital-based) care. We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting.

Barriers to accessing health care can occur for a number of reasons. For example, a person may be unable to get an appointment soon enough, may not have enough money to pay for an appointment at a medical centre or may not have the transport to get there. Often the services appear to be designed to suit the needs of professionals rather than patients. Our health workforce needs to have a good understanding of the people they serve; we need to have a stronger engagement with consumers. In particular, there are two main areas where we need to focus our attention.

Firstly, we must take action in regards to how we respond to the changing needs of our ageing population. We will focus on three responses:

- Recognising that many older people are well, we will develop opportunities for them to contribute valuable consumer support and advice to the care system
- We will provide care for our older people in their community with a clear intent to implement key care pathways and integrate service provision across primary and secondary settings
- Aiming to begin earlier conversations about care towards the end of life, we will lead open and honest conversations with people and whānau about decisions that affect them. By doing so, we will get a better understanding of what matters to the person and their whānau during this time and will be able to focus on supportive care that is the most appropriate for them.

Secondly, the growing Māori and Pasifika population and the persistent inequities that we see in terms of their health outcomes, means that we have to find better ways of engaging with whānau and aiga. We will:

- Create better working relationships that influence Māori and Pasifika health and well-being, acknowledging the formal and informal roles that community-based entities can bring to a partnership. These include iwi, hapū, Treaty settlement entities, Māori providers, individual marae, Pasifika community churches and key Government agencies
- Provide good cultural responsiveness training based on advice and support from experts in Māori and Pasifika cultural practices. We will

ensure that the health system workforce is well prepared and responsive and that resource allocation and service monitoring are informed through effective engagement, especially with Māori

- Work towards having a workforce that is more representative of our community. We have targeted a 10% year-on-year increase in the proportion of Māori staff employed and will focus on culturally appropriate recruitment across the system.

Priority Goal 2: Delivering Consistent High Quality Care

We generally deliver care to a high standard and we have seen some significant improvements in recent years. However, there are still too many examples where patient experience is inadequate and where mistakes that cause harm are made. Delivering high-quality care is about making sure we use all our resources in the best way, with the patients and their family/ whānau at the centre of that care. The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible and without error or undue waiting. Every staff member should be aware of their own responsibilities in quality improvement and safety when delivering day-to-day care. Clinicians are not only responsible for the provision of high-quality patient care, their leadership is also important. Clinical participation in the leadership and governance of health services is essential for creating a culture of effective quality and safety.

Priority Goal 3: Being More Efficient at What We Do

The future will not look the same as the present and that future will require different ways of working to deliver more productive services. Reducing waste in health will make us more efficient and will ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time. The current systems do not effectively incentivise health providers to be responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.

We know that the whole public sector in New Zealand is facing a reduced growth in funding while, at the same time, the health system must deal with increasing expectations and changing needs. Transformation will rely on better understanding of value, smarter use of resources and frank communication among all stakeholders – this includes a clear responsibility on the population to take care of themselves (where they are able), and on providers to respond to reasonable expectations and true needs.

Achieving Regular Financial Surpluses

The DHB is responsible for most of the Government's spending on health in Hawke's Bay – surpluses are planned and must be delivered according to statutory obligations. This will allow us to invest in our infrastructure and services. Over the past four years, through hard work and good management, we have managed to generate an additional investment in our infrastructure with $34 million capital investment planned over the next three years.

Where to Next?

We are stepping up to deliver on our vision through Transform and Sustain. We must continue to recognise and research our population needs, work in partnership for quality health care and become more efficient at what we do. Transformation is happening and remains necessary to move forward in these areas.

The most effective way we can respond to these challenges is by transforming our services by improving quality. Transformation must lead to increased effectiveness – a more efficient system that maximises value for the population and reduces waste.

Financial sustainability is more likely to follow from an effective transformational change programme, where we work with our community so that our services meet their needs. Over time, through that transformation, achieving financial surplus will become business as usual.

How we will Assess Performance

The National Health Board monitors DHB performance on behalf of the Minister of Health. Financial and non-financial performance frameworks are in place as part of wider accountability arrangements providing assurance to the Minister about DHB performance in terms of the legislative requirements and Government priorities. In addition, HBHDB has implemented a performance monitoring process that is closely aligned to the national frameworks and that is used to generate a monthly report so that our Board can assess and query progress against performance objectives set out in our Annual Plan and Statement of Performance Expectations.

Measuring Progress towards Our Vision

We have developed the Hawke's Bay Health Sector performance and reporting framework to measure progress on Transform and Sustain and to show our stakeholders how that will lead us towards our vision. We also align our work to the New Zealand Triple Aim[11] for quality and safety outcomes which will mean:

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Better value for public health systems

The first part of our vision refers to how the system delivers health care:
"Excellent health services working in partnership…"

The second part captures the purpose of our work as:
"… to improve the health and well-being of our people and to reduce health inequities within our community.

Figure 4 below is the Hawke's Bay Health Sector Performance Framework. Our "Vital Signs" represent the outcomes that we expect to see improving over the longer term. We measure the intended outcomes of our work as changes over time and we recognise that the health sector is not solely responsible for achieving them. However, they are all measurable and are aligned to Transform and Sustain objectives as well as NZ Triple Aim dimensions of quality improvement.

Beneath the "Vital Signs" we have a suite of indicators that make up "Supporting Dimensions" – these show the impact of health sector work contributing to the outcomes that we seek.

Appendix 1 contains a matrix of the measures that will be used over time to monitor and report on progress against this framework.

Our outcomes have been modified since our last Statement of Intent. These outcomes are more aligned to other sector frameworks and are consistent with the purposes of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

[11] The New Zealand Triple Aim is adapted from the Triple Aim developed by the Institute for Healthcare Improvement, Cambridge, USA. Details available from www.hqsc.govt.nz.

MEASURING OUR VISION

OURHEALTH HAWKE'S BAY Whakawateatia

HEALTHY HAWKE'S BAY

Excellent health services working in partnership to improve the health and well-being of our people and reduce health inequities within our community

NZ TRIPLE AIM

- Improved quality and safety of care
- Best value for public health system resources
- Improved health and equity for all populations

TRANSFORM & SUSTAIN

- Delivering consistent high-quality health care
- **Being more efficient** at what we do
- Responding to our population

VITAL SIGNS

- Patient experience
- Resource sustainability
- Live healthier and longer

SUPPORTING DIMENSIONS

- Better access to specialist outpatients
- A safer hospital
- Higher-quality general practices
- More older people living independently
- Improved hospital workforce productivity
- Better **staff** engagement
- Reduced infant mortality
- Fewer premature deaths
- Healthier weight
- Reduced readmissions
- A culturally responsive workforce
- More accessible general practice
- Better infrastructure **efficiency**
- Better **staff** retention
- Care closer to home
- More heart and diabetes checks
- Faster cancer treatment
- Fewer women smoking in pregnancy

Figure 4: The Hawke's Bay Health Sector Performance Framework

HAWKE'S BAY
District Health Board
Whakawāteatia

STATEMENT OF PERFORMANCE EXPECTATIONS 2015/16

2. STATEMENT OF PERFORMANCE EXPECTATIONS

This section includes information about the measures and standards against which Hawke's Bay District Health Board (HBDHB) service performance will be assessed. For the purpose of our Statement Performance Expectations (SPE), our services are grouped into four reportable Output Classes: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and, Rehabilitation and Support Services.

The SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) along with each performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

Explaining the contribution that our services make towards achieving the population and system level outcomes and impacts outlined in our Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

FIGURE 2: THE NEW ZEALAND TRIPLE AIM

The system dimension: Best value for public health system resources

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.

The population dimension: Improved health and equity for all populations

Services may target the whole population or specified sub-populations. In either case we select measures that apply to the relevant group. These measures usually refer to rates of coverage or proportions of targeted populations who are served and are indicative or responsiveness to need.

The individual dimension: Improved quality, safety and experience of care

Ensuring quality and safety, within hospitals and wider health services, is a fundamental responsibility of DHBs. Measurements in this dimension indicate how well the system responds to expected standards and contributes to patient and consumer satisfaction.

Note: all targets are an annual target or, where monitored quarterly, show the expected performance by the end of quarter four. Targets are set at the total population level and monitored, where appropriate, across different population groups to gauge the equity of results. A detailed technical description of each indicator is available in a data dictionary maintained by our information services.

The HBDHB Statement of Performance Expectations for the 2015/16 year follows:

X _____
Board Member

X _____
Board Member

2.1 OUTPUT CLASS 1 – PREVENTION SERVICES

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.

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

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.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 5.

Prevention Services	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	11.4	6.1	10.0	6.5	6.9	7.3
Other sources	0.4	0.4	0.1	0.1	0.1	0.1
Income by source	**11.8**	**6.5**	**10.1**	**6.6**	**7.0**	**7.4**
Less:						
Personnel	1.3	1.4	1.4	1.5	1.5	1.5
Clinical supplies	0.1	0.1	0.1	-	-	-
Infrastructure and non clinical supplies	0.3	0.3	0.3	0.3	0.3	0.3
Payments to other providers	8.3	8.2	8.3	8.7	9.1	9.3
Expenditure by type	**10.0**	**10.0**	**10.1**	**10.5**	**10.9**	**11.1**
Net Result	**1.8**	**(3.5)**	**-**	**(3.9)**	**(3.9)**	**(3.7)**

Figure 5 - Funding and Expenditure for Output Class 1: Prevention Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
More smokers are given help and advice to quit	***Health Target: Better help for smokers to quit*** ➢ *% hospitalised smokers offered advice to quit* ➢ *% of PHO enrolled smokers offered advice to quit* ➢ *% of pregnant women offered advice and support to quit*	 98.2%[12] 96.0%[12] 98.1%[12]	 ≥95% ≥90% ≥90%	 95% 89%
Fewer pregnant women are smokers	• *% of pregnant Māori women that are smokefree at 2 weeks postnatal*	58%	≥86%	65%
More children are immunised	***Health Target: Increased immunisation*** • *% of 8 month olds who complete their primary course of Immunisations* • *% of 2 year olds fully immunised* • *% of 4 year olds fully immunised by age 5*	 96.0%[12] 94.4%[12] 90.6%[12]	 ≥95% ≥95% ≥95%	 94%
More girls receive all three HPV immunisations	• *% of girls that have received HPV dose three*	NEW	≥65%	
The impact of rheumatic fever is reduced	• *Rheumatic fever hospitalisation rate per 100,000*	2.6	≤1.9	
More vulnerable elderly receive influenza vaccinations	• *% of high needs 65 years olds and over influenza immunisation rate*	67.9%[13]	≥75%	
More women are screened for cancer	• *% of women aged 50-69 years receiving breast screening in the last 2 years* • *% of women aged 25-69 years receiving cervical screening in the last 3 years*	75.8%[14] 76.9%[15]	≥70% ≥80%	
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	• *Rate of SUDI deaths per 1,000 live births*	1.37	≤0.5	0.9
Better rates of breastfeeding	• *Infants are exclusively or fully breastfed* ➢ *at 6 weeks of age* ➢ *at 3 months of age* • *Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)*	 68%[16] 52%[16] 58%[16]	 ≥75% ≥60% ≥65%	 75% 55% 66%
Delay conception in early teenage years	• *% of youth accessing CPO sexual health service who are Māori*	NEW	>50%	

[12] Oct-Dec 2014
[13] Jan-Dec 2014
[14] 24 months to Dec 2014
[15] 3 years to Dec 2014
[16] 6 months to Dec 2014

2.2 OUTPUT CLASS 2 – EARLY DETECTION AND MANAGEMENT SERVICES

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.

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

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.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 6.

Early Detection and Management	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	86.5	90.1	92.7	94.7	99.4	103.0
Other District Health Boards	2.8	2.9	2.8	2.8	2.9	2.9
Other sources	4.5	4.0	3.4	3.4	3.5	3.6
Income by source	**93.8**	**97.0**	**98.9**	**100.9**	**105.8**	**109.5**
Less:						
Personnel	5.1	5.3	5.6	5.7	5.8	5.9
Outsourced services	0.1	0.1	-	-	-	-
Clinical supplies	0.5	0.4	0.5	0.4	0.4	0.4
Infrastructure and non clinical supplies	1.4	1.4	1.4	1.5	1.5	1.5
Payments to other District Health Boards	2.4	2.6	2.5	2.5	2.5	2.6
Payments to other providers	81.9	86.5	88.3	92.4	96.2	98.9
Expenditure by type	**91.4**	**96.3**	**98.3**	**102.5**	**106.4**	**109.3**
Net Result	**2.4**	**0.7**	**0.6**	**(1.6)**	**(0.6)**	**0.2**

Figure 6 –Funding and Expenditure for Output Class 2: Early Detection and Management Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
More enrolment with primary care	• Proportion of the population enrolled in the PHO	97.3%[17]	≥97%	
More pregnant women under the care of a Lead Maternity Carer (LMC)	• % of women booked with an LMC by week 12 of their pregnancy	51.4%[18]	≥80%	
Hospital service users are reconnected with primary care	• Rate of high intensive users of hospital ED as a proportion of Total ED visits	5.5%[19]	≤5.4%	
More checks for people at risk of long-term conditions	***Health Target: More heart and diabetes checks*** • % of the eligible population having had a CVD risk assessment in the last 5 years	87.7%[20]	≥90 %	87%
Better oral health	• % of eligible pre-school enrolments in DHB-funded oral health services • % of enrolled preschool and primary school children not examined according to planned recall • % of adolescents using DHB-funded dental services • % of children without decay at 5 years of age • Mean 'decayed, missing or filled teeth' score at Year 8	73.9%[21] 4.0%[21] 84.5%[21] 56.5%[21] 1.08[21]	≥90% ≤5% ≥85% ≥66% ≤0.87	73% 57%
Improved management of long-term conditions	• *Proportion of people with diabetes who have good or acceptable glycaemic control*	49.2%[22]	≥55%	
Less waiting for diagnostic services	• *% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days* • % of accepted referrals for MRI scans who receive their scans within 6 weeks	92.6%[23] 61.3%[23]	*≥95%* *≥85%*	
Avoidable hospitalisation is reduced	• *Ambulatory sensitive hospitalisation rate 0-4 years* • *Ambulatory sensitive hospitalisation rate 45-64 years*	TBC TBC	TBA TBA	
More pre-schoolers receive Before School Checks	• *% of 4-year olds that receive a B4 School Check*	81%[24]	≥90%	91%

