HAWKE'S BAY
District Health Board
Whakawāteatia

# 2019

Annual Report

# Contents

# Message from the Chair and Chief Executive

Hawke's Bay DHB funds and provides services for nearly 165,000 people living in the Hawke's Bay region.

This year Hawke's Bay DHB reports an underlying operating deficit of $10.7 million against a planned deficit of $5 million. When one-off costs relating to Holidays Act, impairment and industrial action are added, the total reported deficit is $28.4 million on total revenue of $587.1 million.

The 2018/19 year has been challenging, with a number of significant events including industrial action that impacted on our staff, our primary care colleagues and our communities.

After many years of strong performance and financial results the district health board has experienced some degradation in key areas. Whilst safe and effective services have been maintained, our population is now experiencing delays and barriers to services. The reasons for this are complex but a number are largely attributable to the constraints and inefficiencies of our aged hospital facilities along with our aging and complex population demographics.

The district health board is now focused on step-change, through the leadership of its management team as it navigates itself back to high performance. A number of changes within the Executive Leadership Team have been made and highly experienced executives have been appointed in the Executive Director Provider Services and Chief Executive roles on a temporary basis, to help improve performance.

The district health board's workforce has increased significantly with an additional 89 FTEs. This increase has mostly been in medical personnel and additional nursing resources. Significant and welcome changes have been made to our Information Services unit which is driving and enhancing the district health board's digital environment. This has strengthened and enabled greater partnership to support our clinical teams. Recently Clinical Portal has gone live bringing much needed electronic patient records onto the one system.

As one of the largest organisations in Hawke's Bay we take our impact on the environment seriously and are a member of Global Green and Healthy Hospitals. This year we were pleased to achieve certification from the Certified Emissions Measurement and Reduction Scheme (CEMARS). This is a significant step towards reducing the DHB's carbon footprint. Our GoWell travel plan has increased the use of sustainable transport by 15 percent, reduced single occupancy trips by 18 percent and increased public transport use by 7 percent.

The significant sterilisation of clinical equipment incident this year was dealt with proactively and sensitively and whilst a serious situation we are pleased to report that no patient was harmed as a result. Industrial action this year from the Resident Doctors Association impacted on resources and staffing to maintain safe services during these times. This action combined with a sustained period of

high demand on secondary services especially our emergency services has added to the demands and challenges of a busy year.

We expect the next year to be as challenging, however we anticipate we will bring on additional theatre capacity for elective operations through the Surgical Services Expansion Project. This project was initially delayed because of seismic issues, however it is now making progress and building work is expected to begin in early 2020.

In addition to the theatre expansion other facility projects including radiology refurbishment and the addition of a Linear Accelerator are expected to come on stream in the 2020/21 year, which will help further reduce wait times for our population.

Much work is being done in our rural communities and a new model of care will be developed in partnership with these communities with an aim to provide more equitable services for everyone.

Kevin Atkinson

Chair

Craig Climo

Chief Executive

# 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, which includes the Wairoa, Napier, Hastings and Central Hawke's Bay districts.


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




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



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



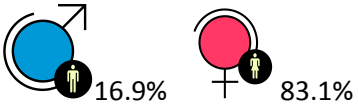
**Central Hawke's Bay Health Centre**
Cook Street
PO Box 521
Waipukurau
Phone: 06 858 9090



Our values:

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

The DHB currently employ 3050 people:




A number of the above are multi-jobbed, with 3360 positions held throughout the organisation.

Of the 3360 positions:

| Workforce Profile – by age bands | |
|---|---|
| <25 years old | 4.7% |
| 25 – 34 years old | 20.2% |
| 35 – 45 years old | 17.7% |
| 45 – 55 years old | 26.3% |
| 55 – 64 years old | 24.2% |
| 65+ years old | 6.9% |

| Workforce Profile – by occupational group | |
|---|---|
| Medical staff | 9.1% |
| Nursing staff | 51.0% |
| Allied Health staff | 18.2% |
| Non-clinical support staff | 6.1% |
| Management & admin staff | 15.6% |

| Ethnicity | Positions filled | % of Total |
|---|---|---|
| NZ and European | 2404 | 71.6 |
| Māori | 506 | 15.1 |
| Pacific Islands | 47 | 1.4 |
| Asian | 240 | 7.1 |
| Other | 115 | 3.4 |
| Not known | 48 | 1.4 |
| Total | 3360 | 100.0 |

| Employee Status | | |
|---|---|---|
| Casual | 14% |  |
| Full time | 33% |  |
| Part time | 53% |  |

# Report on good employer obligations

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

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

In response to feedback received via the Big Listen staff engagement survey, we have developed a People Plan which puts the values and behaviours of the organisation at the centre of the way we do things around here. This People Plan will ensure that our workforce is cared for, well supported, highly skilled, empowered and have joy in their work.

The focus of the People Plan:

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

## Leadership, Accountability and Culture:

Investing in its people and developing leadership capability, remains a priority for Hawke's Bay DHB, as does increasing the capability of our whole workforce. Our focus over the last twelve months has been to develop the coaching and mentoring skills of our managers, providing them with the ability to provide constructive feedback, undertake strengths-based performance conversation and acknowledge and celebrate excellence by their teams. As an organisation we endeavour to 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 Consumer Council (established June 2013) continues to meet monthly and ensures health consumers have an effective voice in health planning and how it is delivered in Hawke's Bay. The Consumer Council and the DHB's sector-wide Clinical Council has a leadership role in monitoring quality of health services delivered throughout Hawke's Bay. The DHB is adopting principles of co-design in service planning, project development and strategy to ensure the consumer voice is heard. Our service directorate partnerships support medical, nursing and allied health leaders to lead and drive clinical quality and improve patient safety.

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

## Recruitment, Selection and Induction:

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

continued focus in the coming year with the development of both a Maori and Pacific Workforce development action plan.

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

### Employee Development, Promotion and Exit:

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

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

The Employment Relations Act, and Health and Safety in Employment Amendment Act 2015 continues to reinforce the need to maintain strong relationships with employees and unions. The Bipartite Union Committee continues to be the forum for Union delegates to be engaged and to discuss common issues. HBDHB 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.

### Flexibility and Work Design:

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

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

### Remuneration, Recognition and Conditions:

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

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

### Harassment and Bullying Prevention:

HBDHB has a zero tolerance to bullying policy which is supported with resources such as clearly defined process supported by policy, manager and staff training, posters throughout the organisation which emphasise respect and acceptable and unacceptable behaviours, and intranet resources provide a centralised information resource for all staff to access. The last year we have co-designed a new approach to dealing with unacceptable behaviours and this will be launched in later 2019.

## Safe and Healthy Environment:

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

HBDHB promotes and provides opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via 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 our Board that the organisation is meeting its obligations. The organisation has also undertaken an assessment through Safe365 online tool to identify any gaps in relation to the new health and safety requirements and will continue to build the capability of all and develop a culture whereby health and safety is embedded in everything we do.

HBDHB maintains its ACC partnership programme which recognises that appropriate systems support a safe environment and are implemented throughout the organisation. A Wellbeing Steering Group has been established and will continue to be refined in the next 12 months ensuring that all our staff wellbeing is prioritised.

## Staff Ethnicity

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

As at the end of the 2018/19 year the target of 16.02 percent of staff identifying as Māori was not reached:

| | |
|---|---|
| Target 2018/19 | 16.02% (489) |
| Actual at 30 June 2019 | 15.15% (462) |
| Gap | 27 people |

## Staff Disability

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

# Hawke's Bay District Health Board Governance

## Role of the Board

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

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

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

## Role of the Chief Executive

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

## Advisory Committees

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

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

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

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

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

Other components of HBDHB's governance structures include:

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

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

Note:

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

Number of Board Meetings held 11

**Kevin Atkinson – Chair**
Meetings attended 11 of 11
Trustee, Te Matau ā Māui Health Trust
Director, New Zealand Health Partnerships Ltd
Trustee Hawke's Bay Power Consumers Trust

**Ngahiwi Tomoana - Deputy Chair**
Meetings attended 9 of 11
Chairman, Ngati Kahungunu Iwi Inc
Member, Treaty Tribes Coalition
Brother is employee of Cranford Hospice
Two Nephews are employees of HBDHB
Waitangi Claim #2687 relating to Napier Hospital land *(from 28 March 2018)*
Waitangi Claim #2575 relating to Treaty of Waitangi Health Claim *(from 19 December 2018)*

**Barbara Arnott**
Meetings attended 11 of 11
Trustee of the Hawke's Bay Air Ambulance Trust *(to 27 February 2019)*
Trustee Hawke's Bay Power Consumers' Trust

**Peter Dunkerley**
Meetings attended 11 of 11
Trustee, Hawke's Bay Rescue Helicopter Trust
Shareholder of Need a Nerd
Shareholder of NZ Technologies

**Diana Kirton**
Meetings attended 11 of 11
Brother is a surgeon for HBDHB
Practicum Manager – EIT School of Health and Sport Science
Trustee, Hawke's Bay Power Consumers' Trust
Member HB Law Society Standards Committee *(to 26 June 2019)*
RENEW Counselling Services counsellor

**Dan Druzianic**
Meetings attended 11 of 11
Director, Markhams Hawke's Bay Limited

**Dr Helen Francis**
Meetings attended 11 of 11
Lifetime member of Alzheimer's Society Napier
Trustee, Hawke's Bay Power Consumers' Trust
Trustee, HB Medical Research Foundation
Independent Consultant to a variety of health organisations (*to 13 March 2019)*
Board member of Federation of Primary Health Aotearoa NZ *(to 13 March 2019)*
Senior Advisor Primary Care, Ministry of Health *(from 13 March 2019)*

**Jacoby Poulain**
Meetings attended 9 of 11
Board Member of Eastern Institute of Technology
Councillor, Hastings District Council

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

**Ana Apatu**
Meetings attended 10 of 11
CEO of Whararaki Trust and HB Tamariki Health Housing Fund
Chair of Directions *(to 30 June 2018)*

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

## Membership of Advisory Committees – statutory

Disability Support Advisory Committee (DSAC)
Community and Public Health Advisory Committee (CPHAC); and
Hospital Advisory Committee (HAC)
No DSAC, CPHAC and HAC meetings were held and all the above named Statutory Committees are made up of Board members. Refer Board interests disclosed.

| | |
|---|---|
| Diana Kirton | Chairperson of DSAC |
| Barbara Arnott | Chairperson of CPHAC |
| Peter Dunkerley | Chairperson of HAC |
| Kevin Atkinson | Ngahiwi Tomoana |
| Dan Druzianic | Helen Francis |
| Jacoby Poulain | Heather Skipworth |
| Ana Apatu | Hine Flood |

## Finance Risk and Audit Committee

Number of FRAC Meetings held 12. Refer Board interests disclosed

| | |
|---|---|
| Dan Druzianic - Chairperson | Meetings attended 11 of 12 |
| Kevin Atkinson | Meetings attended 11 of 12 |
| Ngahiwi Tomoana | Meetings attended 9 of 12 |
| Barbara Arnott | Meetings attended 12 of 12 |
| Peter Dunkerley | Meetings attended 12 of 12 |
| Jacoby Poulain | Meetings attended 10 of 12 |
| Helen Francis | Meetings attended 11 of 12 |
| Diana Kirton | Meetings attended 11 of 12 |
| Heather Skipworth | Meetings attended 11 of 12 |
| Ana Apatu | Meetings attended 11 of 12 |
| Hine Flood | Meetings attended 11 of 12 |

## Māori Relationship Board (MRB)

Number of meetings held 11

**Ngahiwi Tomoana – Chair**
Meetings attended 6 of 11
Refer Board interests disclosed

**Heather Skipworth – Deputy Chair**
Meetings attended 9 of 11
Refer Board interests disclosed

**Ana Apatu**
Meetings attended 10 of 11
Refer Board interests disclosed

**Hine Flood**
Meetings attended 7 of 11
Refer Board interests disclosed

**Beverly TeHuia**
Meetings attended 7 of 11
Ngati Kahungunu Iwi Inc representative
Trustee and employee of Kahungunu Health Services
Employee of Totara Health
Member of the Priority Population Health Committee
Nga Maia O Aotearoa Chair person
Iwi Rep on Te Matua a Maui Health Trust
Te Pitau Health Alliance Group, Board member
NGO Council, Chair
Claimant of Treaty Health Claim currently with the Tribunal; WAI #2575

**Kerri Nuku**
Meetings attended 4 of 11
Ngati Kahungunu Iwi Inc representative
Kaiwhakahaere New Zealand Nurses Association
Trustee of Maunga Haruru Tangitu Trust

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

**Trish Giddens**
Meetings attended 11 of 11
Ngati Kahungunu Iwi Inc representative
Trustee, HB Air Ambulance Trust
Member of Health HB Priority Population Health Committee Member, HB Foundation
Committee Member, Children's Hodlings Foundation
Trustee, Waipukurau Community Marae *(to 10 October 2018)*

**Na Raihania**
Meetings attended 10 of 11
Ngati Kahungunu Iwi Inc representative
Wife employed at Te Taiwhenua o Heretaunga
Member Tairawhiti DHB Maori Relationship Board
Employed as a Corrections Officer
Mother in law, Chaplain at Te Matau a Maui
Board member, Hauroa Tairawhiti

**George Mackey – resigned from MRB 6 June 2019**
Meetings attended 5 of 11
Ngati Kahungunu Iwi Inc representative
Trustee of Te Timatanga Ararau Trust holding several contracts with HBDHB
Wife employed at Te Timatanga Ararau Trust holding several contracts with HBDHB
Director and Shareholder of Iron Màori Ltd
Employee of Te Puni Kokiri

**Lynlee Aitcheson-Johnson**
Meetings attended 3 of 11
Ngati Kahungunu Iwi Inc representative
Chair of Maori Party, Heretaunga Branch
Trustee, Kahuranaki Marae

# Statement of Responsibility

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

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

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

In the opinion of the board and management of Hawke's Bay District Health Board the financial statements and statement of service performance for the year ended 30 June 2019, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

**Kevin Atkinson**
*Chair*

**Dan Druzianic**
*Board Member*

31 October 2019

**Independent Auditor's Report**
**To the readers of**
**Hawke's Bay District Health Board's financial statements and performance information for the year ended 30 June 2019**

The Auditor-General is the auditor of Hawke's Bay District Health Board (the Health Board). 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 Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 50 to 89, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 20 to 47.

## Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the Basis for our qualified opinion section of our report:

- the financial statements of the Health Board on pages 50 to 89:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2019; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 20 to 47:
  - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, 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;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. 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.

### Basis for our qualified opinion

As outlined in note 4.4 on page 80, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $13 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the

amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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 qualified opinion.

### The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1.2 on pages 55 and 56 that outline the financial difficulties being experienced by the Health Board. The Health Board has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

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

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

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

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

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

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

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

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

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

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

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

fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

### Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 16 and 90 to 129, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

### Independence

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

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

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

# Statement of Service Performance 2018/19

This section outlines Hawke's Bay District Health Board's achievement against the 2018/19 Statement of Performance Expectations. Service performance is grouped into four Output Classes: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and, Rehabilitation and Support Services. Across the output classes, we strive to maintain a balance across the three dimensions of the New Zealand Triple Aim **(Figure 1),** in line with the Health Quality and Safety Commission's drive for quality improvement across the health sector.

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

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

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

Figure 1: The New Zealand Triple Aim

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

Hawke's Bay District Health Board endeavours to report data as at June 2019 but due to data availability, this is not always possible. For all measures we have included the latest data available at the time of reporting. Please also note that not all measures are for 12 month periods. Where reporting periods differ these are as specified by the Ministry of Health.

Impact: People are better protected from harm and more informed to support healthier lifestyles and maintenance of wellness. Statement of Service Performance Output Class 1

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

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

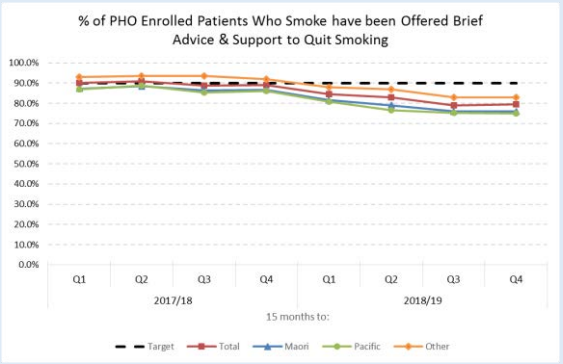
Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly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

**Better Help for Smokers to Quit**

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

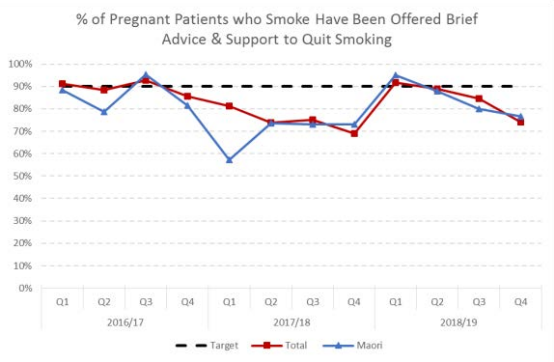
**PHO enrolled patients who smoke are offered advice and support to quit**

Health Hawke's Bay PHO fell short of the Better Help for Smoker to Quit target with a Smoking Brief Advice coverage rate of 79.4% for the 15 month period ending June 2019. This is compared to 89.1% for the previous year. At a practice level, five of 25 practices have achieved the 90% target with a further eight within 10% of the target. Health Hawke's Bay has continued to fund a number of independent nurses to contact patients on behalf of the practices and has increased this number in the latter part of the year.



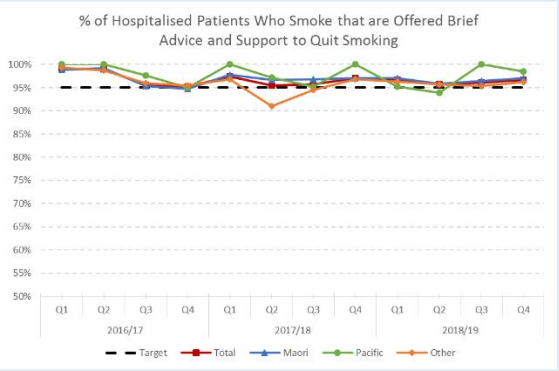
**Pregnant women are offered advice and support to quit**

Of pregnant women who smoke, an average of 83.7%, over the year against a target of ≥90%, were offered Smoking Brief Advice and encouraged to seek cessation support through the Wahine Hapu Increasing Smokefree Pregnancies Programme. This result had Māori at 87.5%. Data from 2018/19 showed that 47.5% of pregnant Māori women giving birth in Hawke's Bay were smokers. This rate is alarmingly high. Tobacco use during pregnancy increases the risk of miscarriage, premature birth and low birth rate, as well as their children's risk of asthma and sudden unexplained death of infant. The maternity component of the health target is aimed at offering brief advice and support to quit smoking for pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer. [1]



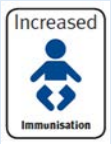

**Hospitalised smokers are offered advice to quit**

In 2018/19, 96.3% of hospitalised patients were offered brief advice and support to quit smoking by a health practitioner. The target of 95% continues to be achieved for Māori and total population with a business as usual approach for the hospital staff.




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

Most recent rates, from July to December 2018, show Total at 45.0% and Māori at 22% against a target of ≥95%. Data for this target is captured from Tamariki Ora / Well Child providers as the care of the baby is transferred from the Midwife / LMC anytime between 4 to 6 weeks post birth. To date there is no data available.




**Increased Immunisation**

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

Poverty and a lack of housing affects a significant number of families in Hawke's Bay. This makes it difficult for them to access or easily accept services. Homelessness, lack of transport, and lack of money all impact on our success in securing high immunisations rates.

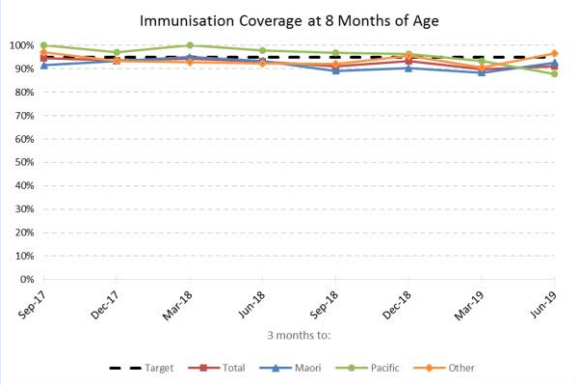
There is also increasing hesitancy regarding immunisation, this is occurring nationally and internationally. Unfortunately many of our families rely on other family members, friends and social media for information regarding immunisation and this can be misinformation. To try to improve this the Hawke's Bay DHB immunisation team does teaching sessions with Family Start, Plunket / Tamariki Ora, and

[1] An internal audit has identified that there is a data integrity issue (accuracy and delay in reporting) and we believe that data is under-reporting

midwives, nurses and other community groups to try to improve knowledge and give consistent messaging and they also have conversations one on one with families

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

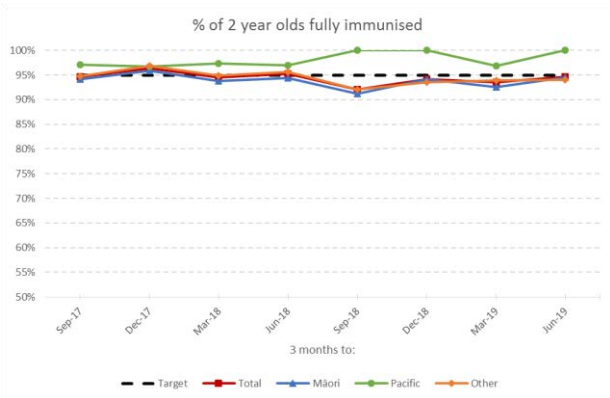
Hawke's Bay statistics remain stable at 91%, against a target of ≥95%, for the 8 month milestone, 88% for Māori and 95% for Pasifika. Good collaboration continues between immunisation providers to try to get our infants immunised on time.




In Hawke's Bay a number of families have complex situations and because of this immunisation is not always the first priority. We have a portion of our population that is very hard to find, moving between family members and between DHBs. This makes it hard for these families to access primary care and for primary care to be able to contact them. Having a variety of service options available for whānau helps to alleviate this. Having a regular weekly drop in clinic in Napier sees a number of children attending. The outreach service also makes contact with referred children to offer immunisation; locating families, booking appointments, getting families to keep appointments and then immunise can at times take numerous contacts.

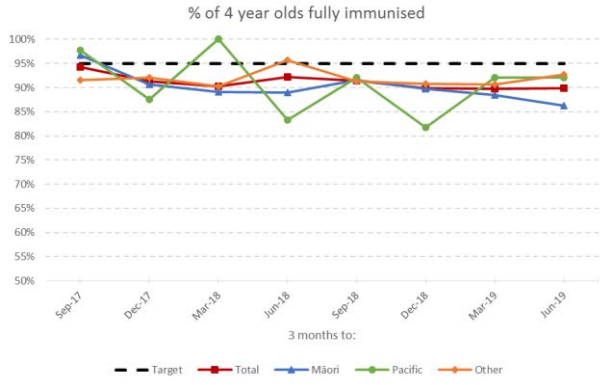
**Children are fully immunised at two years of age**

For the year ended June 2019 immunisaiton rates at two years of age were 95% overall against a target of ≥95%, with equity achieved for Māori and 100% Pasifika.




**Children are fully immunised at four years of age**

The number of children fully immunised at four years is 89.9% coverage, 83.3% Māori and 94.7% Pasifika for the year ending June 2019, against a target of ≥95%. Coverage remains unchanged with some inequity creeping in.




Resource is needed to enable better engagement with these families. Tracking these children is more difficult due to the lack of contact with services following the 15 month immunisation event. There is good collaboration with the Before School Check service and other providers to locate and offer immunisation for these children.

**Girls receive all three Human Papilloma Virus (HPV) immunisations**
Students in year eight are offered the HPV immunisation at school delivered by Public Health Nurses. HPV immunisation protects against nine types of HPV – seven that cause cancer and two that cause genital warts. People need to have all the recommended number of immunisation doses for their age. Younger people need fewer doses (two instead of three) of the immunisation to be protected because they respond better to the immunisation than older people.

