HAWKE'S BAY
District Health Board
Whakawateatia

Every day within the Hawke's Bay health system we will on average spend over $1.3 million admit more than 100 people to Hawke's Bay Hospital complete around 19 elective procedures and 12 acute surgeries in one of the regional hospital's seven operating theatres write at least 4,400 prescription scripts at least six babies will be born in Hawke's Bay district nurses and home service nurses will make 163 visits to clients in the community at least 12 people will be treated for mental health issues around 153 visits will be made each day to support people with mental health issues living in the community 18 people will be resident in the mental health inpatient service, 4 receiving intensive support 7 people with mental health issues will be living in a supported environment and a further 10 will be involved in a residential drug and alcohol rehabilitation programme 260 people will receive meals on wheels 1,560 hours of home help is provided every day to people in their own homes 55 children will receive one of their childhood vaccinations 20 women will have a mammogram and a further 29 a cervical smear test one of the eight community dental clinics will see 6 children for a free oral health check around 1,334 people will see a GP and at least a further 109 an Emergency Department doctor 5,256 laboratory diagnostic tests will be performed the hospital laundry services will deliver 5,915 items of clean laundry around 10 Hawke's Bay people will be at other hospitals receiving specialist treatment at least 11 fragile babies will be in the special care baby unit while at least 9 people will be receiving treatment in the intensive care unit at Hawke's Bay Hospital more than 20 Hawke's Bay people will ring Healthline (0800 611 116) for free health advice from a registered nurse Hawke's Bay GPs will give at least 16 people a free annual diabetes risk assessment 200 people will attend Hawke's Bay Hospital for a specialist outpatient visit vision and hearing technicians will carry out 41 eye and ear screens on children in early childhood centres and schools 30 schools will receive a visit from a public health nurse more than 70 people will be referred for a diagnostic test such as an X-ray or blood test

ANNUAL REPORT 2013

CONTENTS

ACRONYMS USED IN THIS REPORT

BMI	Body Mass Index
CE	Chief Executive
DHB	District Health Board
FTE	Full time equivalent
GP	General Practitioner
GST	Goods and services tax
HBDHB	Hawke's Bay District Health Board
HR	Human Resources
IFRS	International Financial Reporting Standards
KPI	Key Performance Indicator
MoH	Ministry of Health
NGO	Non Government Organisation
NZIFRS	International financial reporting standards
PHO	Primary Health Organisation
The Board	Hawke's Bay District Health Board's governing body
The CE Act	Crown Entities Act 2004
The NZPHD Act	New Zealand Public Health and Disability Act 2000

TECHNICAL REFERENCE SOURCES

Measure	Description	Source of information
Life expectancy	Life expectancy at birth	Health Quality & Safety Commission 2012
Obesity rate	Body Mass Index ≥30, population prevalence rate	NZ Health Survey 2012
Age standardised mortality rates	Death from circulatory system diseases. Death from all causes	NZ Mortality Collection, Ministry of Health. Data is provisional and subject to change.
Working age people in receipt of sickness benefits	Number of working age people in receipt of a sickness benefit for between one and four years	Ministry of Social Development, TLA Factsheets 2012.
Water quality – giardia notifications	Notification rate of giardia per 100,000	EpiSurv v7.2.7.
Ambulatory sensitive hospitalisations	Directly standardised ambulatory sensitive hospitalisation rate per 100000 population	Hawke's Bay District Health Board.
Premature cancer mortality	Percentage of all cancer deaths that occur under 65 years of age	NZ Mortality Collection, Ministry of Health. Data is provisional and subject to change
Premature ischemic heart disease mortality	Percentage of all ischemic heart disease deaths that occur under 65 years of age	NZ Mortality Collection, Ministry of Health. Data is provisional and subject to change.
Emergency Department "high flyers"	Percentage of ED attenders who have been to the ED four or more times in the previous 12 months	Hawke's Bay District Health Board
Standardised elective intervention rates	Standardised rate of specified elective surgery compared indexed across all DHBs	National Minimum Data Set (NMDS), National Non admitted Patient Collection (NNPAC), Statistics NZ population data
Emergency Department Health Target	Proportion of ED patients discharged within 6 hours of presentation	Hawke's Bay District Health Board
Older people supported to live in their own homes	Proportion of clients over 65 years of age in aged residential care compared to those receiving home-based support	Hawke's Bay District Health Board

Message from the Chair and Chief Executive

We are pleased to present the 2013 Hawke's Bay District Health Board Annual Report. Over the past year much has been accomplished across the Hawke's Bay health system and we reflect on another good year's performance, and in the excellent progress made in developing our infrastructure and our services.

We ended the year with an underlying surplus of $3 million, before recognition of a net $0.9 million of unbudgeted expenditure relating to income recognised in prior years, that reduced the surplus to $2.1 million. This is our third consecutive year of surplus and is the result of considerable hard work and extraordinary efforts from many across the organisation to contain costs, control spend and deliver savings.

We have been able to celebrate some great achievements – improved results on quality and safety, better clinical engagement and tangible improvements in equity. More Māori children are fully immunised, more Māori and Pacific women are accessing breast and cervical screening and more Māori are smokefree.

Overall we have performed well against the six national health targets which has meant Hawke's Bay District Health Board has:

- provided 6,678 people with elective surgery. This is a very good result and 17%, or 949 people, more than planned had their elective procedure.
- ensured that people with cancer are consistently receiving timely access to radiotherapy and chemotherapy.
- In the last quarter of the year immunised 95% of our eight month old babies and two year old children on time.
- remained one of the top performers nationally in ensuring people are provided with smoking cessation advice when in contact with their general practitioner or hospital.
- delivered more Hawke's Bay people than ever before are having heart and diabetes checks.

