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Hawke's Bay District Health Board
Annual Report 2021
Presented to the House of Representatives
Pursuant to section 150(3) of the Crown Entities Act

HAWKE'S BAY
District Health Board
Whakawāteatia

2021 Annual Report

Our Mission and Values

Vision

Whānau ora, Hāpori ora — healthy families, healthy communities

Mission

Working together to achieve equitable holistic health and wellbeing for the people of Hawke's Bay.

Our Values

Contents

Part I - Overview

Message from the Chair and Chief Executive

While the 2020/21 year has faced continuing challenges exacerbated by the on-going COVID-19 pandemic Hawke's Bay DHB has made progress with some significant facility upgrades and substantively increased the number of planned care operations it has provided to the community.

A continuing area of challenge for the DHB was our financial performance. In the 20/21 year the DHB reported a deficit of $21.8 million on normal operations, against a planned deficit of $14.5million.

Although a reduced deficit compared to last year, the financial result reflects the continued demand and pressure on the delivery of health services. The DHB has also incurred exceptional costs associated with COVID-19, pay equity and providing for the Holidays Act liability, which takes its overall deficit from $21.8 million to $28.3 million.

Despite the impact of the COVID-19 pandemic affecting construction industry supply the DHB has made significant progress with these building works that incorporate an additional theatre.

This multi-year project will deliver extensive reconfiguration and refurbishment of the DHB's theatre block, including the addition of the eighth theatre that will become operational during 2022/23.

Final preparations are also in place, in partnership with Mid-Central DHB, to provide the facilities required to house a linear accelerator on the Hawke's Bay Hospital campus site, Hastings. This multi-year project with Government investment will enable the DHB to provide radiation oncology services for its community and prevent many people from having to travel out of region for treatment.

HBDHB has a number of aged facilities, which impacts our ability to deliver quality services efficiently. As such the DHB was pleased to have it confirmed that we will be one of four regional hospitals included in the Ministry of Health's regional hospital redevelopment programme.

In the 20/21-year work necessary for a hospital redevelopment has been initiated. This includes system planning, model of care development and the beginning of site master planning.

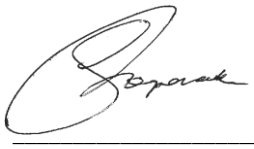
A focus on delivering more planned care operations to the Hawke's Bay community has seen 1,373 more operations in 20/21 than in the previous year, with more planned operations in-house than ever before. There is much focus in this area and improvements are expected to continue in the coming year.

With Chief Executive Keriana Brooking joining the DHB in August 2020, much work has been done to improve and strengthen our processes, work is in hand to improve equity with the development and implementation of an Equity Framework Action Plan and there is a renewed organisational focus on staff and patient safety.

Hawke's Bay DHB is committed to improving health outcomes for its community and as part of that will be working to ensure a smooth transition to Health New Zealand in 2022.

We would like to thank our staff and the wider health community for their extraordinary efforts to meet the unrelenting demand for services in challenging times.

Keriana Brooking
Chief Executive Officer



Shayne Walker
Chair, Hawke's Bay DHB

About Hawke's Bay District Health Board

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. This includes Wairoa District, Napier City, Hastings and Central Hawke's Bay Districts.

Hawke's Bay's current population is 178,510. While the total population grew 2% in the last year, our 65 years and over population grew by 1200 people or 4%. This is due to the ageing of our population and we will continue to see the number of older people increase year on year in Hawke's Bay for the next 20 years. People over the age of 65 will outnumber those under the age of 14 as soon as 2023.

Most of our population live in the large urban areas of Napier and Hastings, located within 20 kilometres of each other. Together they account for 73% of the total population. About 10% of the people live in, or close to, Wairoa, Clive, Waipukurau or Waipawa which are relatively concentrated rural settlements. The remaining 16% 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 (28% vs 17%), more people aged over 65 years (19% vs 16%) and more people living in areas with relatively high material deprivation (28% vs 20%).

Statement of Responsibility

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

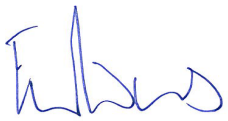
The board and management of Hawke's Bay District Health Board are responsible for any end-of-year performance information provided by the district health board under section 19A of the Public Finance Act 1989;

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

In the opinion of the board and management of Hawke's Bay District Health Board the financial statements and statement of performance for the year ended 30 June 2021, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

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

Shayne Walker
Chair
31 December 2021



Evan Davies
Board Member
31 December 2021

Part II – Improving Outcomes

Performance Framework

What difference have we made for the health of our population?

Hawke's Bay DHB's performance framework demonstrates how the services we fund and the services we provide contribute to the health of our population and achieve our long term outcomes and the government's objectives. Our performance framework reflects national priorities and our local DHB priorities which informs our Annual Plan and our Statement of Performance Expectations (SPE).

Our performance framework focuses on two overall long-term population health outcomes:

- Increase healthy life expectancy for all, and
- Halve the life expectancy gap between Māori and non-Māori.

These are the long term outcomes of the Hawke's Bay Health Strategy Whānau Ora, Hāpori Ora: Healthy Families Healthy Communities (2019-2029) which sets out the Hawke's Bay DHB's strategic intentions over the next 10 years.

2020/21 marks the second year of our long term strategy. The nature of population health is such that it may take several years to see marked improvement against key outcome measures. Our focus here is on maintaining positive trends over time and reducing inequities.

Our medium term outcome goals are closely aligned to the Ministry of Health System Level Measures and other national health priorities such as improving cancer outcomes.

Locally we have also aligned our medium term outcome goals to Hawke's Bay DHB's Health System Priorities (First 1000 Days, Mental Health and Addictions, Long Term conditions, a Responsive Health System and, Frail and Older People).

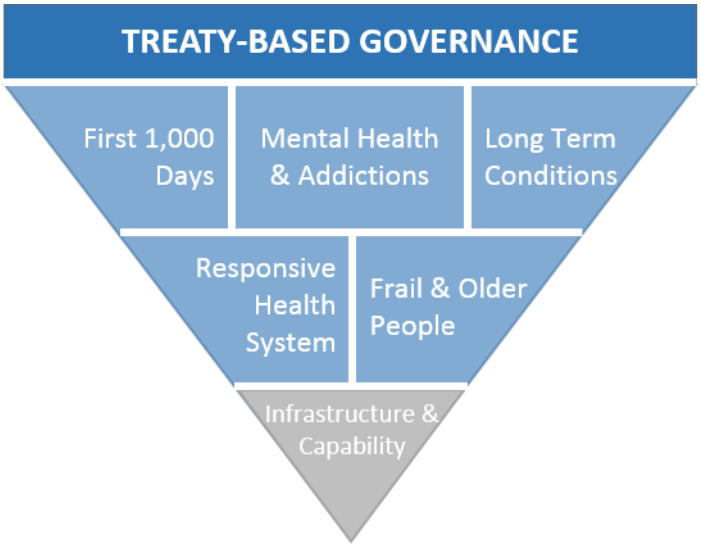


Figure 1: HBDHB System Priority Areas

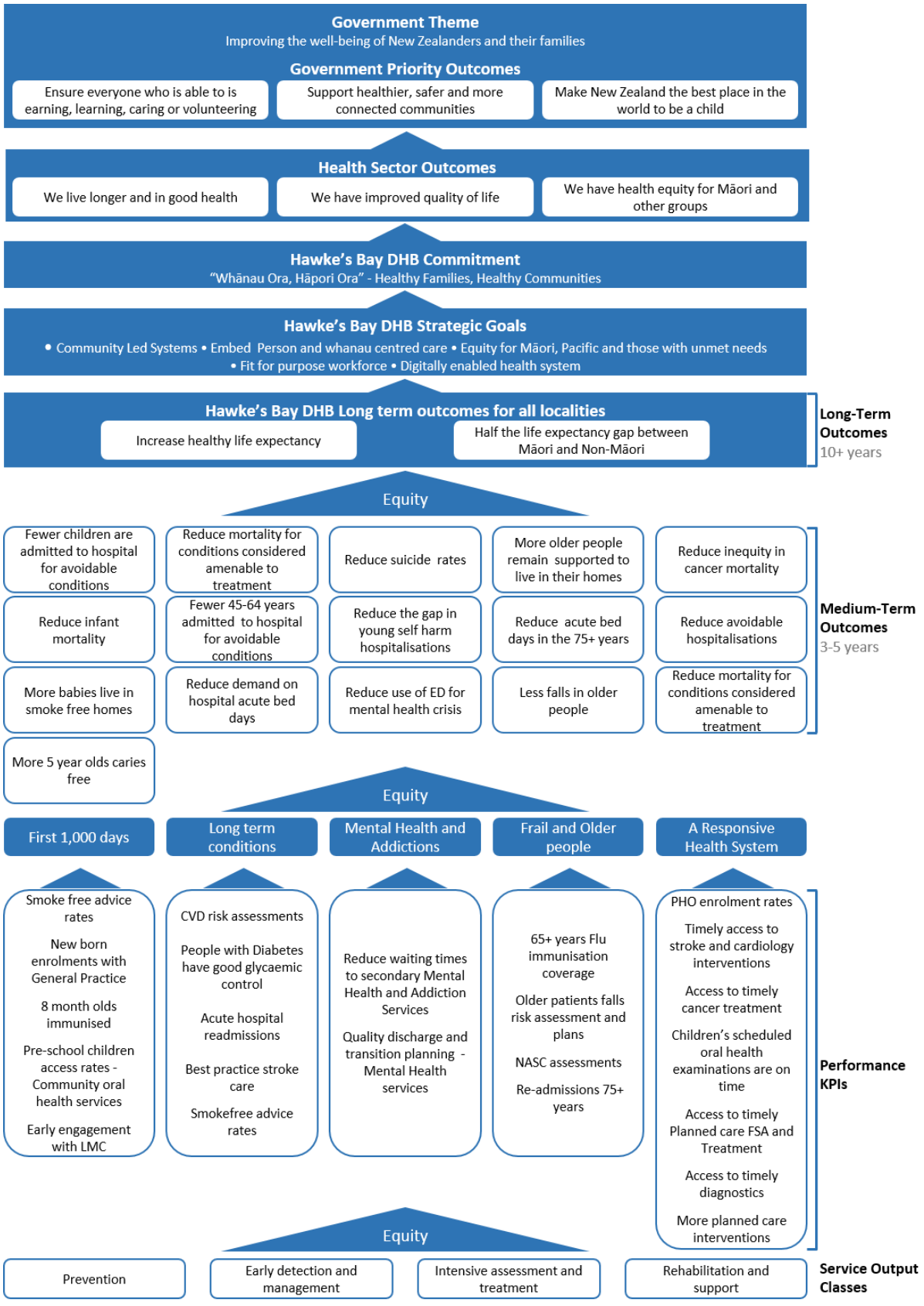
Tracking our performance against the medium term outcomes helps us evaluate our success in areas that are important to the community and the Hawke's Bay DHB. Our priority is addressing inequity of health outcomes for our population. In doing this, we work in partnership with our community.

We use measurable short term key performance indicators (KPI's) to measure the success against our Health System priorities. Our KPIs are also mapped to four Service Output Classes; Prevention, Early Detection and

Management, Intensive Assessment and Treatment, Rehabilitation and Support. We track our performance against the KPI's quarterly.

How well we have performed against these measures and targets in the 2020/21 year is presented in our Statement of Service Performance (outlined in the following section of this report).

Achieving equity is a goal at all levels of our performance framework. Our performance framework is shown below.



Long Term Outcomes

Hawke's Bay DHB's two long term outcomes are improving healthy life expectancy for all and halving the gap in life expectancy between Māori and non-Māori.

The goal of a health system is to maximise the length of life lived in good health. Healthy life expectancy is the number of years a person can be expected to live independently: either free of any disability or with any limitation they can manage without assistance. Improving healthy life expectancy for all is a key long term outcome for our DHB.

Māori and Pasifika people in Hawke's Bay live less years in good health, with high prevalences of living with long-term conditions, such as diabetes, cancers, cardiovascular and respiratory diseases, musckuloskeletal disorders and mental illness. Our goal is to reduce the prevalence and risk of long term conditions in our population.

Life expectancy at birth is recognised as an overall measure of health status, and our overall objective is to halve the gap between Māori and non-Māori over the next 10 years. Gains in life expectancy can be attributed to a number of factors, including access to quality health services, healthier lifestyles and socioeconomic determinants of health such as access to good quality housing, employment and education.

LIFE EXPECTANCY (LE) IN HAWKE'S BAY REGION BY ETHNCITY AND GENDER						
	2005-2007		2012-2014		2017-19	
Sub-group	Hawke's Bay 2005-2007 LE	LE Gap	Hawke's Bay 2012 -14 LE	LE Gap	Hawke's Bay 2017 -19 LE	LE Gap
Male	77.1 years	4.1 years	78.6 years	3.8 years	78.5 years	3.7 years
Female	81.2 years		82.4 years		82.2 years	
Māori Male	69.1 years	9.6 years	71.7 years	8.2 years	72.4 years	7.7 years
non-Māori Male	78.7 years		79.9 years		80.1 years	
Māori - Female	73.8 years	8.7 years	75.9 years	7.7 years	76.3 years	7.3 years
non-Māori Female	82.5 years		83.6 years		83.6 years	

Life Expectancy (LE) for Māori males and females has increased more than non-Māori males and females in the last five years.

In the most recent period the LE gap between Māori and non-Māori males has reduced by 0.5 years (6% reduction) and for females 0.4 years (5% reduction) compared to LE in 2012-14.

Although the gap in life expectancy is decreasing between Māori and non-Māori, the gap remains high at 7.7 years for males and 7.3 years for females. Hawke's Bay Māori males' life expectancy at birth is 72.4 years and for Māori females it is 76.3 years compared to a life expectancy at birth of 80.1 years for non-Māori males and 83.6 years for non-Māori females.

Coronary heart disease, lung cancer and diabetes are some of the main causes of the gap in life expectancy between Māori and non-Māori.

Smoking is a major contributing factor to coronary heart disease, lung cancer and diabetes. There are large inequities in smoking rates, which are 31% for Māori compared to 12% for non-Māori (2018 Census).

While total life expectancy in Hawke's Bay has increased since 2005-2007 by 1.4 years for males and 1 year for females, overall life expectancy for both males and females has decreased in Hawke's Bay between 2012-14 and 2017-19. Hawke's Bay LE for males and females ranks the third lowest of 16 New Zealand regions.

Medium Term Outcomes

Maternal and Child Health

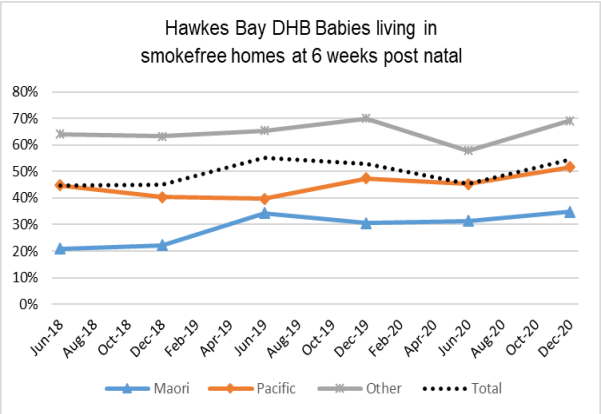
Ensuring that children have the best start in life is crucial to the health and wellbeing of the population. The first 1000 days of life has the biggest impact. Many challenges in later life have their roots in the early years of life, including obesity, heart disease and mental health. Well integrated maternal and child health services which support mothers and babies can prevent health problems and improve health outcomes in these early years. Our goal here is to increase the proportion of babies living in smokefree homes, reduce infant mortality, reduce the number of children admitted to hospital for avoidable conditions and increase the number of children who are caries-free at five years of age.

More babies live in smokefree homes

Hawke's Bay Health Equity report (2018) highlighted our maternal smoking rates are of great concern and smoking rates amongst wāhine Māori must remain a key health equity target.

Smoking in pregnancy and exposure to cigarette smoking in infancy stongly influences pregnancy and childhood health outcomes. This focus area promotes the role health providers collectively play to promote smoking cessation interventions across the maternal and child health continum.

The desirable outcome is for babies to live in a smokefree environment. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment.



The target here is to gain equity between Māori and Other ethnicity rates.
This is a System Level Measure.
Note: The overall results for 2019/20 were impacted by COVID-19 response with less WTCO visits undertaken particulalrly during Alert Level 4.

Well Child Tamariki Ora (WCTO) providers ask about household smoking starting at babies six-week post-natal check. The focus here is to reduce the gap between Māori and Other ethnicity group living in smokefree homes.

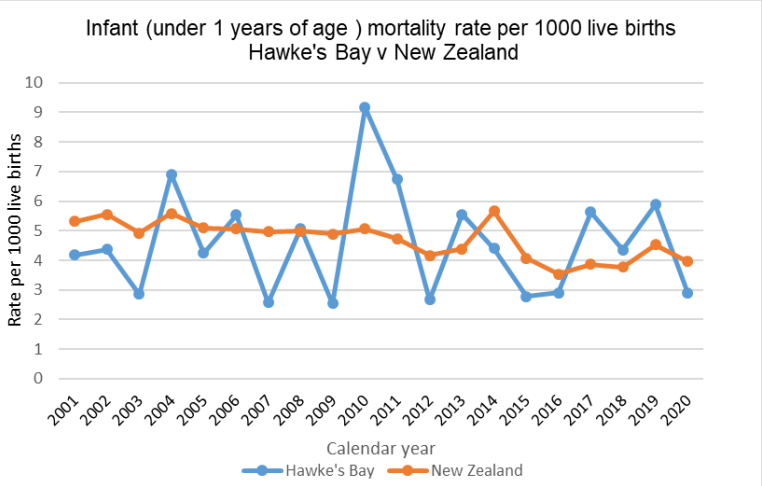
35% of Māori six week old babies live in smokefree homes in the 20/21 period compared to 70% in Other ethnicity group. Māori rates increased from 31% in the 19/20 reporting period to 35% in the 21/22 period. Pacific rates increased from 45% to 52% in the same period.

Although the longer term trend is a narrowing gap in the % of babies living in smokefree homes between Māori, Pacific and Other ethnicity, we didn't see that gap decrease in the 20/21 year.

Reduce infant mortality

Infant mortality is a long established measure of effective maternal and child health care, as well as the impact of broader social factors such as maternal education, smoking and relative deprivation.

Addressing inequities in infant mortality will also contribute to an improvement in life expectancy.



The medium term goal here is to reduce rates.

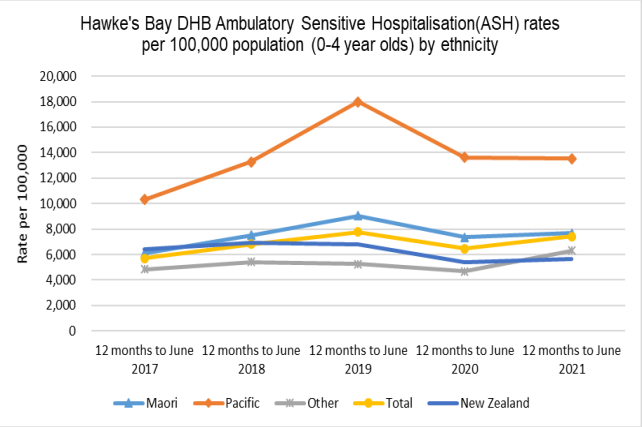
Hawke's Bay infant mortality rates are variable due to small numbers.

However, the long term trend is a decreasing rate. In the 2020 year Hawke's Bay infant mortality rate was 2.9 per 1000 live births which is lower than the national infant mortality rate of 4.0 per 1000 births.