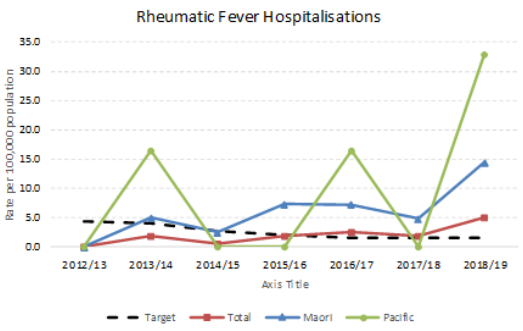
Data ending June 30 2019 for the female population demonstrated that 73.8% of all eligible girls, against a target of ≥75%, had received dose one HPV and 65% had received dose two HPV. Māori girls had a higher rate of immunisation with 85% having dose one and 78% dose two, Pasifika data shows 75% dose one and 68% dose two while 70% Asian completed dose one and 63% completed dose two.

This year 2019 the Ministry of Health changed the denominator used in the reporting for our year 8 HPV population group. Previously the denominator has been census data based and as of 2019 the denominator is now based on birth data.

**Vulnerable elderly receive an influenza vaccine**
Hawke's Bay immunisation services also focus on the older population offering influenza vaccinations for high needs people aged 65 years and over. Seasonal influenza is a contributory factor in the high number of preventable hospitalisations amongst older people, particularly Māori.

The National Immunisation Register shows a coverage of 60%, against a target of ≥75% for the six months to September 2019. Community pharmacies continue to contribute significantly to delivery of this service. The number of influenza vaccinations delivered in community settings, as of June 2019, has shown a 63% increase on 2018 numbers.

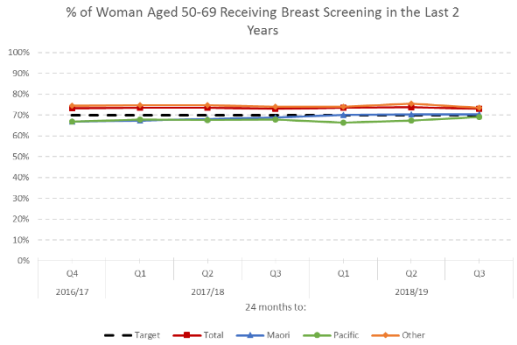
**Rheumatic Fever - Reduced rate of first time hospitalisations for Rheumatic Fever**
Hawke's Bay is categorised as a high incidence DHB for Rheumatic Fever, a preventable disease which has serious consequences. The rate of first time hospitalisations for Rheumatic Fever is at 5.0 per 100,000 population (against a target of ≤1.5 per 100,000); an increase from last year's rate of 2.48 per 100,000. We continue to review cases with a root cause analysis. However all of the known and usual risk factors continue to apply. Input has been sought from the Hawke's Bay DHB Microbiologist around reviewing Group A Streptococcal (GAS) positive swabs and potentially targeting community awareness in areas with high positive GAS. Interest at a national level probiotic trial in Hawke's Bay has also been investigated.




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

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

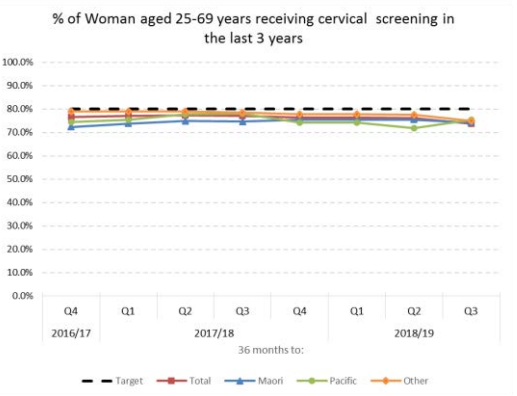
Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 50 and 69. Overall our rate at the end of Q3 was 73% which is favourable to the national target of ≥70%. Both Māori and Pasifika results improved on last year at 70% and 69% respectively. Of note, the rate for Māori has continued to reach target for the year to date.




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

Screening for cervical cancer is offered every three years to all women between the ages of 25 and 69 years. In an attempt to reduce inequities, this is offered free for National Cervical Screening programme priority group women i.e. Māori, Pasifika and Asian women and other women aged 30-69 years who have never had a smear or have not had a smear in the past five years.

Overall our rate is 73.7% which has not achieved the target of ≥80%. Māori rates were 74.3% and Pasifika 75.3%. The DHB Population Screening team, Te Taiwhenua o Heretaunga and Choices are working together in the community offering smears to Māori and Pasifika in the home. We continue to work closely with Health Hawke's Bay to identify solutions to increase screening for Māori and Pasifika.




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

**Breastfeeding**

Breastfeeding provides the optimum nutrition from birth, and is a foundation for later health and well-being. The measure used to track progress for improving breastfeeding rates is the percentage of infants exclusively or fully breastfed at 3 months (Target ≥70%).

| Key Performance Measures | Infants are exclusively of fully breastfed at 3 months | | |
|---|---|---|---|
| | Target | Previous Jun 2018 | Actual Dec 2018 |
| Māori | ≥70% | 36% (U) | 43.1% (U) |
| Total | | 52% (U) | 57.4% (U) |

There has been increase in the three month measure for both Māori and Total with rates of 43.1% and 57.4% respectively. This is up from 36% and 52% last year. Both remain short of the target. Breastfeeding rates amongst Māori mothers remains a focus. Over the past year, Hawke's Bay DHB has developed and implemented a new community based Māori breastfeeding support service via all Well Child Tamariki Ora providers across Hawkes Bay. There are good signs that the programme is responsive to Māori, with a high uptake with 58% of participants.

| Prevention Services | | | |
|---|---|---|---|
| $' millions | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
| Ministry of Health | 8.4 | 8.6 | 9.3 |
| Other sources | 0.3 | 0.4 | 0.4 |
| **Income by Source** | **8.7** | **9.0** | **9.7** |
| Less: | | | |
| Personnel | 2.0 | 1.5 | 1.3 |
| Clinical supplies | 0.1 | 0.1 | - |
| Infrastructure and non-clinical supplies | 0.3 | 0.3 | 0.3 |
| Payments to other providers | 6.4 | 7.1 | 6.9 |
| **Expenditure by type** | **8.8** | **9.0** | **8.5** |
| **Net Result** | **(0.1)** | **-** | **1.2** |

## Early Detection and Management

Impact: People's health issues and risk are detected early and treated to maximise wellbeing. Statement of Service Performance Output Class 2

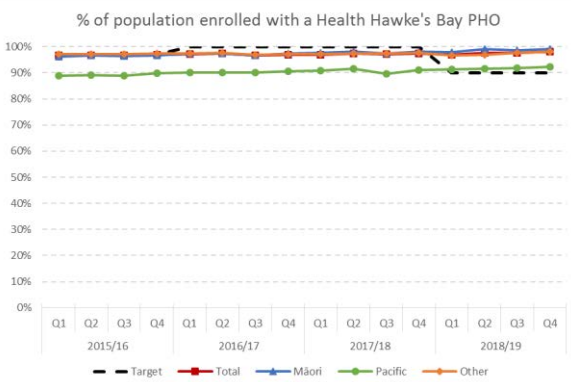
Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes,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

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

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

**Proportion of the population enrolled in the PHO**
Across New Zealand, people are required and encouraged to enrol with a general practice that is affiliated to a Primary Health Organisation (PHO).

Health Hawke's Bay coordinates and manages the targeting of many services to those populations who are known to have a poor health status such as Māori, Pasifika peoples and those living in the most deprived areas. Being enrolled in a PHO and having access to care in the right place at the right time allows for early detection and management of health issues and risks.




As at June 2019, 98.1% of people are enrolled with the PHO which is well above the target of 90%. There has been a steady increase in Māori enrolled with the PHO, reaching 99.1% in Q4. Pasifika has also been increasing over recent years reaching 92.2% in Q4. Health Hawkes Bay continues to work closely with Hawke's Bay DHB and general practice to promote enrolments and offer resources to facilitate the process.

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

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

**0-4 year olds**
ASH rates 0-4 years have increased for both Māori and total populations.

The total population rate was 7,915 per 100,000 for the 12 months to March 2019. No target was set for total population as the emphasis was on reducing inequity. The Māori rate for the same period was 8,710 per 100,000 against a target of ≤6,320 per 100,000. Note that the target for Māori was set based on improved equity between Māori and other.

Work needs to continue to keep children out of hospital and eliminate the inequity. The conditions that have the highest ASH rates are respiratory, ear nose and throat infections, severe dental decay and skin conditions. We continue to focus on these areas to bring down ASH rates and reduce inequities. HBDHB have trialled a Māori Nurse Liaison - Respiratory to work intensively with Māori whānau whose tamariki have been brought to the Emergency Department and / or been admitted for respiratory illness. This pilot is in its infancy and outcomes will be monitoring with a view to implementing this as a permanent resource.

**45-64 years**
The ASH rates for 45-65 years have been slowly increasing since 2015. A large inequity is observed for both Māori and Pasifika.

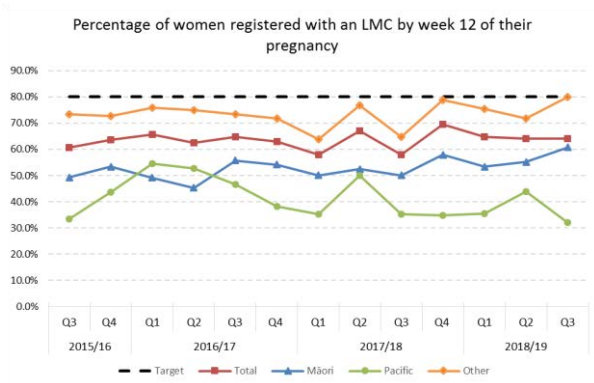
For the 12 months to March 2019 the total population rate was 4,734 per 100,000, but the Māori rate was 9,833 (against a target of ≤7,159) and Pasifika 7,783. Our focus remains on reducing inequities. The DHB has chosen to focus predominantly on cardiac and respiratory conditions with greater emphasis on providing specialist support to targeted primary care practices that show highest admission rates in these areas. In the coming year the reestablishment of community based clinical pathways, and the potential development of hospital based clinical pathways is being prioritised with a particular focus on Congestive Heart Failure and Chronic Obstructive Pulmonary Oedema.

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

The Early Engagement Project, encouraging General Practitioners to help a pregnant women find an LMC and fill in a referral form for Smokefree services, has continued to be promoted. Te Haa Matea, HB Stop Smoking Service continues to offer the Increasing Smokefree Pregnancies Programme (ISPP).

Continuing to provide ISPP resources to GP and LMC clinics and develop a more proactive approach to making the referral process easier for DHB staff. ISPP resource packs are given to women even if they do not want to commit to a referral at the time, allowing them time to reconsider and contact the 0800 300 377 number in the near future.

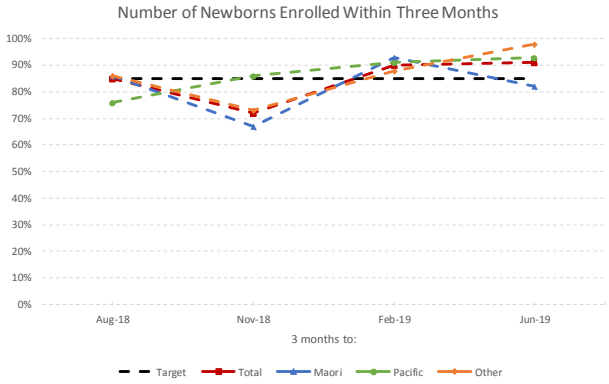
The percentage of women registered with an LMC by week 12 has increased from 58% in Q3 2017/18 to 64% Q3 2018/19 against a target of ≥80%. Māori increased over the year from 50% to 61% whereas Pasifika moved from 35% to 32% during the same period.




It is encouraging to see an improvement in early engagement for Māori. An extension of the age korowai manaaki research project has engaged a number of GP practices to further enable wrap around services for our most disadvantaged women. Of concern is our ongoing low early engagement for our Pasifika women. A specific project in partnership with Pasifika women and our Pasifika navigators is in concept stage currently with a focus on meaningful access.

**Improving new-born enrolment in General Practice**

Babies enrolled with their general practice soon after birth are able to receive essential health care including immunisations on time. The rate for new-borns enrolled in Hawke's Bay practices by three months of age has risen this year to 90.5%, against a target of 85%[2].

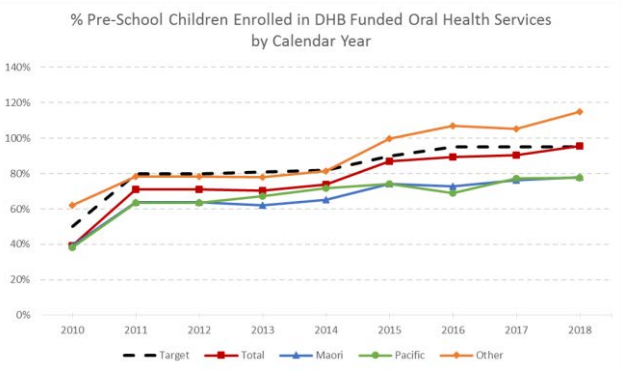



The increase in these numbers is the result of increasing collaboration between services and organisations. This includes work which has been done with Maternity Services and the PHO to ensure that pregnant mothers are enrolled with a GP and that this enrolment is correctly recorded.

**Oral Health**

*Pre-school enrolments with oral health services*

Enrolment continues to be a focus, working in partnership to achieve Quadruple Enrolment at birth (i.e. enrolment with a GP, Well Child Tamariki Ora provider, immunisation register and Oral health services) in Hawke's Bay health services.




In 2018, 95.7% of pre-school children were enrolled in DHB funded oral health services (78% Māori and 77% Pasifika), achieving the target of 95% enrolment.

Some data discrepancies persist which are being addressed. We have concerns regarding the accuracy of the denominator used to calculate the indicator which is externally provided from Ministry of Health data, as discrepancies are

[2] No data for enrolment at 6 weeks has been received

apparent within data from other DHBs also. It is pleasing to note the target of 95% enrolment has been met for the first time in eight years.

**Children and youth attending oral health services**

The 2018/19 year continued a trend of increasing 'arrears', that is tamariki who were not examined according to the planned recall, sitting at an average of 9.85% over the 12 months against a target of <10%. The trend in 2019 however shows an average of 10.4% arrears per month.

Adolescent attendance for 2018 sits at 62% being unfavourable against a target of ≥85%, inequities persist with 36% Māori and 27% Pasifika attendance in comparison with 81% Other. Some discrepancies with the figures (a small proportion of adolescents seen by community oral health services may have been omitted) may slightly improve the equity gap. This inequity needs an ongoing intensive focus.

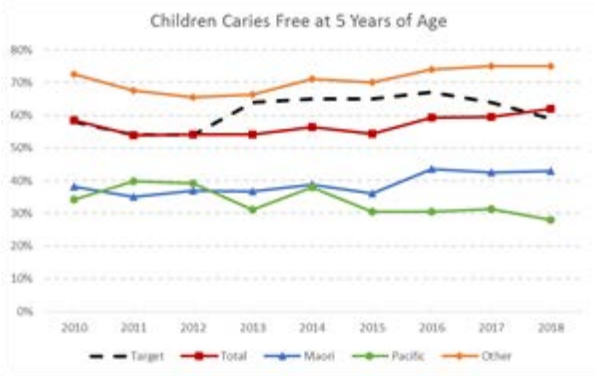
| Percentage of children not examined according to planned recall | | |
|---|---|---|
| Baseline 2017 | Target 2018 | Actual 2018 |
| 8% | <10% | 9.85% (F) |

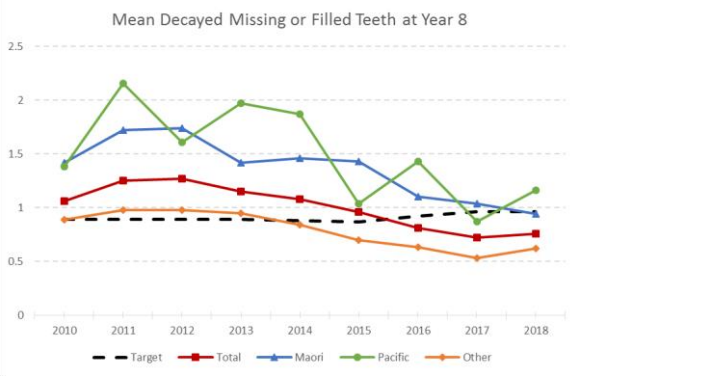
| Percentage of adolescents using DHB funded dental services | | |
|---|---|---|
| Baseline 2017 | Target 2018 | Actual 2018 |
| 75.9% | ≥85% | 62% (U) |

**Children without decay**

In 2018 62.4% of five year olds were caries free, this is an increase on 2017 and favourable against a target of ≥59%. Persistent inequities remain with 43% Māori and 28% Pasifika caries free in comparison with 75% identifying as 'Other' ethnicities.

Children are checked at year 8 for decayed, missing or filled teeth (DMFT). The mean rate of DMFT has increased over the last year from 0.72 to 0.76, against a target of ≤0.75. During the same period, Māori tamariki decreased from 1.04 to 0.94, reducing the equity gap. The dental project continues to work to improve access to oral health services for Māori and Pasifika tamariki.

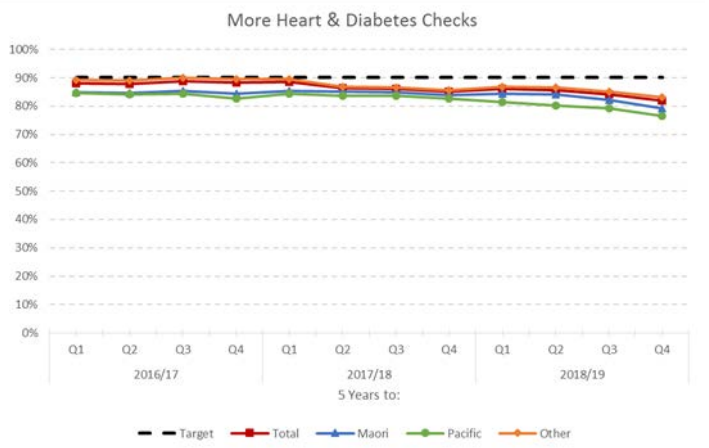



**More Heart and Diabetes Checks**

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

The More Heart and Diabetes Checks indicator monitors the proportion of the eligible population who have had a Cardiovascular Disease Risk Assessment (CVDRA) in the preceding five year period.



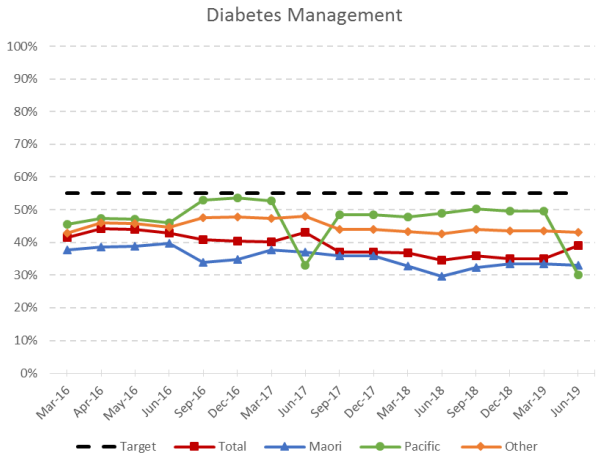

Cardiovascular disease (CVD) disproportionately affects Māori and is preventable with lifestyle

advice and treatment for those at moderate or higher risk.
This year the Ministry of Health recognised that screening for Māori and Pasifika needs to begin earlier; at 35 versus 45 for other population groups, to arrest the onset of any disease damage. The challenge is to move away from traditional screening approaches and move out into the community and into work places to support this population to prevent, and identify early life style changes and health care management.

The target for this indicator is 90%. Q4 figures shows this indicator sitting at 82% compared to 85% in Q4 last year. Currently the Māori male 35-44 screening rate is 65.8%.

**Management of Diabetes**

Good glycaemic control reduces the risk of CVD and renal and other complications and is an indicator of long term conditions management.



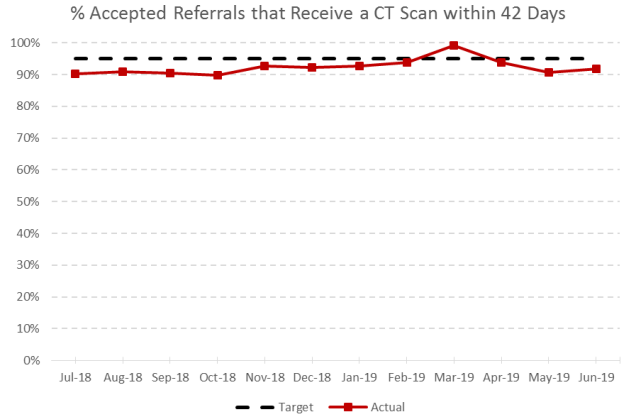

The number of people with good or acceptable glycaemic control remains unfavourable to the target of 55% with Q4 performance at 39%. Health Hawke's Bay PHO will use practice audits to review systems management to support improving the number of annual check events. Increasing enrolment and engagement in primary care is vital as a first step in prevention and early intervention as are programs that support patients in self-management. A number of programs are offered to reinforce this.

**Less Waiting for Diagnostic Services**

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

*Computed Tomography*

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



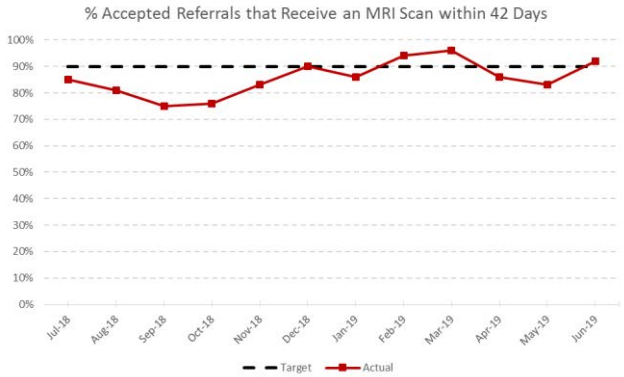

CT wait time indicator compliance has ranged from 90.5% -99.1% across the year with a year end result of 91.8%.

**Magnetic Resonance Imaging**

For Magnetic Resonance Imaging (MRI) the target is that 90% of referrals receive an MRI within 42 days

MRI wait time indicator compliance ranged from 75% - 96% across the year with a year end result of 92%.

Following the initial improvement in compliance in 2017 (introduction of seven day service operation) there has been a sustained compliance between 80-90% from November 2018.



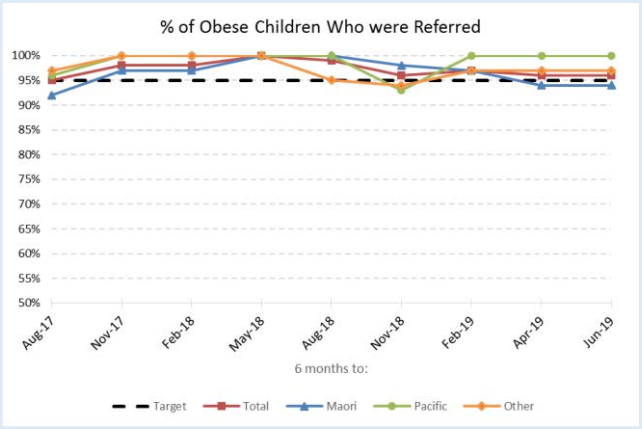

For all the patients treated during the year, 72.8% were treated within the 42 day target. This is lower than the Ministry of Health figure which also includes patients on the wait list.

Non-compliance against the indicator for both CT and MRI has been due to a high level of acute presentations demand, and demand from both FCT and elective services. In 2018/19 11.7% more CT scans and 7.0% more MRI scans were performed, than in 2017/18, with the same hours of work and resources.

**Raising Healthy Kids**

In the last quarter a 98% referral rate to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions was achieved against a target of ≥95%.