High demand for hospital services in the latter half of the 2012/13 year saw the DHB's performance against the Shorter stays in Emergency Departments (ED) remain below the target (95% of people will be admitted, discharged or transferred from ED within six hours). We remain firmly focused on ensuring those patients with acute and unplanned care needs are receiving the appropriate care when and where it is needed. Achieving this target involves a whole of system approach to improve patient outcomes, better access to primary care services and improved hospital capacity demand planning.

The seventh theatre and a new renal unit are now complete, the older people's service changes are being implemented and proposals to develop mental health and maternity services are underway. Improvements in integrated care are taking place and the way our primary and acute care teams work together is changing. For patients this means better, sooner, more convenient health care.

The new Wairoa Integrated Health Service is due to be officially opened in November 2013 This $5 million investment has met budget and project timelines and is changing the way health services are delivered to the Wairoa community.

Throughout the year the Board has been well served by its statutory committees and advisory councils. The Hawke's Bay Clinical Council provides valuable advice to the Board on clinical and quality health care matters and the newly

established Consumer Council brings the consumer voice more prominently to the governance table. Both councils add real value informing our strategic decision-making.

Quality and safety underpins all our activity. This year, and for the first time, Hawke's Bay District Health Board will present its Quality Accounts. These will become an annual public presentation of our assessment of the quality of the services provided across the Hawke's Bay health system, identifying continuous quality improvements, consumer experiences and health outcomes.

Looking forward 2013/14 will bring its own challenges and opportunities as we drive transformational change and put our services on a more sustainable footing. We will continue the debate among staff, clinicians and the wider Hawke's Bay health system about how we can continue to improve the quality and efficiency of our health services.

We acknowledge the commitment and effort of our staff and sector partners over the past twelve months and look forward to making further gains in the health and wellbeing of our community in the 2013/14 year.

Kevin Snee
Chief Executive

Kevin Atkinson
Chair

Organisation profile

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

Public hospital and health facilities

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

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

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

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

Chatham Islands Health Centre
PO Box 21
Chatham Islands
Phone: 03 305 0035

Hawke's Bay DHB vision, values and structure

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

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

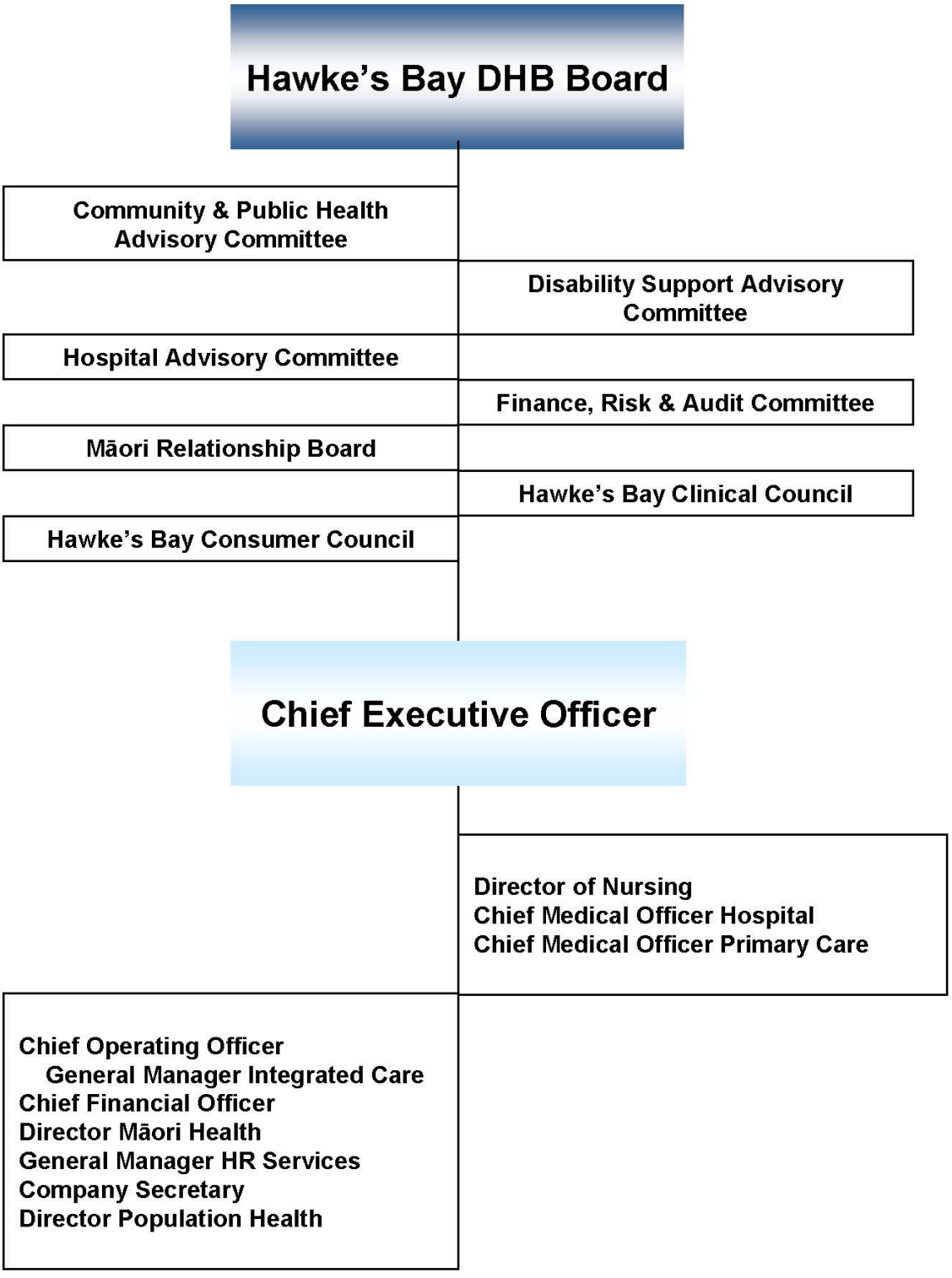
Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