Fewer children are admitted to hospital for avoidable conditions

In Hawke's Bay, 39% (824 events) of all child 0-4 year olds acute admissions to hospital are for conditions that are potentially avoidable through prevention, for instance; immunisation, dental care and management in primary care. These potentially avoidable acute admissions are known as Ambulatory Sensitive Hospitalisations (ASH). These conditions are predominantly respiratory illnesses, dental, gastroenteritis, and skin infections.

Health care access as well as underlying determinants of health (housing quality and crowding, exposure to secondhand cigarette smoke, and poverty) all contribute to ASH rates and the inequities seen in the performance against this measure. Access to population health programmes such as healthy housing interventions and tobacco cessation are important. ASH rates are higher in Māori and Pacific children.



The target here is to reduce Māori ASH (0-4 y) by 5% or less than and equal to 8205 per 100,000 in the 20/21 year.

This is a System Level Measure.

Ambulatory Sensitive Hospitalisation (ASH) (0-4 years) rates have increased in the last 12 months to June 2021 compared to the previous 12 months. The impact of COVID 19 lockdown and other public health measures contributed to a reduction in ASH rates and respiratory conditions in particular in the 12 months to June 2020. There has been a 15 % increase in ASH rates for 0-4 year olds across all ethnicity groups in the last 12 months to June 2021 with the biggest change in rates for Other children. ASH rates in other ethnicity children increased 35 % from 4,670 per 100,000 in 12 months to June 2020 to 6,298 per 100,000 in the 12 months to June 2021 and was predominantly in gastroenteritis/dehydration conditions. Despite Maori 0-4 year rates increasing by 5 % due largely due to hospitalisations for dental conditions, the rate target (pre COVID 19) for Maori was achieved. Pacific ASH 0-4 year olds rate decreased from 13,611 per 100,000 in the 12 months to June 2020 to 13,514 per 100,000 in the 12 months to June 2021. Despite inequity persisting there has been improvement in the last year.

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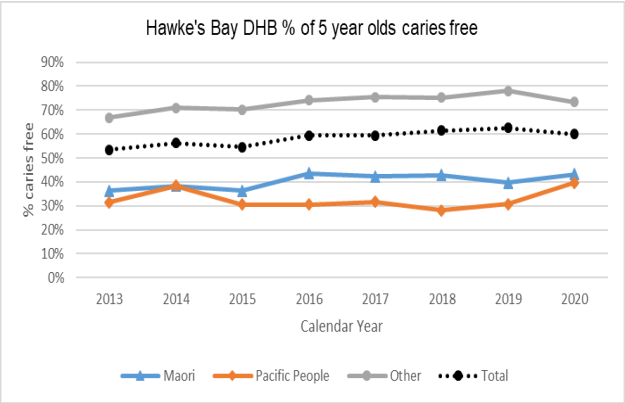
More five year olds are caries-free

Dental decay (dental caries) is one of the most common preventable chronic diseases. Poor dental health in childhood can carry on into adulthood. Dental treatment for caries is a leading cause of avoidable hospitalisations in children. Good oral health indicates that families have received health information, and health promotion and prevention services are engaging effectively with whānau for instance through early enrolment in the community oral health services. Good oral health is part of overall life-long health supporting diet, self-esteem and quality of life.



The goal in the 20/21 year is 62% of 5 year olds are caries free.

The overall percentage of five year olds caries-free in Hawke's Bay has dropped from 63% in 2019 to 60% in 2020. (787 children out of 1311 treated were caries free)

However, there has been improvements in the percentage of Māori and Pacific five year olds caries-free between 2019 and 2020. As a result, the gap in inequity has narrowed.

The percentage of Māori five year olds caries-free increased from 39.7% in 2019 to 43.2% in 2020. (208 out of 482 treated were caries free)

The percentage of Pacific five year olds caries-free increased from 30.8% in 2019 to 39.8% in 2020. (35 out of 88 treated were caries free)

Long Term Conditions

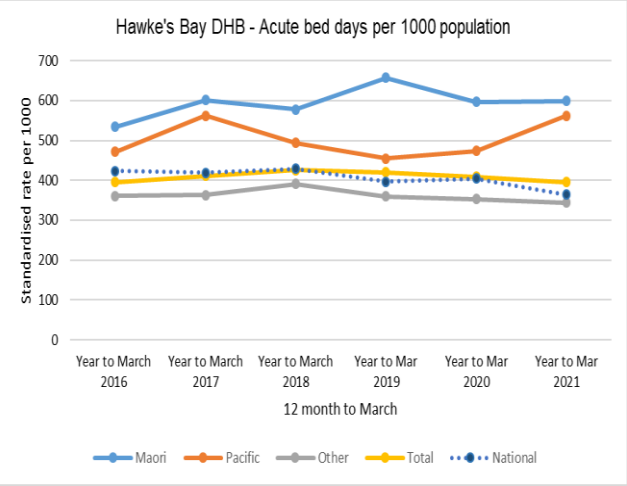
We aim to reduce the prevalence of long term conditions, and to provide the services people need to manage their long term conditions more effectively to reduce avoidable hospitalisations, premature mortality and frailty in older age.

The demand on acute care services is increasing due to an ageing population and the increase in prevalence of long term conditions such as cardiovascular disease, respiratory disease, chronic obstructive pulmonary disease and diabetes. We need to strengthen our ability to manage acute demand, deliver more planned care in the community, be innovative to support people to manage long term conditions and support healthy ageing.

Reduce acute bed days per 1000 population

Acute hospital bed days per capita is a measure of the use of acute services in secondary care. It is used as to assess how effective intervention and treatment in primary care is, and integration of health services across the sector including access to diagnostics. Acute hospital bed days can also be influenced by optimising patient flow within the hospital, discharge planning, community support services and good communication between health care providers.

Overall Hawke's Bay DHB's acute bed days per 1000 population has dropped slightly to 396 bed days per 1000 population in the 12 months to March 2021 compared to 409 bed days per 1000 population in the 12 months to March 2020. This is just short of our 20/21 goal.



The goal here is to see a 3% decrease in rates in 2021 over the previous 12 month period.

This is a System Level Measure.

Māori rates have remained steady over the last two years with 599 bed days per 1000 population in the 12 months to March 2021.

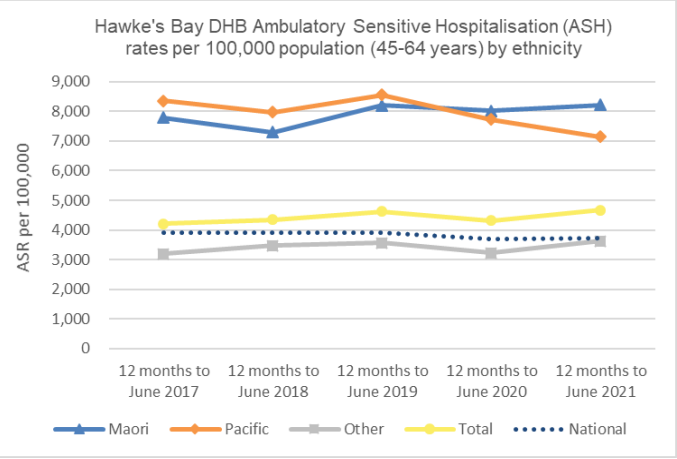
Pacific rates have increased from 474 per 1000 population in the 12months to March 2020 to 562 per 1000 in the 12 months to March 2021.

Māori rates are 70% higher and Pacific rates are 60% higher than the Other ethnicity group. Reducing acute bed days for Māori and Pacific is a focus for 2021/22.

The top conditions contributing to the highest acute bed days in the 12 months to March 2021 are respiratory disorders, stroke, heart failure, tracheostomy and cellulitis.

Reduce avoidable hospitalisations in 45-64 year age group

Ambulatory Sensitive Hospitalisations (ASH 45-64) reflect hospital admissions that are considered amenable to out of hospital management and therefore should be avoided. In the 45-64 year age group ASH hospitalisations can serve as a proxy measure for good access to primary care, and care coordination and management of long term conditions. In Hawke's Bay there are large inequities evident in ASH rates for 45-64 year olds. For people aged 45-64 the top ASH conditions are angina and chest pain, myocardial infarction, cellulitis, and respiratory infections (chronic obstructive pulmonary disease (COPD) and Pneumonia).



The goal is a reduction in rates to less than and equal to 3510 per 100,000 in the 20/21 year.
Age standardisation is based on NZ Standard Population.

In the 12 months to June 2021 there were 2,190 admissions in the 45-64 year age group which were potentially avoidable.

The overall Hawke's Bay DHB 45-64 year olds ASH rate has increased 8% from 4,321 per 100,000 population in the 12 months to June 2020 to 4,665 in the 12 months to June 2021.

The Māori 45-64 year old ASH rate has increased 3% in the same period from 8,013 per 100,000 in 2020 to 8,219 in 2021. Pacific rates dropped 8% from 7,730 in 12 months to June 2020 to 7,141 per 100,000 in the 12 months to June 2021.

While the gap between Māori and Pacific 45-64 years ASH rates and the Other ethnicity group has narrowed over the last two years reporting periods we have not met our overall goal of no inequity. Large inequities remain with Māori rates 2.3 times higher and Pacific two times higher compared to Other ethnicity 45-64 ASH rates in the 12 months to June 2021.

Reducing Māori and Pacific 45-64 year old ASH rates remain a priority for the DHB.

Mental Health and Addictions

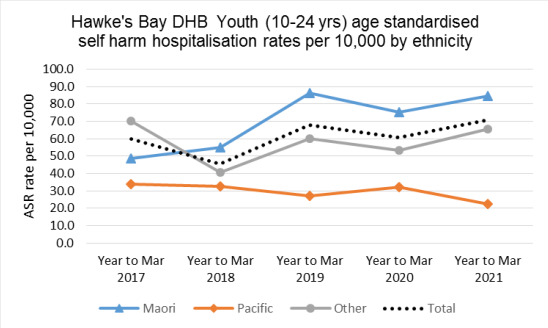
Mental health and addictions impact the lives of many people in Hawke's Bay. Each year, around one in five of our population experience mental illness or significant mental distress. Whānau have told us alcohol and drug addiction, particularly methamphetamine, is having a significant impact on whānau wellbeing in our district.

Specialist mental health and addiction services are funded for people severely affected by mental illness or addictions. Better and timely access to a broad range of services improves people's mental health and wellbeing and contributes to better outcomes and recovery. A new model of primary mental health support (Te Uru Matai) is being implemented across our health system. The model puts mental health and wellbeing at the heart of general practice with Health Improvement Practitioners and Health Coaches working as part of the general practice team. This model is expected to support earlier mental health and addictions intervention and continuity of care for our population.

Reduce self-harm hospitalisations in young people

Intentional self-harm is indicative of young people in distress. This may indicate problems in accessing primary mental health and referral pathways and cross sector/community support.

The measure here is the number of young people (10-24 years) who live in Hawke's Bay who are admitted to hospital for intentional self- harm.



The goal is a 10% reduction in rates between 2019/20 and 20/21.

This is a System Level Measure.

Hawke's Bay DHB youth self-harm hospitalisation rates have increased by 16% from 60.9 per 10,000 young people (10-24 years) in the 12 months to March 2020 to 70.9 per 10,000 in March 2021 (224 events).
Rates for Māori youth has increased 12 % from 75.5 per 10,000 young people in 12 month to March 2020 to 84.6 per 10,000 in 12 months to March 2021 (106 events).
The Other ethncity young people self-harm hospitalisations have increased by 23% in the same period. Māori rates remain 20% higher than the Other ethnicity group in the 12 months to March 2021.
The investment in, and roll-out of, primary mental health services in general practices is aimed to reduce this growing mental health issue.

Reduce suicide rates

Intentional self-harm age standardised mortality rates per 100,000 population.

This measure is not available as updated age standardised rates are not currently available.

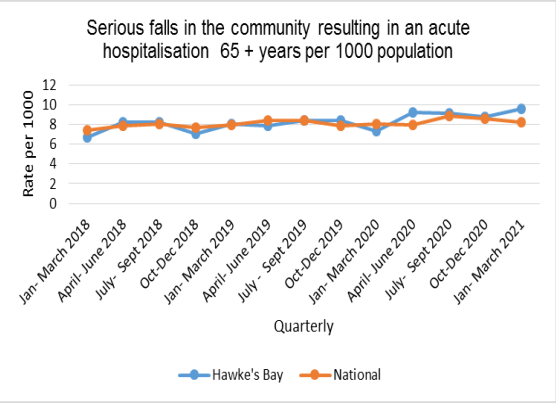
Frail and Older People

With an aging and growing older population in Hawke's Bay, managing frailty and the health and wellbeing of our older population is a priority. Promoting healthy lifestyles including good nutrition, exercise and long term condition management can help people avoid developing and/or exacebating long term health conditions and the progression towards frailty. Early detection and management of frailty and access to primary care and prevention service, for instance falls prevention services, is vital to supporting older people to live independently in the community. As is fair and equitable access to home based support services.

Reducing acute hospitalisations in our older population is a key goal in this priority area and gives us assurance that our older people are supported to live well in their communities.

Reduce serious falls resulting in acute hospitalisation

Falls in older people are common and a leading cause of hospitalisation in Hawke's Bay DHB. Serious falls leads to injury and hospitalisation, a loss of independence, and an increased risk of admission to residential care.



The goal is a reduction in rates.
This is an indicator from the national "Live Stronger for Longer" Falls prevention outcome framework. This programme is a patnership between ACC, Health Quality and Safety Commision and the Ministry of Health and DHB's.

The rate of serious falls resulting in an acute hospitalisation for older people 65 years and over in Hawke's Bay is similar to national rates.

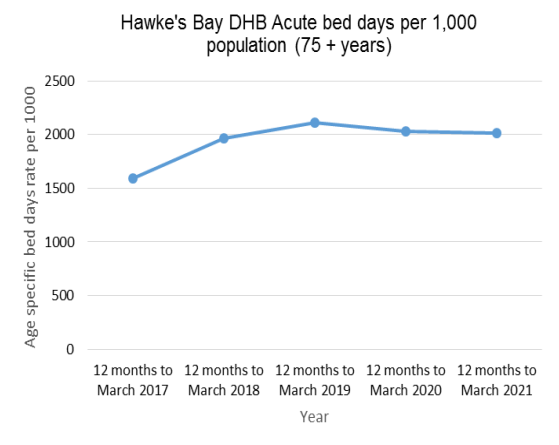
In the last quarter reported Jan - March 2021, 315 older Hawke's Bay people had a fall resulting in injury and hospitalisation or 9.63 per 1000. This was 17% higher than the national rate of 8.2 per 1000 population..

The DHB continue's to work with our cross sector partners to support falls prevention programmes. Early identification of people at risk of falls, for instance in assessment's by General Practitioner/Nurse visits or when in hospital is shown to be effective in a reducing falls in our older population.

In 2020/21 89.6% of older people in hospital were given a falls risk assessment and 93% of those assessed at-risk were given an individualised care plan.

Reduce the acute bed days in 75+ population.

This is a measue of how well our older people 75+ years are supported to remain out of hospital.



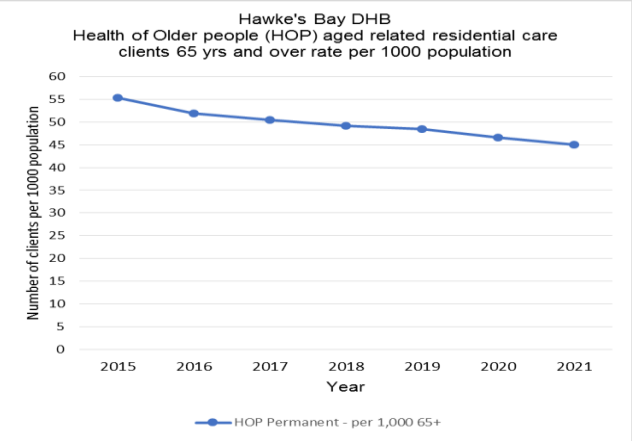
The goal is a reduction in rates.
This is a System Level Measure.

Acute Bed days per 1000 population in the 75 years and older while increasing between 12 months to March 2017 and 12 months to March 2019 rates have declined only slightly.

Acute bed days per 1,000 population in the Hawke's Bay 75 years and over age group declined by 1% between 12 months to March 2020 and 12 months to March 2021.

The absolute bed days have remained static at an average 28,500 bed days in each year over the last three years which indicates no change in absolute acute demand.

Increase the 65 years and over population remaining independent in their own homes



The goal is to see a reduction in rates.
This is a local DHB outcome measure.

There has been a pleasing reduction in the number of clients 65 years and over per 1000 population living in age related residential care. This gives us assurance that we are supporting more of our older people to live independently in the community.

Responsive Health System

A key priority for Hawke's Bay DHB is our people have access to appropriate and responsive health care when health events occur. This could be primary, secondary or tertiary health services.

Access to timely services acrosss the health continum from prevention through to end-of-life is vital to support wellness and quality of life in our population. Our aim here is for fewer people to die prematurely from potentially avoidable conditions such as cardiovascular disease, cancer and diabetes.

Examples of this is the early, timely and equitable access to cancer treatment including diagnostics, surgery, chemotherapy and radiation oncology which contributes to improved survival rates and improved life expectancy outcomes for our population.

Reduce inequity in cancer mortality

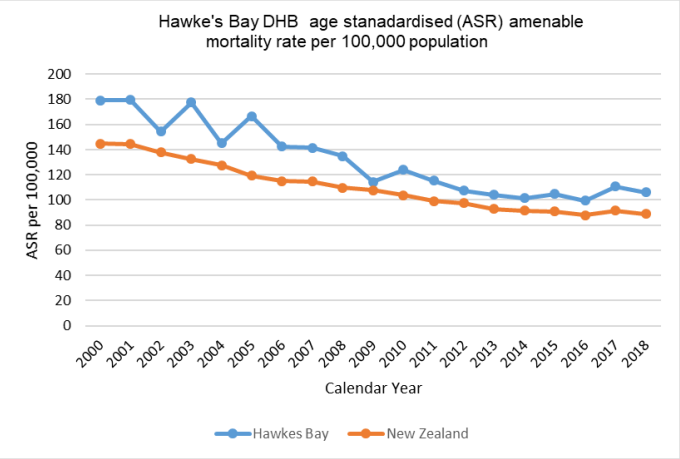
Cancer is one of the leading causes of mortality in Hawke's Bay and contributes to a high proportion of premature deaths. The DHB continues to achieve national Faster Cancer Treatment targets with 88% of people provided with urgent cancer treatment within the target timeframe in 2020/21.

Cancer mortality rates	
Cancer age standardised mortality rates per 100,000 population	This measure is not available as updated age standardised rates are not curently available.

Reduce premature mortality in conditions that are amenable to treatment

The amenable mortality rate measures the number of deaths under age 75 years that could be avoided through effective health prevention, detection and management interventions. Top amenable mortality conditions are coronary heart disease, cancers, diabetes, stroke, chronic obstructive pulmonary disease and suicide.

The top cause of amenable mortality for Māori is coronary heart disease (CVD), using a Cardio Vascular Disease Risk Assessment (CVDRA) is one way to identify the risks of CVD early; lifestyle and drug interventions can reduce the risks and severity of the disease. 80.3% of the eligible poulation has had a CVD risk in the last 5 years which is lower than the 90% or greater national target. Large inequities exist in amenable mortality with Māori rates 2.3 time higher than Other ethnicity group in 2018. The population of Pacific people is too small to assess for inequity in this indicator.