[17] Mar 2015
[18] Jul-Sep 2014
[19] Dec 2014
[20] 5 Years to Dec 2014
[21] 2014 Calendar Year
[22] 12 months to Dec 2014
[23] Dec 2014
[24] Apr 2015

2.3 OUTPUT CLASS 3 – INTENSIVE ASSESSMENT AND TREATMENT SERVICES

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 and Acute services (including outpatients, inpatients, surgical and medical 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.

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 7.

Intensive Assessment and Treatment	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	295.1	303.3	313.8	319.5	322.6	325.5
Other District Health Boards	5.8	6.1	5.7	5.9	5.9	6.1
Other sources	10.1	10.0	9.5	9.6	9.7	9.8
Income by source	**311.0**	**319.4**	**329.0**	**335.0**	**338.2**	**341.4**
Less:						
Personnel	158.7	165.1	175.1	180.3	183.2	186.2
Outsourced services	15.7	13.1	10.6	11.0	11.2	11.3
Clinical supplies	43.3	39.9	42.1	35.5	33.3	34.1
Infrastructure and non clinical supplies	40.5	40.2	38.3	40.2	43.4	43.5
Payments to other District Health Boards	43.9	47.4	45.8	46.1	46.4	46.6
Payments to other providers	11.9	10.9	14.2	14.8	15.3	15.8
Expenditure by type	**314.0**	**316.6**	**326.1**	**327.9**	**332.8**	**337.5**
Net Result	**(3.0)**	**2.8**	**2.9**	**7.1**	**5.4**	**3.9**

Figure 7 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
Less waiting for ED treatment	***Health Target: Shorter stays in EDs*** • *% of patients admitted, discharged or transferred from an ED within 6 hours*	91.5%[25]	≥95%	94%
Faster cancer treatment	***Health Target): Faster Cancer Treatment*** • *% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks*	61.5%[25]	≥85%	66%
More elective surgery	***Health Target: Improved access to elective surgery*** • *Number of elective surgery discharges[26]*	6,103[27]	≥7,109	
Better long-term conditions management	• *Acute coronary syndrome* ➢ *% high-risk patients receiving an angiogram within 3 days* ➢ *% of angiography patients whose data is recorded on national databases* • *Stroke* ➢ *% of potentially eligible patients who are thrombolysed* ➢ *% of patients admitted to the demonstrated stroke pathway*	 50.7%[28] 12.3%[28] 6%[28] 82.1%[28]	 ≥70% ≥95% ≥6% ≥80%	
Equitable access to surgery	• *Standardised intervention rates for surgery (per 10,000 population)* ➢ *Major joint replacement* ➢ *Cataract procedures* ➢ *Cardiac surgery* ➢ *Percutaneous revascularisation* ➢ *Coronary angiography*	 21.3[29] 52.1[29] 5.7[29] 10.9[29] 36.2[29]	 ≥21.0 ≥27.0 ≥6.5 ≥12.5 ≥34.7	

[25] Oct-Dec 2014
[26] Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.
[27] 12 months to Jun 2014
[28] Oct-Dec 2014
[29] 12 months to Dec 2014

Shorter stays in hospital	• *Average length of stay (days)* ➢ *Elective* ➢ *Acute*	 1.74[30] 2.79[30]	 1.59 2.79	 1.67 2.64
Fewer readmissions	• *Acute readmissions to hospital*	7.6%	Reduce	7.8%
Quicker access to diagnostics	• *% coronary angiography completed within 90 days* • *Diagnostic colonoscopy* ➢ *% urgent cases performed within 14 days* ➢ *% diagnostic cases performed within 42 days* • *Surveillance colonoscopy* ➢ *% waiting less than 84 days beyond planned date*	89.8%[31] 92.6%[31] 39.7%[31] 50.7%[31]	≥95% ≥75% ≥65% ≥65%	
Fewer missed outpatient appointments	• *Did not attend (DNA) rate across first specialist assessments*	7.2%[32]	≤7.5%	
Better mental health services ➢ Improving access	***Better access to mental health and addiction services*** • *Proportion of the population seen by mental health and addiction services* ➢ *Child & youth (0-19)* ➢ *Adult (20-64)* ➢ *Older adult (65+)*	 4.1%[33] 5.1%[33] 1.15%[33]	 ≥4% ≥5% ≥1.15	
➢ Reducing waiting times	***Shorter waits for non-urgent mental health and addiction services for 0-19 year olds*** • *% of people seen within 3 weeks of referral* ➢ *Mental Health Provider Arm* ➢ *Addictions (Provider Arm and NGO)* • *% of people seen within 8 weeks of referral* ➢ *Mental Health Provider Arm* ➢ *Addictions (Provider Arm and NGO)*	 56.7[33] 88.3%[33] 82.0[33] 96.1%[33]	 ≥80% ≥80% ≥95% ≥95%	
➢ Improving access and coordination	***Improving mental health services using discharge planning*** • *% children and youth with a transition (discharge) plan*	 24.0%[34]	 ≥95%	
➢ Increasing consumer focus	***More equitable use of Mental Health Act: Section 29 community treatment orders*** • *Rate of s29 orders per 100,000 population*	 81.5%[34]	 ≥80%	

[30] 12 months to Sep 2014
[31] Dec 2014
[32] Oct-Dec 2014
[33] 12 months to Sep 2014
[34] Oct-Dec 2014

2.4 OUTPUT CLASS 4 – REHABILITATION AND SUPPORT SERVICES

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.

Objective: People maintain maximum functional independence and have choices throughout life.

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.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 8.