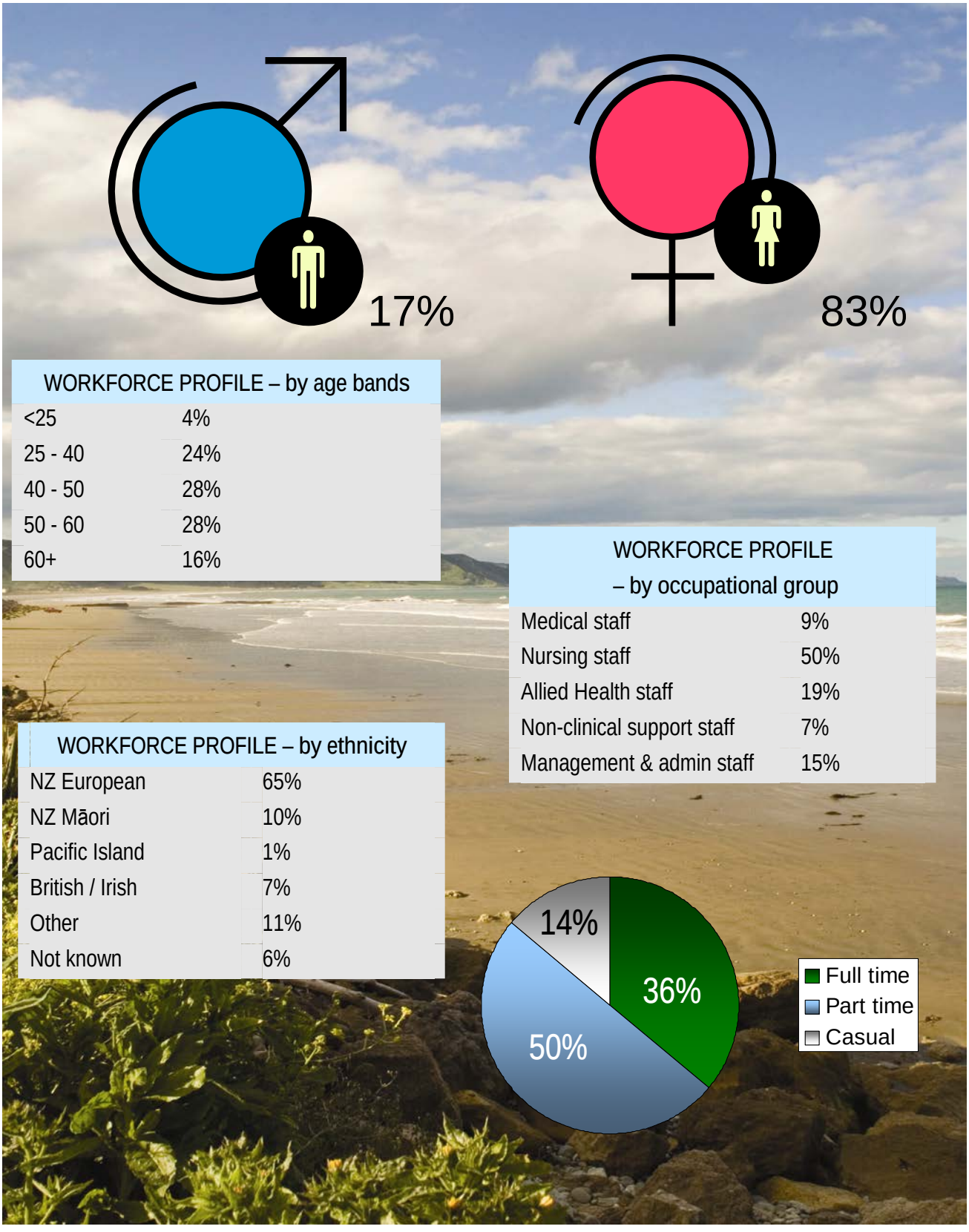
He kauanuanu – showing respect for each other, our staff, patients and consumers

Ākina – continuously improving everything we do


Hawke's Bay DHB Board
Community & Public Health Advisory Committee
Disability Support Advisory Committee
Hospital Advisory Committee
Finance, Risk & Audit Committee
Māori Relationship Board
Hawke's Bay Clinical Council
Hawke's Bay Consumer Council
Chief Executive Officer
Director of Nursing
Chief Medical Officer Hospital
Chief Medical Officer Primary Care
Chief Operating Officer
General Manager Integrated Care
Chief Financial Officer
Director Māori Health
General Manager HR Services
Company Secretary
Director Population Health

Hawke's Bay DHB – our workforce

The DHB currently employs 2522 people, a number of whom are multi-jobbed; with 2776 positions held throughout the organisation. Of these 2776 positions:



WORKFORCE PROFILE – by age bands	
<25	4%
25 - 40	24%
40 - 50	28%
50 - 60	28%
60+	16%

WORKFORCE PROFILE – by occupational group	
Medical staff	9%
Nursing staff	50%
Allied Health staff	19%
Non-clinical support staff	7%
Management & admin staff	15%

WORKFORCE PROFILE – by ethnicity	
NZ European	65%
NZ Māori	10%
Pacific Island	1%
British / Irish	7%
Other	11%
Not known	6%

Report on good employer obligations

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

Current 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 March/April 2013 the DHB conducted its third consecutive staff engagement survey. The results, which showed a second consecutive year of improvement, were evaluated by the executive management team and Bipartite Union Committee. In addition to previous focus areas for improvement a new area was added:

- I have the equipment and supplies to do my job

Continuing areas of focus are:

- I have the information that shows me how my team is performing
- I feel appreciated for the contribution I make
- I have not felt bullied by at work in the last 12 months
- My manager identifies and resolves staff performance issues quickly.