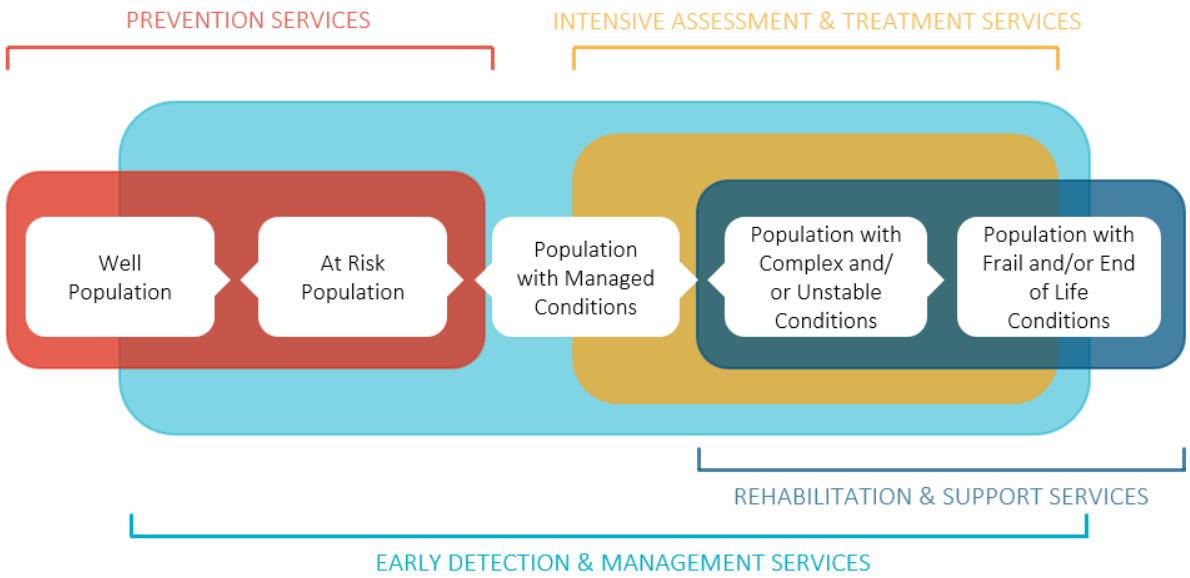
The goal is a reduction in the relative amenable mortality rate from 2.5 times (2016 baseline) between Māori and Other ethnicity group.
This is a System Level Measure.

In 2016 our overall amenable mortality rate is 99.3 per 100,000 population or 226 deaths. The rate has increased to 106 per 100,000 population or 262 deaths in 2018.
Overall amenable mortality rates have increased over the last five years 2014 to 2018. There has been a small decrease in 2018.

However while the amenable mortality relative rate between Māori and the Other ethnicity has narrowed from 2.5 in 2016 to 2.3 in 2018 (the most up to date mortality data available), the Māori amenable mortality rate in 2018 was 2.3 times higher than Other ethnicity group
(193.4 per 100,000 compared to 82.7 per 100,000). This means a large inequity remains for this outcome measure.

Part III – Statement of Service Performance

Output Overview



The Statement of Performance (SP) presents a snapshot of the services provided for our population and how these services are performing, across the continuum of care provided. The SP is grouped into four output classes that are a logical fit with the stages of the continuum of care (see diagram above) and are applicable to all DHBs:

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

These measures help to evaluate the DHB's performance over time are reported for each output class, recognising the funding received, Government priorities, national decision-making and Board priorities.

The performance measures chosen are not an exhaustive list of all our activity, but they provide a good representation of the range of outputs that we fund and/or provide. They also have been chosen to reflect outputs which contribute to the achievement of national, regional, and local outcomes. Where possible, we have included with each measure past performance as a baseline data to support evaluation of our performance.

The criteria against which we measure our output performance is applied to each indicator in the Output Measures section.

Criteria	Rating	
On target or better	Achieved	●
0.1-5% away from target	Substantially achieved	●
>5% to 10% away from target	Not achieved but progress made	●
>10% away from target	Not achieved	●

Output Class 1: Prevention Services

Prevention services help to protect and promote health in our population. A broad view of prevention services encompasses; health promotion to help prevent the development of disease, statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases, and population health protection services (e.g. immunisation and screening services).

Statement of Service Performance Output Class 1

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

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

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

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
BETTER HELP FOR SMOKERS TO QUIT					
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.[1]	Jan 19 - Dec 19	82.20%	[2]90.63%	81.32%	≥90%	
Māori		83.30%	89.47%	82.72%	
% of Primary Health Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months[3]	15m to Dec 19	69%	60.6%	50.2%	≥90%	
Māori		68%	56.1%	47.5%	
Pasifika		65%	56.4%	40.1%	
Other		74%	65.4%	53.6%	

[1] Better help for smokers to quit supported by primary care (Primary health care practitioners and Lead Maternity Carers in pregnancy) are national measures. Smoking rates for Hawke's Bay Māori women are particularly high and giving brief advice and support during pregnancy is a key equity priority. All HBDHB midwives have been equipped with carbon monoxide monitors in the 20/21 year and these have become routine practice when engaging with their clients. The monitors have also supported midwives having conversations with whānau about second hand smoke. This programme will contribute to improving this result. The indicator results for this measure are provided by the Ministry of Health and are not available for all ethnicities.

[2] The 19/20 result published in the Hawke's Bay Annual Report 2019/20 (82%) has been updated this year to 90.63 % due to the correction of records in the maternity information system and the updating of Lead Maternity Carer roles. Ethnicity breakdown was not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[3] The ABC programme refers to health professionals asking about smoking status, providing brief advice and providing cessation support. This performance measure reflects smokers given advice and support in general practice in the last 15 months. The target this year has not been achieved and results have been impacted by the diversion of general practice in responding to the COVID-19

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking[4]	Jan 19 - Dec 19	97%	97%	96%	≥95%	
Māori		97%	97%	96%		
Pasifika		98%	97%	96%		
Other		97%	97%	96%		
IMPROVE BREAST SCREENING RATES					
% of women aged 50-69 years receiving breast screening in the last 2 years[5]	2y to Dec 19	76%	72%	69%	≥70%	
Māori		73%	70%	59%		
Pasifika		70%	96%	60%		
Other		67%	75%	71%		
IMPROVE CERVICAL SCREENING COVERAGE					
% of women aged 25-69 years who have had a cervical screening event in the past 36 months	3y to Dec 19	75%	74%	[6]69%	≥80%	
Māori		75%	74%	62%		
Pasifika		76%	76%	62%		
Other		76%	75%	73%		
INCREASE IMMUNISATION[7]					
% of eight-month-olds olds fully immunised.	Apr 19 - Mar 20	92%	91%	[8]90%	≥95%	
Māori		91%		83%		
Pasifika		95%		96%		
Other		84%		94%		
% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age[9].	Apr 19 - Mar 20	91.00%	91.42%	88.06%	≥95%	
Māori		89.40%	90.29%	86.05%		
Pasifika		94.90%	95.38%	85.16%		
Other		82.50%	89.86%	90.35%		

pandemic. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[4] NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[5] The cervical and breast cancer screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer by allowing for earlier intervention and treatment.

[6]Rates for cervical screening in Hawke's Bay are below target. Māori and Pasifika population estimates, which drives calculation of coverage rates, were updated in 2020 resulting in increased population estimates. The number of smears taken in Hawke's Bay have reduced since COVID 19 with the various challenges of the pandemic and workforce shortages via outreach clinics and general practice. There are limited options for women who are unenrolled in general practice to have access to cervical screening. The DHB Population Health Screening team is working closely with Health Hawke's Bay (PHO) to support improved uptake of screening for Pacific and Māori women who are not meeting the standards in both cervical and breast cancer screening.

[7] Immunisation at eight months, two years and five years are national performance measures

[8]. Māori and Pacific whānau increasingly delaying immunisations for many reasons, including immunisation hesitancy, transitional housing situations, access to appointments, and lack of transport. We are also seeing a decrease in the % of new-borns enrolled with general practice at 6 weeks and 3 months. The current immunisation delivery model is not meeting the needs of Māori and Pacific children in particular. Māori have not met immunisation targets for eight month, two year and five year olds milestones in the 20/21 year

[9] This measure has had a change in its description to be consistent with the Ministry of Health wording of the measure and therefore differs from that used in the 2019/20 Annual Report. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

Output measure	Baseline		Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% of girls and boys fully immunised - HPV vaccine[10]	Jul 18 - Jun19	73.80%	61.32%	63.00%	≥75%	
Māori		85.60%	64.13%	64.10%		
Pasifika		75.00%	67.77%	67.90%		
Other		65.00%	58.18%	78.20%		
% of 65+ year olds immunised - flu vaccine[11]	Mar 19 - Sep 19	60%	60%	73%	≥75%	
Māori		53%	53%	77%		
Pasifika		46%	46%	66%		
Other		61%	61%	74%		
INCREASED IMMUNISATION AT TWO YEARS						
% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years[12]	Jan 19 - Dec 19	93.9%	93.8%	89.6%	≥95%	
Māori		93.2%	93.1%	85.8%		
Pasifika		98.0%	97.8%	94.6%		
Other		93.9%	91.4%	92.0%		
REDUCED INCIDENCE OF FIRST EPISODE OF RHEUMATIC FEVER						
Acute rheumatic fever initial hospitalisation rate per 100,000[13]	Jul 18 - Jun 19	2.3	1.7	5.6	≤1.5 per 100,000	
Māori				14.6		
Pasifika				13.7		
Other				1.8		

[10] This is a national measure where the 20/21 target is 75% of girls and boys in the birth cohort 2007 are fully immunised for HPV. The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV related cancer later in life. We have seen a small increase in our total HPV vaccination coverage rate in the 20/21 year but the result remains below the target of 75%. There has been increasing demand on the vaccination team from the COVID 19 vaccination rollout which as impacted on other vaccination services such as HSV. This is the same nationally and HPV coverage has reduced across the New Zealand. There is ongoing declines in HPV due to misinformation. Work is well underway to increase rates in 2021 in school immunisation programmes and in partnership with Health Hawke's Bay (PHO), using the HPV 14 year old recall initiative. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[11] The measure is reporting vaccinations delivered between March and September 2020 (the influenza season) to the 65 years and over population. The objective is to protect this vulnerable population against flu and reduce avoidable hospitalisations. Significant effort went into increasing the immunisation rates in our 65 years and over population in the 20/21 year as part of the overall COVID-19 health response for instance making vaccination available through mobile programmes in the communities and also through pharmacies. As a result we have seen an increase in influenza immunisation coverage in the 65 years and over age group in the 20/21 year across all ethnicity groups. Māori coverage rates of 77% were above the 75% target. Pasifika rates improved substantially from the previous year but remained under target. The traditional approach to vaccination through primary care has not been as effective for Pacific people. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[12] This measure was not reported in the 2019/20 Annual report.

[13] There has been an increase in acute rheumatic fever initial hospitalisation rates in the 20/21 year. The rate is well above the target 1.5 per 100,000 population. The increase will be associated with the current housing shortage and consequential higher housing costs and household crowding.

Statement of Service Performance Output Class 2

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

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

By promoting regular engagement with health services we support people to maintain good health through earlier detection and management services based in the community. These services provide an opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self- management (avoidance of complications, acute illness and crisis). These services deliver coordination of care, ultimately supporting people to maintain good health.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
BETTER ORAL HEALTH[14]					
% of preschool children (aged 0-4 years of age) enrolled in and accessing community oral health services (Yr1)[15]	Jan 19 - Dec 19	91.2%	91.2%	92.5%	≥95%	
Māori		75.9%	75.9%	77.4%		
Pasifika		83.1%	83.1%	84.9%		
Other		106.8%	106.8%	[16]108.3%		
% of children (aged 0-12 years of age) overdue for their scheduled examinations with Community Oral health[17] service (Yr1)	Jan 19 - Dec 19	13.70%	13.72%	23.99%	≤10%	
Māori		15.20%	15.18%	20.44%		
Pasifika		21.50%	21.50%	16.52%		
Other		12.00%	12.01%	27.03%		

[14] All oral health indicators are for the calendar year prior to the end of the financial year.

[15]This is a national oral health measure. Early enrolment of pre-school children in publicly funded child oral health programmes enables early engagement and provides opportunities for oral health promotion and interventions aimed at prevention of oral disease, and reduces the prevalence of dental decay in children. There has been an increase in children (0-4yrs) enrolled across all ethnicity groups in the 20/21 year. Poorer engagement with Maori and Pasifika have contributed to the variance. Increasing enrolment rates of Māori and Pasifika children remain a focus NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[16] There remains an issue with the denominator "estimated population" in this measure particularly for the Other ethnicity group where there are more 0-4 year old Other children enrolled in the Community Oral Health Service compared to the estimated population. This could indicate a data quality issue in the ethnicity data capture in the Oral Health Information System or an undercount of the Other ethnicity estimated population.

[17] This is a national oral health measure. It provides an indication of the coverage and timeliness of treatment in publicly-funded oral health services for school aged children 0-12 years delivered by the Community Oral Health Service. The measure description differs slightly to that used in the 2020 Annual Report to include the age group and the provider of the service in the description of the measure. Twenty four percent of children were overdue for their scheduled examinations with Community Oral Health Services in 2020 calendar year. The overall results have deteriorated since the baseline. In the current 20/21 year all ethnicity groups are above the target of less than or equal to 10%. This result is reflective of service capacity issues. Staffing continues to be a challenge as our aging workforce retire. The recent introduction of digital radiography throughout the service in 20/21 and the delivery of four new mobile dental vans in the 21/22 year will improve service delivery. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

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Output measure		Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years (Yr1)[18]	Jan 18 - Dec 18	62.4%	61.1%	33.2%	≥85%	🔴
IMPROVED ACCESS PRIMARY CARE						
% of Māori population enrolled in the PHO[19]	Jan 20				≥95% Māori	
Māori		99%	92%	87%		🟡
IMPROVED MANAGEMENT OF LONG- TERM CONDITIONS (CVD, ACUTE HEART HEALTH, DIABETES, AND STROKE)						
% of the eligible population will have had a Cardiovascular disease (CVD) risk assessment in the last five years[20]	5y to Dec 19	82.20%	81.22%	80.30%	≥90%	🔴
Māori		78.00%	76.53%	77.00%		🔴
Pasifika		76.10%	74.90%	75.90%		🔴
Other		84.30%	83.42%	82.00%		🟡
% of people with diabetes who have good or acceptable glycaemic control (HbA1c<64mmols)[21]	Jan 19 - Dec 19	37.3%	[22]39.1%	31.0%	≥60% No Inequity	🔴
Māori		30.4%	32.7%	23.1%		🔴
Pasifika		26.6%	33.3%	21.6%		🔴
Other		42.6%	43.5%	36.9%		🔴
IMPROVING NEW-BORN ENROLMENT IN GENERAL PRACTICE						
% of new-borns enrolled in general practice by 6 weeks[23] of age	Jan 19 - Dec 19	70%	69%	66%	≥55%	🟢
Māori		56%	56%	50%		🟡
Pasifika		81%	84%	67%		🟢
Other		79%	81%	82%		🟢

[18] This is a national oral health measure. There has been a marked deterioration in our adolescent oral health utilisation rate this year. The result 33 % is well below the target of 85 % or greater. Work to identify barriers to adolescent oral health access is a focus for 21/22 including understanding if any data capture issues are contributing to this poor performance. These results are sourced from the Ministry of Health are not split by ethnicity.

[19] This measure has been reported on in previous years for the total population. This year's focus is on Maori rates. Maori rates in previous years have not been audited.

[20] Cardiovascular disease (CVD) is one of the leading causes of death in Hawke's Bay. CVD risk disproportionately impacts Māori and is the leading cause of premature mortality in Hawke's Bay. By identifying those at risk of CVD early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious cardiac event. Our results in the 20/21 year remain below target. General practice is having increasing problems with capacity within the services offered to manage population health / chronic condition management alongside a growing acute demand and ageing population and a focus on COVI 19 response. There is also an increasing % of the population in Hawke's Bay that isn't enrolled in general practice. Health Hawke's Bay (PHO) is implementing a CVD risk programme in the community in 21/22 where people work and play such as rugby clubs targeting Māori males to improve CVD risk assessment rates. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[21] This is a national standard of quality diabetes care. Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of a patient's blood glucose levels) is a means of assessing the management of people's diabetes condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level. The 20/21 performance has deteriorated across all ethnicity groups and large inequities exist and the % of people with diabetes with good or acceptable glycaemic control remain below the quality standard of ≥ 60%. General practice is having increasing problems with capacity within the services offered to manage population health/chronic condition management alongside a growing acute demand and a focus on COVI 19 response There is also an increasing % of the Hawke's Bay population that isn't enrolled in general practice There is 11 GP practice's out of 21 (52 % of all practices in Hawke's Bay) open for new patient enrolments as at June 2021. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[22] The 19/20 result for this measure (66%) has been updated to 39.1 % in 2021 due to an error in data input and therefore differs to that published in the 2019/20 Annual Report.

[23] This is a national measure of the timeliness of new-born enrolment at 6 weeks. Early new-born enrolment with General Practice supports "on time" 6 week immunisations and detection of any early health or social issues emerging. Improving early new-born enrolment remains a focus for the DHB in 21/22 particularly for Māori new-born who remain below the national 6 weeks and 3 month enrolment targets

Output measure		Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% of new-borns enrolled in general practice by 3 months of age	Jan 19 - Dec 19	91.70%	85.00%	80.69%	≥85%	
Māori		75.70%	73.10%	[24]62.17%		
Pasifika		87.50%	95.14%	83.33%		
Other		102.10%	97.34%	99.21%		
INCREASE REFERRALS OF OBESE CHILDREN TO CLINICAL ASSESSMENT AND FAMILY BASED NUTRITION, ACTIVITY AND LIFESTYLE INTERVENTIONS						
% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions[25].	Jan 19 - Dec 19	99.4%	99.6%	100.0%	≥95%	
Māori		99.4%	100.0%	100.0%		
Pasifika		100.0%	100.0%	100.0%		
Other		99.2%	100.0%	100.0%		
LESS WAITING FOR DIAGNOSTIC SERVICES						
% of patients with accepted referrals for Computed Tomography (CT) scans who receive their scan, and scan results are reported, within 6 weeks (42 days)[26]	Jan 19 - Dec 19	85.6%	72.0%	78.0%	≥95%	
Māori				78.0%		
Pasifika				76.0%		
Other				78.0%		
% of patients with accepted referrals for MRI scans who receive their scan, and the scan results are reported, within 6 weeks (42 days).	Jan 19 - Dec 19	85.0%	67.0%	[27]45.0%	≥90%	
Māori				49.0%		
Pasifika				56.0%		
Other				44.0%		
MORE PREGNANT WOMEN UNDER THE CARE OF A LEAD MATERNITY CARER (LMC)						
% of women booked with a Lead Maternity Carer (LMC) by week 12 of their pregnancy[28]	Oct 19 - Dec 19		57%		≥80% Māori	
Māori		53%	53%	49%		

[24] Maori new born enrolment rates at 3 months are below target. Access to enrolment in general practice has deteriorated in Hawke's Bay and is contributing to this result. There is also an increasing % of the Hawke's Bay population that isn't enrolled in general practice. There is 11 GP practice's out of 21 (52 % of all practices in Hawke's Bay) open for new patient enrolments as at June 2021. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[25] NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[26] CT and MRI diagnostic measures are national DHB performance measures and refers to non-urgent scans.

[27] Demand is exceeding our CT and MRI capacity and wait times have increased with less patients are having their CT and MRI and results reported within 6 weeks. Degradation of image quality and equipment downtime and outages (for repair) are key factors in limiting radiology productivity.