Rehabilitation and Support	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	66.1	68.0	69.1	74.0	77.2	79.7
Other District Health Boards	3.0	3.1	3.0	3.0	3.1	3.1
Other sources	0.4	0.4	0.3	0.3	0.3	0.3
Income by source	**69.5**	**71.5**	**72.4**	**77.3**	**80.6**	**83.1**
Less:						
Personnel	5.7	6.0	6.3	6.5	6.6	6.7
Outsourced services	0.1	0.1	0.1	0.1	0.1	0.1
Clinical supplies	0.7	0.7	0.7	0.6	0.6	0.6
Infrastructure and non clinical supplies	1.7	1.7	1.7	1.8	1.8	1.9
Payments to other District Health Boards	3.7	4.0	3.9	3.9	3.9	3.9
Payments to other providers	55.6	56.0	59.2	62.0	64.5	66.3
Expenditure by type	**67.5**	**68.5**	**71.9**	**74.9**	**77.5**	**79.5**
Net Result	**2.0**	**3.0**	**0.5**	**2.4**	**3.1**	**3.6**

Figure 8 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
Better access to acute care for older people	• *Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)* ➢ *75-79 years* ➢ *80-84 years* ➢ *85+ years* • *Acute readmission rate: 75 years +*	 139.5[35] 183.1[35] 254[35] 10.9[36]	 ≤139.5 ≤183.1 ≤231.0 <10%	 10.7%
Better community support for older people	• *% of people receiving home support who have a comprehensive clinical assessment and a completed care plan*	100%[36]	≥95%	
Increased capacity and efficiency in needs assessment and service coordination services	• *Average time from assessment to coordination (65 years and over)* • *Number of needs assessments completed (Disability services)* • *Average time from referral to assessment (Disability services)*	7.3 days[37] 618[37] 6.5 days[37]	<7.3 days >600 <10 days	
Prompt response to palliative care referrals	• *Time from referral receipt to initial Cranford Hospice contact within 48 hours*	92.0%[35]	>80%	
More day services	• *Number of day services*	20,754[36]	≥21,791	
More older patients receive falls risk assessment and care plan	• *% of older patients given a falls risk assessment* • *% of older patients assessed as at risk of falling receive an individualised care plan*	91.8%[35] 76.0%[35]	90% 98%	

[35] Oct to Dec 2014
[36] 12 months to Sep 2014
[37] Dec 2014

3. FINANCIAL PERFORMANCE

The MoH reports consolidated DHB sector financial information to Treasury for incorporation into the Financial Statements of the Crown. These financial statements are published and inform Ministers, Members of Parliament, the financial markets and the public of how the Government is tracking financially compared with its forecasts. Planning regulations require the DHB's Annual Plan to contain detailed financial budgets, and information on how the DHB's performance both as a funder and as a provider of services will be demonstrated. HBDHB monthly financial reporting to the Board complies with these requirements and the Finance, Risk and Audit Committee (FRAC) advises the Board on any emergent issues. This module contains audited financial statements for the 2013/14 financial year, forecast financial statements for 2014/15, and projected financial statements for the 2015 to 2019 period. Separate financial performance statements for the funding of services, providing of services, and governance and funding administration are also included for each of these periods. Performance against the 2015/16 financial year projections will be reported in the 2015/16 Annual Report.

3.1 PROJECTED FINANCIAL STATEMENTS

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $3.99 million in each of the plan years. This is consistent with the DHB's recent track record, and enables us to fund a proportionate capital programme, including in the plan period the completion of major mental health, maternity, endoscopy and renal facilities associated with service redesign.

The financial numbers are also consistent with the DHB's "Transform and Sustain" strategy. Resource deployment and assumed efficiencies are focussed on our three strategic challenges: responding to our population and patients; systematically ensuring quality in all of our services; and increasing our productivity.

Projected Financial Statements

Reporting entity

The financial statements of the DHB comprise the DHB, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The DHB has no subsidiaries.

Cautionary Note

The prospective financial information presented in this section is based on one or more hypothetical but realistic assumptions that reflect possible courses of action for the reported periods concerned, as at the date the information was prepared. Actual results achieved for the period covered are likely to vary from the information presented, and the variations may be material.

The underlying assumptions were adopted on 28 May 2015.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP) that applies for periods beginning on or after 1 July 2014. They comply with Public Benefit Entity Standards (PBE Standards) issued by the New Zealand Accounting Standards Board (NZASB) of the External Reporting Board (XRB). The forecast financial statements have been prepared on a consistent basis.

The DHB prepared its financial statements for the year ended 30 June 2014 in accordance with NZ GAAP that applied at that time. They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other financial reporting standards, as appropriate for public benefit entities.

The terminology used in the financial statements is that of the PBE Standards.

The accounting policies applied in the projected financial statements are included as Appendix 2.

Projected Statement of Comprehensive Revenue and Expense

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Ministry of Health - devolved funding	446,490	454,030	481,942	490,978	502,232	511,629
Ministry of Health - non devolved contracts	12,646	13,541	3,700	3,758	3,818	3,878
Other District Health Boards	11,613	12,078	11,548	11,724	11,903	12,085
Other government and Crown agency sourced	6,375	6,661	6,578	6,682	6,787	6,894
Patient and consumer sourced	1,718	1,471	1,479	1,502	1,526	1,550
Other	7,355	6,667	5,166	5,226	5,308	5,393
Operating income	486,197	494,448	510,414	519,870	531,574	541,429
Employee benefit costs	170,779	177,815	188,426	194,000	197,094	200,259
Outsourced services	15,925	13,308	10,654	11,141	11,252	11,364
Clinical supplies	44,641	41,109	43,432	36,463	34,272	35,137
Infrastructure and non clinical supplies	43,872	43,585	41,717	43,917	47,056	47,287
Payments to non-health board providers	207,758	215,630	222,194	230,359	237,910	243,392
Operating expenditure	482,975	491,448	506,424	515,880	527,584	537,439
Surplus for the period	3,222	3,000	3,990	3,990	3,990	3,990
Revaluation of land and buildings	-	41,232	-	-	-	-
Other comprehensive income for the period	-	41,232	-	-	-	-
Total comprehensive income for the period	**3,222**	**44,232**	**3,990**	**3,990**	**3,990**	**3,990**

Table 1 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Changes in Net Assets/Equity

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Equity as at 1 July	**46,277**	**49,142**	**93,017**	**96,650**	**100,283**	**103,916**
Total comprehensive income for the period:						
Funding of health and disability services	11,165	2,947	3,990	3,990	3,990	3,990
Governance and funding administration	120	139	-	0	0	0
Provision of health services	(8,062)	(86)	-	-	-	-
Revaluation of land and buildings	-	41,232	-	-	-	-
	3,222	44,232	3,990	3,990	3,990	3,990
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	**49,142**	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**

Table 2 - Projected Statement of Comprehensive Revenue and Expense and Projected Statement of Changes in Net Assets/Equity