Organisation-wide action plans to address these focus areas for improvement have been developed with Bipartite Unions (with the DHB's executive management team as organisational owners/sponsors).

Leadership, Accountability and Culture:

Investing in its people and developing leadership capability, remains a priority for Hawke's Bay DHB. In the 2012/13 year leadership throughout the organisation and across the sector was made visible, and celebrated, through monthly executive briefings, monthly CEO report to all staff, annual Hawke's Bay health sector awards and a manager training and development programme.

The DHB's sector-wide Clinical Council has a leadership role in monitoring quality of health services delivered throughout Hawke's Bay while the recently established Consumer Council represents the consumer voice at the governance table. A new Clinical Leadership framework proposal has been developed and once endorsed will guide enhancement of leadership capability across the Hawke's Bay health system.

The DHB continues to run the Basic's Management programme, which is targeted at new first line managers, and those wishing to become a manager. It encompasses the development of management skills, and provides practical advice in regards to managing people. In conjunction with this each individual undertakes a 360 assessment which forms the foundation for a personal development plan.

Additionally, the DHB has implemented a talent management programme, at this stage for reports of Executive Team members, which again is focused on developing those individuals and supporting career and succession planning in the DHB. This will be rolled out further across the organisation in the 2013/14 year and will be supported by the implementation of a transformational leadership programme.

To support the strategy of the organisation, the DHB is currently developing a new clinical leadership structure which will provide for stronger partnerships across clinical teams and operational managers. This will be supported by the implementation of a clinical leadership development framework.

Recruitment, Selection and Induction:

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

Programme Incubator was developed by the DHB in 2007 and targets year 12 and 13 youth from low decile schools in exploring health career options. The programme is proving successful and in addition the DHB's Turuki Māori workforce development initiative is designed to attract, support and mentor Māori looking to take up a career in health. A Māori nurse recruitment action plan has been developed to increase the number of Māori nurses working within the DHB to better meet our community ethnicity.

Employee Development, Promotion and Exit:

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

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

The health workforce is a diverse, highly qualified and often highly specialised workforce. The training and development needs reflect this diversity. HBDHB is committed to supporting all staff to access the appropriate training in accordance with their needs. Approximately 30,000 hours of training are directly delivered by the DHB each year.

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

Flexibility and Work Design:

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

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

Remuneration, Recognition and Conditions:

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

HBDHB has a number of communication medium which are delivered to all staff and key local health sector leaders which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through regular 'Making a Difference" articles, monthly chief executive In Focus newsletter, regular manager updates/ team cascade brief and monthly seminars where individual and team success and achievement is celebrated.

The DHB continues to review its remuneration practices and systems to ensure high performance is recognised.

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, intranet resources provide a centralised information resource for all staff to access. Bullying workshops continue with a further 300 people attending in the 2012/13 year.

Safe and Healthy Environment:

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

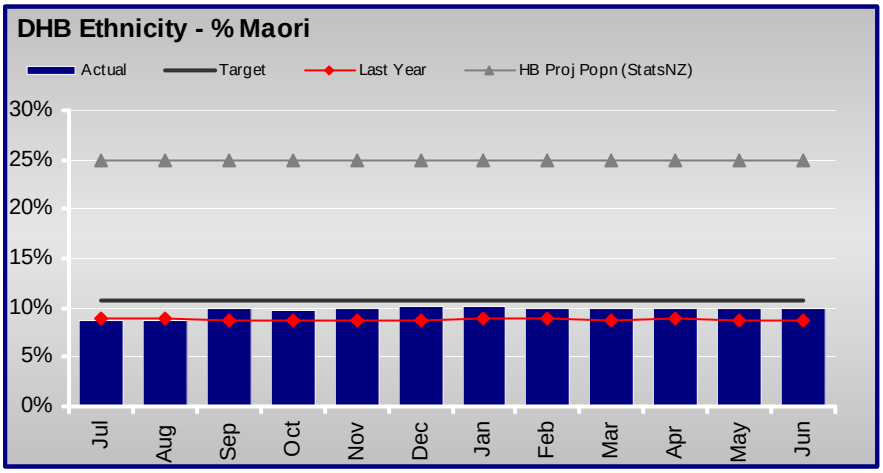
HBDHB maintains entry into the ACC partnership programme at tertiary level which recognises that appropriate systems support a safe environment and are implemented throughout the organisation. HBDHB retains its tertiary status as an outcome of the last audit.

This year the DHB has implemented a number of healthy workplace initiatives focused on fitness, diet, alcohol/drugs, smoking and stress management. These have included Weight Watchers at Work, an organisation wise exercise challenge, healthy heart, diabetes and melanoma checks and increasing influenza immunisation rates.

Staff Ethnicity:

Increasing the number of Māori employees is a priority for HBDHB. A KPI measuring the number of positions where incumbents identify as Māori is reported the DHB's Board on a quarterly basis. The target is set at 10% improvement on previous year with the ultimate aim that the percent Māori more closely reflect the overall Hawke's Bay population mix where it is estimated the Māori population for Hawke's Bay is 25.0%.

As at the end of the 2012/13 year:



Note: June 2013 = 9.94% Māori compared with June 2012 = 8.68% Māori. This comparative improvement is due to increased number of staff self identifying Māori as their ethnicity.