[28] This is a national quality measure for maternity services. Early registration with an LMC is encouraged to promote the good health and wellbeing of mother and the developing baby. Our rates of women booked with an LMC by week 12 of their pregnancy fall well short of the national target. Nga Maia and Māori midwives advise many Māori women do not see the benefit of early engagement with an LMC. Additionally, there may be some reluctance to disclose a pregnancy that could have impacts on work and income benefits. There is an active programme of work in 21/22 to improve early engagement with LMC's. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
REDUCE ASH 45-64					
Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years[29]	Jan 19 - Dec 19	4564	4665	≤3510	
Māori		8044	7843 8219		
Pasifika		8372	7141		
Other		3510	3623		
REDUCE THE DIFFERENCE BETWEEN MĀORI AND OTHER RATE FOR ASH ZERO-FOUR - SLM					
Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years[30]	Jan 19 - Dec 19			≤8205 Māori	
Māori		8637	7323 7680		

[29] Ambulatory Sensitive hospitalisations (ASH) are hospital admissions which could have been avoided through access and interventions in primary care. ASH rates in the age group 45-64 years is a reflection of how effective primary care is in supporting people with long term conditions to manage their conditions and stay out of hospital. The target was set to achieve equity between Māori, Pacific and the Other ethnicity group. There has been increases in ASH rates across all ethnicity groups excluding Pasifika and targets were not meet across all population groups. Access to general practice is providing challenges for the Hawke's Bay Health sector. General practice is facing capacity issues within the services offered to manage population health / chronic condition management alongside a growing acute demand and COVID-19 response. There is also an increasing % of the population that are not enrolled in general practice.

[30] Ambulatory Sensitive hospitalisations (ASH) are hospital admissions which could have been avoided through access and interventions in primary care. In the ASH age group (0-4 years) the target had a focus to improve Māori ASH rates.

Impact

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

Statement of Service Performance Output Class 3

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

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

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

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
BETTER ACCESS TO MH&A SERVICES					
Proportion of the population seen by Mental Health and Addiction (MH&A) services[31] Adult (20-64)	Oct 18 - Sep 19	5.60%	5.55%	4.51%	≥5.4%
Māori		11.00%	10.96%	7.97%	
Pasifika		3.40%	3.75%	3.38%	
Other		3.90%	3.85%	3.25%	
Proportion of the population seen by MH&A services Older adult (65+)[32]	Oct 18 - Sep 19	1.0%	1.00%	0.85%	≥1.15%
Māori		1.4%	1.61%	1.25%	
Pasifika		1.4%	1.03%	1.95%	
Other		1.0%	0.93%	0.80%	

[31] This measure is a national DHB performance measure and standards are set nationally based on the expectation that over 5.4 percent of the adult population (20-64yrs) will need access to specialist mental health support. The Māori population continues to have access rates higher than target. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[32] Traditionally Hawke's Bay has lower access rates in this age group against the nationally set target for Hawke's Bay. Our interpretation of this is that clients are well managed in community settings, however we continue to monitor and address any indicators of an escalation in need. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
Proportion of the population seen by MH&A services Child & youth (zero -19)[33]	Oct 18 - Sep 19	3.70%	3.67%	2.91%	≥4.3%	🔴
Māori		4.10%	4.04%	3.09%		🔴
Pasifika		1.90%	1.98%	2.11%		🔴
Other		3.50%	3.40%	2.78%		🔴
EQUITABLE ACCESS TO CARE FOR STROKE PATIENTS						
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)[34]	Jan 19 - Dec 19	10%	9%	10%	12%	🔴
Māori		7%	10%	14%		🟢
% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital[35]	Jan 19 - Dec 19	75.5%	74.0%	70.2%	80%	🔴
Māori		78.6%	79.4%	68.3%		🔴
Pasifika		88.9%	68.8%	80.0%		🟢
Other		74.4%	73.0%	70.4%		🔴
% of patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission[36]	Jan 19 - Dec 19	69.6%	45.1%	42.6%	≥80%	🔴
Māori		88.9%	50.0%	35.7%		🔴
Pasifika		No Data	50.0%	[37]0.0%		🔴
Other		No Data	43.5%	46.2%		🔴

[33] This measure is a national DHB performance measure and standards are set nationally based on the expectation that over 4.3 percent of the population (under 20 years) will need access to specialist mental health support. A significant number of clinical vacancies in the Child Adolescent and Family Mental Health and Addiction service has impacted on the ability to accept referrals in the 20/21 year and access rates in the 0-19 year age group have dropped and are below target. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[34] This measure has had a change in its description to be consistent with the Ministry of Health wording of the measure and therefore differs from that used in the 19/20 Annual Report. Hawke's Bay 24/7 access to the Central Region Tele-stroke service (provided from Capital & Coast DHB) came into effect at the beginning of March 2021. The measure (proportion of acute stroke patients receiving thrombolysis) improved since then and we anticipate that this service model change will see longer term improvement in performance. The indicator results are not currently available for all ethnicity groups. NOTE: Maori results were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[35] The stroke service measures are set nationally and are based on Australasian Clinical Guidelines for Stroke Management. A stroke pathway is now in place to ensure all Acute Assessment Unit stroke discharges are captured and passed on to the Stroke Clinical Nurse Specialist for appropriate follow up. This will help meet the 80% target of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[36] The continuing high occupancy rate of the Hawke's Bay Regional hospital has impacted on the rehabilitation unit and bed availability and we have not met the 80% target for patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[37] The 0% represented two patients who were not moved to a rehabilitation service within 7 days of an acute stroke admission Although not a good result small numbers of Pasifika patients can create variability in performance.

Output measure	Baseline		Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	Jul 19 - Sep 19	[38]69%			≥60%	
FASTER CANCER TREATMENT (FCT)[39]						
% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat[40].	6m to Dec 19	86.32%	87.00%	89.76%	≥85%	
Māori		92.31%	83.66%	95.68%		
Pasifika		100.00%	75.00%	88.89%		
Other		84.85%	89.30%	88.47%		
% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	6m to Dec 19	87.32%	81.50%	87.68%	≥90%	
Māori		91.67%		96.88%		
Pasifika		100.00%		[41]50.00%		
Other		85.96%		85.58%		
FEWER MISSED OUTPATIENT APPOINTMENTS						
Did not attend (DNA) rate across first specialist assessments[42]	Jan 19 - Dec 19	5.8%	6.0%	5.9%	≤6%[43]	
Māori		11.1%	12.0%	12.3%		
Pasifika		12.9%	13.0%	13.3%		
Other		3.7%	3.9%	3.8%		

[38] Hawke's Bay DHB does not provide a community stroke rehabilitation service. Baseline data published in 20/21 SPE 69% was based on a definition of community rehabilitation which were incorrect.

[39] These indicators are part of the Faster Cancer Treatment pathway and targets are set nationally.

[40] NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[41] Fifty percent of Pasifika (1 out of 2 patients) with high suspicion of cancer received their cancer treatment within 62 day time-frame which was below the target.

[42] This is a local indicator. Māori and Pasifika First Specialist Assessment Did Not Attend (DNA) rates remain consistently below target. Despite a focussed programme within the Pacific Health Team, Pasifika DNA rates have remained stubbornly high. Barriers to access such as time of appointment's, getting time off work to attend, transport issues, whānau availability to support continue to contribute to the poor result.

[43] An error occurred in the HBDHB Annual Plan 20/21, whereby the target was set as ≥6%, when it should have been ≤6%. The later has been used in our rating assessment.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
IMPROVING MENTAL HEALTH SERVICES USING DISCHARGE PLANNING[44]					
Community services transition (discharge) plans:					
% of clients discharged from community MH&A will have a transition (discharge) plan[45]	Oct 18 - Sep 19	77.90%	80.00%	74.57%	≥95%
% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan[46]	Oct 18 - Sep 19	72.50%	64.70%	35.00%	≥95%
% of clients discharged will have a quality transition or wellness plan[47]	Oct 18 - Sep 19	99.4%	99.0%	95.96%	≥95%
INCREASING CONSUMER FOCUS MORE EQUITABLE USE OF MENTAL HEALTH ACT: SECTION 29 COMMUNITY TREATMENT ORDERS					
% reduction in the rate of Māori under s29 orders per 100,000 population					
Māori	Jan 19 - Jun 19	439	439	434	395 ≤Māori
LESS WAITING FOR ED TREATMENT					
% of patients admitted, discharged or transferred from an emergency department (ED) within six hours[48].	Jan 19 - Dec 19	81.4%	79.0%	74.8%	≥95%
Māori		84.5%		79.7%	
Pasifika		86.9%		82.6%	
Other		79.2%		71.7%	
MORE APPROPRIATE ELECTIVE SURGERY					
Number of planned care procedure discharges for people living within the HBDHB region.[49]	Jul 18 - Jun 19	6907	6009	7386	7,427[50]
PATIENTS WITH ACS[51] RECEIVE SEAMLESS, COORDINATED CARE ACROSS THE CLINICAL PATHWAY[52]					
% of Acute Coronary Syndrome (ACS) patients undergoing coronary angiogram - door to cath within 3 days[53]	Jan 19 - Dec 19	59.2%	53.7%	61.0%	≥70%
Māori		66.1%	49.1%	61.3%	
Pasifika		50.0%	60.0%	66.7%	
Other		60.8%	54.7%	61.1%	

[44] These measures are national DHB performance measures. Maintaining and improving patient engagement through the use of a transition/discharge plan ensures that services are responsive to patient needs and that people are better able to manage their mental health condition.

[45] The indicator results are not currently reported by ethnicity.

[46] Improvements in discharge planning to include the community teams earlier will contribute to an improvement in this result. The indicator results are not currently reported by ethnicity.

[47] This measure description differs to that used in the 2019/20 Annual Report. This indicator was worded; % of clients with an open referral to MH&A services of greater than 12 months have a wellness plan. The indicator results are not currently reported by ethnicity.

[48] Emergency Department (ED) performance against the six-hour standard remains significantly below target. The main contributory factor remains very high hospital occupancy and shortage of inpatient bed availability and the impact this has on hospital flow and ED occupancy.

[49] The name of this measure has changed from previous years Annual Reports to reflect the new Ministry of Health Planned care measures. This measure is the elective surgical discharges component of the planned care intervention target set by the Ministry of Health. The other two components are minor procedures and non-surgical procedures which are not assessed in the SSP. Hawkes Bay DHB delivery of elective surgical procedures increased in the 21/22 year over previous years and substantially achieved target. These results are sourced from the Ministry of Health and are not currently available by ethnicity.

[50] This target was set following publication of the HBDHB Annual Plan 20/21; in agreement with the Ministry of Health. The agreed target has been used in our rating assessment.

[51] ACS is an acronym for "Acute Coronary Syndrome"

[52] These are all Australia and New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS-QI) indicators and measure quality standards for acute heart services such as timeliness to Cath Lab, registration completeness on the ANZACS QI register, ACS patients who have an angiogram also have a pre-discharge echocardiogram of LV gram (LVEF) and prescribing of prevention medication. We have seen improvements in performance across all indicators in 20/21.NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[53] The results of 61 % is below the target This is largely due to fixed radiology capacity for coronary angiograms NOTE: Ethnicity results in prior years have not been audited.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF	Jan 19 - Dec 19	71.8%	72.8%	84.1%	≥85%	
Māori		74.6%	75.0%	85.3%		
Pasifika		83.3%	57.1%	90.0%		
Other		70.4%	72.2%	82.9%		
% of ACS patients who undergo coronary angiogram are prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF <40% should also be on a beta blocker (five classes)[54]	Jan 19 - Dec 19	61.0%	60.6%	75.0%	≥85%	
Māori		69.0%	55.2%	70.8%		
Pasifika		100.0%	100.0%	77.8%		
Other		59.3%	63.9%	75.6%		
PLANNED CARE					
% of services that report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less) (ESPI 1)[55]	Jan 19 - Dec 19	73.70%	74.00%	100.00%	100%	
Māori		N/A	84.21%	94.74%		
Pasifika		N/A	70.59%	88.89%		
Other		N/A	78.95%	100.00%		
% of patients waiting over four months for FSA (ESPI 2)[56]	Dec 19	28%	45%	21%	0%	
Māori		28%	47%	23%		
Pasifika		27%	42%	22%		
Other		27%	43%	20%		
% of patients waiting over 120 days for treatment (ESPI 5)[57]	Dec 19	21.8%	43.6%	36.6%	0%	
Māori		19.6%	41.7%	34.5%		
Pasifika		23.4%	46.7%	31.6%		
Other		20.2%	44.0%	37.7%		
% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment[58].	Jun 20	29.9%	31.70%	[59]28.9%	0%	
Māori		38.7%	No Data	No Data		
Pasifika		37.4%	No Data	No Data		
Other		30.1%	No Data	No Data		

[54] This indicator performance for Hawke's Bay is consistent with other DHB;'s within the region. Cardiologists prescribe as closely to these guidelines as clinically possible given consideration to all patient comorbidities. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[55] NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[56] DHBs must manage patient flow processes effectively, in line with the principles of Planned Care. Patient flow processes are measured by a suite of performance indicators referred to as Elective Services Patient Flow Indicators (ESPIs). ESPI 2 is a timeliness measure with a target that no patient waits longer than 4 months for a First specialist assessment. The result is reported as at the end of June 2021. A significant amount of work has gone into reducing the % of patients waiting over 4 months for a First specialist assessment this year after the impact of reduced service delivery over the COVID-19 Lockdown period resulted in an increased patient waiting list. The Hawkes Bay DHB are working closely with the Ministry of Health to deliver against agreed trajectories to reduce our ESPI 2 waitlist. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[57] ESPI 5 is a timeliness measure with a target that no patient given certainty for treatment waits longer than 4 months. The result is reported as at end of June 2021.There has been some improvement in performance compared to 20/21 which was impacted by reduced delivery of elective surgery during COVID-19 Lockdown. An ESPI 5 trajectory has been developed and agreed to with the Ministry of Health. Monitoring trajectories will ensure HBDHB can mitigate any concerns in a timely manner and will improve performance for ESPI 5 indicator. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[58] This measure was reported as numbers of patients in the 2019/20 Annual Report and as percentages this year.

[59] Increase in demand impacted on the result in the 20/21 year.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
Acute readmissions to hospital	Oct 18 - Sep 19	11.90%	11.98%	**12.19%**	≤11.8%	
Māori		12.10%		**11.76%**		
Pasifika		11.40%		**11.05%**		
Other		11.80%		**12.43%**		
QUICKER ACCESS TO DIAGNOSTICS						
% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)[60]	Jan 19 - Dec 19	94.8%	88.0%	85.7%	≥95%	
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days[61], inclusive),	Jan 19 - Dec 19	92.0%	88.0%	91.4%	≥90%	
Māori		85.1%	80.4%	84.3%		
Pasifika		93.1%	64.7%	100.0%		
Other		93.4%	90.4%	92.8%		
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)[62]	Jan 19 - Dec 19	50.1%	34.0%	48.5%	≥70%	
Māori		45.6%	34.0%	41.8%		
Pasifika		55.7%	43.5%	48.0%		
Other		50.8%	33.9%	49.9%		
% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date[63]	Jan 19 - Dec 19	50.8%	41.8%	52.2%	≥70%	
Māori		51.4%	40.4%	51.5%		
Pasifika		58.8%	27.6%	45.5%		
Other		50.7%	42.0%	52.3%		
% of people who returned a positive faecal immunochemical test (FIT) have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP information system.[64]	Jan 20	97%	94%	100%	≥95%	
Māori		98%	98%	100%		
Pasifika		100%	100%	100%		
Other		No Data	95%	100%		
REDUCING WAITING TIMES SHORTER WAITS FOR NON-URGENT MENTAL HEALTH AND ADDICTION SERVICES FOR ZERO-19 YEAR OLDS[65]						
% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm	Jan 19 - Dec 19	75.2%	74.3%	75.0%	≥80%	
Māori		77.7%	76.2%	78.2%		
Pasifika		68.2%	65.2%	78.6%		
Other		73.5%	73.3%	72.8%		

[60] These results are sourced from the Ministry of Health and are not currently available by ethnicity.

[61] NOTE: Ethnicity results in prior years have not been audited.

[62] There has been some improvement in meeting waiting times for non-urgent diagnostic colonoscopy in the 20/21 year however we have not met target. We have had increased demand from the bowel screening programme and on-going capacity issues due to gastroenterologist vacancies in the 20/21 year. The DHB provider arm is actively reviewing their endoscopy recovery plan and capacity and demand modelling to manage performance issues. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[63] There has been some improvement in meeting waiting times for surveillance diagnostic colonoscopy in the 20/21 result. We have had on-going capacity issues due to gastroenterologist vacancies in the 20/21 year which have also impacted on meeting surveillance colonoscopy time frames. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[64] NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[65] These are Mental Health and Addiction wait time measures with targets set nationally. There has been some improvements in these measures in 20/21 particularly for the % of patients seen in the 3 weeks and 8 week waiting time frames in the Mental Health service provider arm. However the % of patients seen within 3 week time frame did not meet the target of 80%. The % of patients seen in 3 weeks and 8 weeks referral waiting time frames for addiction referrals have deteriorated overall in the 20/21 year. Child

Output measure	Baseline		Previous Year (2019/20)	Current year (2020/21)	Target	Rating
% of zero-19 year olds seen within 3 weeks of referral Addictions (provider arm and non-government organisation (NGO))	Jan 19 - Dec 19	83.0%	78.0%	75.0%	≥80%	
Māori		78.9%	68.4%	85.7%		
Pasifika		100.0%	100.0%			
Other		85.2%	87.0%	60.0%		
% of zero-19 year olds seen within 8 weeks of referral Mental health provider arm	Jan 19 - Dec 19	93.3%	92.6%	96.5%	≥95%	
Māori		92.1%	90.9%	97.7%		
Pasifika		100.0%	100.0%	92.9%		
Other		93.8%	93.6%	95.8%		
% of zero-19 year olds seen within 8 weeks of referral Addictions (provider arm and NGO)	Jan 19 - Dec 19	97.9%	96.0%	79.2%	≥95%	
Māori		94.7%	89.5%	85.7%		
Pasifika		100.0%	100.0%	[66]0.0%		
Other		100.0%	100.0%	70.0%		

Adolescent and Family Mental Health and Addiction Services (CAFS) have faced increasing capacity issues with the eight clinical vacancies in the 20/21 year and increasing referrals. While some referrals have been outsourced, the wider capacity issues has impacted on waiting times for non-urgent referrals. A recruitment drive has resulted in five new clinicians recruited to start in the 21/22 year. NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[66] The result for Pasifika 0% represents non-compliance in timeframes in the one Pasifika referral who wasn't seen in the time frame. Small numbers of Pasifika patients can create variability in performance.

Output Class 4: Rehabilitation and support services

Statement of Service Performance Output Class 4

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. Hawke's Bay DHB provides NASC services through NASC Hawke's Bay (in the provider arm). 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 frail and/or end of life conditions.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family/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.