The reduction from 100% is due to a changes in administrative personnel and process. HBDHB anticipate achieving 100% in the next quarter.




The DHB also monitor the percentage of four year olds who receive a Before School Check (B4SC). This has a target of >100%. As at June 2019, we have reached 102% for total population, 100% for Māori and 101% for Pasifika. The figures are over 100% due to movement of people throughout New Zealand and coming into the country from overseas whilst working with a birth cohort established by the Ministry of Health.

**Improved youth access to health services**

Rangatahi (young people) have their own specific health needs as they transition from childhood to adulthood. Most rangatahi in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or 'risk factors'.

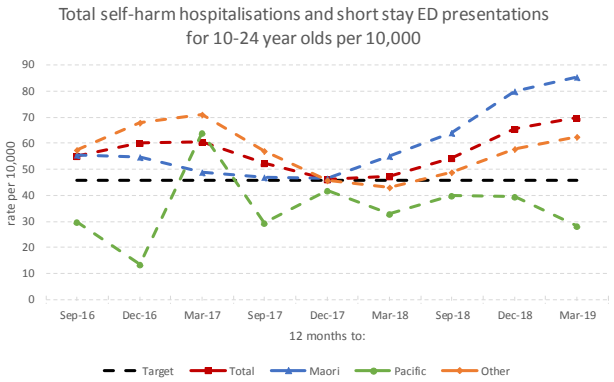
There continues to be noticeable equity gaps in Hawke's Bay for our rangatahi in health and wellbeing outcomes. Our models of delivery are, in some cases, out of date and siloed. This is likely to impact upon these important members of our community, who are a critical part of our present and future. Research shows that rangatahi whose healthcare needs are unmet can lead to increased risk for poor health as adults, and overall poor life outcomes, through disengagement and isolation from society and riskier behaviours in terms of drug and alcohol abuse and criminal activities.

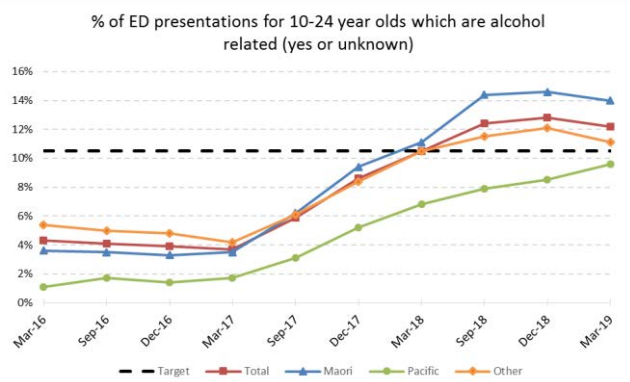
Two measures have been identified by our youth representatives: Total self-harm hospitalisations and short stay ED presentations for <24 year olds (per 10,000), and % of ED presentations for 10-24 year olds which are alcohol related.

The performance over the year shows an increasing gap between target and performance for both measures. Hospitalisations and short stay ED presentations for <24 year olds (per 10,000) relating to self-harm, for Total and Māori, were both significantly above the target of <45.8 at 69.7 and 85.6 respectively. The % of ED presentations for 10-24 year olds which are alcohol related also increased with Total at 12.2% and Māori at 14% against a target of <10.5%.

To improve the quality of data and decrease rangatahi Māori alcohol related presentations in ED will require ongoing service level interventions as well as ongoing data quality refinements.

Additionally a service redesign is in progress to deliver a service that is more beneficial to youth, based on feedback from our local rangatahi.




**Relative Mortality Rate between Māori and Non-Maori Non-Pasifika (NMNP)**

Nearly three-quarters of all deaths before the age of 75 years are avoidable due to either disease prevention or effective treatment and health care. Deaths due to these diseases or conditions can be counted and expressed as a rate. Any difference in these rates by ethnicity or by area of residence can therefore be considered to be a health inequity.

We had seen significant reductions, in deaths which could have been minimised by prevention, early treatment programmes or better access to medical care, however since 2012 improvements have levelled off and the current trend is now moving in the opposite direction.

The top five causes of amenable mortality for total populations are: coronary disease, diabetes, suicide, land transport accidents (excluding trains), and female breast cancer. For Māori the top five causes are coronary disease, suicide, land accidents (excluding trains), diabetes and COPD.

The amenable mortality rate between Māori and Non-Maori, Non-Pasifika in 2016 was 2.53, up from 2.45 in 2015, against a target of <2.15.

| Early detection and management | | | |
|---|---|---|---|
| $' millions | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
| Ministry of Health | 121.2 | 119.1 | 112.6 |
| Other District Health Boards (IDF) | 2.1 | 2.2 | 3.0 |
| Other sources | 3.7 | 3.1 | 2.6 |
| **Income by Source** | **127.0** | **124.4** | **118.2** |
| *Less:* | | | |
| Personnel | 20.4 | 20.1 | 18.7 |
| Outsourced services | 2.6 | 1.4 | 2.6 |
| Clinical supplies | 3.5 | 0.6 | 1.2 |
| Infrastructure and non-clinical supplies | 3.5 | 3.3 | 3.3 |
| Payments to other District Health Boards | 2.9 | 2.8 | 2.7 |
| Payments to other providers | 98.8 | 97.3 | 91.4 |
| **Expenditure by type** | **131.7** | **125.5** | **119.9** |
| **Net Result** | **(4.7)** | **(1.1)** | **(1.7)** |

Impact: Complications of health conditions are minimised and illness progression is slowed down.
Statement of Service Performance Output Class 3

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

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

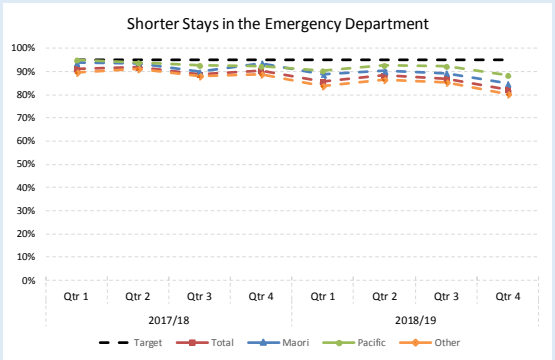
People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health,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


**Shorter Stays in the Emergency Department**

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

*People presenting at ED wait less than six hours*

The target for the percentage of people waiting less than six hours in ED is 95%. Monthly figures have fluctuated over the year with the yearly average of 86%, lower than the previous year's result of 91%. Q4 result was 82%.




Of the 65-70% of ED patients who have their care completed, and are then discharged home without admission, 95% of these had a wait time of under six hours.

The other 30-35% of patients are admitted to hospital. Achieving admission completion and transfer to ward within the target has fallen significantly over the past year.

A number of work streams have now been coordinated into one program of work with a focus on

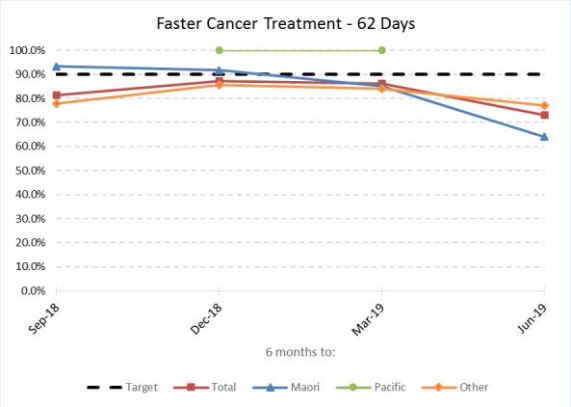
managing capacity and demand and patient flow through the system. Challenges this year have included rolling strikes by a number of work force groups, peaks in winter that have not subsided and the complexity and acuity of patients presenting. A trend that is being seen across New Zealand emergency departments.

**Faster Cancer Treatment (FCT)**

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

The yearly average for people referred with a high suspicion of cancer receiving their first cancer treatment within 62 days was 79%, unfavourable to the target of 90%. Māori rates over the year averaged at 64%.

Areas that have impacted on achievement of target has been a combination of rolling strike action, consultant availability and the capacity within HBDHB's tertiary providers.




Reliance on our tertiary providers for some areas of treatment is being addressed through regional planning to ensure patients can access a wider range of services closer to home, including radiotherapy treatment.

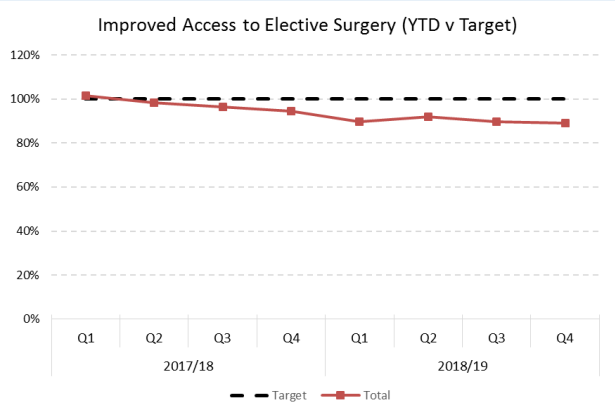
Weekly case meetings and surgical capacity planning continues. Regular reporting to the Finance Risk and Audit Committees highlight issues regarding access to diagnostics and treatments.

The number of patients who received their first cancer treatment (or other management) within 31 days from date of decision-to-treat in Q4 was 83.5%, just short of the target of ≥85%. Performance had been above target for the other three quarters.

**Improved Access to Elective Surgery**
Elective surgery operations improve quality of life for patients suffering from significant medical conditions.

They are planned and do not require immediate hospital treatment therefore, can often be delayed.

Increasing elective volumes requires good collaboration between many parts of the system including outpatients, booking system, surgical procedures, treatment and delivery of care.



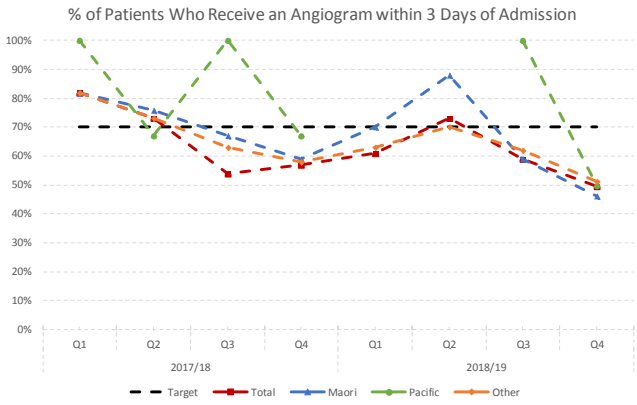

**More people have access to Surgery**
A number of initiatives to improve productivity and throughput have been successfully implemented this year resulting in HBDHB achieving 6,907 elective surgery discharges, but not meeting our target of 7,553.

**Better Management of Long Term Conditions (LTC)**
Across the Central Region there is a commitment to improved timely access to cardiac services. HBDHB supports the regional programme outlined in the Regional Service Plan and also works locally to:

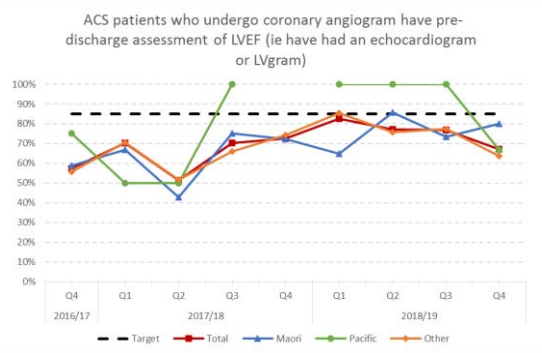
- Improve access to cardiac diagnostics and specialist assessments
- Reduce waiting times for people requiring cardiac services
- Improve prioritisation and selection of cardiac surgical patients
- Increase cardiac surgical discharges
- Reduce variations in access across the region.

In 2018/19, 60% of high risk patients received an angiogram within three days (target 70%). For Māori this was 60%, on a par with all ethnicities but Pasifika which achieved close to target at 69%.

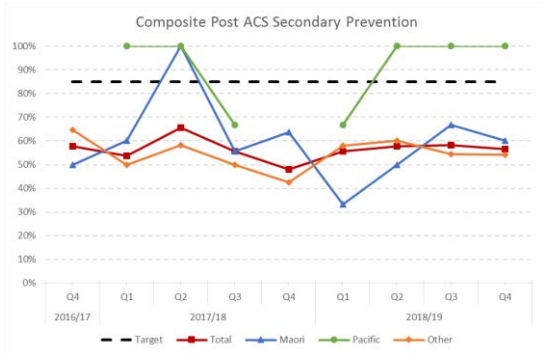
There has been a declining trend throughout the year which has been attributed to inconsistent timely access to tertiary services in Wellington and provision of only twice weekly angiography services at Hawke's Bay Hospital.



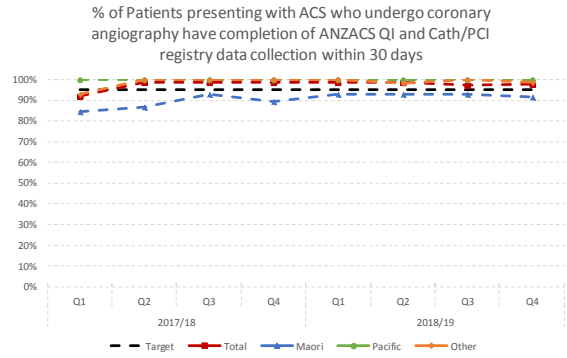

The New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS QI) register collects data to inform future service provision. It allows investigation into the extent, variation and trends in Acute Coronary Syndrome (ACS) as well as inpatient cardiac investigations, medical and surgical interventions,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




The percentage of ACS patients who underwent coronary angiogram and had pre-discharge assessments of LVEF (Left Ventricular Ejection Fraction) was 67% (March - May 2019). This is unfavourable against a target of ≥85%.




In the absence of a documented contraindication / intolerance all ACS patients who undergo coronary angiogram should also be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes). Those with LVEF<40% should also be on a beta blocker (five classes). Performance against the Composite Post ACS Secondary Prevention measure (for March – May 2019) was 56.5%, unfavourable against a target of >85%.

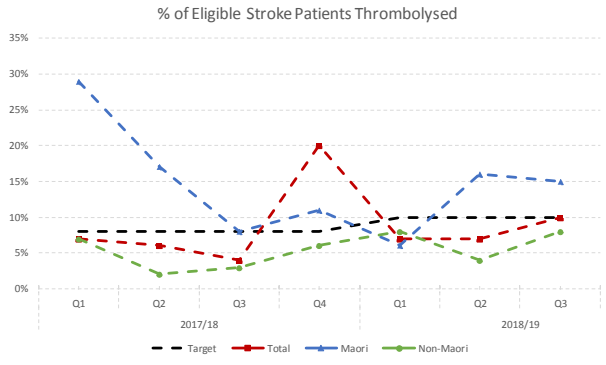



Patients presenting with ACS who undergo coronary angiography have completion of 'All NZ Acute Coronary Syndrome Quality Improvement' registry data collection within 30 days.
The 2018/19 result was 98%, favourable against the target of 95%. This is a good result and an improvement on last year's achievement of 97%.
The results as at three months, for data collection, was 100% in Q4 (March to May 2019), against a target of ≥99%.

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

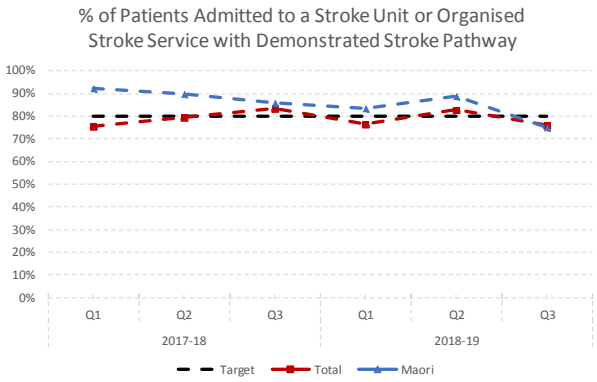
In 2018/19, 10% of eligible patients were thrombolysed, favourable against a target of ≥10%.

This is favourable in respect of last year's achievement of 6.5% against a national target of 6% set by MoH.



The percentage of patients admitted to the 'demonstrated stroke pathway' was 79% for 2018/19 which is slightly short of the target of ≥80%.

The target for percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services, and transferred within seven days of acute admission is >80%. Results over the year have fluctuated, the current average is 90%, this is a significant improvement on last year's average of 67%. A newly developed stroke algorithm pathway has been developed for the wards to help streamline stroke patients' care inclusive of timely referral to the stroke CNS workforce.




The percent of stroke patients referred for community rehabilitation within seven calendar days of hospital discharge is currently unable to be reported. However a process has been created to enable us to report in the following years.

**Standardised Intervention Rates**

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

For Major Joint Replacements HBDHB achieved 19.0 per 10,000 which is below the target of ≥21.0 and a decline from 22.4 per 10,000 in December 2017.

Cardiac surgery intervention rates were unfavourable against the target rate of 6.5 per 10,000 reaching 4.1 per 10,000, a decrease from 4.8 in December 2017.

There has been an increase in percutaneous revascularization rates from 11.9 per 10,000 in December 2017 to 13.9 which comes in above the target of 12.5.

Intervention rates for cataracts procedures are above the target intervention rate of ≥27.0 per 10,000 at 46.1 per 10,000.

Coronary angiography services were favourable against the target of ≥34.7 per 10,000, reaching 41.9 per 10,000, an increase from 36.4 in December 2017.

| Elective Services Standardised Intervention Rates (per 10,000 population) | | | |
|---|---|---|---|
| Key Performance Measures | Baseline December 2017 | Actual March 2019 | Target 2018/19 |
| Major joint replacement | 22.4 | 19.0 (U) | ≥21.0 |
| Cataract procedures | 46.6 | 46.1 (F) | ≥27.0 |
| Cardiac procedures | 4.8 | 4.1 (U) | ≥6.5 |
| Percutaneous revascularization | 11.9 | 13.9(F) | ≥12.5 |
| Coronary angiography services | 36.4 | 41.9(F) | ≥34.7 |

**Average Length of Stay (ALOS)**

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

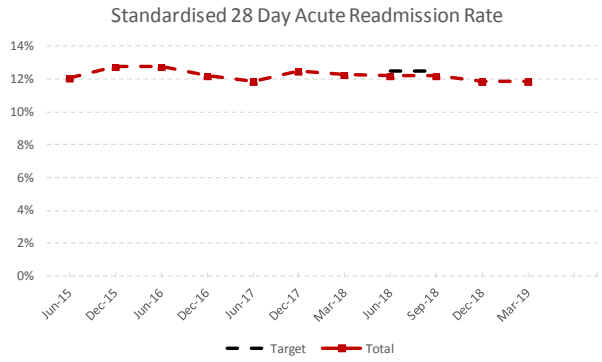
It is expected that in delivering a more patient-centred elective service the ALOS for elective inpatients will reduce. The target was set at ≤1.45 days. Over the year results have fluctuated between 1.57 and 1.58 days; use of Health Round Table data has aided in providing areas of focus.

The Acute ALOS has met target reducing over the year from 2.39 to 2.29 (within target of <2.3). The DHB continues to focus on work to improve patient flow through the hospital to ensure good hospital productivity. The challenge of bed capacity is constant.

| Average Length of Stay | | | |
|---|---|---|---|
| | Baseline<br>December 2017 | Actual<br>March 2019 | Target<br>2018/19 |
| Elective | 1.49 | 1.58 (U) | ≤1.45 days |
| Acute | 2.34 | 2.29 (F) | ≤2.3 days |

**Acute Readmission to Hospital**

In our quest to increase hospital throughput it is important that we measure acute unplanned readmission rates. These occur when treatment, either in hospital or in the 28 days following discharge, has not been effective and a readmission is required urgently.




A low rate is an indication of effective support services in the community (e.g. primary care) and hospital reliability. The result for Q3 was 11.9%. We will continue to target a reduction in readmission rates through better integration with primary and community services.

Part of the Long Term Conditions Framework implementation is looking at processes around effective transitions of care. Currently there is work being done to address readmissions within a 96 hour period. Disease specific pathways of support for patients meeting risk of readmission criteria relating to medication use is being developed and will utilise existing resource allocated to community and clinical pharmacy facilitators to implement.

**Quicker access to diagnostics**

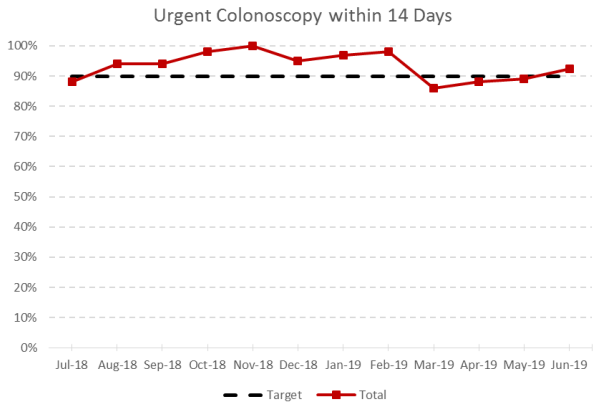
Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care, and therefore improve patient outcomes in a range of areas.

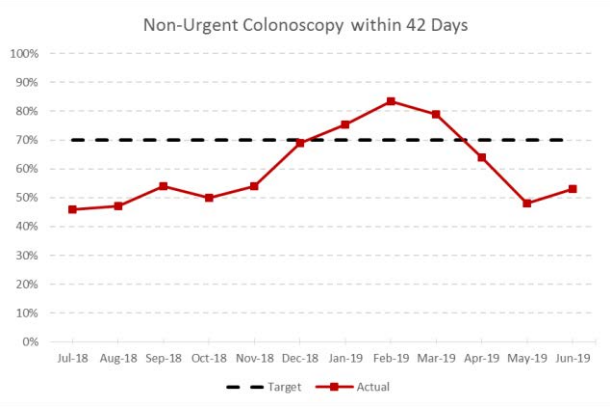
Colonoscopy:
Urgent diagnostic target 90%. As of June 2019, HBDHB achieved 92%. This was down by 4% on last year's performance.
Routine diagnostic (within 42 days) target 70%. HBDHB achieved 53% down by 7% on last year's performance.

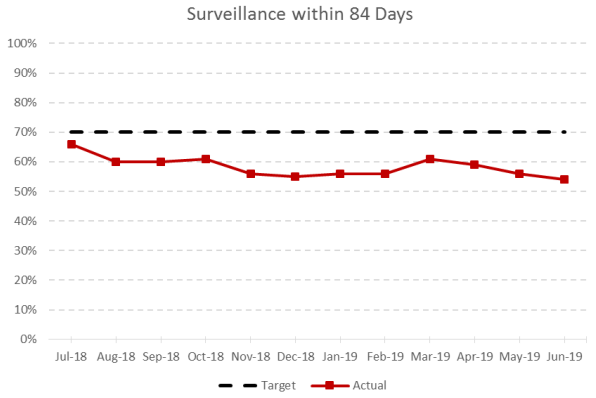
Surveillance (people waiting less than 84 days beyond planned date) target ≥70%. HBDHB achieved 54% compared to 78% on last year's performance.

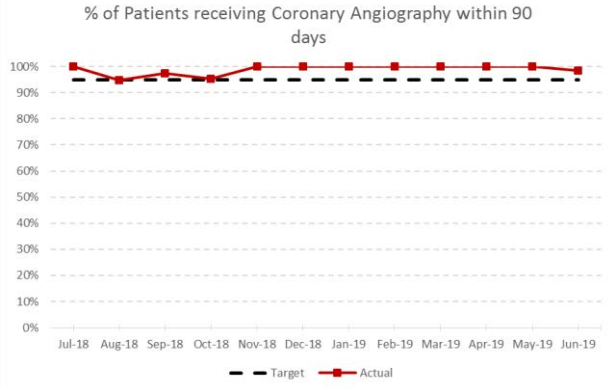
The Ministry of Health is monitoring this performance for improvement

Coronary Angiography:
The percentage of patients receiving coronary angiography within 90 days has fluctuated throughout the year. We ended the year achieving 98.4 %, favourable to the target of ≥95%.