HBDHB has initiated long term and medium terms to improve this KPI performance including:

1. The Turuki Māori Workforce Development programme for HBDHB has many initiatives focused on reducing the barriers to recruitment and retention of Māori.
2. Maintain the Incubator programme which while not excusively targeted on Māori does have a strong Māori focus.
3. Developed a Māori Nurse Recruitment Plan to target improving the number of Māori nurses employed by the DHB. This includes working alongside hiring managers to reduce barriers and developed marketing tools to encourage Māori applicants.

What are the health trends of our population?

An overview of trends in some of Hawke's Bay District Health Board's main measures[1] as reported in the 2012-15 Statement of Intent.[2]

Outcomes

The selection of indicators used to monitor progress towards our intended outcomes is guided by national and regional strategic planning and by HBDHB's own health needs assessment at the district level.

- Between 1992 and 2010, life expectancy increased from 71.7 years to 77.8 years for Hawke's Bay men and from 78.1 years to 82.3 years for Hawke's Bay women. Although a gender gap remains, the disparity has reduced from 6.4 years in 1992 to 4.5 years in 2010. The most recent data for Maori in Hawke's Bay (2004-2006) show life expectancy rates lower than non-Maori by 6.9 years for males and by 7.2 years for females. We have a very strong focus on improving Maori health as a key strategy to advance health equity and we would expect that to be borne out in more recent data.
- Obesity rates are measured via the New Zealand Health Survey. Between the 2002/03 and 2006/07 surveys, there was a reduction in the overall adult obesity rates in New Zealand. The 2011/12 survey shows that the favourable trend has not continued. Rates provided for the Central Region show obesity prevalence has increased by 14% between surveys. In the Central Region, Hawke's Bay DHB is responsible for 18% of the population.
- Between 2001 and 2010 there was an encouraging reduction in the rate of all cause mortality (Figure 1) and circulatory disease mortality (Figure 2) in Hawke's Bay. In the latter, the Hawke's Bay rate is now slightly lower than the national rate. Ongoing disparites between the Maori and non-Maori rates continue to be a significant concern and a driver of targeted services.

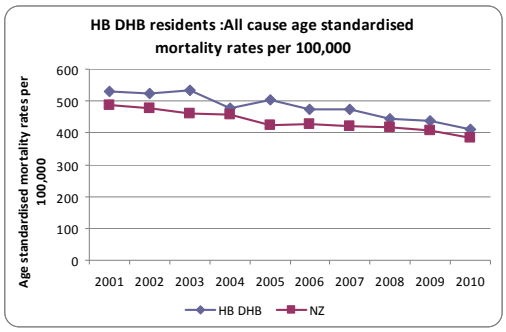


Figure 1: All cause mortality 2001 – 2010

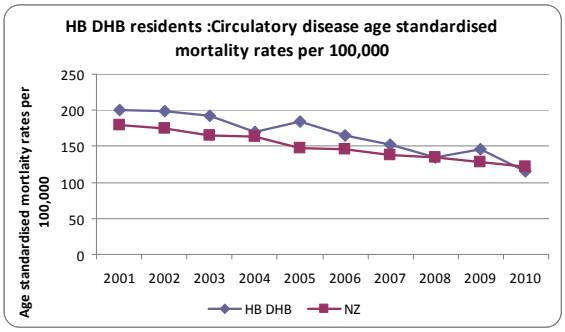


Figure 2: Circulatory disease mortality 2001 – 2010

- The number of working age people claiming sickness benefits has risen steadily since the impact of the global financial crisis in 2008. However, at the end of 2012, the proportion claiming sickness benefits for between one and four years had decreased. This means that a greater proportion are being supported to decrease sickness-benefit dependence within one year and that a smaller proportion are losing independence due to illness.
- We want to ensure that people live in environments that promote and support good health. Giardia is a water-borne disease and notifications are monitored as an indication of water quality. Although giardia notifications have declined in the last 2 years, the Hawke's Bay rate is usually higher than the national rate. The principal

[1] Main measures are population health indicators that we use to assess the outcomes and impact of our work. Most of these indicators take some time to influence as they are the result of effort from a number of sources. Measurement is often somewhat delayed as it relies on national surveys, census data and official mortality statistics, for example.

[2] Technical references are provided in the preface

risk factors for notified cases include rural exposure to animals and water supplies, swimming pools and person-to-person spread, particularly within child care centres.

Impacts

Impacts are the links between outcomes and outputs. There is often no single measure for the impact of the work undertaken and so population health trends are used to measure success.

- Hospitalisation is one way of managing illness but, as science and technology advance, there is an expectation that more and more illness will be managed without resorting to hospitalisation. Ambulatory sensitive hospitalisation (ASH) rates are indicative of how well the whole system works to keep people out of hospital. ASH is a measure of those hospitalisations that are considered to be most responsive to preventative interventions or by better management of patients in the community. A snapshot of rates since the 2007/08 financial year shows that:
    - the rate for all Hawke's Bay 0-74 year olds has decreased from 107% to 102% of the national rate in the 6 months to March 2013; the corresponding rate for Maori dropped from 96% to 92% of the national Maori rate;
    - the rate for 45-64 year olds decreased from 101% to 95% of the national rate in the 6 months to March 2013; the corresponding rate for Maori dropped from 95% to 91% of the national Maori rate
    - the rate for 0-4 year olds increased for the Total population (from 100% to 108% of the national rate) and for the Maori population (from 96% to 104% of national Maori rate)

  We will continue to focus on shifting services out of the hospital environment and into the community in line with the Government's "better, sooner, more convenient" policy. A number of initiatives aimed at integration are in progress and we are confident that these initiatives will continue to impact positively on ASH rates. Continuing to monitor ASH rates will show us when we are succeeding in achieving this important aspect of patient care in Hawke's Bay.