Output measure	Baseline	Previous Year (2019/20)	Current year (2020/21)	Target	Rating
BETTER COMMUNITY SUPPORT FOR OLDER PEOPLE					
Acute readmission rate: 75 years +[67]	Oct 18 - Sep 19	12.3%	12.1%	12.7%	≤12%	
Māori		11.6%	10.8%	11.6%		
Pasifika		9.7%	10.7%	5.9%		
Other		12.4%	12.2%	12.9%		
Acute bed days per 1000 population (in the last 12 months); 65 years + (Māori and Pacific) and 75 years + (Other)[68]	Jan 19 - Dec 19	2002		1929	≤2,002	
Number of Needs Assessment and Service Coordination (NASC) completed assessments (first assessment, reassessments and 3 year routine assessments).[69]	19/20	1795		1910	≥1795	
The average number of subsidised permanent Health of Older People (HOP) and Long Term Support - Chronic Health Conditions (LTS-CHC) residential beds per night per 1,000 of the 65+ population.[70]	18/19	33 per 1,000		31.46 per 1,000	35 per ≤1,000	
MORE OLDER PATIENTS RECEIVE FALLS RISK ASSESSMENT AND CARE PLAN					
% of older patients given a falls risk assessment	Jan 19 - Dec 19	91.0%	90.7%	89.6%	≥90%	
% of older patients assessed as at risk of falling receive an individualised care plan	Jan 19 - Dec 19	94%	92%	93%	≥90%	

[67] NOTE: Ethnicity breakdowns were not reported in the 2019/20 Annual Report but reported this year to support the DHB's equity focus.

[68] This is a new indicator in our SSP.

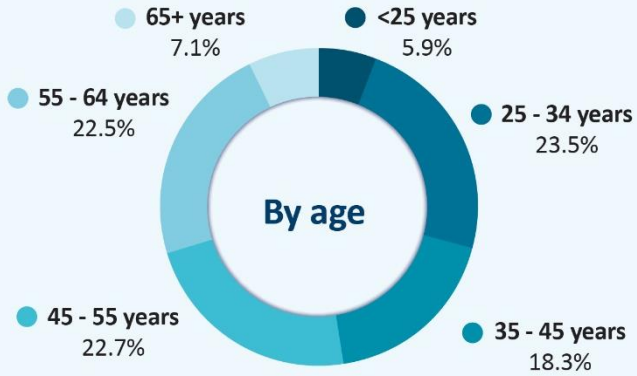
[69] This is a new indicator in our SSP.

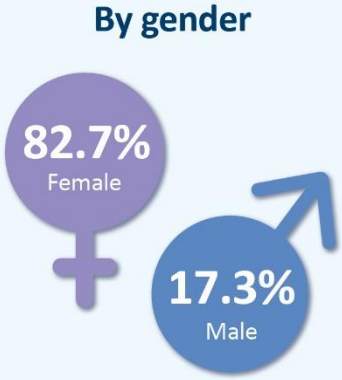
[70] This is a local measure and provides an indication of the effectiveness of DHB Health of Older People Services including rehabilitation services and support services for instance home based support in maintaining or reducing demographic growth in demand for Aged Related Residential Care (ARRC) beds. This is a new Indicator in our SSP

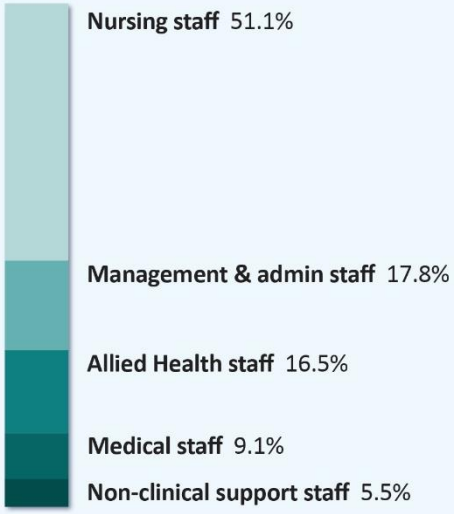
Our People

Hawke's Bay DHB currently employs **3602 people**.

A number of the above are multi-jobbed; with **3997 positions** held throughout the organisation. Of these 3997 positions:







Other includes NZ European, British and Irish, African, Australian, and other European such as Dutch, Italian, and German.

Report on good employer obligations

Hawke's Bay DHB's employment practice is to recruit the best person for the role based on professional skills and values fit to the organisation. Our Human Resource (HR) policies and systems are continuously reviewed and updated to ensure they meet legal compliance, they embody our equity, diversity and inclusion principles, and reinforce they consistency and fairness for all our staff.

Our recruitment and employment procedures are both fair and equitable. There is an active commitment to equal opportunity and the removal of institutional barriers to encourage inclusion. Hawke's Bay DHB takes seriously its legal and moral obligation to honour the Treaty of Waitangi and to be a good employer.

Our updated People Plan puts the values and behaviours of the organisation at the centre of the way we do things. This Plan includes our commitment to actively build an environment which is safe and enhances wellbeing.

The focus of the People Plan:

- Effective short and long term recruiting and building an inclusive representative workforce
- Embedding the values of the organisation in all we do
- Team development and collaboration
- Ensuring the wellbeing of our workforce
- Taking positive action to build a safe and healthy workplace.

Leadership, Accountability and Culture:

Developing leadership capability, remains a priority for Hawke's Bay DHB, as does increasing the capability of our whole workforce. Our focus over the last 12 months has been to develop targeted training programmes to increase our leaders' competence including strengths-based coaching, constructive feedback and effective performance appraisal. We are currently developing a Leadership Development Framework (including national collaboration) with programmes at all levels, from Executive to Aspiring Leaders. We are developing a suite of team development and collaboration tools to build our organisational capability in this area.

As an organisation we continue to engage with our staff through established forums including our Joint Consultative Committee, Bipartite and Nursing forums, and through our Safety and Wellbeing committee.

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

Recruitment, Selection and Induction:

Hawke's Bay DHB has centralised recruitment functions ensuring robust recruitment processes are consistently managed across the DHB.

Our applicant management system tracks the process and the recruitment team provide exceptional candidate care. Hawke's Bay DHB has a continued focus on increasing Māori and Pasifika uptake into health careers.

The recruitment team work collaboratively with the Māori Health team to deliver the Māori and Pasifika Workforce Strategy.

Hiring managers are supported through the recruitment process to ensure efficiency and consistency of recruitment and we focus on competent applicants who also align to the values of the organisation through a values-based recruitment programme.

A key strategic priority is to provide recruitment-based workforce solutions to address short and long term talent shortages, including forming talent pipelines and talent-pools and international recruitment campaigns (including regional and national collaboration).

Employee Development, Promotion and Exit:

To ensure all staff have clarity about performance expectations HBDHB utilise a performance appraisal system based on strengths-based coaching, incorporating the principles of positive psychology. The process is well documented and available to all staff to enable constructive conversations to occur on a regular basis, where the staff member is able to identify personal development needs and document career aspirations.

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

The Employment Relations Act, and the Health and Safety at Work Act 2015, continue to underpin our relationships with employees and unions. The Bipartite Union Committee continues to be the forum for Union delegates to be engaged and to discuss common issues.

Hawke's Bay DHB has an agreed health and safety strategy to ensure that as an organisation we are meeting our obligations and create a "Safe Place, Safe People and Safe Care" culture. The union organisers also participate in the Safety and Wellbeing Committee to help us design the best systems and processes we can.

An approved programme for the 2021/22 financial year is an Exit Survey & Data framework, involving organisation-wide leavers survey, exit interviews, data analytics and retention strategy.

Flexibility and Work Design:

The DHB gives consideration to flexible work practices to accommodate staff wherever practical. Guidelines to assist managers to respond to requests for flexible work arrangements requests are available on the DHB's intranet. Post-COVID-19 lockdown, "Working from Home" guidelines have been updated to embed these new ways of working and provide more flexibility within the system.

The DHB's Human Resource Service also works closely with managers and the Bipartite Union

Committee as required to implement change in work practice that meets the needs of staff and assists the organisation to achieve its service and financial performance objectives.

Remuneration, Recognition and Conditions:

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

Hawke's Bay DHB utilise a number of communication media to engage all staff and key local health sector leaders, which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through Our Hub (intranet) and annual health sector–wide health awards where success and achievement is celebrated.

Harassment and Bullying Prevention:

Hawke's Bay DHB has a zero tolerance policy which is supported with resources such as clearly defined process, manager and staff training, posters throughout the organisation which emphasise respect and acceptable and unacceptable behaviours, and intranet resources provide a centralised information resource for all staff to access.

Employee Wellbeing:

Hawke's Bay DHB will undertake an organisation-wide employee survey on Wellbeing/Psychosocial Health via the 'AskYourTeam' platform in September/October 2021. This provides all teams and managers in the organisation with helpful information to make improvements and at a strategic level, guide the priorities of our organisation-wide wellbeing programme of work. To assess progress, follow up spot surveys are part of the package.

Approved programmes include anti-bullying, stress & resilience and management of violence & aggression against employees.

Safe and Healthy Environment:

The DHB is continuing to make changes to our policies and procedures to ensure effective Health and Safety system implementation.

We promote and provide opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via Safety and Wellbeing Representatives and within the Safety and Wellbeing Committee. The Board are committed to ensuring that health and safety is embedded across the organisation and have established a Board Health and Safety Champion role, providing assurance to the Board that the organisation is meeting its obligations. The organisation has also undertaken an assessment through Safe365 online tool to identify any gaps in health and safety requirements and will continue to build the capability of all and develop a culture whereby health and safety is embedded in everything we do. To further verify our progress we have commenced the accreditation process for ISO 45001.

Hawke's Bay DHB maintains its ACC partnership programme which recognises that appropriate systems support a safe environment and are implemented throughout the organisation.

Staff Ethnicity:

Increasing the number of Māori employees is a priority. A KPI measuring the number of positions where incumbents identify as Māori is reported the DHB's Board on a quarterly basis. The target is set at 10 percent improvement on previous year with the ultimate aim that the workforce reflects the Hawke's Bay population mix. The aim of this programme is that in the future we will reflect the population within our workforces and therefore the final aim is to have 27 percent Māori represented.

As at the end of the 2020/21 year progress was made, although the target of 17.5% percent of staff identifying as Māori was not reached.

Target 2021/22:	18.0%
Actual at 30 June 2021	16.4%
Gap	59 employees

Staff Disability:

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

Role of the Board

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

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

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

Role of the CEO

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

Advisory Committees

A DHB is required to establish three statutory advisory committees: Community and Public Health Advisory Committee (CPHAC); Disability Support Advisory Committee (DSAC); Hospital Advisory Committee (HAC) but may establish other committees for a particular purpose. Whilst HBDHB has established the three Statutory Advisory Committees, on which all Board members sit they no longer routinely meet. No DSAC, CPHAC and HAC meetings were held in 2019/20.

The Board may assign defined levels of authority to its advisory committees which operate under terms of reference and may advise the Board on issues which have been referred to them. Committees may meet collectively as required to discuss the Annual Plan and other strategic issues.

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

Finance Risk and Audit Committee:

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

Māori Relationship Board (MRB):

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

Other components of HBDHB's governance structures include:

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

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

Note:

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

Board and Committee Membership

There are 11 Board members, who collectively possess a broad range of skills, knowledge and experience. Seven of these members are elected through the triennial local government elections, and four are appointed by the Minister of Health. In making the appointments, the Minister ensures any skills gaps are met, including a minimum of two Māori Board members.

The election term is for three years. The current Board took office on 9 December 2019. Transitional arrangements were put in place to ensure a smooth transition from the outgoing to the incoming Board.

One board member resigned in October 2020 due to her nomination and subsequent successful appointment as the MP for Tukituki. Therefore as of October 2020, there were 10 board members, with no plans to fill the vacant position.

Board and Committee Member Attendance

Board and committee member attendance for 2020/21 is set out in the following lists the name of the board and committee meetings, with the number of meetings held noted in parentheses.

Eleven Meetings were held for each of the following:

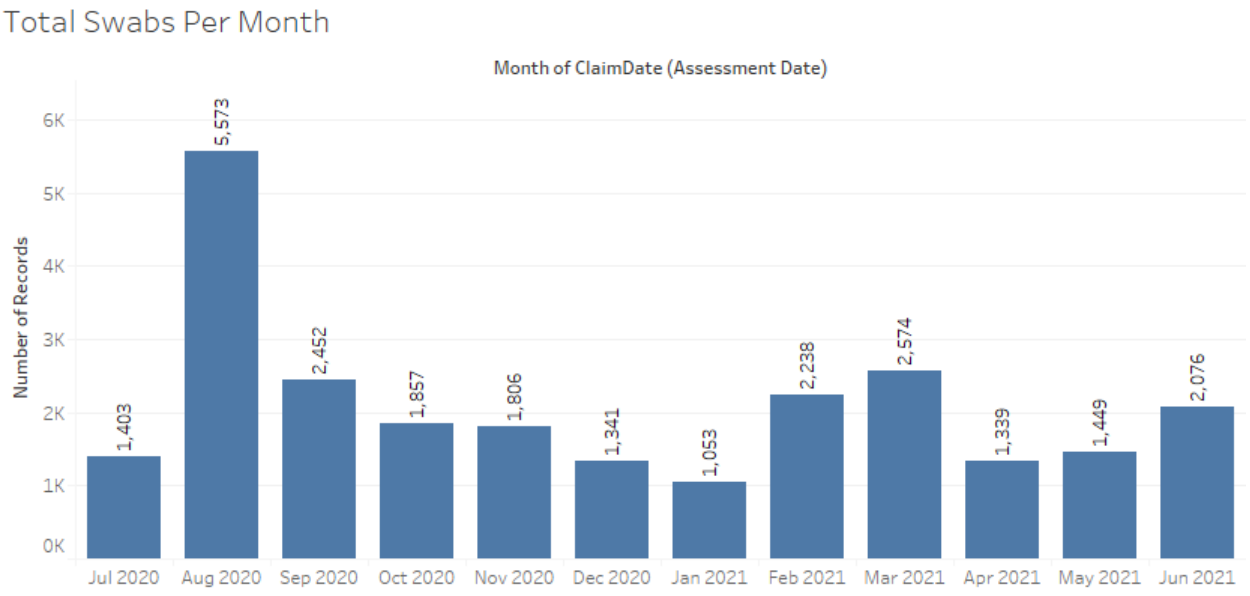
- HBDHB Board
- FRAC Finance, Risk and Audit Committee (FRAC)
- MRB Māori Relationship Board (MRB)

Member	Board	FRAC	MRB
Hayley Anderson	10	12	0
Ana Apatu	11	12	12
Kevin Atkinson	11	11	0
David Davidson	11	11	0
Evan Davies	11	12	0
Peter Dunkerley	10	11	0
Joanne Edwards	10	10	2
Charlie Lambert	9	6	5
Heather Skipworth	10	10	7
Shayne Walker	11	11	3
Anna Lorck (resigned 22 October 2020)	3	3	0

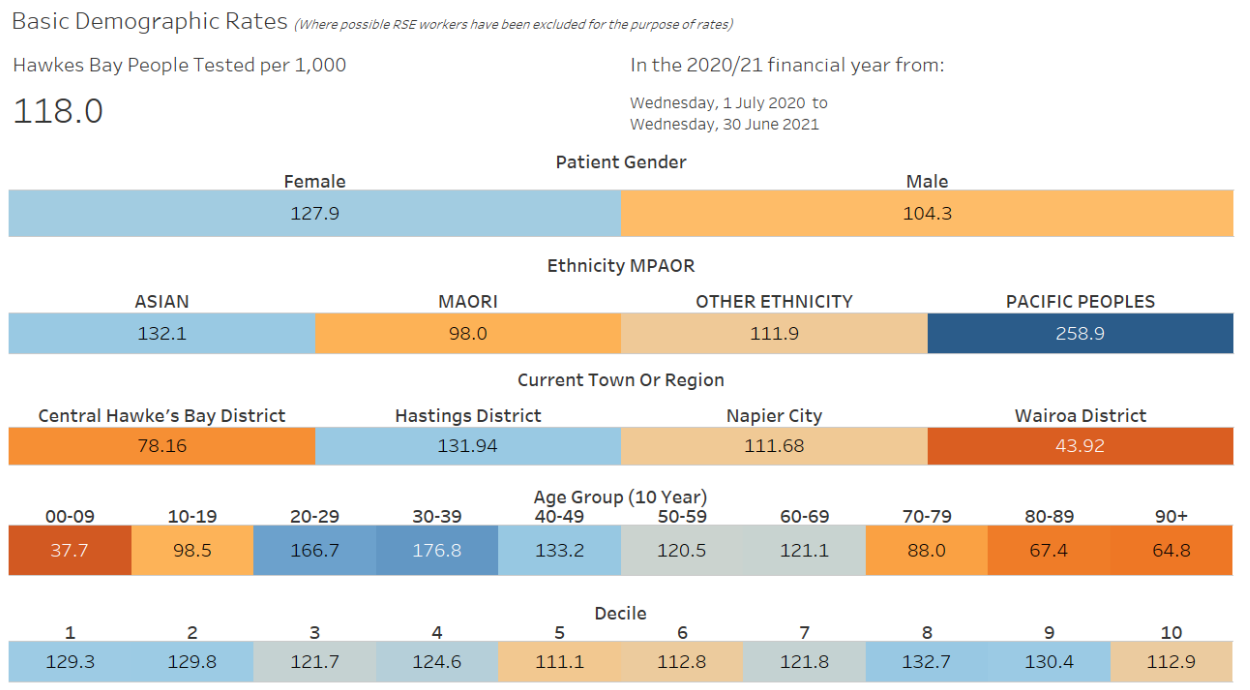
COVID-19 response 20/21 year

The early focus in the 20/21 COVID-19 response was ensuring our community has equitable and timely access to services. Working to clear the backlog of activity that was deferred during the 2020 lockdown and returning access and participation rates to levels seen prior to the emergence of COVID-19 pandemic was a priority. We have seen improvements in our planned care delivery and reduction in numbers waiting outside time frames for First Specialist Assessment and Treatment (including elective surgery) in the 20/21 year.

COVID-19 testing continued throughout 20/21 with a focus on border and RSE workers. 25,161 swabs were taken in the 20/21 year which was an average 2,097 swabs per month. Surveillance swabbing continues to be a large part of our work as Napier City is a port city.



Source: Health Hawke's Bay



Source: Health Hawke's Bay

COVID-19 resurgence planning

Hawke's Bay DHB's priority continues to be to build and maintain capacity and capability in the tracking and tracing work force. This has allowed our trained workforce to provide tracking and tracing services in other regions to support managing outbreaks, for instance in Auckland.

COVID-19 Vaccination roll out

Significant work has been undertaken in the 20/21 year to roll out the national COVID-19 vaccination programme in Hawke's Bay. There has been significant recruitment, re- deployment and training of the

vaccination workforce to build capacity within the local COVID-19 vaccination programme. In the 20/21 year a total 43,257 vaccine doses were administered in the Hawke's Bay against planned volume of 35,725.

Thirteen percent of the eligible population was fully vaccinated as at 30 June 2021.

Of the 43,257 vaccines administered in the 20/21 year, 14% (6,059) were administered to Maori, 5.5%

(2,368) to Pacific peoples,4.7 % (2,042) Asian people and 75 % Other (32,442)).