Projected Statement of Financial Position

in thousands of New Zealand Dollars

As at 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Equity						
Paid in equity	37,586	37,229	36,871	36,515	36,158	35,801
Asset revaluation reserve	31,744	72,976	72,976	72,976	72,976	72,976
Asset replacement reserve	14,437	15,627	-	-	-	-
Accumulated deficit	(34,625)	(32,815)	(13,198)	(9,208)	(5,218)	(1,228)
	49,141	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**
Represented by:						
Current assets						
Cash	8	7	7	7	7	7
Short term investments	17,000	7,474	10,469	4,667	7,655	16,041
Short term investments (special funds/clinical trials)	3,064	3,172	3,172	3,173	3,173	3,173
Receivables and prepayments	17,516	17,774	18,133	18,502	18,885	19,262
Loans (Hawke's Bay Helicopter Rescue Trust)	11	12	13	13	14	15
Inventories	3,713	3,768	3,845	3,922	4,003	4,083
Assets classified as held for sale	1,744	1,275	-	-	-	-
	43,056	33,482	35,639	30,284	33,737	42,581
Non current assets						
Property, plant and equipment	110,389	160,830	165,876	175,584	178,648	176,730
Intangible assets	3,757	3,870	4,721	5,739	5,881	5,714
Investment property	153	140	140	140	140	140
Investment in associates	4,030	5,414	6,805	6,805	5,636	4,467
Other long term investments	-	-	-	-	-	-
Loans (Hawke's Bay Helicopter Rescue Trust)	67	55	42	-	-	-
	118,395	170,308	177,583	188,268	190,305	187,051
Total assets	**161,451**	**203,790**	**213,223**	**218,552**	**224,042**	**229,632**
Less:						
Current liabilities						
Payables and accruals	35,027	33,274	33,982	34,669	35,388	36,096
Employee entitlements	32,219	32,639	32,660	33,599	34,658	35,820
Loans and borrowings	10,268	-	-	6,000	11,500	-
	77,514	65,914	66,642	74,268	81,546	71,916
Non current liabilities						
Employee entitlements	2,295	2,360	2,431	2,501	2,580	2,667
Loans and borrowings	32,500	42,500	47,500	41,500	36,000	47,500
	34,795	44,860	49,931	44,001	38,580	50,167
Total liabilities	**112,309**	**110,774**	**116,573**	**118,269**	**120,126**	**122,083**
Net assets	**49,141**	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**

Table 3 - Projected Statements of Financial Position

Projected Statement of Cash Flows

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	483,371	496,499	509,033	523,377	535,173	545,178
Cash paid to suppliers and service providers	(285,591)	(304,738)	(290,079)	(310,224)	(313,462)	(319,389)
Cash paid to employees	(168,618)	(175,281)	(188,334)	(188,724)	(192,970)	(195,487)
Cash generated from operations	**29,162**	**16,480**	**30,620**	**24,429**	**28,741**	**30,302**
Interest received	1,246	1,364	1,008	582	270	339
Dividends received	60	60	60	60	60	60
Interest paid	(2,531)	(2,510)	(2,089)	(2,575)	(2,575)	(2,575)
Capital charge paid	(3,664)	(3,923)	(4,055)	(4,354)	(4,566)	(4,908)
Cash flow from investing activities	24,273	11,470	25,544	18,142	21,930	23,218
Proceeds from sale of property, plant and equipment	(1,839)	-	1,275	-	-	-
Acquisition of property, plant and equipment	(10,815)	(19,278)	(23,923)	(22,025)	(17,310)	(13,425)
Acquisition of intangible assets	(266)	(944)	(1,500)	(1,562)	(1,275)	(1,050)
Acquisition of investments	(92)	(1,391)	(1,379)	-	-	-
Cash flow from financing activities	(13,013)	(21,613)	(25,527)	(23,587)	(18,585)	(14,475)
Proceeds from borrowings	-	-	5,000	-	-	-
Repayment of borrowings	-	-	-	-	-	-
Repayment of finance lease liabilities	(375)	(268)	-	-	-	-
Equity repayment to the Crown	(357)	(357)	(2,022)	(357)	(357)	(357)
	(733)	(625)	2,978	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	10,527	(10,768)	2,995	(5,802)	2,988	8,386
Cash and cash equivalents at beginning of year	9,330	19,857	9,090	12,085	6,283	9,271
Cash and cash equivalents at end of year	19,857	9,090	12,085	6,283	9,271	17,657
Represented by:						
Cash	8	7	7	7	7	7
Short term investments	19,849	9,082	12,078	6,276	9,264	17,650
	19,857	9,090	12,085	6,283	9,271	17,657

Table 4 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Ministry of Health - devolved funding	446,490	454,030	481,942	490,978	502,232	511,629
Inter district patient inflows	8,647	8,015	7,483	7,595	7,709	7,825
Other income	145	137	93	95	96	98
	455,282	**462,182**	**489,518**	**498,668**	**510,037**	**519,552**
Expenditure						
Governance and funding administration	3,002	2,781	3,140	3,298	3,172	3,203
Own DHB provided services						
Personal health	197,837	206,380	215,584	216,270	219,538	222,853
Mental health	24,537	24,366	25,005	25,084	25,462	25,845
Disability support	10,003	9,161	14,677	14,725	14,946	15,172
Public health	562	502	4,327	4,339	4,407	4,475
Maori health	418	414	601	603	612	622
Other DHB provided services (Inter district outflows)	233,357	240,824	260,194	261,021	264,965	268,967
Personal health	44,342	48,370	46,784	47,071	47,360	47,649
Mental health	2,394	2,428	2,398	2,412	2,427	2,442
Disability support	3,307	3,210	3,000	3,019	3,037	3,056
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
Other provider services	50,043	54,009	52,182	52,502	52,824	53,147
Personal health	88,074	89,857	97,312	102,935	107,795	111,144
Mental health	10,133	10,467	10,994	11,640	12,195	12,578
Disability support	54,236	56,109	56,409	57,793	59,418	60,705
Public health	1,457	1,515	1,515	1,621	1,705	1,762
Maori health	3,815	3,674	3,782	3,868	3,973	4,056
	157,715	161,622	170,012	177,857	185,086	190,245
Total Expenditure	**444,118**	**459,235**	**485,528**	**494,678**	**506,047**	**515,562**
Net Result	**11,165**	**2,947**	**3,990**	**3,990**	**3,990**	**3,990**

Table 5 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Funding	3,002	2,781	3,140	3,298	3,172	3,203
Other government and Crown agency sourced	-	-	-	-	-	-
Other income	5	8	30	8	8	8
	3,007	2,789	3,170	3,306	3,180	3,211
Expenditure						
Employee benefit costs	858	716	1,044	1,010	1,020	1,030
Outsourced services	392	410	507	437	442	446
Clinical supplies	2	(0)	1	-	-	-
Infrastructure and non clinical supplies	708	591	685	916	765	773
	1,961	1,717	2,237	2,363	2,227	2,249
Plus: allocated from Provider Arm	927	933	933	943	953	962
Net Result	**120**	**139**	**-**	**0**	**0**	**0**

Table 6 - Projected Governance and Funding Administration Operating Results

Projected Provider Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Funding	233,357	240,824	260,194	261,021	264,965	268,967
Ministry of Health - non devolved contracts	12,646	13,541	3,700	3,758	3,818	3,878
Other District Health Boards	2,965	4,063	4,065	4,129	4,194	4,260
Accident Insurance	5,903	6,143	6,164	6,261	6,359	6,459
Other government and Crown agency sourced	472	518	414	421	428	435
Patient and consumer sourced	1,718	1,471	1,479	1,502	1,526	1,550
Other income	7,205	6,522	5,043	5,123	5,204	5,287
	264,267	273,082	281,060	282,215	286,494	290,836
Expenditure						
Employee benefit costs	169,920	177,099	187,382	192,990	196,074	199,229
Outsourced services	15,533	12,898	10,148	10,704	10,810	10,918
Clinical Supplies	44,639	41,110	43,431	36,463	34,272	35,137
Infrastructure and non clinical supplies	43,164	42,994	41,032	43,001	46,291	46,514
	273,256	274,100	281,993	283,158	287,447	291,798
Less: allocated to Governance & Funding Admin.	927	933	933	943	953	962
Surplus for the period	(8,062)	(86)	-	-	-	-
Revaluation of land and buildings	-	41,232	-	-	-	-
Net Result	(8,062)	**41,146**	-	-	-	-