- Premature mortality is death before age 65. The rate is higher for Māori in Hawke's Bay than for the total Hawke's Bay population. With our focus on long-term conditions, we expect earlier detection and management of those chronic diseases to reduce the rate of premature mortality and, with targeted programmes, to reduce the inequality too. Figures 3 and 4 show trends for two of the DHB's key chronic conditions - cancer and ischemic heart disease (IHD). In 2010, the rates for both had declined for the Total population and were both lower than the national rate. However, the disparity in IHD rates had widened:

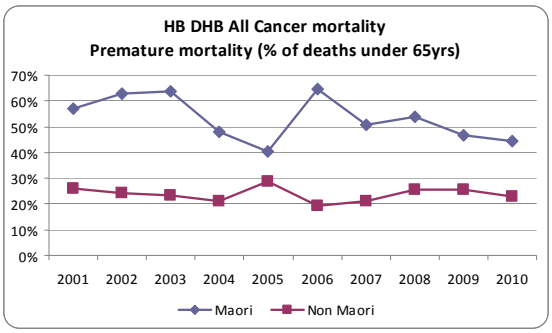


Figure 3: Premature cancer mortality

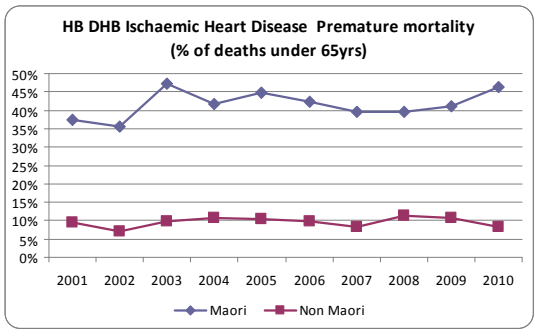


Figure 4: Premature IHD mortality

- Regular use of the emergency department by any one individual is seen as an inequity resulting from disconnection with primary care. The proportion of "high-flyers" at our emergency department has decreased

slightly from 5.1% in December June 2012 to 4.9% by December 2012. Reducing this rate indicates more equitable access to care and shows that more people are choosing a "home" for the first-level care.

- Our standardised elective intervention rates have not improved over the last year at the Total population level. However, we are achieving a higher intervention rate for Maori (214 per 100,000) and Pacific (265 per 100,000) people than for Others (212 per 100,000). Whilst we would like to achieve the higher level for the Total population, it is important that we maintain the relatively higher rate for Maori and Pacific because we believe that will contribute positively to reducing disparity.
- We have been very close to the national target for shorter stays in the emergency department during the whole of 2012/13. Although we ended the year unfavourable at 93.3% (against a target of 95%), we are focused on achieving the intent of the target by supporting a comprehensive, whole-of-system approach to acute care ranging from prior to hospital, through hospital care and on to discharge back to primary care.
- Although the number of clients being supported in aged residential care increased to 1,219 as at 30th June, the number being supported at home increased more to 3,166. This means that, proportionately, we are supporting more older people to remain in their own homes.

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 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 CEO
- Delegating responsibility to the CEO and monitoring the CEO's performance
- Monitoring the implementation and performance of plans that will have a significant effect on HBDHB
- Ensuring compliance with the NZPHD Act, the CE Act and all other relevant legislation
- Fostering community participation in health improvement, including participation by Māori.

Role of the CEO

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

Statutory Advisory Committees

The Board is required to establish three statutory advisory committees: Community and Public Health Advisory Committee; Disability Support Advisory Committee; Hospital Advisory Committee. The Board may assign defined levels of authority to them. Advisory committees operate under terms of reference and comprise of Board members and members of the community and advise the Board on issues which have been referred to them.

During the year, the Board adopted the practice of these three Committees meeting collectively, to discuss the Annual Plan and other Strategic issues.

Advisory Committees – other

Māori Relationship Board through its integrated relationships with the HBDHB Board, its statutory advisory committees, Ngati Kahungunu Iwi Inc, the Māori Relationship Board (MRB) advises the HBDHB Board and assists program development to improve the health of Māori and to assist in the monitoring of health improvement for the Māori population of Hawke's Bay and the Chatham Islands.

Finance Risk and Audit Committee This committee is responsible for monitoring and oversight of the management of the HBDHB's strategic, operational, clinical and financial risks, the control environment, financial reporting, audit processes and compliance with regulatory matters and standards.

Meeting Information & Disclosure of Interests

Number of Board Meetings held 11

KEVIN ATKINSON – Chair
Meetings attended 10
Chairman, Unison Networks Limited
Director, Unison Fibre Limited
Trustee, HB Medical Research Foundation
Director, Hawke's Bay Rugby Football Union
Principal Shareholder / MD of Information Management Services Limited

NGAHIWI TOMOANA - Deputy Chair
Meetings attended 9
Chairman – Ngati Kahungunu Iwi Inc
Member – Treaty Tribes Coalition
Brother of employee of HBDHB
Brother is employee of Cranford Hospice
Two Nephews are employees of HBDHB

BARBARA ARNOTT
Meetings attended 10
Husband David Arnott – Maxillofacial Surgeon
Trustee of the Hawke's Bay Air Ambulance Trust
Mayor of Napier City

DAVID BARRY
Meetings attended 11
Paediatrician – works as locum consultant paediatrician through locum agency, Kiwistat (until 24 April 2013)
Medical Director and member of the Council of the Hawke's Bay Medical Research Foundation
Patron and Medical Advisor – Asthma Hawke's Bay

DAVID DAVIDSON
Meetings attended 11
Medical Officer employed by Cranford Hospice (until 28 February 2013)
Family Trust holds shares in Wakefield Health Limited

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

HELEN FRANCIS

Meetings attended 9

Committee member of Alzheimers Napier

Employee of Hastings Health Centre

Trustee HB Power Consumer Trust

DIANA KIRTON

Meetings attended 10

Assistant Head – EIT School of Health and Sport Science.