Hawke's Bay DHB COVID Vaccination Overall Summary

Data period : 1st July 2020 - June 2021

Vaccine doses administered by DHB			
DHB of service	Dose 1	Dose 2	Total
Hawkes Bay	**26,055**	**17,202**	**43,257**

Hawke's Bay DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 5)	% Fully vaccinated	**13.03%**

Vaccine doses administered by age group (note 4)			
Age range (years)	Dose 1	Dose 2	Total
12 to 15	1	0	1
16 to 19	307	200	507
20 to 24	755	509	1,264
25 to 29	1,105	805	1,910
30 to 34	1,184	843	2,027
35 to 39	978	743	1,721
40 to 44	1,149	886	2,035
45 to 49	1,379	1,039	2,418
50 to 54	1,553	1,218	2,771
55 to 59	1,875	1,415	3,290
60 to 64	2,239	1,561	3,800
65 to 69	3,457	1,965	5,422
70 to 74	3,745	2,148	5,893
75 to 79	2,713	1,573	4,286
80 to 84	1,941	1,150	3,091
85 to 89	1,005	643	1,648
90+	669	504	1,173
Total	**26,055**	**17,202**	**43,257**

Eligible population fully vaccinated by age group (note 5) Proportion fully vaccinated (note 1)	
Age range (years)	%
12 to 15	
16 to 19	2.69%
20 to 24	6.05%
25 to 29	7.83%
30 to 34	8.43%
35 to 39	8.26%
40 to 44	9.47%
45 to 49	9.72%
50 to 54	11.51%
55 to 59	12.63%
60 to 64	14.77%
65 to 69	20.22%
70 to 74	24.24%
75 to 79	26.02%
80 to 84	28.70%
85 to 89	27.39%
90+	39.26%
Total	**13.03%**

Vaccine doses administered by ethnicity (note 4)				
Ethnicity	Dose 1	Dose 2	Total	%
Asian	1131	911	2042	4.7%
European or other	19444	12998	32442	75.0%
Māori	3732	2327	6059	14.0%
Pacific peoples	1,531	837	2368	5.5%
Unknown	217	129	346	0.8%
Total	**26,055**	**17,202**	**43257**	**100%**

Eligible population fully vaccinated by age group (note 5) Proportion fully vaccinated (note 1)	
Ethnicity	%
Asian	14.70%
European or other	14.19%
Māori	8.09%
Pacific peoples	18.51%
Unknown	25.93%
Total	**13.03%**

Vaccine doses administered by sequencing group (note 4)			
Sequencing group (note 3)	Dose 1	Dose 2	Total
Group 1	783	677	1,460
Group 2	10,375	8,753	19,128
Group 3	11,009	5,808	16,817
Group 4	3,888	1,964	5,852
Total	**26,055**	**17,202**	**43,257**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level

The Total population estimate based on HSU as at 30 June 2020 is 174,504. This is 4,096 below the Stats NZ total projected population of 178,600 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Part V – Financial Performance

Result

The operating result for 2020/21, the result relating to business as usual, is a $15.7 million deficit against a planned deficit of $14.5 million. The operating result is the $28.3 million deficit in the surplus/(deficit) line of the statement of comprehensive revenue and expense, excluding Holidays Act remediation provisioning of $4 million, COVID-19 pandemic costs net of related MOH funding of $2.5 million and unfunded nurses pay equity of $6.1 million.

The higher than planned operating deficit is largely the result of continuing pressure on delivery of health services driven by the impact of population growth and other demographic factors (Hawke's Bay has higher than the national average for both socio-economic deprivation, and the proportion of people aged 65 plus), and out-dated facilities creating barriers to modern and efficient service provision.

Cash flow

The $4.6 million operating cash surplus, $0.5 million from the sale of assets, and equity injections for capital projects ($5.2 million) and deficit support ($25 million), provided the funding used for the $21.1 million investment in long term assets, the repayment of $0.4 million of equity, and the $13.8 million reduction in bank overdraft.

Auditors

The Auditor-General is required under section 15 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements and performance information presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2020/21 annual report, amount to $157,000.

Ministerial directions

Directions that remain current include:

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

Five-year financial performance summary

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

Performance Indicator	Target	2021	2020	2019	2018	2017
Return on net funds employed	(3.6)%	(19.6)%	(39.5)%	(12.9)%	(0.1)%	7.3%
Operating margin to revenue	(1.0)%	(3.5)%	(9.0)%	(3.4)%	0.0%	1.8%
Revenue to net funds employed	4.4	5.6	4.8	3.8	3.8	3.8
Net result before financing & abnormal	(6.1)m	(23.6)m	(54.6)m	(19.8)m	(0.2)m	10.3m
Net result	(14.5)m	(28.3)m	(62.9)m	(28.4)m	(8.6)m	3.6m
Ratio of earnings to revenue	1.4%	(1.2)%	(6.7)%	(1.3)%	2.4%	4.5%
Average cost per paid FTE	$100,722	$103,976	$98,526	$94,114	$89,090	$87,731
Average revenue per paid FTE	$252,753	$249,775	$238,548	$241,417	$238,336	$239,610

Statement of comprehensive revenue and expense

For the year ended 30 June 2021
in thousands of New Zealand Dollars

	Notes	30 June 2021	Budget 30 June 2021	30 June 2020
Patient care revenue	2.5	669,709	652,513	604,720
Interest revenue		90	44	150
Other operating revenue	2.6	7,412	3,336	3,776
Total revenue		677,211	655,893	608,646
Personnel costs	2.7	282,004	261,373	250,137
Outsourced services		26,806	14,668	24,557
Clinical supplies		58,500	63,361	54,441
Infrastructure and non-clinical expenses		32,283	35,281	29,352
Payments to other DHBs		63,034	64,933	60,621
Payments to non-health board providers		215,955	207,123	202,411
Other operating expenses	2.8	6,941	-	28,259
Depreciation and amortisation expense	3.6, 3.7	15,476	15,255	13,576
Financing costs	2.9	184	289	244
Capital charge	2.10	4,569	8,079	8,103
Impairment losses	3.7	-	-	-
Total expenses		705,752	670,362	671,701
Share of associate surplus/(deficit)	3.9	230	-	152
Surplus/(deficit)		**(28,311)**	**(14,469)**	**(62,903)**
Other comprehensive revenue and expense				
Revaluation of land and buildings	3.6	14,932	-	-
Total comprehensive revenue and expense		**(13,379)**	**(14,469)**	**(62,903)**

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

Some of the budget figures are not directly comparable to the 2020/21 Annual Plan due more detailed reporting requirements for these financial statements.

DHBs are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2021 was overspent by $0.9 million (2020: as planned). Mental health payments were $0.6 million more than funding over the 21 years since 1 July 2001 (30 June 2020: $0.3 million less).

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

Statement of changes in equity

For the year ended 30 June 2021
in thousands of New Zealand Dollars

	Notes	30 June 2021	Budget 30 June 2021	30 June 2020
Balance at 1 July		101,673	134,487	143,641
Total comprehensive revenue and expense		(13,379)	(14,469)	(62,903)
Owner transactions				
Equity injections from the Crown		30,188	45,772	21,292
Equity repayments to the Crown		(357)	(357)	(357)
Balance at 30 June	**4.5**	**118,125**	**165,433**	**101,673**

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

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

Statement of financial position

As at 30 June 2021

in thousands of New Zealand Dollars

	Notes	30 June 2021	Budget 30 June 2021	30 June 2020
Assets				
Current assets				
Cash and cash equivalents (excluding bank overdraft)	3.1	624	14	1,200
Short term investments	3.1	1,443	2,636	1,449
Receivables and prepayments	3.2	22,480	22,725	20,897
Inventories	3.4	4,975	5,040	4,626
Total current assets		29,522	30,415	28,172
Non-current assets				
Property, plant and equipment	3.6	208,997	227,655	189,697
Intangible assets	3.7	16,572	5,258	15,743
Investment property	3.8	209	694	694
Investment in associate	3.9	1,350	1,120	1,341
Total non-current assets		227,128	234,727	207,475
Total assets		**256,650**	**265,142**	**235,647**
Liabilities				
Current liabilities				
Bank overdraft	3.1	42	10,170	14,433
Payables and deferred revenue	4.2	43,177	31,688	36,672
Employee entitlements	4.3	53,760	54,784	44,856
Provisions	4.4	38,457	-	34,724
Total current liabilities		135,436	96,642	130,685
Non-current liabilities				
Employee entitlements	4.3	3,089	3,068	3,289
Total non-current liabilities		3,089	3,068	3,289
Total liabilities		**138,525**	**99,710**	**133,974**
Net assets		**118,125**	**165,432**	**101,673**
Equity				
Contributed capital	4.5	142,711	158,296	112,880
Property revaluation reserves	4.5	111,035	96,103	96,103
Restricted funds	4.5	2,014	-	2,163
Accumulated surpluses/(deficits)	4.5	(137,635)	(88,967)	(109,473)
Total equity		**118,125**	**165,432**	**101,673**

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

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

Statement of cash flows

For the year ended 30 June 2021
in thousands of New Zealand Dollars

	Notes	30 June 2021	Budget 30 June 2021	30 June 2020
Cash flows from operating activities				
Receipts from patient care		668,691	655,752	608,413
Receipts from donations, bequests and clinical trials		517	-	401
Other receipts		11,645	-	9,765
Payments to suppliers		(405,524)	(385,053)	(376,663)
Payments to employees		(266,434)	(261,373)	(244,336)
Goods and services tax (net)		334	-	904
Cash generated from operations		9,229	9,326	(1,516)
Dividends received		-	-	69
Interest received		90	44	150
Interest paid		(184)	(453)	(244)
Capital charge paid		(4,569)	(8,080)	(8,103)
Net cash inflow/(outflow) from operating activities		**4,566**	**837**	**(9,644)**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		90	(9)	11
Proceeds from sale of investment property		415	-	-
Acquisition of property, plant and equipment		(18,292)	(43,282)	(12,395)
Acquisition of intangible assets		(2,802)	(2,776)	(3,125)
Acquisition of investments		-	15	-
Net cash inflow/(outflow) to investing activities		**(20,589)**	**(46,052)**	**(15,509)**
Cash flows from financing activities				
Proceeds from equity injections by the Crown		30,188	45,772	21,293
Net proceeds from short term investments		7	-	423
Repayment of equity to the Crown		(357)	(357)	(357)
Net cash inflow/(outflow) from financing activities		**29,838**	**45,415**	**21,359**
Net increase/(decrease) in cash and cash equivalents		13,815	200	(3,794)
Add: opening cash		(13,233)	(9,601)	(9,439)
Cash and cash equivalents at end of year	3.1	**582**	**(9,401)**	**(13,233)**

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

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

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

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

For the year ended 30 June 2021

in thousands of New Zealand Dollars

	Notes	30 June 2021	30 June 2020
Surplus/(deficit) for the year		**(28,311)**	**(62,903)**
Add back non-cash items:			
Share of associate surplus		(230)	152
Depreciation and amortisation		15,476	13,576
Increase in provisions		4,119	-
Add back items classified as investing activity:			
Net loss/(gain) on disposal of property, plant and equipment		391	142
Debt forgiven (Hawke's Bay Helicopter Rescue Trust)		-	15
Dividends from associate		-	69
Movement in working capital:			
(Increase)/decrease in receivables and prepayments		(1,353)	7,989
(Increase)/decrease in inventories		(349)	(603)
Increase/(decrease) in payables and deferred revenue		6,505	5,187
Increase/(decrease) in employee entitlements		8,904	6,796
Increase/(decrease) in provisions		(386)	19,648
Net movement in working capital		13,321	39,017
Other movements not in working capital			
Increase/(decrease) in employee entitlements		(200)	288
Net cash inflow/(outflow) from operating activities		**4,566**	**(9,644)**

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

For the year ended 30 June 2021
in thousands of New Zealand Dollars

In preparing the 2021 financial statements, the notes have been grouped into sections under five key categories which are considered to be the most relevant for stakeholders and other users.

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

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

1. Reporting entity and basis of preparation

1.1 Reporting Entity

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

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

The financial statements of HBDHB comprise the DHB, its 16.7% interest in associate Allied Laundry Services Limited (see note 3.9), its 16.7% investment in Central Region's Technical Advisory Services Limited (TAS), and its 3.7% investment in New Zealand Health Partnerships Limited (NZHP).

TAS provides regional services to the central region DHBs, and national services to the DHB and wider health sectors. This includes national programme management, education and support, audit and assurance services, planning and collaboration, business insights and analysis, and strategic workforce services. TAS has a mostly independent board that combined with its ownership and activities, means HBDHB does not have significant influence over the company. Consequently, the interest in TAS is treated as an investment.

NZHP provides national services to the DHB sector, including arranging banking and insurance services, national procurement and development of the Finance, Procurement and Information Management system. The minor holding in the company means HBDHB does not have significant influence over the company. Consequently the interest in NZHP is treated as an investment.

The financial statements for HBDHB are for the year ended 30 June 2021, and were approved by the Board on 15 December 2021.

1.2 Basis of preparation

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly. Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including utilising the approved overdraft facility and equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 4.4 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with the DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

Borrowing covenants and forecast borrowing requirements

The forecast for the next year prepared by the DHB shows that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions. While the Board is confident in the ability of the DHB to continue as a going concern until disestablishment, if the forecast information relating to operational viability and cash flow requirements is not achieved, there would be significant uncertainty as to whether the DHB would be able to continue as a going concern based on current trading terms and legislative requirements. If the DHB was unable to continue as a going concern, adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Statement of compliance

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

Presentation currency and rounding

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

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective, that have not been early adopted are:

Amendment to PBE IPSAS 2 Cash Flow Statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. HBDHB does not intend to early adopt the amendment.

PBE FRS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 *Financial Instruments* and will be effective for the year ending 30 June 2023, with earlier adoption permitted. HBDHB has assessed that there is little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. HBDHB does not intend to early adopt the new standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 *Presentation of Financial Statements* and is effective for the year ending 30 June 2023, with earlier adoption permitted. HBDHB has not yet determined how application of PBE FRS 48 will affect its statement of performance, and does not plan to early adopt the standard.

in thousands of New Zealand Dollars

2. Result for the year

2.1 Performance by Arm

Hawke's Bay DHB's annual plan includes separate operating statements for funding, governance and funding administration and providing health services. The following table compares performance against the plan for the 2020/21 year.

	Achieved $m	Plan $m	Variance $m
Revenue			
Funding health services	643.0	627.1	15.9
Governance and funding administration	3.6	3.6	-
Providing health services	402.5	394.7	7.8
Eliminations	(371.7)	(369.5)	(2.2)
	677.4	655.9	21.5
Surplus/(Deficit)			
Funding health services	(7.7)	(14.5)	6.8
Governance and funding administration	(0.2)	-	(0.2)
Providing health services	(20.4)	-	(14.3)
	(28.3)	(14.5)	(7.7)

Providing health services includes $9.6 million (2020: $9.5 million) of claims for pharmaceutical expenditure through Ministry of Health Sector Services that are ultimately paid for from the funding health services category. These claims are eliminated in the financial statements, but are included in the above table to provide a more useful comparison.
Eliminations are transactions between funding of health services, governance and funding administration and providing of health services, which need to be eliminated when the income of these arms are consolidated.
The favourable funding health services result largely arises from a higher rebate from the PHARMAC Discretionary Pharmaceutical Fund, supported by higher revenue and lower expenditure relating to inter district flows.
The main contributors to the providing health services deficit were additional nursing to manage occupancy/additional bed capacity and length of stay issues, locums providing vacancy and leave cover, an increase in the provision for Holidays Act remediation, accrual for the interim settlement of the nurses pay equity claim, supply cost increases from COVID-19 impacts on manufacturing and international supply chains, and expenditure net of revenue for the COVID-19 recovery and vaccination programmes.

2.2 Performance against budget

Accounting Policy

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

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

Financial Performance

The deficit for the year is $13.8 million adverse to plan, including:

- $4.0 million increase in the provision for Holidays Act remediation;
- $6.1 million accrual for the interim settlement of the nurses pay equity claim;
- $2.5 million net expenditure for the COVID-19 recovery and vaccination programme;
- $1.0 million approved by the Board for overspend on gastroenterology and radiology;
- $0.2 million overspend approved by management as a result of insufficient MOH funding of the clerical pay equity settlement.

Financial Position

Equity at 30 June 2021 was $47.3 million less than projected in the annual plan. This reflects the $13.8 million higher than planned deficit mentioned above, the $32.8 million higher deficit for 2019/20 than forecast in the 2020/21 Annual Plan (mainly Holidays Act remediation provisioning), and $15.6 million less than planned equity injections due to slippage in capital expenditure. They were partly offset by $14.9 million from land and building revaluations.

Assets were $8.4 million lower than budget largely due to the slippage in capital projects, and partly offset by the land and building revaluation. Liabilities were $38.8 million higher than plan, mainly relating to the $20.9 million increase in the Holidays Act remediation provision in 2019/20 that was not allowed for in the 2020/21 Annual Plan, and a further $3.6 million net of project costs allowed in 2020/21. An increase in the revenue from MOH for which the DHB is yet to provide services, the accrual for the interim settlement of the nurses pay equity claim, and higher leave balances due to lower than projected leave taken also increased liabilities.

Cash Flow

Cash from operating activities was $3.7 million higher than plan, mainly reflecting the increase in revenue received from MOH that has been treated as income in advance. Cash outflow to investment activities, mainly the purchase of property, plant and equipment, was $25.5 million lower than plan reflecting slippage in projects due to supply chain issues relating to the COVID-19 pandemic, and from lead times to achieve equity funding approvals. Financing cash flow were $15.6 million lower than plan reflecting the reduced equity needed to fund the lower capital spend.

2.3 Critical accounting estimates and assumptions

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

- Note 3.6: Estimating the fair value of land and buildings
- Note 3.7: Estimating useful lives of intangible assets with definite lives
- Note 4.3: Measuring the liability for long service leave, retirement gratuities, sabbatical leave, sick leave, and continuing medical education leave.
- Note 4.4: Measuring the liability for Holidays Act 2003 remediation and the ACC Accredited Employers Programme.

2.4 Critical judgements in applying accounting policy

In the process of applying HBDHB's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. The critical judgements management has exercised in applying accounting policies are included in the note to which they relate, namely:

- Note 3.7: Impairment of intangible assets with indefinite lives

in thousands of New Zealand Dollars

2.5 Patient care revenue

Accounting policy

Ministry of Health population-based revenue

Hawke's Bay DHB receives annual funding from the Ministry of Health via the Population Based Funding Formula (PBFF) which determines Hawke's Bay's share of funding based on population, rurality and other demographics. Changes in population and demographics impact the PBFF over time. Revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health contract revenue

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

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

Revenue from other DHBs

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

Other Crown entity contracted revenue

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

	30 June 2021	30 June 2020
Ministry of Health population-based revenue	584,865	525,266
Ministry of Health contract revenue	63,014	59,970
Revenue from other DHBs	14,322	12,469
Other Crown entity contracted revenue	6,006	5,591
Other patient care related revenue	1,502	1,424
	669,709	**604,720**

Other Crown entity contract revenue includes funding from the Ministry of Education for early childhood education purposes. Receipts in 2020/21 amounted to $173 thousand (2020: $171 thousand), and the balance of funds as at 30 June 2021, included in Note 4.2 under income in advance, amounted to $56 thousand (30 June 2020: $54 thousand).

Reconciliation of Vote Health: Health & Disability Support Services – Hawke's Bay DHB appropriation to population-based revenue

	30 June 2021	30 June 2020
Budget appropriation	584,103	524,166
Supplementary estimates	4,000	13,842
Less: classified under Ministry of Health Contract Revenue		
Pay equity funding devolution	-	11,662
Combined Pharmaceutical Budget (CPB) adjustments	2,004	-
Contract income treated as income in advance	(5,242)	-
Other	-	1,080
Ministry of Health population-based revenue	**584,865**	**525,266**

in thousands of New Zealand Dollars

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

2.6 Other operating revenue

Accounting policy

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

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Rental revenue

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

Sale of goods

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

Provision of services

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

Vested assets

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

Donated services

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

	30 June 2021	30 June 2020
Donations and bequests received	874	252
Rental revenue	900	685
Cafeteria and food sales	932	979
Other operating revenue	4,371	2,301
Gain on sale of property, plant and equipment	335	39
Clinical trials income transferred to an independent charitable trust	-	(480)
	7,412	**3,776**

2.7 Personnel costs

Accounting policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services

Superannuation schemes

Defined contribution schemes

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

in thousands of New Zealand Dollars

Defined Benefit Plan Contributors Scheme

The DHB 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 or 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.