Table 7 – Projected Provider Arm Operating Results

3.2 SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the Finance, Procurement and Supply Chain (FPSC) shared service project previously managed by Health Benefits Limited (HBL).
- Allowance has been made for net additional costs arising from the Central Regional Information Services Project (CRISP) of $0.7 million in 2015/16 with full implementation complete by June 2016.
- Catch-up demographic funding for 2015/16 has reduced the pressure for material performance improvement actions in 2015/16. However $4.3 million of new investment in service provision and the full year impact of ongoing transformation expenditure has required an $8.5 million efficiency programme for the 2015/16 year.

Revenue

- Crown funding under the national population based funding formula will be $452.4 million for 2015/16. Funding for the 2016/17, 2017/18 and 2018/19 years will include nominal increases of $12.2 million, $10.8 million and $8.9 million respectively.
- Crown funding for non-devolved services of $28.7 million is based on agreements already in place with the appropriate Ministry of Health directorates. Increases of 1.6% have been allowed for 2016/17, 2017/18 and 2018/19.
- Revenue banking of $0.8 million (of the $5 million funding left with the Ministry of Health in 2011/12 due to sales proceeds from the Napier Hill site sale) is to be drawn down in 2015/16.
- Inter district flows revenue is in accordance with Ministry of Health advice. Increases of 1.5% have been allowed for each of 2016/17, 2017/18 and 2018/19.
- Other income has been budgeted at the District Health Board's best estimates of likely income. Increases of 2.075%, 2.0% and 2.0% have been allowed for 2016/17, 2017/18 and 2018/19 based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2014 published 16 December 2014 and updated 14 January 2015).

Personnel Costs and Outsourced Services

- Workforce costs for 2015/16 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Increases of 0.7% per annum have been allowed for 2016/17, 2017/18 and 2018/19, which is the District Health Board's best estimates of likely increases.
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2014/15. The District Health Board is managing internally to a cap of 400 FTEs.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the DHB's best estimates of likely cost.
- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.
- Increases of 2.075%, 2.0% and 2.0% have been allowed for 2016/17, 2017/18 and 2018/19 based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year

Economic and Fiscal Update 2014 published 16 December 2014 and updated 14 January 2015).

Services Provided by Other DHB's

- Inter district flows expenditure is in accordance with MoH advice. Increases of 0.6% have been allowed for each of 2016/17, 2017/18 and 2018/19.

Other Provider Payments

- Other provider payments have been budgeted at the DHB's best estimate of likely costs. Costs increases have been included for 2016/17, 2017/18 and 2018/19 at 2.0%, 2.5% and 2.0% respectively.

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investments in HBL and CRISP give the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- Interest rates of 4.925%, 5.175% and 5.250% have been applied for new borrowings and from maturity for expiring facilities in 2016/17, 2017/18 and 2018/19 respectively based on 15 points above Treasury forecasts for 10 year bonds (30 June Year composite rates based on the 31 March interest rates in the Half Year Economic and Fiscal Update 2014 published 16 December 2014 and updated 14 January 2015).
- The capital charge rate remains at 8%.

Investment

- The purchase of class B shares in Health Benefits Limited (HBL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- The investment in CRISP has been included at $1,391,000 for 2015/16, taking the total investment to $5,844,000. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- No collaborative regional or sub-regional initiatives have been included other than CRISP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below (note this excludes $990 thousand of additional funding that is likely to be invested in property, plant and equipment):

Investment	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Buildings and Plant	9,383	9,627	6,900	5,700
Clinical Equipment	5,200	8,060	6,360	3,900
Other Equipment	3,775	2,775	2,775	2,775
Information Technology	3,000	3,125	2,550	2,100
Capital Investment	**21,358**	**23,587**	**18,585**	**14,475**
Investment in HBL	-	-	-	-
Investment in CRISP	1,391	-	-	-
Total Investment	**22,749**	**23,587**	**18,585**	**14,475**

Capital Investment Funding

- Capital investment will be funded from a number of sources including working capital in accordance with the following table:

Investment Funding	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Total Investment	22,749	23,587	18,585	14,475
Funded by:				
Depreciation and amortisation	14,206	14,823	15,736	16,956
Operating surplus	3,000	3,000	3,000	3,000
Property disposal	1,200	-	-	-
Borrowings	5,000	-	-	-
Cash holdings	(657)	5,764	(151)	(5,481)
Capital Investment Funding	**22,749**	**23,587**	**18,585**	**14,475**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. A revaluation as at 30 June 2015 has been included based on preliminary figures provided by the valuer. No adjustment has been made for the effect of any other revaluation over the time horizon of the plan. Property, plant and equipment relating to Chatham Islands services has been excluded as these assets will transfer by Order in Council to Canterbury District Health Board on 1 July 2015.

Debt and Equity

- Debt will be at the levels in the table below. Loans and borrowings are included in the table at face value. This differs from the projected financial statements (see above) in which these instruments are carried at fair value as required by PBE standards.

Debt	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Borrowing	47.5	47.5	47.5	47.5
Finance leases	-	-	-	-
Total debt	**47.5**	**47.5**	**47.5**	**47.5**
Debt/(Debt+Equity) Ratio	*33.0%*	*32.1%*	*31.4%*	*30.6%*

- Debt funding from the Crown will increase $5 million to $47.5 million in 2014/15 as the DHB draws down the debt facility relating to the Napier Hill site sale. There are no banking covenants relating to the debt.

Key Lenders	Facility	Limit $'m	Termination Date
Crown	Term Debt	$47.5 million	31 December 2021

- Equity movements will be in accordance with the table below.

Equity	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Opening equity	93.0	96.7	100.3	103.9
Surplus	4.0	4.0	4.0	3.9
Equity repayments (FRS3)	(0.3)	(0.4)	(0.4)	(0.3)
Closing equity	**96.7**	**100.3**	**103.9**	**107.5**

Additional Information and Explanations

Disposal of Land
Disposal of land is subject to current legislative requirement and protection mechanisms. HBDHB is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

4. STEWARDSHIP & ORGANISATIONAL CAPABILITY

In order to make progress against our strategic outcomes, we have put in place our 'Transform and Sustain' programme, which in time will transform the whole Hawke's Bay health system. Some work is already underway and we are building on those successes and we are using the New Zealand Triple Aim as a guide to ensure we keep change in balance.