Manager in charge of Hauora Programme

Brother is a surgeon for HBDHB

DAN DRUZIANIC

Meetings attended 10

Director Markhams Hawke's Bay Limited

Director of Hawke's Bay Rugby Football Union (HBRFU)

DENISE EAGLESOME

Meetings attended 11

Deputy Mayor of Wairoa District Council

KIRSTEN WISE

Meetings attended 9

Director of Black & White Accounting Limited

Membership of Advisory Committees – statutory

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)
Number of DSAC and Combined Committee Meetings held 6

Diana Kirton – Chairperson
Meetings attended 5
Refer Board interests disclosed

Helen Francis
Meetings attended 4
Refer Board interests disclosed

Denise Eaglesome
Meetings attended 5
Refer Board interests disclosed

David Davidson
Meetings attended 5
Refer Board interests disclosed

Heather Campbell (from 29 March 2012)
Meetings attended 4
Manager at WIT (Whatever it Takes) organisation funded by the HBDHB
Sister is employee of HBDHB

Laureen Sutherland
Meetings attended 4
Operations / Quality Manager ACW Ltd
Board Member of Napier Masonic District Trust
Executive Member, NZ Aged Care Association HB Branch
Committee Member, EIT School of Nursing Advisory
Aged Care representative for
Employers Chamber of Commerce Central (ECCC)
HB Branch (from 28/9/11)

Dianne Walsh (from 5 July 2012)
Meetings attended 4

Vaun McCormick (from 5 July 2012 to 1 February 2013)
Meetings attended 1

Andy White (from 5 July 2012)
Meetings attended 4

Terry Kingston
Meetings attended 5
Elected Member of CHB District Council

Tatiana Cowan-Greening
Meetings attended 6
Ngati Kahungunu Iwi Inc representative
Trustee, Te Matau a Maui Health Trust
Hastings District Council, Tangata Whenua Committee
Husband is employee of Te Kupenga Hauora
Deputy Chair – Te Haaro

Ngatai Huata (until 1 April 2013)
Meetings attended 4
Ngati Kahungunu Iwi Inc representative
Waipatu Marae Mandated Representative, Heretaunga/Tamatea
Inquiry District Treaty Claims
Member, He Toa Takitini Taumata & Executive
Member, Kahungunu Runanga Wahine
Researcher , Tautoko Research Unit

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)
Number of CPHAC and Combined Committee Meetings held 5.

Barbara Arnott - Chairperson
Meetings attended 5
Refer Board interests disclosed

Helen Francis
Meetings attended 3
Refer Board interests disclosed

Peter Dunkerley
Meetings attended 5
Refer Board interests disclosed

Ngahiwi Tomoana
Meetings attended 4
Refer Board interests disclosed

Diana Kirton
Meetings attended 3
Refer Board interests disclosed

Graeme Norton
Meetings attended 4
Director/Shareholder, 3R Group Limited
Deputy Chair, NZ Sustainable Business Council
Chair, HB Diabetes Leadership Team
Chair, Advisory Group, NZ Life Cycle Management Centre

Di Petersen
Meetings attended 4
Chair, Central Hawke's Bay Mayoral Health Taskforce
Trustee, CHB Health Nominees (CHB Health Centre Building)
Member, HB Medical Research Council
Trustee, CHB District Community Trust
Chair Lotteries HB Distribution Committee

Joan Sye
Meetings attended 3
Member of University of the Third Age (U3A) Havelock North
Member of Grey Power
Assistant Parent Educator, Parentcraft
Son is an independent Physiotherapist in Napier
Daughter in law is a physiotherapist (HBDHB)

John Newland
Meetings attended 4
Director Health Hawkes Bay Limited
Director of Direct Imports Limited
Director of Marist Holdings Limited – Mission Wines
Chair of Hawke's Bay Power Consumer Trust

Bayden Barber
Meetings attended 5
Director of Health Hawkes Bay Limited
Contracted to Nga Kairauhii Trust
Trustee of He Pataka Hawora Trust

Tatiana Cowan-Greening
Meetings attended 4
Ngati Kahungunu Iwi Inc representative
Refer to Disability Support Advisory Committee interests disclosed

Amber Logan-Riley
Meetings attended 3
Ngati Kahungunu Iwi Inc representative
Contractor – Kahungunu Hikoi Whenua

HOSPITAL ADVISORY COMMITTEE (HAC)
Number of HAC and Combined Committee Meetings held 5

David Barry – Chairperson
Meetings attended 5
Refer Board interests disclosed

David Davidson
Meetings attended 3
Refer Board interests disclosed

Kirsten Wise
Meetings attended 4
Refer Board interests disclosed

Dan Druzianic
Meetings attended 4
Refer Board interests disclosed

Kevin Atkinson
Meetings attended 4
Refer Board interests disclosed

Eileen Page
Meetings attended 5
Consultant and Coach in professional life

Des Ratima
Meetings attended 5
Ngati Kahungunu Iwi Inc representative
Chairperson, Te Whanantahi Trust
Chairperson, Takitimu Māori Wardens Trust
Chairperson, Ahuriri District Health Trust

Amber Logan-Riley
Meetings attended 3
Ngati Kahungunu Iwi Inc representative
Refer Community and Public Health Advisory Committee interests disclosed.

Membership of Advisory Committees - other

MAORI RELATIONSHIP BOARD (MRB)
Number of MRB and Annual Planning Meetings held 5.