The funding arrangements for the scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed. This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve nether a surplus nor deficit in the trust fund of the scheme at the time that the last contributor ceases to contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

In practice, at present, a single contribution rate is determined for all employers, which is expressed as a multiple of the contributions of members of the scheme who are employees of that employer. The current employer contribution rate is three times contributor contributions, inclusive of Employer Contribution Withholding Tax. The Actuary has recommended stepped approach to changing the employer contribution rate, as follows:

- 1 April 2021 – 31 March 2022: Four times contributor contributions
- From 1 April 2022: Five times contributor contributions.

There is no minimum funding requirement.

As at 31 March 2021, the scheme had a past service surplus of $1.3 million or 2.2% of the liabilities (2020: $2.8 million or 4.1% of the liabilities. This amount was exclusive of employer superannuation contribution tax. This surplus was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 39 *Employee Benefits*.

The Scheme had 91 members (2020: 110) at 31 March 2021, two (2020: two) of whom are employees of the DHB.

	30 June 2021	30 June 2020
Salaries and wages	265,520	237,663
Employer contributions to defined contribution plans	8,425	7,626
Increase/(decrease) in employee entitlements	8,059	4,848
	282,004	**250,137**

Remuneration – Board members

During the COVID-19 response and recovery, Shayne Walker supported the National Chair's agreement to donate 20 percent of their fees as Chair of the Board, to a charity for a period of three months. Shayne's donation to Women's Refuge is through payroll gifting, and does not reduce the amount reported as the Chair's Board fee. The gifting was from fees for both the 2019/20 and 2020/21 financial years.

Board member Hayley Anderson was remunerated for her work as an Incident Controller for the Coordinated Incident Management System (CIMS) during the year. The remuneration was what would be paid in a normal supplier relationship on terms and conditions no more favourable than those the DHB would have adopted if dealing with those individuals at arm's length in the same circumstances.

in thousands of New Zealand Dollars

Payments for committee meetings include the Finance, Risk and Audit Committee (FRAC), and Māori Relationship Board. Payments were also made to Hayley Anderson who as chair of the Community and Public Health Advisory Committee attended the Pasifika Health Leadership Group and reported back to the Board.

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

	30 June 2021		30 June 2020	
in whole New Zealand Dollars	Board	Committees	Board	Committees
Shayne Walker *Chair (appointed member)*	46,403	3,250	26,771	2,000
Evan Davies *Deputy Chair (appointed member)*	28,963	3,125	16,710	2,313
Hayley Anderson	23,171	4,000	13,368	2,250
Ana Apatu	23,171	5,375	21,999	5,250
Kevin Atkinson *Chair until October 2019*	23,171	2,500	31,862	2,500
David Davidson	23,171	2,500	13,368	1,750
Peter Dunkerley	23,171	2,500	21,999	2,686
Joanne Edwards *(appointed member)*	23,171	3,000	13,368	2,000
Charlie Lambert *(appointed member)*	23,171	2,500	13,368	1,500
Anna Lorck *(resigned October 2020)*	5,347	750	13,368	2,000
Heather Skipworth	23,171	4,000	21,999	5,250
Retired October 2019				
Barbara Arnott	-	-	9,416	1,250
Ngahiwi Tomoana *Deputy Chair*	-	-	11,769	1,250
Dan Druzianic	-	-	9,416	1,560
Hine Flood	-	-	9,416	3,250
Helen Francis	-	-	9,416	750
Diana Kirton	-	-	9,416	1,000
Jacoby Poulain *(resigned July 2019)*	-	-	1,569	-
	266,081	33,500	268,598	38,559

Remuneration – Committee members who are not board members or employees

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

Compensations

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

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

in thousands of New Zealand Dollars

Employee Remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands are as follows:

	30 June 2021	30 June 2020		30 June 2021	30 June 2020
100,000-109,999	166	142	320,000-329,999	2	5
110,000-119,999	105	83	330,000-339,999	6	4
120,000-129,999	41	38	340,000-349,999	3	1
130,000-139,999	34	32	350,000-359,999	4	1
140,000-149,999	26	23	360,000-369,999	2	3
150,000-159,999	12	9	370,000-379,999	2	7
160,000-169,999	17	15	380,000-389,999	1	1
170,000-179,999	15	12	390,000-399,999	4	1
180,000-189,999	12	12	400,000-409,999	3	1
190,000-199,999	8	5	410,000-419,999	3	1
200,000-209,999	6	5	430,000-439,999	-	1
210,000-219,999	9	11	440,000-449,999	-	2
220,000-229,999	6	8	450,000-459,999	1	-
230,000-239,999	10	14	460,000-469,999	1	1
240,000-249,999	10	6	470,000-479,999	1	1
250,000-259,999	8	7	480,000-489,999	1	-
260,000-269,999	9	7	490,000-499,999	2	-
270,000-279,999	10	11	500,000-509,999	-	1
280,000-289,999	10	4	520,000-529,999	-	1
290,000-299,999	6	6	530,000-539,999	1	-
300,000-309,999	4	7	610,000-619,999	-	1
310,000-319,999	8	7			

During the year, four (30 June 2020: nine) employees received compensation and other benefits in relation to cessation totalling $50,614 (30 June 2020: $262,236).

in thousands of New Zealand Dollars

2.8 Other operating expenses

Accounting policy

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

	30 June 2021	30 June 2020
Impairment of receivables (bad and doubtful debts)	5	62
Loss on disposal of property, plant and equipment	691	148
Fees to auditor for the audit of the financial statements	157	153
Fees to board members	300	307
Operating lease expenses	5,653	5,368
Increase/(decrease) in provisions	133	22,218
Koha	2	3
	6,941	**28,259**

2.9 Financing costs

Accounting Policy
Borrowing costs are recognised as an expense in the financial year in which they are incurred.
Attributed interest on finance leases are charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Overdraft interest expense was $184 thousand (2020: $244 thousand). The DHB had no other borrowings or finance leases at balance date.

2.10 Capital charge

Accounting policy

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

DHBs pay a capital charge to the Crown on their taxpayers' funds as at 30 June and 31 December each year. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2021 was 5% (2020: 6%).

in thousands of New Zealand Dollars

3. Resourcing the DHB's activities

3.1 Cash and cash equivalents and short-term investments

Accounting policy

Cash and cash equivalents include cash on hand, deposits held on call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are presented separately in current liabilities in the statement of financial position.

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

Cash and cash equivalents	30 June 2021	30 June 2020
Cash	4	4
Bank balances	48	2
30 day deposits – special funds	315	414
30 day deposits – clinical trials	257	780
Cash and cash equivalents (excluding bank overdraft)	**624**	**1,200**
Bank overdraft	(42)	(14,433)
Cash and cash equivalents	**582**	**(13,233)**

Short term investments		
Term deposits – special funds	1,219	1,207
Term deposits – clinical trials	224	242
	1,443	**1,449**

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

The entity has $63.9 million of undrawn equity injections from the Ministry of Health that is available when expenditure on approved capital projects is incurred.

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

Special funds		
Opening balance	1,621	1,578
Donations and bequests	23	138
Interest received	21	37
Expenditure during the year	(132)	(132)
	1,533	**1,621**

in thousands of New Zealand Dollars

Clinical Trials	30 June 2021	30 June 2020
Opening balance	1,021	1,058
Receipts	122	256
Interest received	4	17
Expenditure during the year	(187)	-
Transfer to charitable trust	(479)	(310)
	481	**1,021**

DHB Treasury Services Agreement

Hawke's Bay DHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHP) and participating DHBs. The agreement enables NZHP to "sweep" DHB bank account balances and invest the pool of surplus funds on their behalf. The agreement also allows individual DHBs to have a negative balance that will incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's provider arm funding plus GST. As at 30 June 2021 this limit for HBDHB was $35 million (2020: $32 million).

Expected credit losses

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9 *Financial Instruments*, no allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Credit card facility

Hawke's Bay DHB has a $200 thousand BNZ Business Visa Card facility.

3.2 Receivables and prepayments

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. The DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis for customer categories that possess shared credit risk characteristics. They have been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include failure to make contractual payments for a period of greater than 90 days past due.

Receivables with no allowances for credit losses	30 June 2021	30 June 2020
Ministry of Health receivables	4,120	1,975
Ministry of Health accrued revenue	12,950	8,429
Other accrued revenue	2,123	8,207
Prepayments	1,936	997
	21,129	**19,608**
Receivables with allowances for credit losses		
Trade receivables (gross)	1,640	1,671
Less: Allowance for credit losses	(289)	(382)
	1,351	**1,289**
Receivables and prepayments	**22,480**	**20,897**

in thousands of New Zealand Dollars

Receivables and prepayments comprise	30 June 2021	30 June 2020
Receivables from the sales of goods and services (exchange transactions)	5,410	10,493
Less: Receivables from devolved funding (non-exchange transactions)	17,070	10,404
	22,480	**20,897**

The expected credit loss rates for receivables as at 30 June 2021 and 30 June 2020 are based on the payment profile of revenue on credit over a number of years, and the historical credit losses experienced over that period for a number of customer categories. The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

There have been no changes during the reporting period in the estimation techniques or significant assumptions used in measuring the loss allowance.

The aggregated allowance for credit losses across all customer categories at 30 June 2021 and 30 June 2020 are as follows:

30 June 2021	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.1%	1.0%	4.1%	66.7%	1.4%
Gross carrying amount	19,745	399	317	372	20,833
Lifetime expected credit loss	24	4	13	248	289

30 June 2020	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.1%	38.9%	21.4%	36.2%	1.9%
Gross carrying amount	19,254	36	14	978	20,282
Lifetime expected credit loss	11	14	3	354	382

The movement in the allowance for credit losses is as follows:

	30 June 2021	30 June 2020
Opening allowance for credit losses as at 1 July	382	412
Increase in loss allowance made during the year	(6)	62
Receivables written-off during the year	(87)	(92)
Balance at 30 June	**289**	**382**

3.3 Loans

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

The DHB has no loans outstanding with any other organisations.

in thousands of New Zealand Dollars

3.4 Inventories

Accounting Policy

Inventories held for distribution

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

Inventories held for sale

Inventories held for sale or use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.
The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Inventories held for distribution	30 June 2021	30 June 2020
Pharmaceuticals	1,050	951
Surgical and medical supplies	2,477	2,158
Other supplies	1,448	1,517
	4,975	**4,626**

Write-down of inventories amounted to $43 thousand (2020: $138 thousand). No reversal of previously recognised write-downs was made in the current year. Inventory recognised as an expense during the year was $48.1 million (2020: $44.1 million). No inventories were held at current replacement cost at 30 June 2021 (30 June 2020: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

3.5 Non-current assets held for sales

Accounting policy

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.
Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.
HBDHB has no non-current assets held for sale.

in thousands of New Zealand Dollars

3.6 Property, plant and equipment

Accounting policy

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

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

Revaluations

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

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

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated. In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

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

Subsequent costs

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

Depreciation

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

Class of asset	Estimated life	Depreciation rate
Buildings	2 to 57 years	1.75% to 50%
Clinical equipment	3 to 20 years	5% to 33.33%
Information technology	2 to 10 years	10% to 50%
Motor vehicles	3.75 to 20 years	5% to 26.67%
Other equipment	3 to 30 years	3.33% to 33.33%

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 asset is reviewed, and adjusted if applicable, at each financial year end.

Impairment of property, plant and equipment

Hawke's Bay DHB does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use. Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. Impairment losses and reversal of impairment losses are recognised in the surplus or deficit, unless the asset is carried at a revalued amount. Any impairment loss or reversal relating to a revalued asset are treated as revaluation adjustments.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid MPropertyStudies BCom FNZIV FPINZ of Added Valuation Limited. The valuation was effective as at 30 June 2021. The valuations of land and buildings were updated to reflect the movement in building costs in Hawke's Bay, and the useful lives of buildings were updated to recognise the planned timing of building upgrades and replacements.

Land

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

Buildings

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

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

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

The Board believes that the net book value of plant and equipment is the fair value at 30 June 2021.

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

Cash Flow

The DHB acquired plant, property and equipment with an aggregate cost of $18.292 million during the year. Of this amount $5.188 million was reimbursed by the Ministry of Health through equity injections. Cash payments of $17.620 million were made to purchase property, plant and equipment.

No liabilities arose from financing activities relating to property, plant and equipment, during the year, as the activities resulted from either movement in short term investments or the equity injections. Equity injections provided to purchase property, plant and equipment are not subject to capital charge.

Impairment

The revaluation of buildings as at 30 June 2019 and 30 June 2021 incorporate adjustments to buildings identified as requiring seismic remediation. Consequently no impairment losses have been recognised in either of the year ended 30 June 2020 and the year ended 30 June 2021. No reversals of impairment losses have occurred during the year.

Restrictions

Hawke's Bay DHB does not have full title to the Crown land it occupies, but transfer is arranged if and when land is sold. The disposal of certain properties might be subject to the provisions of section 40 of the Public Works Act 1981. Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975. The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

For the year ended 30 June 2021

in thousands of New Zealand Dollars

30 June 2021	1 July 2020									30 June 2021		
Owned assets	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions /transfers from investment properties	Transfers from work in progress	Revaluation of land and buildings	Disposals	Depreciation expense	Depreciation write back on disposal/ revaluation	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Land	12,127	-	12,127	70	152	2,899	-	-	-	15,248	-	15,248
Buildings	156,129	(7,748)	148,381	-	7,034	(3,658)	(14)	(7,948)	15,696	159,491	-	159,491
Clinical equipment	38,377	(24,560)	13,817	-	5,852	-	(3,564)	(3,441)	3,452	40,665	(24,549)	16,116
Information tech.	10,165	(6,407)	3,758	-	1,547	-	(961)	(1,738)	960	10,751	(7,185)	3,566
Motor vehicles	1,864	(1,591)	273	-	66	-	(165)	(121)	165	1,765	(1,547)	218
Other equipment	4,802	(2,201)	2,601	-	382	-	(120)	(362)	77	5,064	(2,486)	2,578
	223,464	(42,507)	180,957	70	15,033	(759)	(4,824)	(13,610)	20,350	232,984	(35,767)	197,217
Leased assets												
Alterations	1,771	(821)	950	-	146	-	(1)	(218)	1	1,916	(1,038)	878
	1,771	(821)	950	-	146	-	(1)	(218)	1	1,916	(1,038)	878
Work in Progress												
Buildings	6,016	-	6,016	10,565	(7,332)	-	-	-	-	9,249	-	9,249
Clinical equipment	1,477	-	1,477	5,532	(5,852)	-	-	-	-	1,157	-	1,157
Information tech.	236	-	236	1,576	(1,547)	-	-	-	-	265	-	265
Motor vehicles	-	-	-	107	(66)	-	-	-	-	41	-	41
Other equipment	61	-	61	511	(382)	-	-	-	-	190	-	190
	7,790	-	7,790	18,291	(15,179)	-	-	-	-	10,902	-	10,902
	233,025	(43,328)	189,697	18,361		(759)	(4,825)	(13,828)	20,351	245,802	(36,805)	208,997

in thousands of New Zealand Dollars

	1 July 2019								30 June 2020			
30 June 2020	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions	Transfers from work in progress	Disposals	Depreciation expense	Depreciation write back on disposal	Cost/ valuation	Accumulated Depreciation	Carrying Amount	
Owned assets												
Land	12,127	-	12,127	-	-	-	-	-	12,127	-	12,127	
Buildings	153,649	-	153,649	-	2,480	-	(7,748)	-	156,129	(7,748)	148,381	
Clinical equipment	36,244	(23,752)	12,492	-	4,657	(2,524)	(3,189)	2,381	38,377	(24,560)	13,817	
Information tech.	8,347	(5,351)	2,996	-	1,955	(137)	(1,184)	128	10,165	(6,407)	3,758	
Motor vehicles	1,876	(1,455)	421	-	-	(12)	(148)	12	1,864	(1,591)	273	
Other equipment	4,386	(2,010)	2,376	-	580	(164)	(354)	163	4,802	(2,201)	2,601	
	216,629	(32,568)	184,061	-	9,672	(2,837)	(12,623)	2,684	223,464	(42,507)	180,957	
Leased assets												
Alterations	1,683	(644)	1,039	-	88	-	(177)	-	1,771	(821)	950	
	1,683	(644)	1,039	-	88	-	(177)	-	1,771	(821)	950	
Work in Progress												
Buildings	3,129	-	3,129	5,455	(2,568)	-	-	-	6,016	-	6,016	
Clinical equipment	1,447	-	1,447	4,687	(4,657)	-	-	-	1,477	-	1,477	
Information tech.	397	-	397	1,793	(1,954)	-	-	-	236	-	236	
Other equipment	182	-	182	460	(581)	-	-	-	61	-	61	
	5,155	-	5,155	12,395	(9,760)	-	-	-	7,790	-	7,790	
	223,467	(33,212)	190,255	12,395		(2,837)	(12,800)	2,684	233,025	(43,328)	189,697	

3.7 Intangible assets

Accounting policy

Software acquisition and development
Acquired software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include costs of materials and services, employee costs and any directly attributable overheads. Staff training costs are recognised as an expense when incurred.
Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.
Rights in shared software developments are considered to have indefinite useful life, as the DHB has the ability and intention to review any service level agreement indefinitely. As the rights are considered to have indefinite life, the intangible asset is not amortised and is tested for impairment annually.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset 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 10 years	10% to 33.33%
Developed computer software	3 to 10 years	10% to 33.33%

Impairment of intangible assets
Hawke's Bay DHB does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.
Intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.
Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

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

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

Critical accounting estimates and assumptions

Estimating useful lives of intangible assets with definite lives

Assessing the appropriateness of useful life estimates requires the DHB to consider a number of factors such as the extent to which the asset meets the DHB's needs and advances in technology. An incorrect assessment of the useful life or any residual value will affect the amortisation expense recognised in the surplus of deficit and the asset's carrying value. The DHB minimises the risk of this estimation uncertainty by review of asset effectiveness and technology platforms. The DHB has not made significant changes to past assumptions concerning useful lives.

Critical judgements in applying accounting policies

Impairment of intangible assets with indefinite lives

The investment in the Health Finance, Procurement and Information Management System (FPIM) was impaired in 2018/19 for its full remaining value of $2.638 million. The DHB will be able to implement the system at a future date, should it become economic to do so, by contributing its share of any further development costs incurred by the DHBs who implement the system.

The Regional Digital Health Service (RDHS) provides a number of clinical systems for the Central Region DHBs, which are subject to an annual impairment test. HBDHB remains committed to the RDHS programme but has determined that it will defer joining the regional version of the Web-based patient administration system (WebPAS). Instead HBDHB will continue to access the additional functionality currently available in its local WebPAS solution and interface with the regional solution. The combined regional/local solution is expected to provide the information requirements of HBDHB, and the DHBs investment in the regional solution was necessary for those information requirements to be met. Consequently, the investment in RDHS has not been impaired.

in thousands of New Zealand Dollars

	1 July 2020								30 June 2021		
30 June 2021	Cost/	Accumulated	Carrying	Acquisitions	Transfers	Disposals/	Amortisation	Amortisation	Cost/	Accumulated	Carrying
Owned assets	Valuation	Amortisation	Amount			Impairment	Expense	written back	Valuation	Amortisation	Amount
Software	16,484	(10,927)	5,557	-	10,826	(1,435)	(1,647)	1,111	25,875	(11,463)	14,412
	16,484	(10,927)	5,557	-	10,826	(1,435)	(1,647)	1,111	25,875	(11,463)	14,412
Work in Progress											
Software	10,186	-	10,186	2,440	(10,826)	-	-	-	1,836	-	1,836
Health Sector Catalogue	-	-	-	324	-	-	-	-	324	-	324
	10,186	-	10,186	2,764	(10,826)	-	-	-	2,160	-	2,160
	26,670	(10,927)	15,743	2,764		(1,435)	(1,647)	1,111	28,035	(11,463)	16,572

Health Sector Catalogue is the DHB's share of the assets comprising the Health Sector Catalogue project facilitated by NZ Health Partnerships Limited (NZHP). The intangible asset recognises the DHB's right to use the catalogue, and its ownership of a proportion of the systems assets. The project is in the early phase of development and the work in progress at 30 June 2021 is considered to be fit for purpose, and supported by the DHB sector. HBDHB considers the carrying amount of the assets (the cost of the system build), is equivalent to the recoverable service amount using depreciated replacement cost, and consequently no impairment of the assets is necessary.