Delivering on Transform and Sustain will mean people in Hawke's Bay will experience:

- A health system that is responsive to need
- Consistent high-quality health care
- A more efficient health system

We are also implementing some cultural and structural changes to the system to support transformation and align it with the values that underpin our vision:

- TAUWHIRO: delivering high-quality care to patients and consumers
- RĀRANGA TE TIRA: working together in partnership across the system
- HE KAUANANU: showing respect for each other, our staff, patients and consumers
- ĀKINA: continuously improving everything we do.

QUALITY

Transform and Sustain is providing:

- An organisational development programme to support our workforce so they are empowered and valued to make the biggest contribution they can
- A means of reviewing progress in the three aims we have identified
- A model to measure, target and report our expenditure so we move our resources to where we bring about transformational change.

The Sustain programme consolidates the improvements we make in order to support the Transform programme that, together, will significantly improve the value of our services to the people of Hawke's Bay.

Creating Headroom for Change

Over the recent past, individuals across the health system have worked extremely hard to make the improvements that have been necessary. It is important we recognise those efforts and create the right environment and culture for ongoing change that links quality improvement and system integration. While we know we can't make change everywhere at once, we need to identify those services that could lead and support others.

The objectives of the programme cannot be achieved in one year, but readying the whole system for transformation is not something that we could put off. Rather, we have attempted to free-up some systems and processes so those who are ready can make a start. Time and energy continues to be invested in establishing, strengthening and maintaining relationships for better liaison across the system. The transformation agenda has taken time to initiate, but the momentum is gathering as people's expectations change and we respond to patients' needs in different ways.

In the first instance, we attempted to pinpoint opportunities that could easily be implemented in order to release some time and create the space for everyone to come together to design innovative solutions. That included identifying better administrative processes and more flexible budgeting, removing obstacles, facilitating better working partnerships and supporting the generation of new ideas while spending less time on non-essential tasks.

Fundamentally, teams at all levels are being encouraged to make more time to discuss, plan, implement and review improvement opportunities. Managers and team leaders are being supported to make this happen.

4.1 ORGANISATIONAL DEVELOPMENT

Workforce
The health system needs skilled clinical leaders, team leaders and managers in place to support team performance so that we can achieve transformation. Our teams must continually focus on providing excellent services, improving health and well-being, working in partnership and reducing inequities, and they must be empowered to try new ways of doing things. This applies to service delivery and support functions. We are working together to support and develop the workforce and the organisations.

Organisational development programmes are focusing on the following:

- Embedding our new Service Directorate structure of Service Director, Medical/Surgical Director and Nurse Director
- Clinical leadership and engagement
- Talent Management Programme including succession planning
- Transformational management and leadership capability
- Increasing staff engagement, health and well-being
- High performing teams, including re-skilling and up-skilling of staff
- Building capability, through structured development of current staff and recruitment of high calibre individuals
- Increasing Māori staff representation and increasing effective engagement with Māori
- Maintaining high levels of Union engagement
- Continued development of smart systems and reporting
- Robust health and safety systems including hazard identification and mitigation
- Enhanced blended and on-line learning and development programmes for clinicians and staff

Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications
We are committed to ongoing innovation in our communications to staff, our consumers and our community, and to improving the way we promote our vision, services, challenges, successes and solutions. We are also engendering a safe and trusting environment in which people can propose changes and new ideas plus some extra focus on communicating and celebrating successful initiatives already implemented.

Health Information
In transforming the health system, one of the biggest challenges we face is developing an information system that matches our ambitions for service integration. We are working with our regional partners to deliver a regional health informatics strategy to support improvements in Information Communication Technology (ICT) over the outlook period. The Central Region ICT vision is about the efficient delivery of the right information to the right people at the right time, on an anywhere, anyhow basis to achieve the desired health outcomes and improved organisational performance

Achieving the region's vision for health informatics will contribute to improved consumer experience, better support for clinicians and other health professionals and more integrated care.

There are many areas that require better ICT support and we recognise the importance of rigorous investment to achieve this. We have developed and information systems strategy and a business intelligence work plan to underpin and complement Transform and Sustain.

4.2 KEY INTENTIONS

We have described what our core challenges are:

1. Responding to our population - we believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau
2. Delivering consistent high-quality health care - the best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting
3. Being more efficient at what we do - reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.

Transform and Sustain includes a number of key intentions that, when implemented, will support us to address our core challenges.

- **TRANSFORMING OUR ENGAGEMENT WITH MĀORI**
- **TRANSFORMING PATIENT INVOLVEMENT**
- **TRANSFORMING HEALTH PROMOTION AND HEALTH LITERACY**
- **TRANSFORMING MULTI-AGENCY WORKING**
- **TRANSFORMING CLINICAL QUALITY THROUGH CLINICAL GOVERNANCE**
- **TRANSFORMING PATIENT EXPERIENCE THROUGH BETTER CLINICAL PATHWAYS**
- **TRANSFORMING THROUGH INTEGRATION OF RURAL SERVICES**
- **TRANSFORMING PRIMARY HEALTH CARE**
- **TRANSFORMING URGENT CARE**
- **TRANSFORMING OUT-OF-HOURS HOSPITAL INPATIENT CARE**
- **TRANSFORMING BUSINESS MODELS**

PROCESSES FOR ACHIEVING REGULAR FINANCIAL SURPLUSES

Closing the gap between planned expenditure and expected income is normal business in the health system. As the world economic environment puts even more pressure on all Government spending, Hawke's Bay DHB, as the lead Government agent for the Hawke's Bay public health budget, must continually look for ways to live within an expectation of lower funding growth.

Hawke's Bay DHB continues with its strategic direction to provide a $3m year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

We continue with our strategy of responsible reduction in our cost base by

- Stopping doing things that are clinically ineffective of for which there is insufficient supporting evidence
- Doing things more efficiently by redesigning processes to drive out waste or errors
- Embracing opportunity to enhance quality by providing better care with the available resources

Our focus on reducing our cost base together with opportunities to increase our revenues will produce additional resources for our transformation program.

SHIFTING RESOURCES

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time. Figure 3 illustrates a model for measuring and managing a shift of resources. The aim is to measure, monitor and realign expenditure in these categories and to shift resources purposely.

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not

about shifting resources from one provider to another, but rather it is about changing the service model.