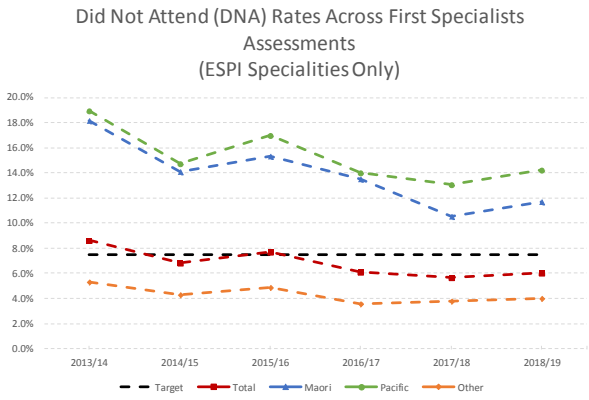




**Attendance at First Specialist Appointment**
Low 'did not attend' (DNA) rates to specialist outpatient appointments are an indicator of good communication between patient, referrer and specialist services. It is a measure of the rate of scheduled first specialist appointments (FSAs) that do not proceed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

The overall DNA rate in 2018/19 was 5.6% which is favourable against the target of ≤7.5%. However, the Māori DNA rate is 11.7% and Pasifika 14.2% indicating significant inequity gaps.

Of note, all three indicators have decreased from the previous year. Customer focussed booking has moved from project mode to business as usual. Preventative pathways have been put in place through strong relationships with Māori and Pasifika Health teams.



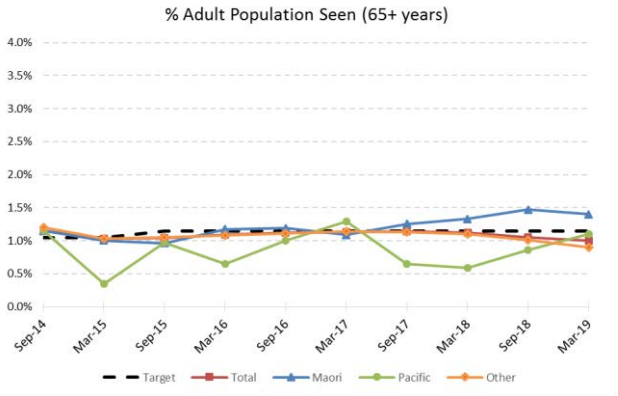
**Mental Health and Addiction Services**

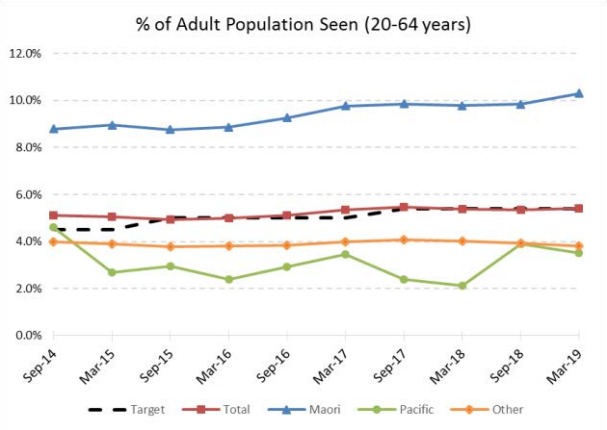
Specialist mental health and addiction services are funded for people who are severely affected by mental illness or addictions. Better and timelier access to a broad range of services improves people's mental health and wellbeing and contributes to better outcomes and recovery.

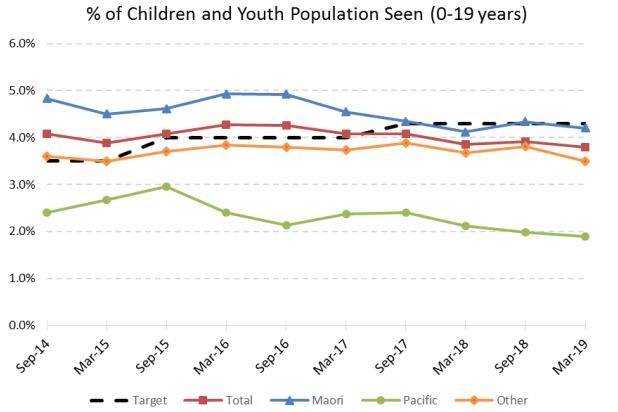
**Improved access to services:**

In the year ending March 2019, 3.8% of 0-19 year old (target ≥4.3%), 5.4% of 20-64 year olds (target ≥5.4%) and 1% of 65+ year olds (target ≥1.15%) accessed mental health services.

While access to services increased overall for 0-19 year olds, including increased access for Māori 0-19 year olds in first half of the year, all 0-19 year old groupings were unfavourable to targets.



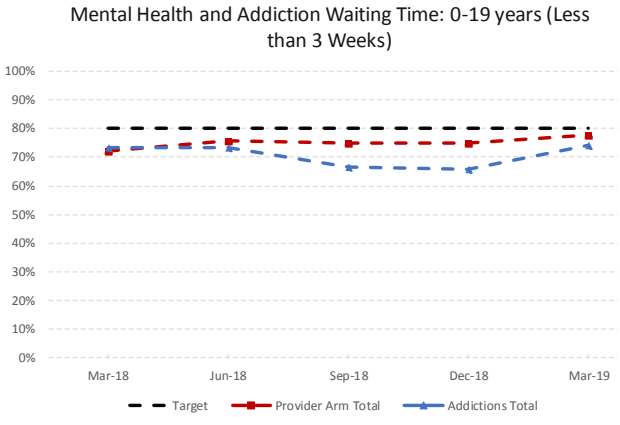




Access exceeded targets for 20-64 and 65+year old Māori and Pasifika due to rising demand. Significant challenges with recruiting workforce for 2018/19 impacted on the ability for this population to be seen by the team. This was mitigated by contracting services externally with the results from that work not reflected in the data presented here.

**Improved Waiting Times:**

Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. The DHB differentiate the targets in two ways: firstly, between the mental health services that are delivered by the provider arm and the addiction services that are delivered by the DHB's provider arm and some NGO providers; and secondly, we consider results after three weeks of referral and again after eight weeks of referral.

For mental health services, the waiting time expectation of three weeks was achieved in 77.7% of cases and the eight week result was 92.1%. Both of these results are below the targets of 80% and 95% respectively.



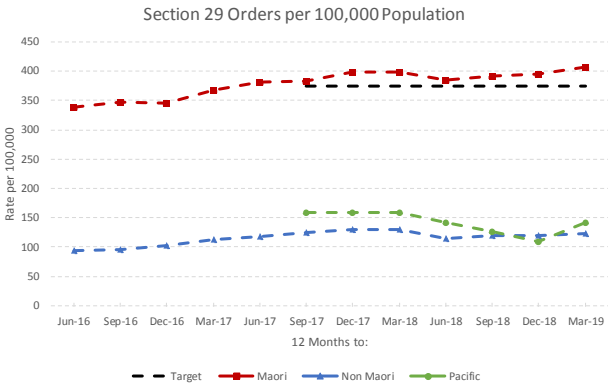

For addictions services with Child Adolescent and Family Services (CAFS), 74.4% were seen within three weeks and 89.7% seen within eight weeks. The services maintain clear focus on referral response and turnaround time. The Child, Adolescent and Family team are committed to ensuring delays are kept to a minimum but this has been impacted by a

number of factors, the rise in demand, and challenges around addiction workforce especially for youth.

**Improved Mental Health Services Using Discharge Planning:**
Maintaining and improving patient engagement through the use of a transition/discharge plan will ensure that services are responsive to patients needs and that people are better able to manage their own health condition.

Due to issues with underlying data no results for this measure are able to be reported. For the 12 months to March 2019, a figure of 78.5% against a target of ≥95% had been reported to the Ministry of Health, but this is likely to be overstated due to the data issues. We are currently working through these.

**Mental Health (Compulsory Assessment and Treatment) Act 1992**
There is a disproportionately high rate of Māori placed under Section 29 (s29) compulsory treatment order (CTO) and HBDHB aims to reduce this inequity. For the 12 month period ending March 2019, the rate of s29 orders per 100,000 was 123 for non-Māori. The rate for Māori was high at 407 per 100,000 against a target of ≤375 per 100,000.




This is not a straightforward matter as all the social and health inequities which Māori experience contribute to increased use of the Mental Health (Compulsory Assessment and Treatment) Act 1992. We continue to work on services to provide early interventions for people with mental health problems and as alternatives to hospitalisation. These include; home-based treatment; NGO provided recovery orientated short term day programmes; resilience focussed community group programmes; and the Harekeke acute day programme based in Ngā Rau Rākau as well as partnership with Police.

**Patient Experience of Care**
How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved consumer experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

The response rate to Patient Experience of Care (PEC) Surveys in Secondary Care (inpatient) improved over the year beginning at 15% and ending at 28% which was favourable to a target of 25%.
The response rate to Patient Experience of Care Surveys in Primary Care (General Practice) did not reach the target of 25% with quarterly results ranging from 11% to 22.5%. Māori and Pasifika rates are still low indicating that the method of collection needs further work.

**Standardised acute hospital bed days**
Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers.

This indicator was favourable to a target of ≤530 per 1,000 population for total population, ranging from 407 to 420 over the 12 months to June 2018.

Performance for Māori was unfavourable to target ranging from 588 to 657 per 1,000 over the same period and requires continued focus.

| Intensive assessment and treatment | | | |
|---|---|---|---|
| $' millions | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
| Ministry of Health | 351.4 | 341.2 | 328.5 |
| Other District Health Boards (IDF) | 4.5 | 4.5 | 2.2 |
| Other sources | 13.0 | 13.2 | 14.6 |
| **Income by Source** | **368.9** | **358.9** | **345.3** |
| *Less:* | | | |
| Personnel | 197.7 | 196.4 | 182.0 |
| Outsourced services | 17.6 | 15.8 | 16.7 |
| Clinical supplies | 51.5 | 45.4 | 47.6 |
| Infrastructure and non-clinical supplies | 61.5 | 45.7 | 46.8 |
| Payments to other District Health Boards | 52.2 | 51.1 | 50.3 |
| Payments to other providers | 5.1 | 7.7 | 10.0 |
| **Expenditure by type** | **385.6** | **362.1** | **353.4** |
| **Net Result** | **(16.7)** | **(3.2)** | **(8.1)** |

Impact: People Maintain Maximum functional independence and have choices throughout life. Statement of Service Performance Output Class 4

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

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

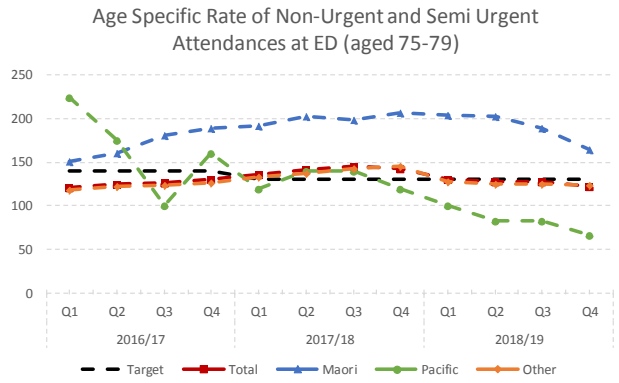
**Better access to care for older people**

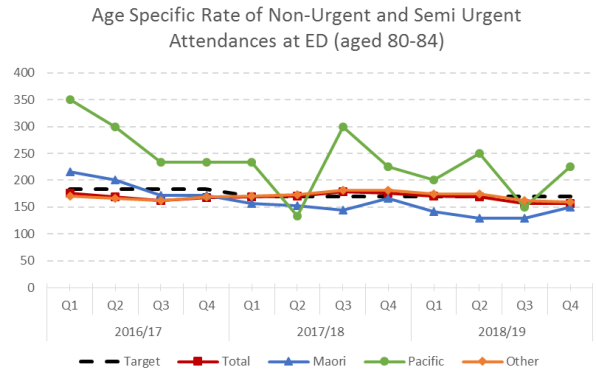
Age specific rate of non-urgent and semi urgent attendances at the Emergency Department are monitored for ages 75-79, 80-84 and 85+.

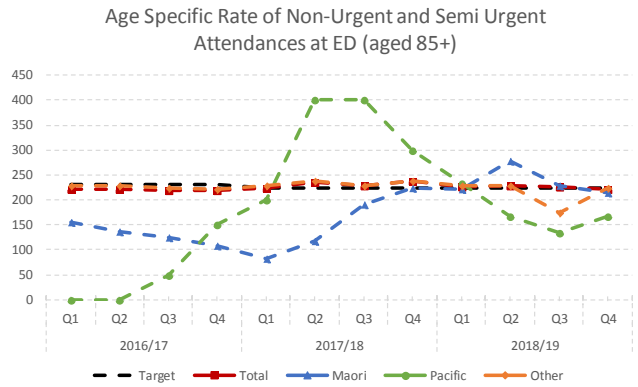
A decrease in these rates is an indicator of the services available to keep elderly safe and independent in their own homes.

For the 75-79 group, the annual result was 122.8, favourable to target of 130. The 80-84 group result was 156, favourable to a target of 170. The 85+ result also came in favourably at 221 against a target of 225.

An equity gap remains visible for Māori in the 75-79 age bracket and for Pasifika in the 80-84 bracket. The engAGE model, whereby the ORBIT inter-professional allied health team and engAGE community teams support frail older people to remain independent at home, continues to work in this area whilst the ageing population increases.

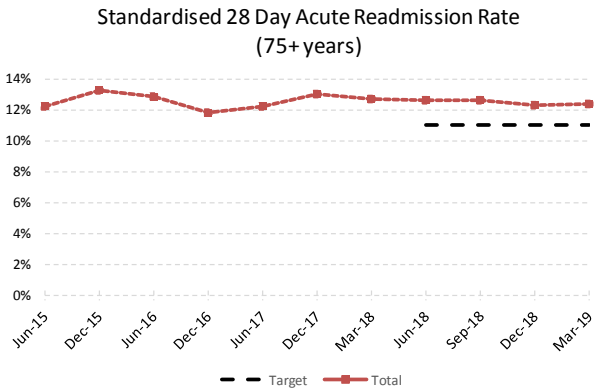


The rate of acute readmission, as discussed above in output class 3, is a measure of effective support services and treatment.

Reducing the readmission rate in this age group is especially important for sustainability as the over 75 population continues to grow. At March 2019 our rate was 12.4% against a target of ≤11%.




**Better community support for older people**

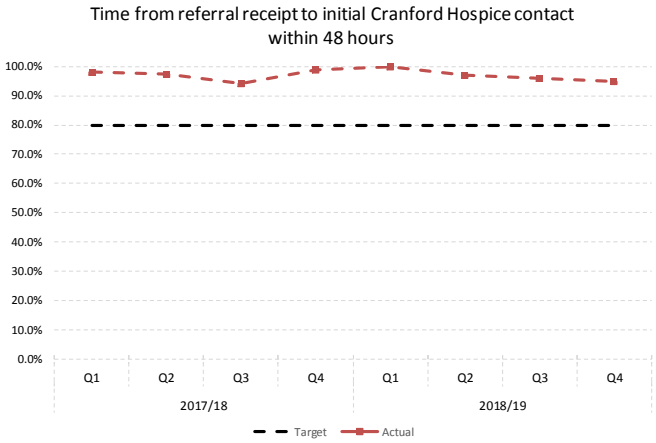
Delivering coordinated high quality services to older people supports New Zealanders to live longer, healthier and more independent lives. By providing better community support for elderly, we would expect that they are able to maintain independence and function in their own homes, therefore reducing rest home bed utilisation for the growing population. One hundred percent of people using long term home support receive an InterRAI assessment. Client centered care plans are developed for all clients of home support, these are an integral component of keeping people safe in their own homes and maintaining their independence.

Due to data challenges not all local indicators are currently able to be reported on. Indicators not reported on include: Rate of carer stress: Informal helper expresses feelings of distress = YES (expressed as a percent of all Home Care assessments) this target is ≤26%; percent of people having homecare assessments who have indicated loneliness this target is ≤26%, Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency this target is to be confirmed; and Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment has a target of11%. We are working on a resolution to enable reporting on these targets for the coming year.

**Prompt response to palliative referrals**

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

Ensuring that most referrals to our district's community-based provider, Cranford Hospice, are responded to within 48 hours will improve service access, affirm that the service is responding in a timely way and show that capacity constraints are being appropriately managed. The target response standard of 48 hours was met in 95% of cases in Q4 and the target of ≥90% was well exceeded all year.

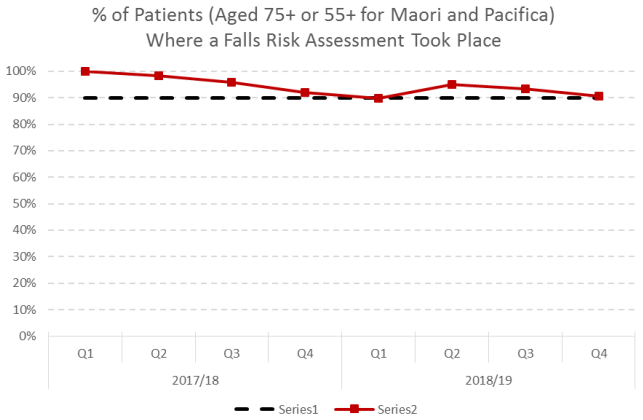


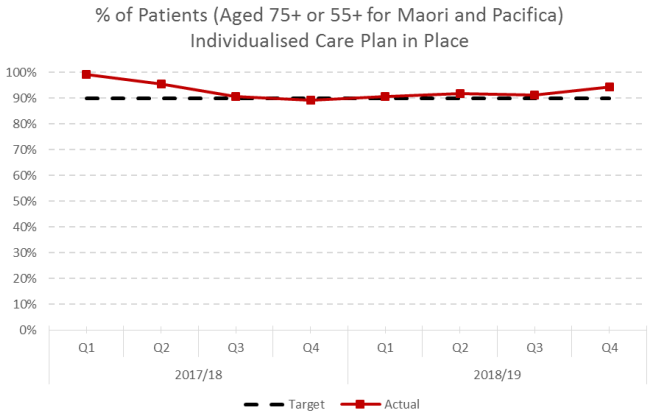
**Reducing harm from falls**

Reducing harm from falls is one of HBDHB's priority Quality and Safety Markers.

In 2018/19, a falls risk assessment was completed for 91.7% of elderly patients which is above the target of ≥90%. We ended the year at 90.7%.

If assessed to be at risk of falling, a patient needs an individualised care plan to minimise the risk. For the year a plan was completed for 92.1% of at risk patients which is favourable to target of ≥90%. We ended the year at 94.3%.



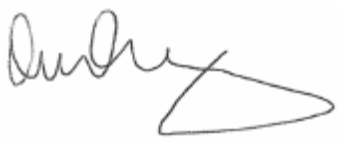




| Rehabilitation and Support | | | |
|---|---|---|---|
| $' millions | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
| Ministry of Health | 79.9 | 73.5 | 80.5 |
| Other District Health Boards (IDF) | 2.3 | 2.4 | 3.0 |
| Other sources | 0.3 | 0.1 | 0.1 |
| **Income by Source** | **82.5** | **76.0** | **83.6** |
| *Less:* | | | |
| Personnel | 8.8 | 6.6 | 6.2 |
| Clinical supplies | 1.0 | 0.7 | 0.8 |
| Infrastructure and non-clinical supplies | 1.8 | 1.8 | 1.8 |
| Payments to other District Health Boards | 4.4 | 4.3 | 4.2 |
| Payments to other providers | 73.4 | 63.3 | 70.6 |
| **Expenditure by type** | **89.4** | **76.7** | **83.6** |
| **Net Result** | **(6.9)** | **(0.7)** | **-** |

# Financial Report for the year ended 30 June 2019

The board members are pleased to present the Financial Statements of HBDHB for the year ended 30 June 2019.

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



**Kevin Atkinson**
*Chair*

**Dan Druzianic**
*Board Member*

31 October 2019

# 2018/19 Financial Performance

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

**Result**

The result for 2018/19 is an underlying operating deficit of $10.7 million in comparison to the $8.6 million deficit reported last year. Provisioning of $13 million for Holidays Act remediation, $2.6 million full impairment of the investment in the Health Finance, Procurement and Information Management System (FPIM) formerly the National Oracle Solution (NOS), and $2.1 million of costs resulting from industrial action in 2018/19, take the result to the $28.4 million reported in the Statement of Comprehensive Revenue and Expense on revenue of $587.1 million.

The underlying operating deficit is $5.7 million higher than the $5 million deficit projected in the 2018/19 Statement of Performance Expectations, and mainly reflects costs resulting from increasing demands placed on DHBs by higher acuity and patient volumes arising from demographic trends and technological advances.

**Cash flow**

Cash held at the beginning of the year together with draw-downs from the DHB's overdraft facility, provided $16.9 million of the funding used for the $18.6 million net capital investment in long term assets, the $8.2 million operating cash deficit and the repayment of $0.4 million of equity. The remaining funding came from an equity injection of $10.3million from the Crown to support cash flow.

**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 2018/19 annual report, amount to $135,380.

**Ministerial directions**

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

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

The DHB implemented the December 2018 milestones for the NZBN Directive. Planning is underway to identify the key changes and actions required for the DHB to implement the remaining requirements by the December 2020 milestone date.