Cash Flow

The DHB acquired intangible assets with an aggregate cost of $2.764 million during the year. Cash payments of $2.311 million were made to purchase intangible assets.

No liabilities arose from financing activities relating to intangible assets as the activities resulted from movements in short term investments.

in thousands of New Zealand Dollars

	1 July 2019						30 June 2020		
30 June 2020	Cost/	Accumulated	Carrying	Acquisitions	Transfers	Amortisation	Cost/	Accumulated	Carrying
Owned assets	Valuation	Amortisation	Amount			Expense	Valuation	Amortisation	Amount
Software	13,164	(10,151)	3,013	-	3,320	(776)	16,484	(10,927)	5,557
	13,164	(10,151)	3,013	-	3,320	(776)	16,484	(10,927)	5,557
Work in Progress									
Software	1,101	-	1,101	3,126	5,959	-	10,186	-	10,186
RDHS (previously RHIP)	9,279	-	9,279	-	(9,279)	-	-	-	-
	10,380	-	10,380	3,126	(3,320)	-	10,186	-	10,186
	23,544	(10,151)	13,393	3,126		(776)	26,670	(10,927)	15,743

in thousands of New Zealand Dollars

3.8 Investment property

Accounting policy
Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued will provide an assessment on the fair values of the properties. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing where the parties had each acted knowledgeably, prudently and without compulsion.
Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above). When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to retained earnings. Any loss arising in this manner is recognised immediately in the surplus or deficit.

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

	30 June 2021	30 June 2020
Balance at beginning of year	694	694
Transfers to property, plant and equipment	(70)	-
Transfers from non-current assets held for sale	-	-
Fair value adjustments	-	-
Disposals	(415)	-
Balance at end of year	209	694

No revaluation was completed for investment properties as at 30 June 2021 due to the minimal value of the properties. The properties were last revalued as at 30 June 2018 by John Reid of Added Valuation, who holds an annual practicing certificate and has held registration since 1985. The fair value of the investment properties was determined using market-based evidence.

3.9 Investment in associates

Accounting policy
An associate is an entity over which the DHB has significant influence, and that is neither a subsidiary nor an interest in a joint venture. The DHB's investment in its associate entity is accounted for using the equity method. The investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the DHB's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount of the investment in the statement of financial position.
If the share of deficits of an associate equal or exceed the DHB's interest in the associate, further deficits are not recognised. After the DHB's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that the DHB has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the DHB will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

in thousands of New Zealand Dollars

Hawke's Bay DHB has an investment in one associate entity, Allied Laundry Services Limited (ALSL), whose principal activity is the provision of laundry services. The interest held at 30 June 2021 was 16.67% (30 June 2020: 16.67%). ALSL has been treated as an associate entity because its shares are held equally by six DHB shareholders, who appoint one director each, and contribute 92% of the company's income. The associates balance date is 30 June. There are no significant restrictions on the ability of the associate to transfer funds to HBDHB in the form of cash dividends.

Summarised financial information of Allied Laundry Services Limited	30 June 2021	30 June 2020
Presented on a gross basis		
Assets	13,017	11,899
Liabilities	4,612	4,151
Revenue	13,087	11,761
Surplus/(deficit)	656	753
HBDHB ownership interest	16.67%	16.67%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Capital commitments	-	-

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited draft accounts as at 30 June 2021, and their audited financial statements as at 30 June 2020.

4. Financing the DHB's activities

4.1 Borrowings and finance leases

The DHB had no borrowings or finance leases at balance date, other than the overdraft facility through New Zealand Health Partnerships.

4.2 Payables and deferred revenue

Accounting policy

Payables and deferred revenue are recorded at their face value.

Payables and deferred revenue under exchange transactions	30 June 2021	30 June 2020
Trade payables	3,902	3,281
Income in advance relating to contracts with specific performance obligations	6,207	1,281
Other non-trade payables and accrued expenses	29,951	29,473
	40,060	34,035
Payables and deferred revenue under non-exchange transactions		
ACC levy payable	235	233
Goods and services tax	2,882	2,404
	3,117	2,637
Total payables and deferred revenue	**43,177**	**36,672**

Payables and deferred revenue are non-interest bearing and are normally settled within 10 days of processing into the DHB's accounts payable system or on 7-day terms, therefore the carrying value of payables and deferred revenue approximates their fair value.

4.3 Employee entitlements

Accounting policy

Short-term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.
These include salaries and wages accrued up to balance date, annual leave and continuing medical education leave earned, but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

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

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

Long-term employee entitlements

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

Presentation of employee entitlements

Annual leave, sick leave, continuing medical education leave, and sabbatical leave that are available for use are classified as a current liability. Long service leave and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions

Employee entitlement provisions

The calculation of sick leave, sabbatical leave, long service leave, and retirement gratuity liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $6,146 million (2020: $6.352 million).

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 0.38% (2020: 0.22%) in year one to 4.30% (2020: 3.77%) after 30 (2020: 52) years. The salary inflation factor is the DHB's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates are 1% lower, or salary increases 1% higher, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $309 thousand higher (2020: $287 thousand higher). Conversely if the discount rates are 1% higher, or salary increases 1% lower, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $279 thousand lower (2020: $259 thousand lower).

in thousands of New Zealand Dollars

Non-current liabilities	30 June 2021	30 June 2020
Long service leave	3,069	3,192
Retirement gratuities	20	97
	3,089	**3,289**

Current liabilities	30 June 2021	30 June 2020
Accrued salaries and wages	15,466	8,709
Annual leave	29,119	27,229
Sick leave	518	465
Continuing medical education leave and expenses	6,118	5,855
Sabbatical leave	609	638
Long service leave	1,815	1,844
Retirement gratuities	115	116
	53,760	**44,856**

4.4 Provisions

Accounting policy

Provisions

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

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

Critical accounting estimates and assumptions

This note provides information about estimates and assumptions applied in determining the DHB's liability under the ACC Partnership Programme, and Holidays Act remediation.

	30 June 2021	30 June 2020
Balance at beginning of year	34,724	13,808
Additional provisions made	4,119	22,218
Amounts used	(386)	(1,302)
Unused amounts reversed	-	-
Balance at end of year	**38,457**	**34,724**

All provisions are classified as current.

ACC Accredited Employers Programme

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

Liability valuation

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

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

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

Hawke's Bay DHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will carry the total cost of claims up to $2.7 million (2020: $2.2 million) for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceed the stop loss limit, the DHB will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

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

An independent consulting actuary, Peter Davies B.Bus.Sc, FIA, FNZSA has calculated the DHB's liability, and the valuation is effective 30 June 2021. The actuary has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the consulting actuary's report.

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

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

in thousands of New Zealand Dollars

Holidays Act remediation

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act"). Work has been ongoing since 2016 on behalf of 20 DHBs and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs.

DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance progressed during the 2019/20 and current financial years, with a number of issues to be clarified, and Holidays Act compliant systems to be implemented. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Hawke's Bay DHB has reassessed the likely liability at $37.5 million (2020: $33.9 million), recognising growth since 1 July 2020, and increased administrative costs of the remediation process. The financial liability was originally calculated based on identified areas of non-compliance with the Holidays Act, and the recalculation of a sample of current and former employees, extrapolated to the full population of affected people. The additional liability this year has been recognised in personnel costs (last year the increase was recognised in other operating expenses as it was for 10 years of liability).

The liability amount is HBDHB's best estimate at this stage of the remediation project, however there remains a level of uncertainty until the project is complete. Estimates and assumptions may change as further work is completed, and result in further adjustment to the carrying amount of the provision, or payments to current and former employees that differ significantly from the estimation of the liability.

4.5 Equity

	Crown Equity	Property Revaluation Reserves	Restricted Funds	Accumulated Deficit	Total Equity
Balance at 1 July 2020	112,880	96,103	2,163	(109,473)	101,673
Surplus/(deficit) for the year	-	-	-	(28,311)	(28,311)
Revaluation of land and buildings	-	14,932	-	-	14,932
Transfers between reserves	-	-	(149)	149	-
Injection from the Crown	30,188	-	-	-	30,188
Repayment to the Crown	(357)	-	-	-	(357)
Balance at 30 June 2021	**142,711**	**111,035**	**2,014**	**(137,635)**	**118,125**

in thousands of New Zealand Dollars

	Crown Equity	Property Revaluation Reserves	Restricted Funds	Accumulated Deficit	Total Equity
Balance at 1 July 2019	91,945	96,103	2,636	(47,043)	143,641
Surplus/(deficit) for the year	-	-	-	(62,903)	(62,903)
Transfers between reserves	-	-	(473)	473	-
Injection from the Crown	21,292	-	-	-	21,292
Repayment to the Crown	(357)	-	-	-	(357)
Balance at 30 June 2020	**112,880**	**96,103**	**2,163**	**(109,473)**	**101,673**

Property Revaluation Reserves

These reserves result from the revaluation of land and buildings to fair value. The revaluation reserve consists of amounts as follows:

	30 June 2021	30 June 2020
Land	13,556	10,657
Buildings	97,479	85,446
	111,035	**96,103**

Restricted Funds

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

5. Other disclosures

5.1 Taxes

Accounting policy

Goods and services tax

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hawke's Bay DHB is a public authority and consequently is exempt from the payment of income tax under section CB3 of the Income Tax Act 2007.

in thousands of New Zealand Dollars

5.2 Capital commitments and operating leases

Capital commitments	30 June 2021	30 June 2020
Property, plant and equipment		
Buildings	12,538	1,674
Clinical equipment	2,954	741
Plant	384	10
Information technology	139	80
Motor vehicles	724	-
Intangible assets		
Software	5	38
Regional Digital Health Service (RDHS)	1,216	1,051
Health Sector Catalogue	333	-
	18,293	3,594

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

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

Non-cancellable commitments – operating leases	30 June 2021	30 June 2020
Not more than one year	3,381	3,178
One to five years	10,520	9,670
Later than five years	9,629	1,732
	23,530	14,580

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

- The Napier Health Centre lease was extended in February 2021 from the December 2023 expiry date for a further ten years ending December 2033, with a right of renewal for a further two periods of six years each, and an escalation clause allowing for annual increases in line with the consumer price index.
- The lease of the administration building at 100 McLeod Street was varied in February 2018, for a ten year period, with two right of renewal periods of four years each. The lease is reviewed to market every two years.
- The lease of the store building on Omahu Road was renewed in April 2021, for a term of 10 years with two rights of renewal periods of five years each, with a 2% increase each year and a review to market on each renewal date.
- The Central Hawke's Bay Health Centre was renewed from July 2015, for four years, with a right of renewal for a further two periods of four years each, and an escalation clause allowing for annual increases in line with the consumer price index.

5.3 Financial instruments

a. Financial instrument categories

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

in thousands of New Zealand Dollars

Financial Assets

Financial assets measured at amortised cost	30 June 2021	30 June 2020
Cash and cash equivalents	624	1,200
Short term investments	1,442	1,449
Receivable and prepayments	22,480	21,118
	24,546	**23,767**

Financial Liabilities

Financial liabilities measured at amortised cost		
NZ Health Partnerships	42	14,433
Payables and deferred revenue	43,177	36,672
	43,219	**51,105**

b. Fair value hierarchy disclosures

Hawke's Bay DHB recognises no financial instruments at fair value in the statement of financial position.

c. Financial instrument risks

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

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices, The DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to bank deposits. This exposure is not considered significant and is not actively managed.

Hawke's Bay DHB's investment policy requires a spread of investment maturity dates, and a spread of interest rate re-pricing dates to limit the exposure to short-term interest rate movements. The DHB currently has no variable interest rate investments.

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

in thousands of New Zealand Dollars

30 June 2021	Effective Interest Rates	Total	6 months or less	6 months to 1 year	1 year to 2 years
Cash and cash equivalents					
Cash	-	4	4	-	-
Bank balances	-	48	48	-	-
Short term deposits	0.58%	572	572	-	
Short term investments	1.65%	1,442	1,182	-	260
Repricing gap		**2,066**	**1,806**	**-**	**260**

30 June 2020	Effective Interest Rates	Total	6 months or less
Cash and cash equivalents			
Cash	-	4	4
Bank balances	-	2	2
Short term deposits	0.20%	1,194	1,194
Short term investments	2.18%	1,449	1,449
Repricing gap		**2,649**	**2,649**

Currency risk

Currency risk is the risk that the fair value or future cash flows on a financial instrument will fluctuate because of changes in foreign exchange rates. HBDHB purchases clinical equipment from overseas, which may require transactions denominated in in foreign currencies and, as a result, exposure to foreign currency risk may arise.

The DHB's policy is to hedge foreign currency risks arising from contractual commitments and liabilities, by entering into forward foreign exchange contracts for purchases over NZ$100,000 to manage the foreign currency risk exposure.

The DHB had no foreign currency contracts over NZ$100,000 during 2020/21 (2020: Nil), and no outstanding foreign denominated payables over NZ$100,000 at 30 June 2021 (2020: Nil).

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 96% (30 June 2020: 96%) of the DHB's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

in thousands of New Zealand Dollars

Sensitivity analysis

At 30 June 2021, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2021/22, as the DHB has no term debt, and only the net interest from cash holdings would be affected.

Credit quality of financial assets

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

	30 June 2021	30 June 2020
Counterparties with credit ratings		
Cash, cash equivalents and investments		
AA-	2,014	2,642
Total cash and cash equivalents	2,014	2,642
Counterparties without credit ratings		
Cash and cash equivalents		
NZ Health Partnerships – no defaults in the past	-	-

All instruments in this table have a loss allowance based on 12-month expected credit losses.

Liquidity risk

Liquidity risk is the risk that HBDHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions. The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities

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

Forecasted transactions

Hawke's Bay DHB does not hedge forecasted transactions.

5.4 Contingent assets

There are no contingent assets at 30 June 2021 (2020: Nil).

in thousands of New Zealand Dollars

5.5 Contingent liabilities

Lawsuits against the DHB

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

5.6 Related party transactions

Hawke's Bay DHB is a wholly owned entity of the Crown.

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

There were no related party transactions during the year (2020: Nil).

Key management personnel compensation

	30 June 2021	30 June 2020
Board Members		
Remuneration	300	307
Full time equivalent members	*1.2*	*1.3*
Executive management team		
Remuneration	2,765	3,603
Full time equivalent members	*10.4*	*13.3*
Total key management personnel remuneration	**3,065**	**3,910**
Total full time equivalent personnel	**11.6**	**14.6**

The full time equivalent for Board members has been determined based on the expectation that members and chairs will spend 30 days and 50 days respectively on Board business per annum. One executive position (2020: Three) covered by contractors on an interim basis for parts of the year, are included in the 30 June 2021 and 30 June 2020 figures, including accommodation and transport valued at the cost incurred by the DHB. One executive position was held by an employee of Health Hawke's Bay, the Hawke's Bay PHO, and has been excluded from the table.

in thousands of New Zealand Dollars

5.7 Summary cost of services by output class

Accounting policy

Cost allocation

The cost of outputs has been determined using the cost allocation system outlined below.

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

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

	Achieved 30 June 2021 $m	Plan 30 June 2021 $m	Achieved 30 June 2020 $m
Revenue			
Prevention	8.6	9.6	9.4
Early detection and management	156.7	145.8	150.9
Intensive assessment and treatment	428.3	406.7	366.6
Rehabilitation and support	83.6	91.1	81.9
Total revenue	677.2	655.9	608.8
Less:			
Expenditure			
Prevention	9.8	9.6	9.9
Early detection and management	180.1	148.5	155.6
Intensive assessment and treatment	422.1	421.2	418.0
Rehabilitation and support	93.5	91.1	88.2
Total expenditure	705.5	670.4	671.7
Surplus/(Deficit)	**(28.3)**	**(14.5)**	**(62.9)**

5.8 Capital management

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

5.9 Events after balance date

There are no significant events after balance date.

5.10 Publication of the 2021/22 Statement of Performance Expectations

The 2021/22 Statement of Performance Expectations (SPE) was not published on the DHB's website by 30 June 2021, as required by section 149L of the Crown Entities Act 2004. The SPE included financial information that the Minister of Health would not have been aware of or able to review by that date.

5.11 COVID-19

During August and September 2020 and February and March 2021, the Auckland Region moved into Alert Levels 3 and 2 and other parts of the country, which includes the DHB's service area, moved into Alert Level 2.

At Alert Level 2, the operating capacity of the DHB was reduced. At Alert Level 1, the DHB resumed normal business activity and in some instances at a higher level than pre-COVID-19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels.

Government funding

The MOH provided funding of $5.9 million to the DHB to assist with the COVID-19 response, a further $1.8 million to reimburse laboratory testing and support Community Based Assessment Centres (CBACs), and $0.8 million in the form of equipment and clinical supplies.

Personnel expenses

Personnel expenses increased by $2.2 million due to an increase in permanent and casual staff. Also, staff have taken less leave during the pandemic declaration.

Other expenses

There was an increase in payments to non DHB providers, outsourced services, infrastructure costs, and clinical supplies of $8.8 million, mainly driven by the cost of Community Based Assessment Centres, support for primary and residential care providers, and changes to the dispensing of pharmaceuticals.

Valuation of land and buildings

The DHB's land and buildings were revalued on 30 June 2021 as part of the normal three yearly cycle. The valuations were prepared on an Optimised Depreciated Replacement Cost basis, and consequently reflect the effect of COVID-19 on the supply chains that influence building costs and drive replacement value. With property values remaining firm in the commercial sector, and strengthening significantly in the residential market, the DHB considers the impact of COVID-19 on the valuations of its land and buildings are not material.

Independent Auditor's Report

To the readers of Hawke's Bay District Health Board's Group financial statements and performance information for the year ended 30 June 2021

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

We have audited:

- the financial statements of the Group on pages 46 to 88, that comprise the statement of financial position as at 30 June 2021, the statement of revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 9 to 33 and 42 to 44.

Opinion

In our opinion:

- the financial statements of the Group on pages 46 to 88, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Group on pages 9 to 33 and 42 to 44:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2021, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 December 2021. This is the date at which our opinion is expressed.

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

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1.2 on page 51 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 4.4 on page 80 outlines that the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Group has estimated a provision of $37.5 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The Group is reliant on financial support from the Crown

Note 1.2 on page 51 outlines the Group's financial performance difficulties. There is uncertainty whether the Group will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The Group therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Group with financial support, where necessary.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Pages 42 to 44 outline the information used by the Group to report on its Covid-19 vaccine coverage. The Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 42 to 44. This outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 5.11 on page 88 of the financial statements which outlines the impact of Covid-19 on the Group.

Basis for our opinion

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

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

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

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

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

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

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

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

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

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

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 8, 34 to 41 and 45, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

Kelly Rushton
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

HAWKE'S BAY DISTRICT HEALTH BOARD

PRIVATE BAG 9014

HASTINGS 4156