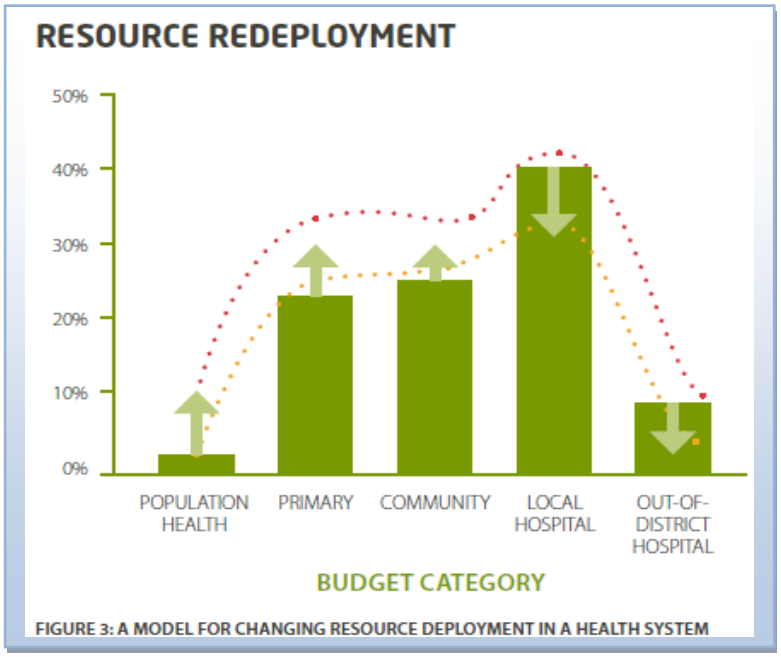

FIGURE 3: A MODEL FOR CHANGING RESOURCE DEPLOYMENT IN A HEALTH SYSTEM

SUMMARY

Our transform and sustain programme is already showing good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. Initiatives such as Acute Inpatient Management 24/7 (AIM 24/7) and others focusing on our after-hours services, theatre productivity, mental health model of care and health of older persons services, are all delivering significant improvement across our the sector. These improvements are being achieved within our current funding. In addition, our engagement with and commitment to the Health Quality and Safety Commission's programmes – specifically, Quality and Safety Markers (QSMs), Quality Accounts, and Patient Experience Indicators – provide the public with evidence and transparent links comparing our performance to national benchmarks and declarations about the quality of the services we fund and provide.

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[36] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB and Whanganui DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

Note C: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement and is updated every 2 years. The last update was in April 2014

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[36] As defined in section 58 of the Companies Act 1993

5. APPENDICES

APPENDIX 1 Our Strategic Framework

APPENDIX 2 Notes to the Financial Statements

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.

The 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, as defined under XRB A1.

The projected financial statements of the HBDHB comprise the DHB, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services (CR TAS) Limited which is jointly controlled by the six DHBs in the central region.

BASIS OF PREPARATION

Statement of Compliance

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

These financial statements are the first set of prospective financial statements presented in accordance with PBE standards.

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

Measurement Base

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

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

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

Judgements made by management in the application of PBE standards that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in the assumptions.

Functional and Presentation Currency

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

Changes in Accounting Policy

PBE standards are to be applied by public benefit entities for periods beginning on or after 1 July 2014. Earlier application is not permitted. Other than the change to PBE standards, there have been no changes in accounting policies since publication of the DHB's 2013/14 Annual Report. The DHB has not applied any transitional provisions in any PBE standard.

Basis for Consolidation

Subsidiaries

HBDHB has no subsidiaries.

Associates

Associates are those entities in which HBDHB has significant influence, but not control, over the financial and operating policies.

The projected financial statements include HBDHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. The investment in an associate is initially recognised at cost and the carrying amount is increased or decreased to recognise the DHB's share of the surplus or deficit of the associate after the date of recognition as an associate. When the DHB's share of losses exceeds its interest in an associate, the carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that the DHB has incurred legal or constructive obligations or made payments on behalf of an 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. Distributions received from the associate reduce the carrying amount of the investment.

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

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

Joint Ventures

Joint ventures are those entities over whose activities HBDHB has joint control, established by contractual agreement. The financial statements include the DHB's interest in joint ventures, using the proportionate method, from the date that joint control commences until the date that joint control ceases.

Foreign Currency

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

Budget Figures

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

SIGNIFICANT ACCOUNTING POLICIES

Revenue

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

Crown Funding

The HBDHB is primarily funded through revenue received from the Crown under a Crown Funding Agreement. The funding is restricted in its use for the purpose of meeting the DHB' objectives as specified in the statement of intent.

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

Revenue from other DHBs

Inter district patient inflow revenue occurs when a patient treated within the HBDHB region is domiciled outside of Hawke's Bay. The MoH 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.

ACC Contracted Revenue

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

Sale of goods

Revenue from goods sold is recognised when 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

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

Vested Assets

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

The activities of the HBDHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB due to the difficulty of measuring their fair value with reliability.

Rental Income

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

Interest Income

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

Expenses

Operating Lease Payments

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

Finance Lease Payments

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

Borrowing Costs

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

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

Capital charge

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

Cash and Cash Equivalents

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

Debtors and Other Receivables

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

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

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

Investments

Bank Deposits

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

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

Derivative Financial Instruments

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

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

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

Inventories

Inventories Held for Distribution

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

Inventories Held for Sale

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

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

Non-current Assets held for Sale

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

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

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

Property, Plant and Equipment

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

- Freehold land
- Freehold buildings
- Clinical equipment
- Information technology
- Motor vehicles
- Other equipment
- Work in progress.

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

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually by an independent Valuer to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

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

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the 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 at no cost, or for a nominal cost, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying value of the asset. Gains and losses on disposals are reported net in the surplus or deficit.

Subsequent Costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to 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	3 to 40 years	2.5% to 33%
• Clinical equipment	3 to 23 years	4.3% to 33%
• Information technology	3 to 10 years	10% to 33%
• Motor vehicles	3 to 20 years	5% to 33%
• Other equipment	3 to 40 years	2.5% to 33%

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

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

Intangible Assets

Software Acquisition and Development

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

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

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation

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

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

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

Impairment of Property, Plant and Equipment and Intangible Assets

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

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

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

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

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

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

Investment Properties

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value, an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, will provide an assessment of the fair value 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.

Interest-bearing Loans and Borrowings

Interest-bearing loans and borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, interest-bearing

loans and borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities HBDHB has an unconditional right to defer the settlement of the liability for at least 12 months after balance date. Borrowings where the DHB has an unconditional right to defer the settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

Creditors and Other Payables

Creditors and other payables are recorded at their face value.

Employee Benefits

Short-term Employee Entitlements

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

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

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

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation.

Long-term Employee Entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlements information; and
- The present value of the estimated future cash flows.

Superannuation Schemes

Defined contribution Schemes

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

Defined benefit Schemes

The 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.

Provisions

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

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a discount rate that reflects

current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in financing costs.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either has been announced publicly to those affected, of for which implementation has already commenced.

ACC Partnership Programme

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

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

Goods and Services Tax (GST)

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income Tax

HBDHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 2007.

Income and Cost Allocation

Output Classes

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

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

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

Critical Accounting Estimates and Assumptions

In preparing these financial statements, estimates and assumptions have been made concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that

have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Employee Entitlement Provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time

Workplace Accident Self-insurance

The liability for the ACC partnership programme is measured at the value of anticipated future payments to be made in respect of the employee injuries and claims using actuarial techniques. Expected future wage and salary levels and the incidence of employee claims and injuries are inherently uncertain.

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 projected financial statements. Management has not yet exercised any critical judgements in applying accounting policies for the year ended 30 June 2016