## Five year financial performance summary

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

| Performance Indicator | Target | 2019 | 2018 | 2017 | 2016 | 2015 |
|---|---|---|---|---|---|---|
| Return on net funds employed | 2.3% | (12.9)% | (0.1)% | 7.3% | 9.8% | 8.3% |
| Operating margin to revenue | 0.6% | (3.4)% | 0.0% | 1.8% | 2.2% | 1.4% |
| Revenue to net funds employed | 3.6 | 3.8 | 3.8 | 3.8 | 3.8 | 4.5 |
| Net result before financing & abnormal | 3.6m | (19.8)m | (0.2)m | 10.3m | 13.2m | 9.1m |
| Net result | (5.0)m | (28.4)m | (8.6)m | 3.6m | 4.4m | 3.1m |
| Ratio of earnings to revenue | 3.0% | (1.3)% | 2.4% | 4.5% | 5.2% | 4.7% |
| Average cost per paid FTE | $92,887 | $94,114 | $89,090 | $87,731 | $86,563 | $84,085 |
| Average revenue per paid FTE | $234,734 | $241,417 | $238,336 | $239,610 | $238,939 | $232,975 |

# Statement of comprehensive revenue and expense

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

| | Notes | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
|---|---|---|---|---|
| Patient care revenue | 2.5 | 581,251 | 562,822 | 550,792 |
| Interest revenue | | 387 | 765 | 876 |
| Other operating revenue | 2.6 | 5,415 | 4,094 | 5,228 |
| Total revenue | | 587,053 | 567,681 | 556,896 |
| | | | | |
| Personnel costs | 2.7 | 228,856 | 224,637 | 208,167 |
| Outsourced services | | 20,227 | 17,160 | 19,291 |
| Clinical supplies | | 52,900 | 46,794 | 46,432 |
| Infrastructure and non-clinical expenses | | 27,024 | 23,271 | 26,238 |
| Payments to other DHBs | | 59,532 | 58,604 | 57,228 |
| Payments to non-health board providers | | 183,721 | 174,948 | 178,873 |
| Other operating expenses | 2.8 | 19,853 | 5,020 | 7,014 |
| Depreciation and amortisation expense | 3.6, 3.7 | 12,272 | 13,652 | 13,639 |
| Financing costs | 2.9 | 81 | - | - |
| Capital charge | 2.10 | 8,541 | 8,595 | 8,378 |
| Impairment losses | 3.7 | 2,638 | - | 212 |
| Total expenses | | 615,645 | 572,681 | 565,472 |
| | | | | |
| Share of associate surplus/(deficit) | 3.9 | 167 | - | - |
| | | | | |
| **Surplus/(deficit)** | | **(28,425)** | (5,000) | **(8,576)** |
| | | | | |
| **Other comprehensive revenue and expense** | | | | |
| Revaluation of land and buildings | 3.6 | 13,399 | - | 15,312 |
| | | | | |
| **Total comprehensive revenue and expense** | | **(15,026)** | (5,000) | **6,736** |

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

DHBs are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2019 was underspent by $0.2 million (2018: overspent by $0.2 million). Mental health payments are $0.3 million less than funding over the eighteen years since 1 July 2001 (30 June 2018: $0.1 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 2019** *in thousands of New Zealand Dollars*

| | Notes | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
|---|---|---|---|---|
| Balance at 1 July | | 148,724 | 154,452 | 142,345 |
| | | | | |
| Total comprehensive revenue and expense | | (15,026) | (5,000) | 6,736 |
| Owner transactions | | | | |
| Equity injections from the Crown | | 10,300 | - | - |
| Equity repayments to the Crown | | (357) | (357) | (357) |
| | | | | |
| **Balance at 30 June** | 4.5 | **143,641** | **149,094** | **148,724** |

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 2019** *in thousands of New Zealand Dollars*

| | Note | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
|---|---|---|---|---|
| **Assets** | | | | |
| *Current assets* | | | | |
| Cash and cash equivalents (excluding bank overdraft) | 3.1 | 777 | 4 | 7,685 |
| Short term investments | 3.1 | 1,872 | 2,877 | 1,645 |
| Receivables and prepayments | 3.2 | 29,327 | 25,034 | 25,460 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 3.3 | 15 | 12 | 14 |
| Inventories | 3.4 | 4,023 | 4,520 | 3,907 |
| **Total current assets** | | 36,014 | 32,447 | 38,711 |
| | | | | |
| *Non-current assets* | | | | |
| Property, plant and equipment | 3.6 | 190,255 | 184,887 | 173,641 |
| Intangible assets (1) | 3.7 | 13,393 | 14,642 | 12,736 |
| Investment property | 3.8 | 694 | 960 | 960 |
| Investment in associate (1) | 3.9 | 1,189 | 1,092 | 1,160 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 3.3 | - | - | 15 |
| **Total non-current assets** | | 205,531 | 201,581 | 188,512 |
| **Total assets** | | **241,545** | **234,028** | **227,223** |
| | | | | |
| **Liabilities** | | | | |
| *Current liabilities* | | | | |
| Bank overdraft | 3.1 | 10,216 | 8,311 | - |
| Payables and deferred revenue | 4.2 | 32,345 | 36,242 | 36,973 |
| Employee entitlements | 4.3 | 38,534 | 37,579 | 37,971 |
| Provisions | 4.4 | 13,808 | - | 936 |
| **Total current liabilities** | | 94,903 | 82,132 | 75,880 |
| | | | | |
| *Non-current liabilities* | | | | |
| Employee entitlements | 4.3 | 3,001 | 2,802 | 2,619 |
| **Total non-current liabilities** | | 3,001 | 2,802 | 2,619 |
| **Total liabilities** | | **97,904** | **84,934** | **78,499** |
| **Net assets** | | **143,641** | **149,094** | **148,724** |
| | | | | |
| **Equity** | | | | |
| Contributed capital | 4.5 | 91,945 | 81,644 | 82,002 |
| Property revaluation reserves | 4.5 | 96,103 | 86,704 | 82,704 |
| Restricted funds | 4.5 | 2,636 | 3,364 | 2,841 |
| Accumulated surpluses/(deficits) | 4.5 | (47,043) | (22,618) | (18,823) |
| **Total equity** | | **143,641** | **149,094** | **148,724** |

(1) The $8.202 million investment in national and regional information technology projects, has been transferred from Investment in associate to Intangible assets in the budget column to reflect the classification used in the results for 2019 and 2018. The two items were $6.440 million and 9.294 million respectively in the 2018/19 Statement of Performance Expectations.

The 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 2019** *in thousands of New Zealand Dollars*

| | Notes | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Receipts from patient care | | 575,359 | 567,102 | 551,188 |
| Receipts from donations, bequests and clinical trials | | 298 | - | 574 |
| Other receipts | | 4,774 | - | 3,167 |
| Payments to suppliers | | (350,934) | (328,390) | (328,255) |
| Payments to employees | | (229,156) | (223,429) | (204,727) |
| Goods and services tax (net) | | (318) | - | (1,436) |
| Cash generated from operations | | **23** | **15,283** | **20,511** |
| Interest received | | 387 | 765 | 876 |
| Interest paid | | (81) | (164) | - |
| Capital charge paid | | (8,541) | (8,021) | (8,378) |
| Net cash inflow/(outflow) from operating activities | | **(8,212)** | **7,863** | **13,009** |
| | | | | |
| **Cash flows from investing activities** | | | | |
| Proceeds from sale of property, plant and equipment | | 494 | - | 660 |
| Acquisition of property, plant and equipment | | (15,354) | (20,568) | (19,364) |
| Acquisition of intangible assets | | (2,249) | (1,600) | (920) |
| Acquisition of investments | | (1,519) | (114) | (1,928) |
| Net cash inflow/(outflow) to investing activities | | **(18,628)** | **(22,282)** | **(21,552)** |
| | | | | |
| **Cash flows from financing activities** | | | | |
| Proceeds from equity injections by the Crown | | 10,300 | - | - |
| Proceeds from movement in short term investments (net) | | (227) | - | (7) |
| Repayment of equity to the Crown | | (357) | (357) | (357) |
| Net cash inflow/(outflow) from financing activities | | **9,716** | **(357)** | **(364)** |
| | | | | |
| Net increase/(decrease) in cash and cash equivalents | | (17,124) | (14,776) | (8,907) |
| Add: opening cash | | 7,685 | 7,444 | 16,592 |
| **Cash and cash equivalents at end of year** | 3.1 | **(9,439)** | **(7,332)** | **7,685** |

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 2019** *in thousands of New Zealand Dollars*

| | Notes | 30 June 2019 | Budget 30 June 2019 | 30 June 2018 |
|---|---|---|---|---|
| **Surplus/(deficit) for the year** | | **(28,425)** | **(5,000)** | **(8,576)** |
| **Add back non-cash items:** | | | | |
| Share of associate surplus | | (167) | - | - |
| Depreciation and amortisation | | 12,271 | 13,652 | 13,639 |
| Impairment of investment in FPIM | | 2,638 | - | 212 |
| **Add back items classified as investing activity:** | | | | |
| Net loss/(gain) on disposal of property, plant and equipment | | 111 | - | 42 |
| Debt forgiven (Hawke's Bay Helicopter Rescue Trust) | | 14 | 15 | 13 |
| Dividends from associate | | 138 | - | - |
| **Movement in working capital:** | | | | |
| (Increase)/decrease in receivables and prepayments | | (3,868) | 539 | 1,262 |
| (Increase)/decrease in inventories | | (115) | (613) | 527 |
| Increase/(decrease) in payables and deferred revenue | | (4,496) | 2,069 | 372 |
| Increase/(decrease) in employee entitlements | | (565) | (2441) | 4,902 |
| Increase/(decrease) in provisions | | 13,870 | (541) | 635 |
| Net movement in working capital | | 4,826 | (987) | 7,698 |
| **Other movements not in working capital** | | | | |
| Increase/(decrease) in employee entitlements | | 382 | 183 | (19) |
| **Net cash inflow/(outflow) from operating activities** | | **(8,212)** | **7,863** | **13,009** |

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

# Notes to the financial statements

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

In preparing the 2019 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

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

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

The financial statements of HBDHB comprise the DHB, its 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, which 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 2019, and were approved by the Board on 31 October 2019.

### 1.2 Basis of preparation

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

### Statement of going concern

The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue to operate for the foreseeable future, based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances that it considers likely to affect the DHB during the period of one year from the date of signing the 2018/19 financial statements, and to circumstances that it knows will occur after that date that could affect the validity of the going concern assumption (as set out in its current statement of intent). The key considerations are set out below.

### Letter of comfort

The Board has received a letter of comfort, dated 21 October 2019 from the Ministers of Health and Finance which states that equity support will be provided 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, 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 early adopted

In line with the Financial Statements of the Government, HBDHB has elected to early adopt PBE IFRS 9 Financial Instruments. In accordance with transitional provisions, HBDHB has decided not to restate the information from previous years to comply with PBE FRS 9.

PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 5.3.

### 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 Statement of Cash Flows*

An amendment to PBE IPSAS 2 Statement of Cash Flows 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 annual periods beginning on or after 1 January 2021, with early application permitted. HBDHB does not intend to early adopt the amendment.

*PBE IPSAS 34-38*

PBE IPSAS 34-38 replaces the existing standard for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019. HBDHB will apply these new standards in preparing the 30 June 2020 financial statements. No effect is expected as a result of this change.

*PBE IPSAS 41 Financial Instruments*

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although the DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

*PBE FRS 48 Service Performance Reporting*

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. HBDHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

## 2. Result for the year

### 2.1 Performance by Arm

HBDHB's Statement of Performance Expectations includes separate operating statements for funding, governance and funding administration and providing health services. The following table compares performance against the plan for the 2018/19 year.

| | Achieved $m | Planned $m | Variance $m |
|---|---|---|---|
| **Revenue** | | | |
| Funding health services | 554.8 | 537.6 | 17.2 |
| Governance and funding administration | 3.5 | 3.4 | 0.1 |
| Providing health services | 340.6 | 335.7 | 4.9 |
| Eliminations | (311.8) | (309.0) | (2.8) |
| | 587.1 | 567.7 | 19.4 |
| **Surplus/(Deficit)** | | | |
| Funding health services | (0.1) | (5.0) | 4.9 |
| Governance and funding administration | 0.1 | - | 0.1 |
| Providing health services | (28.4) | - | (28.4) |
| | (28.4) | (5.0) | (23.4) |

*Notes:*

*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 additional funding provided for MECA settlements, workforce capacity and CCDM implementation. The costs associated with this funding form part of the adverse variance in the providing health services deficit.

The providing health services deficit also includes the $13 million provision for Holidays Act remediation, $2.6m full impairment of the investment in in the Health Finance, Procurement and Information Management System, $2.1 million of costs resulting from industrial relations activity and additional operating costs driven by increased patient volumes and acuity arising from demographic trends and technological advances.

### 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 Information*. PBE FRS 42 requires the DHB to present a comparison of the prospective financial information with the actual financial results being reported. This requirement is met by including the budget information in the financial statements.

**Financial Performance**

The result for the year is $23.4 million adverse to the Statement of Service Performance, including $13 million provisioning for Holidays Act remediation, $2.6m full impairment of the investment in in the Health Finance, Procurement and Information Management System and $2.1 million directly resulting from industrial relations activity. The remaining $5.7 million unfavourable operating result was driven by increased patient volumes and acuity arising from demographic trends and technological advances resulting in higher costs for the DHB.

**Financial Position**

Equity ended the year $5.5 million lower than budget, reflecting the differing opening positions between the plan and actual result. The $23.4 million adverse variance from the planned deficit was offset by the $13.4 million property revaluation and a $10.3 million equity injection. Current assets were $3.6 million higher than budget largely as Ministry of Health receivables increase in line with funding. Non-current assets were $4.0 million higher than budget comprising the effect of the property revaluation, full impairment of FPIM, and capital expenditure net of depreciation expense. Liabilities were $13 million higher than plan as a result of provisioning for Holidays Act remediation.

**Cash Flow**

Cash from operating activities was $16.1 million lower than plan, reflecting the cost of higher patient volumes and acuity. Financing cash flow benefited from the $10.3 million equity injection.

## 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.

## 2.4 Critical judgements in applying accounting policies

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

## 2.5 Patient care revenue

*Accounting policy*

### Ministry of Health population-based revenue

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

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

### 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 2019 | 30 June 2018 |
|---|---|---|
| Ministry of Health population-based revenue | 501,131 | 482,426 |
| Ministry of Health contract revenue | 59,726 | 48,492 |
| Revenue from other DHBs | 13,340 | 12,710 |
| Other Crown entity contracted revenue | 5,760 | 6,046 |
| Other patient care related revenue | 1,294 | 1,118 |
| | **581,251** | **550,792** |

Clinical Training Agency revenue has been reclassified from Ministry of Health population-based revenue to Ministry of Health contract revenue from this year. To give a valid comparison, the 30 June 2018 figures have been restated by reclassifying $3.816 million from Ministry of Health population-based revenue to Ministry of Health contract revenue.

Ministry of Education funding for early childhood education purposes has been transferred from special funds to other Crown entity contract revenue from this year. Receipts in 2018/19 amounted to $161 thousand (2018: $163 thousand), and the balance of funds as at 30 June 2019, included in Note 4.2 under revenue in advance, amounted to $58 thousand (30 June 2018: $63 thousand).

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

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

| | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Budget appropriation | 497,215 | 484,193 |
| Supplementary estimates | 3,916 | (1,767) |
| Ministry of Health population-based revenue | 501,131 | 482,426 |

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.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

## 2.6 Other operating revenue

*Accounting policy*

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

### Interest revenue

Interest revenue is recognised using the effective interest rate method.

### Rental revenue

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

### Sale of goods

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

### Provision of services

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

### Vested assets

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

### Donated services

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

| | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Donations and bequests received | 145 | 288 |
| Rental revenue | 690 | 605 |
| Cafeteria and food sales | 1,065 | 1,017 |
| Other operating revenue | 3,336 | 3,261 |
| Gain on sale of property, plant and equipment | 179 | 57 |
| | **5,415** | **5,228** |

## 2.7 Personnel costs

| | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Salaries and wages | 218,752 | 198,116 |
| Employer contributions to defined contribution plans | 7,039 | 6,104 |
| Increase/(decrease) in employee entitlements | 3,065 | 3,947 |
| | **228,856** | **208,167** |

**For the year ended 30 June 2019** *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 2019 | 30 June 2018 |
|---|---|---|
| Impairment of receivables (bad and doubtful debts) | 170 | 47 |
| Loss on disposal of property, plant and equipment | 259 | 67 |
| Fees to auditor for the audit of the financial statements | 135 | 129 |
| Fees to board members | 289 | 251 |
| Operating lease expenses | 4,879 | 5,074 |
| Increase/(decrease) in provisions | 14,117 | 1,444 |
| Koha | 4 | 2 |
| | **19,853** | **7,014** |

## 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 $81 thousand (2018: Nil). 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 2019 was 6% (2018: 6%).

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

3. Resourcing the DHB's activities

## 3.1 Cash and cash equivalents and short term investments

*Accounting policy*

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

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

While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses in trivial.

| **Cash and cash equivalents** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Cash | 4 | 4 |
| Bank balances | 9 | 12 |
| Credit balance (NZ Health Partnerships Limited) | - | 6,473 |
| 30 day deposits – special funds | 392 | 777 |
| 30 day deposits – clinical trials | 372 | 419 |
| Cash and cash equivalents (excluding bank overdraft) | **777** | **7,685** |
| Bank overdraft | (10,216) | - |
| Cash and cash equivalents | **(9,439)** | **7,685** |

| **Short term investments** | | |
|---|---|---|
| Term deposits – special funds | 1,186 | 942 |
| Term deposits – clinical trials | 686 | 703 |
| | **1,872** | **1,645** |

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

*Financial assets recognised subject to restrictions*

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

| **Special funds** | | |
|---|---|---|
| Opening balance | 1,719 | 1,878 |
| Donations and bequests | 66 | 261 |
| Interest received | 43 | 49 |
| Transfer to operating funds | (127) | - |
| Expenditure during the year | (123) | (469) |
| | **1,578** | **1,719** |

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

| Clinical Trials | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Opening balance | 1,122 | 1,093 |
| Receipts | 284 | 348 |
| Interest received | 28 | 23 |
| Expenditure during the year | (376) | (342) |
| | **1,058** | **1,122** |

**DHB Treasury Services Agreement**

HBDHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHP) and all DHBs. This agreement enables NZHP to sweep DHB bank account balances and invest the pool of surplus funds on their behalf. The agreement also allows individual DHBs to borrow from the pool of surplus funds at the on-call interest rate earned on the pool plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's provider arm funding plus GST. As at 30 June 2019 this limit for HBDHB was $29.3 million (2018: $26.9 million).

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

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

**Credit card facility**

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

## 3.2 Receivables and prepayments

*Accounting policy*

Receivables and prepayments are recorded at their face value, less any allowance for credit losses. In measuring credit losses, short-term receivables have been assessed collectively by customer type, as each customer type shares similar credit risk characteristics. They have been grouped on days past due. Short-term receivables are written off when there is no reasonable expectation of recovery.

| | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Ministry of Health receivables | 2,413 | 1,754 |
| Trade receivables | 3,588 | 1,656 |
| Ministry of Health accrued revenue | 13,114 | 11,012 |
| Other accrued revenue | 9,676 | 10,486 |
| Prepayments | 536 | 552 |
| | **29,327** | **25,460** |

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

The carrying value of receivables that would otherwise be past due, but not impaired, whose terms have been renegotiated is $143 thousand (2018: $306 thousand).

Receivables are shown net of impairments amounting to $412 thousand (2017: $334 thousand) recognised in the current year and arising from non-resident fees and small service charges that can be uneconomic to collect.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

As at 30 June 2019 and 2018, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

| | Gross 30 June 2019 | Impairment 30 June 2019 | Net 30 June 2019 | Gross 30 June 2018 | Impairment 30 June 2018 | Net 30 June 2018 |
|---|---|---|---|---|---|---|
| Not past due/past due<30days | 4,007 | (16) | 3,991 | 2,344 | (13) | 2,331 |
| Past due 31-60 days | 253 | (6) | 247 | 411 | (6) | 405 |
| Past due 61-90 days | 611 | (30) | 581 | 113 | (4) | 109 |
| Past due >90 days | 1,542 | (360) | 1,182 | 876 | (311) | 565 |
| | **6,413** | **(412)** | **6,001** | **3,744** | **(334)** | **3,410** |

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

| | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Balance at beginning of year | 334 | 329 |
| Additional provisions made during the year | 179 | 51 |
| Receivables written-off during period | (101) | (46) |
| Balance at end of year | 412 | 334 |

## 3.3 Loans

*Accounting policy*

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

| **Loan to Hawke's Bay Helicopter Rescue Trust** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Non-current | - | 15 |
| Current | 15 | 14 |
| | **15** | **29** |

The remaining loan is current at 30 June 2019. Consequently its fair value is equivalent to its face value.

## 3.4 Inventories

*Accounting Policy*

### Inventories held for distribution

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

### Inventories held for sale

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

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

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

| **Inventories held for distribution** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Pharmaceuticals | 776 | 792 |
| Surgical and medical supplies | 2,144 | 2,041 |
| Other supplies | 1,103 | 1,074 |
| | **4,023** | **3,907** |

Write-down of inventories amounted to $46 thousand (2018: $10 thousand). No reversal of previously recognised write-downs was made in the current year. The amount of inventories recognised as an expense during the year was $45.1 million (2018: $40.6 million). No inventories were held at current replacement cost at 30 June 2019 (30 June 2018: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

## 3.5 Non-current assets held for sale

*Accounting policy*
Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale, are measured at the lower of their carrying amount and fair value less costs to sell.
Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.
Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

The sale date of a property declared surplus in October 2013 is uncertain as it is currently leased to other health providers. The property is currently classified as an investment property.

## 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.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

### 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 | 60 to 5 years | 1.6% to 20% |
| Clinical equipment | 20 to 2 years | 5% to 50% |
| Information technology | 10 to 3 years | 10% to 33% |
| Motor vehicles | 20 to 7 years | 5% to 14% |
| Other equipment | 30 to 3 years | 3% to 33% |

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

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

### Impairment of property, plant and equipment

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

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

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

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. 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 useful lives of property, plant and equipment

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 but has made a prospective change for future years.

# Notes to the financial statements (continued)

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

| | 1 July 2018 | | | | | | | | | 30 June 2019 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2019** | Cost/ Valuation | Accumulated Depreciation | Carrying Amount | Acquisitions | Transfers from work in progress | Revaluation of land and buildings | Disposals/ transfers to investment properties | Depreciation expense | Depreciation write back on disposal/ revaluation | Cost/ valuation | Accumulated Depreciation | Carrying Amount |
| **Owned assets** | | | | | | | | | | | | |
| Land | 9,745 | - | 9,745 | - | - | 2,382 | - | - | - | 12,127 | - | 12,127 |
| Buildings | 130,307 | - | 130,307 | - | 19,477 | 3,952 | (87) | (7,065) | 7,065 | 153,649 | - | 153,649 |
| Clinical equipment | 36,252 | (23,086) | 13,166 | - | 2,648 | - | (2,656) | (3,159) | 2,493 | 36,244 | (23,752) | 12,492 |
| Information tech. | 7,333 | (5,775) | 1,558 | - | 2,368 | - | (1,354) | (914) | 1,338 | 8,347 | (5,351) | 2,996 |
| Motor vehicles | 1,844 | (1,304) | 540 | - | 38 | - | (6) | (156) | 5 | 1,876 | (1,455) | 421 |
| Other equipment | 3,542 | (1,910) | 1,632 | - | 1,161 | - | (317) | (344) | 244 | 4,386 | (2,010) | 2,376 |
| | 189,023 | (32,075) | 156,948 | - | 25,692 | 6,334 | (4,420) | (11,638) | 11,145 | 216,629 | (32,568) | 184,061 |
| **Leased assets** | | | | | | | | | | | | |
| Alterations | 1,658 | (483) | 1,175 | - | 25 | - | - | (161) | - | 1,683 | (644) | 1,039 |
| | 1,658 | (483) | 1,175 | - | 25 | - | - | (161) | - | 1,683 | (644) | 1,039 |
| **Work in Progress** | | | | | | | | | | | | |
| Buildings | 14,094 | - | 14,094 | 8,537 | (19,502) | - | - | - | - | 3,129 | - | 3,129 |
| Clinical equipment | 277 | - | 277 | 3,818 | (2,648) | - | - | - | - | 1,447 | - | 1,447 |
| Information tech. | 1,147 | - | 1,147 | 1,618 | (2,368) | - | - | - | - | 397 | - | 397 |
| Motor vehicles | - | - | - | 38 | (38) | - | - | - | - | - | - | - |
| Other equipment | - | - | - | 1,343 | (1,161) | - | - | - | - | 182 | - | 182 |
| | 15,518 | - | 15,518 | 15,354 | (25,717) | - | - | - | - | 5,155 | - | 5,155 |
| | 206,199 | (32,558) | 173,641 | 15,354 | | 6,334 | (4,420) | (11,799) | 11,145 | 223,467 | (33,212) | 190,255 |

**Valuation**

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid MPropertyStudies BCom FNZIV FPINZ of Added Valuation Limited. The valuation was effective as at 30 June 2019. The valuations of land and buildings have been updated to reflect the movement in building costs in Hawke's Bay over the year, and the useful lives of buildings have been updated to recognise the impact of the National Asset Management Plan and the DHB's cash position on the timing of buildings upgrades and replacement.

*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 2019.

**Impairment**

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

**Restrictions**

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

# Notes to the financial statements (continued)

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

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

## 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 | 25 to 2 years | 4% to 50% |
| Developed computer software | 15 to 3 years | 7% to 33% |
| RHIP assets (PACS Archive) | 10 years | 10% |

### Impairment of intangible assets

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

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

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**

Investment in the Health Finance, Procurement and Information Management System (FPIM) formerly the National Oracle Solution (NOS), was intended to enable significant procurement savings through the development of a national catalogue, as a part of a national financial and procurement information system. A Cabinet decision on 28 June 2018 paused the NOS Programme and required a revisit of the business case, which resulted in a rescoping of the programme. As a part of the rescope process HBDHB gave ongoing commitment to a shared vision for the development of a national shared procurement catalogue, data standards, data repository and compliance processes, to improve procurement value for money. However, acknowledging developments in technology which could allow national catalogue functionality without migration to a shared system, HBDHB declined to join the FPIM system in the medium term. This was captured in the new FPIM business case, which was approved by Cabinet on 24 June 2019 and as a consequence the investment has been impaired 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 RHIP has not been impaired.

# Notes to the financial statements (continued)

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

| | 1 July 2018 | | | | | | | | 30 June 2019 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **30 June 2019 Owned assets** | Cost/ Valuation | Accumulated Amortisation | Carrying Amount | Acquisitions | Transfers | Disposals/ Impairment | Amortisation Expense | Amortisation written back | Cost/ Valuation | Accumulated Amortisation | Carrying Amount |
| Software | 11,369 | (9,890) | 1,479 | - | 2,007 | (212) | (473) | 212 | 13,164 | (10,151) | 3,013 |
| | 11,369 | (9,890) | 1,479 | - | 2,007 | (212) | (473) | 212 | 13,164 | (10,151) | 3,013 |
| **Work in Progress** | | | | | | | | | | | |
| Software | 859 | - | 859 | 2,249 | (2,007) | - | - | - | 1,101 | - | 1,101 |
| FPIM rights | 2,293 | - | 2,293 | 345 | - | (2,638) | - | - | - | - | - |
| RHIP assets | 8,105 | - | 8,105 | 1,174 | - | - | - | - | 9,279 | - | 9,279 |
| | 11,257 | - | 11,257 | 3,768 | (2,007) | (2,638) | - | - | 10,380 | - | 10,380 |
| | 22,626 | (9,890) | 12,736 | 3,768 | | (2,850) | (473) | 212 | 23,544 | (10,151) | 13,393 |

The FPIM (formerly NOS) rights represented the DHB's right to access, under a service agreement, shared finance, procurement and supply chain systems using assets funded by the DHBs. The intangible asset was recognised at the cost of capital invested by the DHB in FPIM, a national initiative facilitated by New Zealand Health Partnerships (NZHP), whereby all 20 DHBs can move to a shared systems model for the provision of FPIM systems. NZHP is a company owned collectively by the 20 DHBs with equal voting rights. The FPIM rights have been fully impaired - see the "Impairment of intangible assets with indefinite lives" section of this note above.

The RHIP assets are the DHB's share of the assets comprising the Regional Health Informatics Programme (RHIP) facilitated by Central Region's Technical Advisory Services Limited (CRTAS). The intangible asset recognises the DHB's right to use the RHIP clinical information systems, and its ownership of a proportion of the systems assets. During the year ended 30 June 2015 RHIP was reclassified into the four clinical systems and the supporting regional infrastructure it comprises, and will be amortised or depreciated when these assets are complete. The RHIP work in progress at 30 June 2019 is considered to be fit for purpose, and the DHBs in the central region continue to support the project. HBDHB considers the carrying amount of the assets (the cost of the system build), is equivalent to the recoverable service amount using depreciated replacement cost, and consequently no impairment of the assets, is necessary.

# Notes to the financial statements (continued)

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

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

**For the year ended 30 June 2019** *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 2019 | 30 June 2018 |
|---|---|---|
| Balance at beginning of year | 960 | 131 |
| Transfers from property, plant and equipment | 84 | - |
| Transfers from non-current assets held for sale | - | 625 |
| Fair value adjustments | - | 204 |
| Disposals | (350) | - |
| Balance at end of year | **694** | **960** |

No revaluation was completed for investment properties as at 30 June 2019 due to the minimal value of the properties. The properties were last revalued as at 30 June 2018 by John Reid MPropertyStudies BCom FNZIV FPINV of Added Valuation, who holds an annual practicing certificate and has held registration since 1985. The fair value of the investment properties was determined using market based evidence.

## 3.9 Investments in associates

*Accounting policy*

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

If the share of deficits of an associate equals or exceeds the DHB's interest in the associate, further deficits are not recognised. After the DHB's interest is reduced to zero, additional deficits are 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.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

HBDHB has an investment in one associate entity, Allied Laundry Services Limited (ALSL), whose principal activity is the provision of laundry services. The interest held at 30 June 2019 was 16.67% (30 June 2018: 17.42%). 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 90% 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 2019 | 30 June 2018 |
|---|---|---|
| *Presented on a gross basis* | | |
| Assets | 9,918 | 10,014 |
| Liabilities | 2,544 | 3,177 |
| Revenue | 10,924 | 10,590 |
| Surplus/(deficit) | 648 | 543 |
| HBDHB ownership interest | 16.67% | 17.42% |
| 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 2019, and their audited financial statements as at 30 June 2018.

## 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 2019 | 30 June 2018 |
|---|---|---|
| Trade payables | 5,620 | 3,717 |
| Revenue in advance relating to contracts with specific performance obligations | 502 | 2,835 |
| Other non-trade payables and accrued expenses | 22,976 | 26,940 |
| | 29,098 | 33,492 |
| **Payables and deferred revenue under non exchange transactions** | | |
| ACC levy payable | 1,027 | 1,157 |
| Goods and services tax | 2,220 | 2,324 |
| | 3,247 | 3,481 |
| **Total payables and deferred revenue** | **32,345** | **36,973** |

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

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

## 4.3 Employee entitlements

*Accounting policy*

### Short-term employee entitlements

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

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

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

### Long-term employee entitlements

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

**Superannuation schemes**

### Defined contribution schemes

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

### Defined benefit schemes

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

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

*Critical accounting estimates and assumptions*

### Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $5.830 million (2018: $5.339 million).

| **Non-current liabilities** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Long service leave | 2,892 | 2,524 |
| Retirement gratuities | 109 | 95 |
| | **3,001** | **2,619** |

**For the year ended 30 June 2018** *in thousands of New Zealand Dollars*

| **Current liabilities** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Accrued salaries and wages | 6,947 | 9,067 |
| Annual leave | 23,865 | 20,955 |
| Sick leave | 438 | 393 |
| Continuing medical education leave and expenses | 4,893 | 5,229 |
| Sabbatical leave | 637 | 716 |
| Long service leave | 1,658 | 1,530 |
| Retirement gratuities | 96 | 81 |
| | **38,534** | **37,971** |

**Key assumptions in measuring employee entitlements**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 1.26% (2018: 1.78%) in year one to 4.30% (2018: 4.75%) after 52 (2018: 37) years. The salary inflation factor is the DHB's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates are 1% lower, or salary increases 1% higher, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $277 thousand higher (2018: $237 thousand higher). Conversely if the discount rates are 1% higher, or salary increases 1% lower, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $249 thousand lower (2018: $214 thousand lower).

## 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 financing 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.

**For the year ended 30 June 2018** *in thousands of New Zealand Dollars*

| | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Balance at beginning of year | 936 | 334 |
| Additional provisions made | 14,117 | 1,444 |
| Amounts used | (1,245) | (842) |
| Unused amounts reversed | - | - |
| Balance at end of year | **13,808** | **936** |

All provisions are classified as current.

**ACC Accredited Employers Programme**

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

*Liability valuation*

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

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

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

HBDHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will carry the total cost of claims up to $2.2 million (2018: $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 2019. 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.

**For the year ended 30 June 2018** *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 will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS. This is expected to be undertaken over 18 months, although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, HBDHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability. This was based on a review of payroll processes which identified potential instances of non-compliance with the Act and the requirements of the MOU. A number of early assumptions and extrapolation techniques were used to then calculate an indicative liability for those current and former employees.

Holidays Act remediation was reclassified from a contingent liability to a $13 million provision as at June 2019. This indicative liability amount is HBDHBs best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties. The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

## 4.5 Equity

| | Crown Equity | Property Revaluation Reserves | Restricted Funds | Accumulated Deficit | Total Equity |
|---|---|---|---|---|---|
| Balance at 1 July 2018 | 82,002 | 82,704 | 2,841 | (18,823) | 148,724 |
| Surplus/(deficit) for the year | - | - | - | (28,425) | (28,425) |
| Revaluation of land and buildings | - | 13,399 | - | - | 13,399 |
| Transfers between reserves | - | - | (205) | 205 | - |
| Injection from the Crown | 10,300 | - | - | - | 10,300 |
| Repayment to the Crown | (357) | - | - | - | (357) |
| **Balance at 30 June 2019** | **91,945** | **96,103** | **2,636** | **(47,043)** | **143,641** |

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

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

**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 2019 | 30 June 2018 |
|---|---|---|
| Land | 10,657 | 8,275 |
| Buildings | 85,446 | 74,429 |
| | **96,103** | **82,704** |

**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 income is accrued in accordance with section 9(7) of the Goods and Services Tax Act 1985.

Commitments and contingencies are disclosed exclusive of GST.

**Income tax**

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

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

## 5.2 Capital commitments and operating leases

| **Capital commitments** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Property, plant and equipment | | |
| Buildings | 457 | 4,800 |
| Clinical equipment | 883 | 163 |
| Plant | 14 | 693 |
| Information technology | 23 | 199 |
| Intangible assets | | |
| Software | 66 | 23 |
| Regional Health Information Project (RHIP) | 971 | 263 |
| New Zealand Health Partnerships | - | 440 |
| | 2,414 | 6,581 |

Capital commitments include orders issued for property, plant and equipment, and future agreed contributions to RHIP.
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

| **Non-cancellable commitments – operating leases** | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Not more than one year | 3,184 | 2,632 |
| One to five years | 11,189 | 6,664 |
| Later than five years | 2,350 | 504 |
| | **16,723** | **9,800** |

## 5.3 Financial instruments

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

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

### a. Financial instrument categories

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

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

**Financial Assets**

| Financial assets measured at amortised cost (2018: Loans and receivables) | 30 June 2019 | 30 June 2018 |
|---|---|---|
| Cash and cash equivalents | 777 | 7,685 |
| Short term investments | 1,872 | 1,645 |
| Loans | 15 | 29 |
| Receivable and prepayments | 29,327 | 25,460 |
| | **31,991** | **34,819** |

**Financial Liabilities**

| Financial liabilities measured at amortised cost | | |
|---|---|---|
| NZ Health Partnerships | 10,216 | - |
| Payables and deferred revenue | 32,345 | 36,973 |
| | **42,548** | **36,973** |

**b. Fair value hierarchy disclosures**

HBDHB recognises no financial instruments at fair value in the statement of financial position. The measurement categories and carrying amounts for financial liabilities have not changed between the opening and closing balances as a result of transition to PBE IFRS 9.

**c. Financial instrument risks**

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

**Market risk**

*Fair value interest rate risk*

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

*Cash flow interest rate risk*

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

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

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

In respect of income-earning financial assets and interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance 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.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

| 30 June 2019 | Effective Interest Rates | Total | 6 months or less |
|---|---|---|---|
| Cash and cash equivalents | | | |
| Cash | - | 4 | 4 |
| Bank balances | - | 9 | 9 |
| Short term deposits | 0.63% | 764 | 764 |
| Short term investments | 3.10% | 1,872 | 1,872 |
| | | **2,649** | **2,649** |

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

*Currency risk*

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

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

*Sensitivity analysis*

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

**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 2018: 95%) of the DHB's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

At the 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.

*Sensitivity analysis*

At 30 June 2019, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2019/20, 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 2019 | 30 June 2018 |
|---|---|---|
| **Counterparties with credit ratings** | | |
| **Cash, cash equivalents and investments** | | |
| AA- | 2,636 | 2,841 |
| *Total cash and cash equivalents* | 2,636 | 2,841 |
| | | |
| **Counterparties without credit ratings** | | |
| **Cash and cash equivalents** | | |
| NZ Health Partnerships – no defaults in the past | - | 6,473 |
| **Receivables and prepayments** | | |
| Receivables and prepayments with no defaults in the past | 29,184 | 25,154 |
| Receivables and prepayments with defaults in the past | 143 | 306 |
| Total receivables and prepayments | 29,327 | 25,460 |
| **Loans** | | |
| Hawke's Bay Helicopter Rescue Trust - no defaults in the past | 15 | 29 |

**Liquidity risk**

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

**Contractual maturity analysis of financial liabilities**

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

**Forecasted transactions**

HBDHB does not hedge forecasted transactions.

## 5.4 Contingent assets

There are no contingent assets at 30 June 2019 (2018: Nil).

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

## 5.5 Contingent liabilities

**Lawsuits against the DHB**

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

**Superannuation schemes**

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

Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the Scheme, the extent to which the deficit will affect future contributions by employers, as there is no prescribed basis for allocation.

As at 31 March 2019, the scheme had a past service deficit of $1.8 million (1.9% of the liabilities). This amount was exclusive of employer superannuation contribution tax. This deficit 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 25.

The current employer contribution rate is one times contributor contributions, inclusive of Employer Contribution Withholding Tax. The Actuary has recommended a stepped approach to changing the employer contribution rate, as follows:

| | |
|---|---|
| 1 April 2020 – 31 March 2021 | Three times contributor contributions |
| 1 April 2021 – 31 March 2022 | Four times contributor contributions |
| From 1 April 2022 | Five times contributor contributions |

The key assumptions in the review were:

- the difference between the future investment returns and the rates of CPI inflation assumed when calculating future factors for transfers from this Scheme to the DBP Annuitants Scheme (DBPA Scheme)
- the pensioner mortality assumptions, which are based on the results of a recent pensioners' mortality investigation, and include an allowance for improving mortality
- the future investment returns assumed for the Scheme over the next ten years.

The scheme had 141 members at 31 March 2019 (2018: 180), three of whom are employees of the DHB (2018: five).

## 5.6 Related party transactions

HBDHB is a wholly owned entity of the Crown.

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

***For the year ended 30 June 2019*** *in thousands of New Zealand Dollars*

***Key management personnel compensation***

| | *30 June 2019* | *30 June 2018* |
|---|---|---|
| ***Board Members*** | | |
| Remuneration | 289 | 284 |
| *Full time equivalent members* | *1.3* | *1.3* |
| **Executive management team** | | |
| Remuneration | 3,306 | 2,932 |
| *Full time equivalent members* | *13.2* | *11.0* |
| **Total key management personnel remuneration** | **3,595** | **3,216** |
| ***Total full time equivalent personnel*** | ***14.5*** | ***12.3*** |

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

## 5.7 Remuneration

**Remuneration – Board members**

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

| | **30 June 2019** | | **30 June 2018** | |
|---|---|---|---|---|
| *in whole New Zealand Dollars* | **Board** | **Committees** | **Board** | **Committees** |
| Kevin Atkinson *Chair* | 42,000 | 2,500 | 42,000 | 2,500 |
| Ngahiwi Tomoana *Deputy Chair* | 25,500 | 3,750 | 25,500 | 2,125 |
| Ana Apatu *(elected October 2016)* | 20,400 | 5,000 | 20,400 | 4,000 |
| Barbara Arnott | 20,400 | 3,750 | 20,400 | 3,250 |
| Dan Druzianic | 20,400 | 3,120 | 20,825 | 3,120 |
| Peter Dunkerley | 20,400 | 2,500 | 20,400 | 2,562 |
| Hine Flood *(appointed October 2016)* | 20,400 | 4,250 | 20,400 | 3,250 |
| Helen Francis | 20,400 | 2,500 | 20,400 | 2,500 |
| Diana Kirton | 20,400 | 2,500 | 20,400 | 2,500 |
| Jacoby Poulain | 20,400 | 2,500 | 20,400 | 2,500 |
| Heather Skipworth | 20,400 | 5,313 | 20,400 | 4,188 |
| | 251,100 | 37,683 | 251,525 | 32,495 |

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

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

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

**For the year ended 30 June 2019** *in thousands of New Zealand Dollars*

**Employee Remuneration**

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

| | 30 June 2019 | 30 June 2018 | | 30 June 2019 | 30 June 2018 |
|---|---|---|---|---|---|
| 100,000-109,999 | 123 | 78 | 340,000-349,999 | 4 | 1 |
| 110,000-119,999 | 65 | 33 | 350,000-359,999 | 1 | 3 |
| 120,000-129,999 | 29 | 31 | 360,000-369,999 | 2 | 3 |
| 130,000-139,999 | 22 | 21 | 370,000-379,999 | 1 | 1 |
| 140,000-149,999 | 13 | 14 | 380,000-389,999 | 1 | - |
| 150,000-159,999 | 18 | 10 | 390,000-399,999 | 2 | 1 |
| 160,000-169,999 | 9 | 12 | 400,000-409,999 | 1 | 1 |
| 170,000-179,999 | 10 | 8 | 410,000-419,999 | 3 | - |
| 180,000-189,999 | 8 | 12 | 420,000-429,999 | 1 | - |
| 190,000-199,999 | 7 | 8 | 430,000-439,999 | 2 | 1 |
| 200,000-209,999 | 10 | 11 | 440,000-449,999 | 1 | 1 |
| 210,000-219,999 | 8 | 10 | 450,000-459,999 | - | - |
| 220,000-229,999 | 8 | 7 | 460,000-469,999 | - | - |
| 230,000-239,999 | 13 | 4 | 470,000-479,999 | - | - |
| 240,000-249,999 | 12 | 6 | 480,000-489,999 | - | - |
| 250,000-259,999 | 8 | 5 | 490,000-499,999 | 3 | 1 |
| 260,000-269,999 | 2 | 6 | 500,000-509,999 | - | - |
| 270,000-279,999 | 4 | 3 | 510,000-519,999 | - | - |
| 280,000-289,999 | 9 | 10 | 520,000-529,999 | - | - |
| 290,000-299,999 | 6 | 7 | 530,000-539,999 | 2 | - |
| 300,000-309,999 | 5 | 4 | 540,000-549,999 | 1 | - |
| 310,000-319,999 | 5 | 7 | 550,000-559,999 | - | - |
| 320,000-329,999 | 2 | 3 | 560,000-569,999 | - | 1 |
| 330,000-339,999 | 3 | 1 | 570,000-579,999 | 1 | - |

The above table includes $2.1 million of payments made to senior medical officers during the Resident Doctors Association strikes during the year. This has affected the distribution within the bands compared to last year.

During the year, one (30 June 2018: six) employee received compensation and other benefits in relation to cessation totalling $22,745 (30 June 2018: $275,586).

**Compensations**

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

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

## 5.8. Capital management

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

## 5.9. Events after balance date

There are no significant events after balance date.

# Appendix One – Technical Results Report

**Key for technical results report**

| | |
|---|---|
| **Baseline** | Latest available data for planning purpose |
| **Target 2018/19** | Target 2018/19 |
| **Actual to date** | Actual to date (the DHB endeavours to report data as at June 2019, due to data availability this is not always possible and the DHB has included the latest data available at the time of end of year reporting) |
| **F (Favourable)** | Actual to date is favourable to target<br>(above or within 0.5% of target) |
| **U (Unfavourable)** | Actual to date is unfavourable to target |

## OUTPUT CLASS 1: PREVENTION SERVICES

### Population and Individual Dimensions

| **Better help for smokers to quit -** % of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 99.0% – October to December 2016 | ≥95% | 97.4% (F) – July to September 2017 |
| | | | 95.5% (F) – October to December 2017 |
| | | | 95.7% (F) – January to March 2018 |
| | | | 97.1% (F) – April to June 2018 |
| 2018/19 | 96.1% – January to December 2017 | ≥95% | 96.7% (F) – July to September 2018 |
| | | | 95.7% (F) – October to December 2018 |
| | | | 96.1% (F) – January to March 2019 |
| | | | 96.7% (F) – April to June 2019 |

| **Better help for smokers to quit -** % of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Ministry of Health | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 87.4% | ≥90% | 90.2% (F) – July to September 2017 |
| | | | 90.9% (F) – October to December 2017 |
| | | | 88.9% (U) – January to March 2018 |

| | | | |
|---|---|---|---|
| | October to December 2016 (Source: DHBNZ) | | 89.0% (U) – April to June 2018 |
| 2018/19 | 90.2%<br>October to December 2017 (Source: DHBNZ) | ≥90% | 84.7% (U) – July to September 2018 |
| | | | 83.0% (U) – October to December 2018 |
| | | | 79.0% (U) – January to March 2019 |
| | | | 79.4% (U) – April to June 2019 |

| **Better help for smokers to quit -** % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Ministry of Health | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 88.5%<br>October - December 2016 | ≥90% | 81.3% (U) – July to September 2017 |
| | | | 73.9% (U) – October to December 2017 |
| | | | 75.0% (U) – January to March 2018 |
| | | | 69.0% (U) – April to June 2018 |
| 2018/19 | 86.7%<br>January - December 2017 | ≥90% | 91.7% (F) – July to September 2018 |
| | | | 88.9% (U) – October to December 2018 |
| | | | 84.6% (U) – January to March 2019 |
| | | | 74.0% (U) – April to June 2019 |

| **Better help for smokers to quit** Number of babies who live in a smoke-free household at six weeks post-natal | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 80.0%<br>July to December 2015 | ≥95% | 66.1% (U) July to December 2017 |
| 2018/19 | 66.1%<br>July to December 2017 | ≥95% | 45.0% (U) July to December 2018 |

| **Increased immunisation -** % of 8 month olds will have their primary course of immunisation (six weeks, three months and five month events) on time | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2017/18 | 95.3%<br>October to December 2016 | ≥95% | 94.5% (F) – July to September 2017 |
| | | | 93.6% (U) – October to December 2017 |
| | | | 94.3% (U) – January to March 2018 |
| | | | 94.0% (U) – April to June 2018 |
| 2018/19 | 95%<br>January to December 2017 | ≥95% | 91.0% (U) – July to September 2018 |
| | | | 93.3% (U) – October to December 2018 |
| | | | 89.8% (U) – January to March 2019 |
| | | | 91.2% (U) – April to June 2019 |
| **MĀORI** | | | |
| 2017/18 | 94.4%<br>October to December 2016 | ≥95% | 91.5% (U) – July to September 2017 |
| | | | 93.4% (U) – October to December 2017 |
| | | | 95.0% (F) – January to March 2018 |
| | | | 94.7% (F) – April to June 2018 |
| 2018/19 | 93%<br>January to December 2017 | ≥95% | 89.1% (U) – July to September 2018 |
| | | | 90.2% (U) – October to December 2018 |
| | | | 88.4% (F) – January to March 2019 |
| | | | 92.6% (F) – April to June 2019 |

| **Increased immunisation -** % of 2 year olds fully immunised | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2017/18 | 94.7%<br>October to December 2016 | ≥95% | 94.6% (F) – July to September 2017 |
| | | | 96.4% (F) – October to December 2017 |
| | | | 94.5% (F) – January to March 2018 |
| | | | 95.7% (F) – April to June 2018 |
| 2018/19 | 94%<br>January to December 2017 | ≥95% | 92.1% (U) – July to September 2018 |
| | | | 94.1% (U) – October to December 2018 |
| | | | 93.5% (U) – January to March 2019 |
| | | | 94.6% (F) – April to June 2019 |
| **MĀORI** | | | |
| 2017/18 | 95.4%<br>October to December 2016 | ≥95% | 94.1% (U) – July to September 2017 |
| | | | 95.8% (F) – October to December 2017 |
| | | | 93.8% (U) – January to March 2018 |
| | | | 94.8% (F) – April to June 2018 |
| 2018/19 | 95%<br>January to December 2017 | ≥95% | 91.2% (U) – July to September 2018 |
| | | | 94.1% (U) – October to December 2018 |
| | | | 92.6% (U) – January to March 2019 |
| | | | 94.5% (F) – April to June 2019 |

| **Increased immunisation -** % of 5 year olds fully immunised | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2017/18 | 93.5%<br>October to December 2016 | ≥95% | 94.2% (U) – July to September 2017 |
| | | | 91.3% (U) – October to December 2017 |
| | | | 90.3% (U) – January to March 2018 |
| | | | 93.0% (U) – April to June 2018 |
| 2018/19 | 94%<br>January to December 2017 | ≥95% | 91.4% (U) – July to September 2018 |
| | | | 89.9% (U) – October to December 2018 |
| | | | 89.8% (U) – January to March 2019 |
| | | | 89.9% (U) – April to June 2019 |
| **MĀORI** | | | |
| 2017/18 | 95.8%<br>October to December 2016 | ≥95% | 96.7% (F) – July to September 2017 |
| | | | 90.7% (U) – October to December 2017 |
| | | | 89.1% (U) – January to March 2018 |
| | | | 89.8% (U) – April to June 2018 |
| 2018/19 | 93%<br>January to December 2017 | ≥95% | 91.5% (U) – July to September 2018 |
| | | | 89.7% (U) – October to December 2018 |
| | | | 88.4% (U) – January to March 2019 |
| | | | 86.3% (U) – April to June 2019 |

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

| | | | |
|---|---|---|---|
| 2018/19 | 70.4%<br>2002 – June 2017 | ≥75% | 73.8% (U) 2005 – June 2019 |
| **MĀORI** | | | |
| 2017/18 | 87.8%<br>2002 – June 2016 | ≥75% | 84.9% (F) 2004 – June 2018 |
| 2018/19 | 76.9%<br>2002 – June 2017 | ≥75% | 85.6% (F) 2005 – June 2019 |

| **Increased immunisation** % of 65+ year olds immunised – flu vaccine | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 60.0% - January to December 2016 | ≥75% | 58% March 2018 – September 2018 |
| 2018/19 | 58.5% - January to December 2017 | ≥75% | 60% (U) March 2019 – September 2019 |

| **Reduced incidence of first episode Rheumatic Fever** Acute rheumatic fever initial hospitalisation rate per 100,000 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 2.48 per 100,000<br>July 2015 – June 2016 | ≤1.5 | 1.86 per 100,000 (U)<br>July 2017 – June 2018 |
| 2018/19 | 1.5 per 100,000<br>July 2016 – June 2017 | ≤1.5<br>per 100,000 | 5 per 100,000 (U)<br>July 2018 – June 2019 |

| **Improve breast screening rates** % of women aged 50-69 years receiving breast screening in the last 2 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: Breast Screen Aotearoa | **Baseline** | **Target** | **Actual to Date** |
| **OVERALL RATE** | | | |
| 2017/18 | 73.6%<br>24 months to December 2016 | ≥70% | 71.8% (F) - 24 months to 31 March 2018 |

| | | | |
|---|---|---|---|
| 2018/19 | 73.6%<br>24 months to December 2017 | ≥70% | 73.0% (F) - 24 months to 31 March 2019 |
| **MĀORI** | | | |
| 2017/18 | 64.7%<br>24 months to December 2016 | ≥70% | 64.6% (U) - 24 months to 31 March 2018 |
| 2018/19 | 68.0%<br>24 months to December 2017 | ≥70% | 70.3% (F) - 24 months to 31 March 2019 |
| **PACIFIC** | | | |
| 2017/18 | 65.4%<br>24 months to December 2016 | ≥70% | 72.8% (F) - 24 months to 31 March 2018 |
| 2018/19 | 67.5%<br>24 months to December 2017 | ≥70% | 69.1% (U) - 24 months to 31 March 2019 |

| **Improve cervical screening coverage** % of women aged 25–69 years who have had a cervical screening event in the past 36 months | | | |
|---|---|---|---|
| **Financial Year**<br>Source: National Screening Unit | **Baseline** | **Target** | **Actual to Date** |
| **OVERALL RATE** | | | |
| 2017/18 | 76.7%<br>36 months to 31 December 2016 | ≥80% | 77.1% (U) - 36 months to May 2018 |
| 2018/19 | 77.4%<br>36 months to 31 December 2017 | ≥80% | 73.7% (U) - 36 months to March 2019 |
| **MĀORI** | | | |
| 2017/18 | 72.8%<br>36 months to 31 December 2016 | ≥80% | 74.6% (U) - 36 months to May 2018 |
| 2018/19 | 74.9%<br>36 months to 31 December 2017 | ≥80% | 74.3% (U) - 36 months to March 2019 |

| **PACIFIC** | | | |
|---|---|---|---|
| 2017/18 | 74.8%<br>36 months to 31 December 2016 | ≥80% | 78.1% (U) - 36 months to May 2018 |
| 2018/19 | 77.7%<br>36 months to 31 December 2017 | ≥80% | 75.3% (U) - 36 months to March 2019 |

| **Better rates of breastfeeding** % of infants that are exclusively or fully breastfed | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **At 3 Months Total** | | | |
| 2017/18 | 51%<br>January 2016 to June 2016 | ≥60% | 51% (U) – July 2017 to December 2017 |
| 2018/19 | 51%<br>July to December 2017 | ≥70% | 57.4% (U) – July 2018 to December 2018 |
| **At 3 Months Maori:** | | | |
| 2017/18 | 39%<br>January 2016 to June 2016 | ≥60% | 41% (U) - July 2017 to December 2017 |
| 2018/19 | 41%<br>July to December 2017 | ≥70% | 43.1% (U) - July 2018 to December 2018 |

## OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

| **Improved access primary care -** % of the population enrolled in the PHO | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 97.1%<br>October 2016 | ≥100% | 97.4% (U) - July to September 2017 |
| | | | 97.6% (U) – October to December 2017 |
| | | | 97.5% (U) – January to March 2018 |
| | | | 97.9% (U) - April to June 2018 |
| 2018/19 | 97.6%<br>October 2016 | ≥90% | 96.8% (F) - July to September 2018 |
| | | | 97.7% (F) – October to December 2018 |
| | | | 97.7% (F) – January to March 2019 |
| | | | 98.1% (F) - April to June 2019 |
| **MĀORI:** | | | |
| 2017/18 | 96.8%<br>October 2016 | ≥100% | 96.6% (U) - July to September 2017 |
| | | | 96.6% (U) – October to December 2017 |
| | | | 98.3% (U) – January to March 2018 |
| | | | 98.8% (U) - April to June 2018 |
| 2018/19 | 96.6%<br>October 2016 | ≥90% | 97.9% (F) - July to September 2018 |
| | | | 99.0% (F) – October to December 2018 |
| | | | 98.5% (F) – January to March 2019 |
| | | | 99.18% (F) - April to June 2019 |

| **Reduce the difference between Māori and other rate for ASH 0-4** - Ambulatory sensitive hospitalisation rate per 100,000 0-4 years | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 5,272<br>October 2015 to September 2016 | NA | 5,794 - 12 months to September 2017<br>6,360 -12 months to March 2018 |
| 2018/19 | 6,000<br>January 17 to December 2017 | NA | 7,865 - 12 months to September 2018<br>7,915 -12 months to March 2019 |
| **MĀORI:** | | | |
| 2015/16 | 5,755<br>October 2015 to September 2016 | Gap Māori and other ≤1,028 | 6,434 - 12 months to September 2017<br>7,259 - 12 months to March 2018 |
| 2018/19 | 6,693<br>January 17 to December 2017 | ≤6,320 | 8,658 - 12 months to September 2018<br>8,710 - 12 months to March 2019 |

| **Reduce ASH 45-64** - Ambulatory sensitive hospitalisation rate per 100,000 45-64 years | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 4,129<br>October 2015 to September 2016 | <4,129 | 4,373 - 12 months to September 2017<br>4,414 -12 months to June 2018 |
| 2018/19 | 4,370<br>January 17 to December 2017 | NA | 4,564 - 12 months to September 2018<br>4,734 -12 months to March 2019 |
| **MĀORI:** | | | |
| 2017/18 | 7,636<br>October 2015 to September 2016 | <4,129 | 8,165 - 12 months to September 2017<br>8,302 - 12 months to June 2018 |
| 2018/19 | 8,092 | <7,159 | 8,710 (U) - 12 months to September 2018 |

| | | | |
|---|---|---|---|
| | January 17 to December 2017 | | 9,833 (U) - 12 months to March 2019 |
| **Pacific** | | | |
| 2017/18 | 7,636<br>October 2015 to September 2016 | | 7,168 - 12 months to September 2017 |
| | | | 7,954 - 12 months to June 2018 |
| 2018/19 | 8,043<br>January 17 to December 2017 | NA | 8,833 - 12 months to September 2018 |
| | | | 7,783 - 12 months to March 2019 |

| **More pregnant women under the care of a Lead Maternity Carer (LMC)** % of women booked with an LMC by week 12 of their pregnancy | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 65.7%<br>July to September 2016 | ≥80% | 63.0% (U) – April to June 2017 |
| | | | 57.9% (U) – July to September 2017 |
| | | | 67.1% (U) – October to December 2017 |
| | | | 57.9% (U) – January to March 2018 |
| 2018/19 | 67.1%<br>October to December 2017 | ≥80% | 69.6% (U) – April to June 2018 |
| | | | 64.8% (U) – July to September 2018 |
| | | | 64.0% (U) – October to December 2018 |
| | | | 64.0% (U) – January to March 2019 |
| **MĀORI:** | | | |
| 2017/18 | 49.2%<br>July to September 2016 | ≥80% | 54.1% (U) – April to June 2017 |
| | | | 50.0% (U) – July to September 2017 |
| | | | 52.4% (U) – October to December 2017 |
| | | | 50.0% (U) – January to March 2018 |

| | | | |
|---|---|---|---|
| 2018/19 | 52.4%<br>October to December 2017 | ≥80% | 57.9% (U) – April to June 2018 |
| | | | 53.3% (U) – July to September 2018 |
| | | | 55.2% (U) – October to December 2018 |
| | | | 60.7% (U) – January to March 2019 |

| **Improving new-born enrolment in General Practice -** | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **% of new-borns enrolled in General Practice by 6 weeks of age** | | | |
| New | New | New | - |
| 2018/19 | No data available | ≥55% | No Data Available |
| **% of new-borns enrolled in General Practice by 3 months of age** | | | |
| New | New | New | - |
| 2018/19 | 80%<br>June to August 2018 | ≥85% | 90.5% (F) May to June 2019 |

| **Better oral health** - % of eligible pre-school enrolments in DHB-funded oral health services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 89.2%<br>2016 calendar year | ≥95% | 90.5% (U) - 2017 calendar year |
| 2018/19 | 90.5%<br>2017 calendar year | ≥95% | 95.7% (F) - 2018 calendar year |
| **MĀORI:** | | | |
| 2017/18 | 72.7%<br>2016 calendar year | ≥95% | 76.1% (U) - 2017 calendar year |
| 2018/19 | 76.1%<br>2017 calendar year | ≥95% | 78.0% (U) - 2018 calendar year |
| **PACIFIC:** | | | |
| 2017/18 | 69.1% | ≥95% | 77.1% (U) - 2017 calendar year |

| | | | |
|---|---|---|---|
| | 2016 calendar year | | |
| 2018/19 | 77.1%<br>2017 calendar year | ≥95% | 77.5% (U) - 2018 calendar year |

| **Better oral health** % of children who are carries free at 5 years of age | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 59.0% 2016 calendar year | ≥64% | 59.5% (U) – 2017 calendar year |
| 2018/19 | 59.5% 2017 calendar year | ≥59% | 62.0% (U) – 2018 calendar year |

| **Better oral health** % of enrolled preschool and primary school children not examined according to planned recall | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 2.8%<br>2015 calendar year | <10% | 8.0% (F) - 2017 calendar year |
| 2018/19 | 8.0%<br>2017 calendar year | <10% | 9.85% (F) - 2018 calendar year |

| **Better oral health** % of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 75.9%<br>2015 calendar year | ≥85% | 66.6% (U) – 2017 calendar year |
| 2018/19 | 68.8%<br>2017 calendar year | ≥95% | 62.4% (U) – 2018 calendar year |

| **Better oral health** Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 0.81<br>2016 calendar year | <0.96 | 0.72 (F) – 2017 calendar year |
| 2018/19 | 0.72<br>2017 calendar year | <0.75 | 0.76 (U) – 2018 calendar year |

| **Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke)** Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 65.4%<br>12 months to December 2016 | ≥65.4% | 34.8% (U) – July to September 2017 |
| | | | 31.4% (U) – October to December 2017 |
| | | | 34.7% (U) – January to March 2018 |
| | | | 34.9% (U) – April to June 2018 |
| 2018/19 | 43.0%<br>12 months to December 2017 | ≥55% | 36.0% (U) – July to September 2018 |
| | | | 34.9% (U) – October to December 2018 |
| | | | 34.9% (U) – January to March 2019 |
| | | | 39.0% (U) – April to June 2019 |
| **MĀORI:** | | | |
| 2017/18 | 46.2%<br>12 months to December 2016 | ≥65.4% | 33.3% (U) – July to September 2017 |
| | | | 27.8% (U) – October to December 2017 |
| | | | 30.4% (U) – January to March 2018 |
| | | | 30.6% (U) – April to June 2018 |
| 2018/19 | 35.0%<br>12 months to December 2017 | ≥55% | 32.3% (U) – July to September 2018 |
| | | | 33.5% (U) – October to December 2018 |
| | | | 33.5% (U) – January to March 2019 |
| | | | 33.0% (U) – April to June 2019 |
| **PACIFIC:** | | | |
| 2017/18 | 39.3%<br>12 months to December 2016 | ≥65.4% | 49.8% (U) – July to September 2017 |
| | | | 44.6% (U) – October to December 2017 |

| | | | |
|---|---|---|---|
| | | | 49.0% (U) – January to March 2018 |
| | | | 48.8% (U) – April to June 2018 |
| 2018/19 | 33.0%<br>12 months to December 2017 | ≥55% | 50.2% (U) – July to September 2018 |
| | | | 49.6% (U) – October to December 2018 |
| | | | 49.6% (U) – January to March 2019 |
| | | | 30.0% (U) – April to June 2019 |

| **Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke)** % of the eligible population will have had a CVD risk assessment in the last 5 years | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL:** | | | |
| 2017/18 | 87.8<br>5 years to December 2016 | ≥90% | 88.4% (U) – 5 years to September 2017 |
| | | | 86.3% (U) – 5 years to December 2017 |
| | | | 86.1% (U) – 5 years to March 2018 |
| | | | 85.2% (U) – 5 years to June 2018 |
| 2018/19 | 86.3<br>5 years to December 2017 | ≥90% | 86.1% (U) – 5 years to September 2018 |
| | | | 85.7% (U) – 5 years to December 2018 |
| | | | 84.1% (U) – 5 years to March 2019 |
| | | | 82.0% (U) – 5 years to June 2019 |
| **MĀORI** | | | |
| 2017/18 | 84.5%<br>5 years to December 2016 | ≥90% | 85.4% (U) – 5 years to September 2017 |
| | | | 85.0% (U) – 5 years to December 2017 |
| | | | 84.8% (U) – 5 years to March 2018 |
| | | | 83.8% (U) – 5 years to June 2018 |

| | | | |
|---|---|---|---|
| 2018/19 | 85.0%<br>5 years to December 2017 | ≥90% | 84.3% (U) – 5 years to September 2018 |
| | | | 84.0% (U) – 5 years to December 2018 |
| | | | 82.2% (U) – 5 years to March 2019 |
| | | | 79.2% (U) – 5 years to June 2019 |
| **PACIFIC** | | | |
| 2017/18 | 84.0%<br>5 years to December 2016 | ≥90% | 84.3% (U) – 5 years to September 2017 |
| | | | 83.6% (U) – 5 years to December 2017 |
| | | | 83.5% (U) – 5 years to March 2018 |
| | | | 82.7% (U) – 5 years to June 2018 |
| 2018/19 | 86.7%<br>5 years to December 2017 | ≥90% | 81.5% (U) – 5 years to September 2018 |
| | | | 80.2% (U) – 5 years to December 2018 |
| | | | 79.2% (U) – 5 years to March 2019 |
| | | | 76.4% (U) – 5 years to June 2019 |

| **Less waiting for diagnostic services** % of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2017/18 | 95.1% December 2016 | ≥95% | 96.1% (F) September 2017 |
| | | | 92.5% (U) December 2017 |
| | | | 96.7% (F) March 2018 |
| | | | 91.6% (U) June 2018 |
| 2018/19 | 92.5% December 2017 | ≥95% | 90.5% (U) September 2018 |
| | | | 92.2% (U) December 2018 |
| | | | 99.1% (F) March 2019 |
| | | | 91.8% (U) June 2019 |

| **Less waiting for diagnostic services** % of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2017/18 | 48.0% December 2016 | ≥90% | 91.7% (F) September 2017 |
| | | | 93.8 % (F) December 2017 |
| | | | 97.3% (F) March 2018 |
| | | | 80.0% (U) June 2018 |
| 2018/19 | 93.8% December 2017 | ≥90% | 75.0% (U) September 2018 |
| | | | 90.0 % (F) December 2018 |
| | | | 96.0% (F) March 2019 |
| | | | 92.0% (F) June 2019 |

| **Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions** - % of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 40% - June to November 2016 | ≥95% | 95.0% (F) – March to August 2017 |
| | | | 98.0% (F) – June to November 2017 |
| | | | 98.0% (F) – August to February 2018 |
| | | | 100% (F) – December to May 2018 |
| 2018/19 | 98% - 6 months to February 2018 | ≥95% | 99.0% (F) – March to August 2018 |
| | | | 96.0% (F) – June to November 2018 |
| | | | 97.0% (F) – August to February 2019 |
| | | | 96.0% (F) – December to May 2019 |

| **Improved youth access to health services -** Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000 | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 55.2<br>12 months to March 2018 | ≤ 45.8 | |
| | | | 54.3 (U) 12 months to September 2018 |
| | | | 65.6 (U) 12 months to December 2018 |

| | | | |
|---|---|---|---|
| | | | 69.7 (U) 12 months to March 2019 |

| **Improved youth access to health services -** % of ED presentations for 10-24 year olds which are alcohol related | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 10.5%<br>12 months to March 2018 | ≤ 10.5% | <br>12.4% (U) July to September 2018<br>12.8% (U) October to December 2018<br>12.2% (U) January to March 2019 |

| **Amenable Mortality** - Relative Rate between Māori and Non-Maori Non-Pasifika (NMNP) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 2.45 Relative Rate<br>2015 | ≤ 2.15 Relative Rate | 2.53 (U) 2016 Calendar Year |

## OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

| **Less waiting for ED treatment** - % of patients admitted, discharged or transferred from an ED within 6 hours | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 94.7% – October to December 2016 | ≥95% | 91.4% (U) – July to September 2017 |
| | | | 92.2% (U) – October to December 2017 |
| | | | 89.0% (U) – January to March 2018 |
| | | | 90.5% (U) – April to June 2018 |
| 2018/19 | 93.9% – October to December 2017 | ≥95% | 85.9% (U) – July to September 2018 |
| | | | 88.3% (U) – October to December 2018 |
| | | | 87.0% (U) – January to March 2019 |
| | | | 82.4% (U) – April to June 2019 |

| **Faster cancer treatment** - % of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 65.4 % October to December 2016 | ≥90% | 88.1% (U) - April to September 2017 |
| | | | 95.0% (F) – July to December 2017 |
| | | | 91.2% (F) – October 2015 to March 2018 |
| | | | 88.0% (U) – January to June 2018 |
| 2018/19 | 95.0% October to December 2017 | ≥90% | 81.3% (U) - April to September 2018 |
| | | | 87.1% (U) – July to December 2018 |
| | | | 86.1% (U) – October 2015 to March 2019 |
| | | | 73.0% (U) – January to June 2019 |

| **Faster cancer treatment** - % of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| New | New | New | |
| 2018/19 | 89% | ≥85% | 85.7% (U) - April to September 2018 |
| | | | 86.2% (U) – July to December 2018 |

| | | | |
|---|---|---|---|
| | July to December 2017 | | 86.1% (F) – October 2015 to March 2019 |
| | | | 83.5% (U) – January to June 2019 |

| **Patients with Acute Coronary Syndrome (ACS) receive seamless, coordinated care across the clinical pathway** | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| % of high-risk patients will receiving an angiogram within 3 days of admission. | | | |
| **TOTAL** | | | |
| 2017/18 | 73.1%<br>October to December 2016 | ≥70% | 82.1% (F)- July to September 2017 |
| | | | 73.5% (F)– October to December 2017 |
| | | | 55.2% (U) – January to March 2018 |
| | | | 58.9% (U) - April to June 2018 |
| 2018/19 | 73.5%<br>October to December 2017 | ≥70% | 61.0% (U)- July to September 2018 |
| | | | 73.0% (U)– October to December 2018 |
| | | | 59.0% (U) – January to March 2019 |
| | | | 49.5% (U) - April to June 2019 |
| **MĀORI** | | | |
| 2017/18 | 61.1%<br>October to December 2016 | ≥70% | 81.8% (F)- July to September 2017 |
| | | | 76.5% (F)– October to December 2017 |
| | | | 66.7% (U) – January to March 2018 |
| | | | 60.0% (U) - April to June 2018 |
| 2018/19 | 76.5%<br>October to December 2017 | ≥70% | 70.0% (F)- July to September 2018 |
| | | | 88.0% (F)– October to December 2018 |
| | | | 59.0% (U) – January to March 2019 |
| | | | 46.2% (U) - April to June 2019 |
| % of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF | | | |
| New | New | New | - |

| | | | |
|---|---|---|---|
| | | | - |
| | | | - |
| | | | - |
| 2018/19 | 51%<br>September to November 2017 | ≥85% | 82.7% (U) - June to August 2018 |
| | | | 77.1% (U) – September to November 2018 |
| | | | 76.8% (U) – December to February 2019 |
| | | | 67.0% (U) - March to May 2019 |
| **MĀORI** | | | |
| New | New | New | - |
| | | | - |
| | | | - |
| | | | - |
| 2018/19 | 43%<br>September to November 2017 | ≥85% | 64.7% (U) - June to August 2018 |
| | | | 85.7% (U) – September to November 2018 |
| | | | 73.3% (U) – December to February 2019 |
| | | | 80.0% (U) - March to May 2019 |

| | | | |
|---|---|---|---|
| Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be 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) | | | |
| New | New | New | - |
| | | | - |
| | | | - |
| | | | - |
| 2018/19 | 66%<br>September to November 2017 | ≥85% | 55.6% (U) - June to August 2018 |
| | | | 57.7% (U) – September to November 2018 |
| | | | 58.3% (U) – December to February 2019 |
| | | | 56.5% (U) - March to May 2019 |
| **MĀORI** | | | |

| | | | |
|---|---|---|---|
| New | New | New | - |
| | | | - |
| | | | - |
| | | | - |
| 2018/19 | 100%<br>September to November 2017 | ≥85% | 33.3% (U) - June to August 2018 |
| | | | 50.0% (U) – September to November 2018 |
| | | | 66.7% (U) – December to February 2019 |
| | | | 60.0% (U) - March to May 2019 |

| | | | |
|---|---|---|---|
| % of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within a) 30 days of discharge and b) within 3 months | | | |
| 30 Day Indicator | | | |
| **Total** | | | |
| 2018/19 | 51%<br>September to November 2017 | ≥95% | 98.5% (F) - June to August 2018 |
| | | | 98.7% (F) – September to November 2018 |
| | | | 97.5% (F) – December to February 2019 |
| | | | 98.0% (F) - March to May 2019 |
| **Maori** | | | |
| 2018/19 | 43%<br>September to November 2017 | ≥95% | 92.9% (U) - June to August 2018 |
| | | | 92.9% (U) – September to November 2018 |
| | | | 92.9% (U) – December to February 2019 |
| | | | 91.7% (U) - March to May 2019 |

| | | | |
|---|---|---|---|
| 3 Month Indicator | | | |
| **Total** | | | |
| 2017/18 | New | New | - |
| | | | - |
| | | | - |
| | | | - |

| | | | |
|---|---|---|---|
| 2018/19 | New | ≥99% | 98.9% (U) - June to August 2018 |
| | | | 100% (F) – September to November 2018 |
| | | | 98.7% (U) – December to February 2019 |
| | | | 100% (F) - March to May 2019 |

| **Equitable access to care for stroke patients** - % of potentially eligible stroke patients who are thrombolysed 24/7 | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 10.2%<br>October to December 2016 | ≥6% | 7.9% (F) - April to June 2017 |
| | | | 7.3% (F) - July to September 2017 |
| | | | 5.9% (U) – October to December 2017 |
| | | | 5.0% (U) – January to March 2018 |
| 2018/19 | 5.9%<br>October to December 2017 | ≥10% | 20% (F) - April to June 2018 |
| | | | 7% (U) - July to September 2018 |
| | | | 7% (U) – October to December 2018 |
| | | | 10% (F) – January to March 2019 |

| **Equitable access to care for stroke patients** - % of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 88.1%<br>October to December 2016 | ≥80% | 84.2% (F) - April to June 2017 |
| | | | 75.6% (U) - July to September 2017 |
| | | | 79.4% (F) – October to December 2017 |
| | | | 93.8 % (F) – January to March 2018 |
| 2018/19 | 79.0% | ≥80% | 82.9% (F) - April to June 2018 |

| | | | |
|---|---|---|---|
| | October to December 2017 | | 76.4% (U) - July to September 2018 |
| | | | 83.0% (F) – October to December 2018 |
| | | | 76.0 % (U) – January to March 2019 |

| **Equitable access to care for stroke patients** - % of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 58.0%<br>October to December 2016 | ≥80% | 71.4% (U) - April to June 2017 |
| | | | 57.9% (U) - July to September 2017 |
| | | | 37.5% (U) – October to December 2017 |
| | | | 95.2% (F) – January to March 2018 |
| 2018/19 | 57.0%<br>October to December 2017 | ≥80% | 100% (U) - April to June 2018 |
| | | | 81.0% (F) - July to September 2018 |
| | | | 100% (F) – October to December 2018 |
| | | | 83.3% (F) – January to March 2019 |

| **Equitable access to surgery** - Standardised intervention rates for surgery per 10,000 population for: | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| Major joint replacement | | | |
| 2017/18 | 21.5<br>12 months to September 2016 | ≥21.0 | 21.8 (F) – July 2015 to June 2017 |
| | | | 22.9 (F) – October 2015 to September 2017 |
| | | | 22.4 (F) – January 2016 to December 2017 |

| | | | |
|---|---|---|---|
| | | | 21.8 (F) - April 2016 to March 2018 |
| 2018/19 | 22.4<br>12 months to September 2017 | ≥21.0 | 19.8 (U) – July 2015 to June 2018 |
| | | | 19.6 (U) – October 2015 to September 2018 |
| | | | 19.7 (U) – January 2016 to December 2018 |
| | | | 19.0 (U) - April 2016 to March 2019 |
| Cataract procedures | | | |
| 2017/18 | 58.7<br>12 months to September 2016 | ≥27.0 | 46.4 (F) – July 2015 to June 2017 |
| | | | 49.7 (F) – October 2015 to September 2017 |
| | | | 46.6 (F) – January 2016 to December 2017 |
| | | | 47.5 (F) - April 2016 to March 2018 |
| 2018/19 | 46.6<br>12 months to September 2017 | ≥27.0 | 47.0 (F) – July 2015 to June 2018 |
| | | | 46.5 (F) – October 2015 to September 2018 |
| | | | 46.0 (F) – January 2016 to December 2018 |
| | | | 46.1 (F) - April 2016 to March 2019 |
| Cardiac surgery | | | |
| 2017/18 | 6.6<br>12 months to September 2016 | ≥6.5 | 5.2 (U) – July 2015 to June 2017 |
| | | | 4.7 (U) – October 2015 to September 2017 |
| | | | 4.8 (U) – January 2016 to December 2017 |
| | | | 5.4 (U) - April 2016 to March 2018 |
| 2018/19 | 4.8<br>12 months to September 2017 | ≥6.5 | 5.3 (U) – July 2015 to June 2018 |
| | | | 5.3 (U) – October 2015 to September 2018 |
| | | | 4.9 (U) – January 2016 to December 2018 |
| | | | 4.1 (U) - April 2016 to March 2019 |
| Percutaneous revascularisation | | | |
| 2017/18 | 12.4<br>12 months to September 2016 | ≥12.5 | 12.2 (U) – July 2015 to June 2017 |
| | | | 11.96 (U) – October 2015 to September 2017 |

| | | | |
|---|---|---|---|
| | | | 11.85 (U) – January 2016 to December 2017 |
| | | | 11.64 (U) - April 2016 to March 2018 |
| 2018/19 | 11.9<br>12 months to September 2017 | ≥12.5 | 12.7 (F) – July 2015 to June 2018 |
| | | | 13.2 (F) – October 2015 to September 2018 |
| | | | 12.9 (F) – January 2016 to December 2019 |
| | | | 13.9 (F) - April 2016 to March 2019 |
| Coronary angiography services | | | |
| 2017/18 | 39.5<br>12 months to September 2016 | ≥34.7 | 35.5 (F) – July 2015 to June 2017 |
| | | | 36.55 (F) – October 2015 to September 2017 |
| | | | 36.4 (F) – January 2016 to December 2017 |
| | | | 35.9 (F) - April 2016 to March 2018 |
| 2018/19 | 36.4<br>12 months to September 2017 | ≥34.7 | 38.1 (F) – July 2015 to June 2018 |
| | | | 39.6 (F) – October 2015 to September 2018 |
| | | | 40.0 (F) – January 2016 to December 2018 |
| | | | 41.9 (F) - April 2016 to March 2019 |

| **Shorter stays in hospital** - Length of stay Elective (days) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 1.56 days<br>12 months to September 2016 | ≤1.47 days | 1.58 (U) – July 2016 to June 2017 |
| | | | 1.55 (U) – October 2016 to September 2017 |
| | | | 1.52 (U) – January 2017 to December 2017 |
| | | | 1.55 (U) – April 2017 to March 2018 |
| 2018/19 | 1.52 days<br>12 months to September 2017 | ≤1.45 days | 1.57 (U) – July 2016 to June 2018 |
| | | | 1.59 (U) – October 2016 to September 2018 |
| | | | 1.59 (U) – January 2017 to December 2018 |
| | | | 1.58 (U) – April 2017 to March 2019 |

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

| **Shorter stays in hospital** - Length of stay Acute (days) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 2.48<br>12 months to September 2016 | ≤2.3 days | 2.46 (U) – July 2016 to June 2017 |
| | | | 2.41 (U) – October 2016 to September 2017 |
| | | | 2.39 (U) – January 2017 to December 2017 |
| | | | 2.39 (U) – April 2017 to March 2018 |
| 2018/19 | 2.39<br>12 months to September 2017 | ≤2.3 days | 2.4 (U) – July 2016 to June 2018 |
| | | | 2.37 (U) – October 2016 to September 2018 |
| | | | 2.31 (F) – January 2017 to December 2018 |
| | | | 2.29 (F) – April 2017 to March 2019 |

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

| **Fewer readmissions** - Acute readmissions to hospital | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 7.3%<br>January to December 2016 | TBC | 12.2% January 2016 to December 2016 |
| | | | 11.9% July 2016 to June 2017 |
| | | | 12.5% January 2017 to December 2017 |
| | | | 12.3% April 2017 to March 2018 |
| 2018/19 | 12.5%<br>January to December 2017 | <12.5% | 12.2 (F) 12 months to June 2018 |
| | | | 12.2 (F) 12 months to September 2018 |
| | | | 11.9% (F) 12 months to December 2018 |
| | | | 11.9% (F) 12 months to March 2019 |

***for 2017/18 the ministry reported data for information purposes only in line with the new definition.**

| **Quicker access to diagnostics** - % accepted referrals for elective coronary angiography completed within 90 days | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 97.7%<br>December 2016 | 95% | 98.0% (F) - September 2017 |
| | | | 87.8% (U) –December 2017 |
| | | | 88.5% (U) – March 2018 |
| | | | 94.4% (U) - June 2018 |
| 2018/19 | 87.8%<br>December 2017 | 95% | 97.5% (F) - September 2018 |
| | | | 100% (U) –December 2018 |
| | | | 100% (U) – March 2019 |
| | | | 98.4% (U) - June 2019 |

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

| | | | |
|---|---|---|---|
| 2018/19 | 93.5%<br>December 2017 | ≥90% | 94.0% (F) - September 2018 |
| | | | 95.0% (F) –December 2018 |
| | | | 86.0% (U) – March 2019 |
| | | | 92.3% (F) - June 2019 |

| **Quicker access to diagnostics** - % of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 93.9%<br>December 2016 | ≥70% | 80.7% (F) - September 2017 |
| | | | 58.6% (U) –December 2017 |
| | | | 81.6% (F) – March 2018 |
| | | | 55% (U) - June 2018 |
| 2018/19 | 59.0%<br>December 2017 | ≥70% | 54.0% (U) - September 2018 |
| | | | 69.0% (U) –December 2018 |
| | | | 79.0% (F) – March 2019 |
| | | | 53% (U) - June 2019 |

| **Quicker access to diagnostics** - % of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 98.1%<br>December 2016 | ≥70% | 97.4% (F) - September 2017 |
| | | | 76.9% (F) –December 2017 |
| | | | 68.0% (U) – March 2018 |
| | | | 78.0% (F) - June 2018 |
| 2018/19 | 68.0%<br>December 2017 | ≥70% | 60.0% (U) - September 2018 |
| | | | 55.0% (U) –December 2018 |
| | | | 61.0% (U) – March 2019 |
| | | | 54.0% (U) - June 2019 |

| **Fewer missed outpatient appointments** - Did not attend (DNA) rate across first specialist assessments | | | |
|---|---|---|---|
| **Financial Year**<br><br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **TOTAL** | | | |
| 2017/18 | 6.7%<br><br>October to December 2016 | ≤7.5% | 5.2% (F) - July to September 2017 |
| | | | 5.3% (F) – October to December 2017 |
| | | | 5.7% (F) – January to March 2018 |
| | | | 6.5% (F) - April to June 2018 |
| 2018/19 | 5.3%<br><br>October to December 2017 | ≤7.5% | 6.3% (F) - July to September 2018 |
| | | | 5.5% (F) – October to December 2018 |
| | | | 6.5% (F) – January to March 2019 |
| | | | 5.6% (F) - April to June 2019 |
| **MĀORI** | | | |
| 2017/18 | 14.2%<br><br>October to December 2016 | ≤7.5% | 10.4% (U) - July to September 2017 |
| | | | 9.2% (U) – October to December 2017 |
| | | | 10.2% (U) – January to March 2018 |
| | | | 12.3% (U) - April to June 2018 |
| 2018/19 | 9.2%<br><br>October to December 2017 | ≤7.5% | 12.2% (U) - July to September 2018 |
| | | | 10.9% (U) – October to December 2018 |
| | | | 12.7% (U) – January to March 2019 |
| | | | 11.5% (U) - April to June 2019 |

| **Better mental health services Improving access Better access to mental health and addiction services** - Proportion of the) population seen by mental health and addiction services | | | |
|---|---|---|---|
| **Financial Year**<br><br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **Child and Youth (0-19)** | | | |
| **TOTAL** | | | |
| 2017/18 | 4.26% October 2015 to September 2016 | ≥4.3% | 4.07% (U) – October 2016 to September 2017<br>3.86% (U) - April 2017 to March 2018 |
| 2018/19 | 4.07% October 2016 to September 2017 | ≥4.3% | 3.9% (U) – October 2016 to September 2018<br>3.8% (U) - April 2017 to March 2019 |
| **MĀORI** | | | |
| 2017/18 | 4.92% October 2015 to September 2016 | ≥4.3% | 4.34% (F) – October 2016 to September 2017<br>4.12% (U) - April 2017 to March 2018 |
| 2018/19 | 4.34% October 2016 to September 2017 | ≥4.3% | 4.3% (F) – October 2016 to September 2018<br>4.2% (U) - April 2017 to March 2019 |
| **Adult (20-64)** | | | |
| **TOTAL** | | | |
| 2017/18 | 5.11% October 2015 to September 2016 | ≥5.4% | 5.46% (F) – October 2016 to September 2017<br>5.39% (U) - April 2017 to March 2018 |
| 2018/19 | 5.39% October 2016 to September 2017 | ≥5.4% | 5.3% (U) – October 2016 to September 2018<br>5.4% (F) - April 2017 to March 2019 |
| **MĀORI** | | | |
| 2017/18 | 9.26% October 2015 to September 2016 | ≥5.4% | 9.85% (F) – October 2016 to September 2017<br>9.78% (F) - April 2017 to March 2018 |

| | | | |
|---|---|---|---|
| 2018/19 | 9.85% October 2016 to September 2017 | ≥5.4% | 9.8% (F) – October 2016 to September 2018 |
| | | | 10.3% (F) - April 2017 to March 2019 |
| **Older Adult (65+)** | | | |
| **TOTAL** | | | |
| 2017/18 | 1.12% October 2015 to September 2016 | ≥1.15% | 1.14% (U) – October 2016 to September 2017 |
| | | | 1.12% (U) - April 2017 to March 2018 |
| 2018/19 | 1.12% October 2016 to September 2017 | ≥1.15% | 1.05% (U) – October 2016 to September 2018 |
| | | | 1.0% (U) - April 2017 to March 2019 |
| **MĀORI** | | | |
| 2017/18 | 1.19% October 2015 to September 2016 | ≥1.15% | 1.25% (F) – October 2016 to September 2017 |
| | | | 1.33% (F) - April 2017 to March 2018 |
| 2018/19 | 1.25% October 2016 to September 2017 | ≥1.15% | 1.47% (F) – October 2016 to September 2018 |
| | | | 1.40% (F) - April 2017 to March 2019 |

| **Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds** | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| % of 0-19 year olds seen within 3 weeks of referral | | | |
| **MENTAL HEALTH PROVIDER ARM** | | | |
| 2017/18 | 73.2%<br>12 months to December 2016 | ≥80% | 70.5% (U) - July 2016 to June 2017 |
| | | | 71.3% (U) - October 2016 to September 2017 |
| | | | 72.5% (U) – January 2017 to December 2017 |

| | | | |
|---|---|---|---|
| | | | 72.2% (U) - April 2017 to March 2018 |
| 2018/19 | 72.5%<br>12 months to December 2017 | ≥80% | 75.7% (U) - July 2016 to June 2018 |
| | | | 74.9% (U) - October 2016 to September 2018 |
| | | | 75.0% (U) – January 2017 to December 2018 |
| | | | 77.7% (U) - April 2017 to March 2019 |
| **ADDICTIONS (PROVIDER ARM AND NGO)** | | | |
| 2017/18 | 81.1%<br>12 months to September 2016 | ≥80% | 76.8% (U) - July 2016 to June 2017 |
| | | | 73.4% (U) - October 2016 to September 2017 |
| | | | 72.1% (U) – January 2017 to December 2017 |
| | | | 73.2% (U) - April 2017 to March 2018 |
| 2018/19 | 72.1%<br>12 months to September 2017 | ≥80% | 73.2% (U) - July 2016 to June 2018 |
| | | | 66.7% (U) - October 2016 to September 2018 |
| | | | 65.7% (U) – January 2017 to December 2018 |
| | | | 74.4% (U) - April 2017 to March 2019 |
| % of 0-19 year olds seen within 8 weeks of referral | | | |
| **MENTAL HEALTH PROVIDER ARM** | | | |
| 2017/18 | 91.7%<br>12 months to September 2016 | ≥95% | 91.4% (U) - July 2016 to June 2017 |
| | | | 90.9% (U) - October 2016 to September 2017 |
| | | | 91.2% (U) – January 2017 to December 2017 |
| | | | 92.2% (U) - April 2017 to March 2018 |
| 2018/19 | 91.2% | ≥95% | 93.2% (U) - July 2016 to June 2018 |

| | | | |
|---|---|---|---|
| | 12 months to September 2017 | | 91.6% (U) - October 2016 to September 2018 |
| | | | 91.2% (U) – January 2017 to December 2018 |
| | | | 92.1% (U) - April 2017 to March 2019 |
| **ADDICTIONS (PROVIDER ARM AND NGO)** | | | |
| 2017/18 | 94.6%<br>12 months to September 2016 | ≥95% | 94.6% (U) - July 2016 to June 2017 |
| | | | 92.2% (U) - October 2016 to September 2017 |
| | | | 95.6% (F) – January 2017 to December 2017 |
| | | | 92.9% (U) - April 2017 to March 2018 |
| 2018/19 | 95.6%<br>12 months to September 2016 | ≥95% | 98.2% (F) - July 2016 to June 2018 |
| | | | 88.9% (U) - October 2016 to September 2018 |
| | | | 88.6% (U) – January 2017 to December 2018 |
| | | | 89.7% (U) - April 2017 to March 2019 |

| **Improving mental health services using discharge planning -** % of clients discharged will have a quality transition or wellness plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | | ≥95% | - |
| | | | 79.1% (U) 12 months to September 2018 |
| | | | 79.8% (U) 12 months to December 2018 |
| | | | 78.5% (U) 12 months to March 2019 |

| **Increasing consumer focus More equitable use of Mental Health Act:** Section 29 community treatment orders - Rate of s29 orders per 100,000 population | | | |
|---|---|---|---|
| **Financial Year**<br>Source: DHB Shared Services | **Baseline** | **Target** | **Actual to Date** |
| **PACIFIC** | | | |

| | | | |
|---|---|---|---|
| 2017/18 | 90.1<br>October to December 2016 | ≤81.5 | No Data |
| | | | 159 – October 2016 to September 2017 |
| | | | 159 – January 2017 to December 2017 |
| | | | 159 – April 2017 to March 2018 |
| 2018/19 | 158.7<br>October to December 2016 | NA | 141 – July 2017 to June 2018 |
| | | | 126 – October 2017 to September 2018 |
| | | | 109 – January 2018 to December 2018 |
| | | | 141 – April 2018 to March 2019 |
| **MĀORI** | | | |
| 2017/18 | 179.9<br>October to December 2016 | ≤81.5 | 382 (U) – July 2016 to June 2017 |
| | | | 384 (U) – October 2016 to September 2017 |
| | | | 398 (U) – January 2017 to December 2017 |
| | | | 398 (U) – April 2017 to March 2018 |
| 2018/19 | 398.2<br>October to December 2016 | ≤375 | 385 (U) – July 2017 to June 2018 |
| | | | 392 (U) – October 2017 to September 2018 |
| | | | 395 (U) – January 2018 to December 2018 |
| | | | 407 (U) – April 2018 to March 2019 |

| **Better patient experience -** Response rate for Patient Experience Surveys - inpatient and general practice | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 15% Inpatient<br>23% General Practice | 25% Inpatient<br>25% General Practice | No Data |
| | | | |
| | | | |
| | | | |

| **Better aligned services -** Total acute hospital bed days per capita (per 1,000 population) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 336<br>12 months to June 2017 | ≤ 530 | 407 (F) 12 months to June 2018 |
| | | | 408 (F) 12 months to June 2018 |
| | | | 410 (F) 12 months to June 2018 |
| | | | 420 (F) 12 months to June 2018 |

| **More elective surgery** - Number of elective surgery discharges | | | |
|---|---|---|---|
| **Financial Year**<br>Please note data is subject to change over time | **Baseline** | **Target** | **Actual to Date** |
| **NUMBER OF ELECTIVE DISCHARGES (VOLUMES)**(Source: Ministry of Health) | | | |
| 2017/18 | 7,469<br>2015/2016 | ≥7,574 | 7,159 (U) - July 2017 to June 2018 |
| 2018/19 | 7,467<br>2016/2017 | ≥7,753 | 6,907 (U) - July 2018 to June 2019 |

## OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

| **Better access to acute care for older people** - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 75-79 Years | | | |
| 2017/18 | 136.5<br>January 2016 to December 2016 | ≤139.5 | 120.1 (F) - October 2015 to September 2017 |
| | | | 124.0 (F) – January 2015 to December 2017 |
| | | | 135.1 (F) – April 2016 to March 2018 |
| | | | 139.4 (F) - July 2016 to June 2018 |
| 2018/19 | 137.8<br>January 2017 to December 2017 | ≤130 | 130.4 (U) - October 2017 to September 2018 |
| | | | 127.5 (F) – January 2018 to December 2018 |
| | | | 127.1 (F) – April 2018 to March 2019 |
| | | | 122.8 (F) - July 2018 to June 2019 |
| 80-84 Years | | | |
| 2017/18 | 167.8<br>October to December 2016 | ≤170 | 168.9 (F) - October 2016 to September 2017 |
| | | | 170.8 (U) – January 2017 to December 2017 |
| | | | 178.3 (U) – April 2017 to March 2018 |
| | | | 178.8 (U) - July 2017 to June 2018 |
| 2018/19 | 170.8<br>January 2017 to December 2017 | ≤170 | 169.8 (F) - October 2017 to September 2018 |
| | | | 169.1 (F) – January 2018 to December 2018 |
| | | | 156.3 (F) – April 2018 to March 2019 |
| | | | 156.0 (F) - July 2018 to June 2019 |
| 85+ Years | | | |
| 2017/18 | | | 223.6 (U) - October 2016 to September 2017 |

| | | | |
|---|---|---|---|
| | 216.6<br>October to December 2016 | ≤225 | 235.9 (U) – January 2017 to December 2017 |
| | | | 228.7 (U) – April 2017 to March 2018 |
| | | | 237.1 (U) - July 2017 to June 2018 |
| 2018/19 | 239<br>January 2017 to December 2017 | ≤225 | 225.2 (U) - October 2017 to September 2018 |
| | | | 227.5 (U) – January 2018 to December 2018 |
| | | | 226.1 (U) – April 2018 to March 2019 |
| | | | 221.0 (F) - July 2018 to June 2019 |

| **Better community support for older people** Acute readmissions to hospital 75 Years + | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 10.2%<br>12 months to December 2016 | <10% | 11.8% - January 2016 to December 2016 |
| | | | 12.2% - October 2016 to September 2017 |
| | | | 13.0% - January 2017 to December 2017 |
| | | | 12.7% - April 2017 to March 2018 |
| 2018/19 | 13.0%<br>12 months to December 2017 | <11% | 12.6% (U) - July 2017 to June 2018 |
| | | | 12.6% (U) - October 2017 to September 2018 |
| | | | 12.3% (U) - January 2018 to December 2018 |
| | | | 12.4% (U) - April 2018 to March 2019 |

| **Better community support for older people** - Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 26%<br>October to December 2017 | ≤26% | No Data |
| | | | |
| | | | |
| | | | |

| **Better community support for older people** - % of people having homecare assessments who have indicated loneliness | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 26%<br>October to December 2017 | ≤26% | No Data |
| | | | |
| | | | |
| | | | |

| **Increased capacity and efficiency in needs assessment and service coordination services** - Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | | TBC | No Data |
| | | | |
| | | | |
| | | | |

| **Increased capacity and efficiency in needs assessment and service coordination services** - Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2018/19 | 7%<br>October to December 2017 | 11% | No Data |
| | | | |
| | | | |
| | | | |

| **Prompt response to palliative care referrals** - Time from referral receipt to initial Cranford Hospice contact within 48 hours | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 100%<br>October to December 2016 | ≥80% | 98.0% (F) – July to September 2017 |
| | | | 97.5% (F) - October to December 2017 |
| | | | 94.0% (F) – January to March 2018 |
| | | | 99.0% (F) – April to June 2018 |
| 2018/19 | 97.5% | ≥90% | 100% (F) – July to September 2018 |
| | | | 97% (F) - October to December 2018 |

| | | | |
|---|---|---|---|
| | October to December 2017 | | 96% (F) – January to March 2019 |
| | | | 95% (F) – April to June 2019 |

| **More older patients receive falls risk assessment and care plan** - % of older patients given a falls risk assessment | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 96.7%<br>October to December 2016 | ≥90% | 100% (F) – July to September 2017 |
| | | | 98.3% (F) - October to December 2017 |
| | | | 95.8% (F) – January to March 2018 |
| | | | 92.1% (F) – April to June 2018 |
| 2018/19 | 98.3%<br>October to December 2017 | ≥90% | 89.9% (F) – July to September 2018 |
| | | | 95% (F) - October to December 2018 |
| | | | 93.4% (F) – January to March 2019 |
| | | | 90.7% (F) – April to June 2019 |

| **More older patients receive falls risk assessment and care plan** - % of older patients assessed as at risk of falling receive an individualised care plan | | | |
|---|---|---|---|
| **Financial Year** | **Baseline** | **Target** | **Actual to Date** |
| 2017/18 | 98.0%<br>October to December 2015 | ≥98% | 99.3% (F) – July to September 2017 |
| | | | 95.5% (F) - October to December 2017 |
| | | | 90.6% (U) – January to March 2018 |
| | | | 88.2% (U) – April to June 2018 |
| 2018/19 | 95.5%<br>October to December 2017 | ≥90% | 90.6% (F) – July to September 2018 |
| | | | 91.7% (F) - October to December 2018 |
| | | | 91.3% (F) – January to March 2019 |
| | | | 94.3% (F) – April to June 2019 |


HAWKE'S BAY
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Whakawāteatia