Ngahiwi Tomoana – Chairperson
Meetings attended 5
Refer Board interests disclosed

Tatiana Cowan-Greening
Meetings attended 3
Refer Disability Support Advisory Committee interests disclosed

Denise Eaglesome
Meetings attended 1
Refer Board interests disclosed

Helen Francis (from April 2013)
Meetings attended 1

Peter Dunkerley (from April 2013)
Meetings attended 0

Amber Logan-Riley
Meetings attended 1
Refer Community and Public Health Advisory Committee interests disclosed

Des Ratima
Meetings attended 4
Refer Hospital Services Advisory Committee interests disclosed

Ngati Huata (until 1 April 2013)
Meetings attended 2
Refer Disability Support Advisory Committee interests disclosed

Frances Smiler Edwards
Meetings attended 2
General Manager of Te Roopu Hiuhuinga Hauora
Chairperson of Hauora Provider Council

Kerri Nuku
Meetings attended 2
Kaiwhakahaere New Zealand Nurses Association
Trustee Directions Youth Health
Managing Director Hei Nursing
Komiti member Maunga Haruru Tangitu Incorporated
Member of National Cervical Screening Advisory Group
Committee member E Hine Māori Youth Research Otago
Advisory member Nga Manukura o Apopo

Les Hokianga
Meetings attended 0
Employee of Hikoa Koutoa Charitable Trust
Spouse is a trustee of the Hikoi Koutou Charitable Trust

FINANCE RISK AND AUDIT COMMITTEE (FRAC)
Number of FRAC Meetings held 11

Dan Druzianic - Chairperson
Meetings attended 10
Refer Board interests disclosed

Barbara Arnott
Meetings attended 11
Refer Board interests disclosed

David Barry
Meetings attended 11
Refer Board interests disclosed

Peter Dunkerley
Meetings attended 11
Refer Board interests disclosed

Kirsten Wise
Meetings attended 9
Refer Board interests disclosed

Kevin Atkinson
Meetings attended 10
Refer Board interests disclosed


Healthy Hawke's Bay
Te Hauora O Te Matau-Ā-Māui

Statement of Responsibility

The board and management of Hawke's Bay District Health Board accept responsibility 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 accepts responsibility 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 2013, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

Kevin Atkinson
Chair

Peter Dunkerley
Board Member

24 October 2013

Independent Auditor's Report
To the readers of Hawke's Bay District Health Board financial statements and performance information for the year ended 30 June 2013

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

We have audited:

- the financial statements of the Health Board on pages 62 to 103, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, 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 that comprises the statement of service performance on pages 30 to 58 and pages 104 to123 and the report about outcomes and impacts on pages 14 to 16.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 62 to 103:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for out qualified opinion

Some significant performance measures of the Health Board, including some of the national health targets, rely on information from third-party health providers, such as primary health organisations. The Health Boards's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control.

Qualified Opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 30 to 58 and 104 to 123:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
  - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
  - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 24 October 2013. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control 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.

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of all disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

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

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our opinion, we did not obtain all the information and explanation we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

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

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

- fairly reflect its service performance achievements and outcomes.

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

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

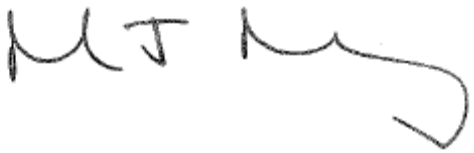
Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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



Mark Moloney

Audit New Zealand

On behalf of the Auditor-General

Palmerston North, New Zealand

Statement of Service Performance 2012/13

Service performance considers two questions in relation to Hawke's Bay DHB's programme of work – how much was done and how well it was done. In the ensuing report, how much was done is simply reflected as numbers of, for example, attendances, contacts or enrolments. How well it was done reflects our quality framework.

Quality measurement helps us to embed continuous improvement and review into practice. To achieve that, our quality framework mirrors the "STEEEP" (safety, timeliness, effectiveness, efficiency, equity and patient-focus) working definition of the Patients First[3] initiative. Under this framework, quality improvement is systematic and sector-wide and aims to apply measurements and indicators to achieve effective service performance that improves patient outcomes.

The dimensions of the framework are explained in Figure 1 below.

Dimension	*Ref*	*Examples*
Safety	S	Absence of errors, prevention of harm, conformance to standards, reliability
Timeliness	T	Time between and clearly defined points in the process of care
Effectiveness	Ef	Has the desired effect in terms of clinical outcomes, absences of complications
Efficiency	Ey	Improvements on cost, consumption of resources, consumption of patient time
Equity	Eq	Greater access to all or to targeted groups, cultural sensitivity, closing disparities
Patient-focus	P	Ease of understanding, convenience, choice, experience of care

Figure 1: STEEEP framework of quality

The reference symbol for each of these dimensions of quality will be reflected in the ensuing report on service performance to assist with understanding of this holistic view of quality.

District Health Boards report performance quarterly, semi-annually and annually depending on the availability of data. This report 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 next to the actual result to clarify whether or not the forecast performance target has been achieved.

For the purposes of our Statement of Service Performance, we have grouped the measures in each output class according to the overarching health system objective of better, sooner, more convenient health care.

[3] Patients First is a joint programme of work between The Royal New Zealand College of General Practitioners and General Practice New Zealand. One of it's objectives is integrating quality and information for primary care. www.patientsfirst.org.nz accessed February 2012. Note: there have been recent developments driven by the Health Quality and Safety Commission to define quality in terms of the NZ Triple Aim framework. Hawke's Bay District Health Board will be realigning our framework over the next 2 years. For details see the website of Health Quality Measures New Zealand: www.hqmnz.org.nz

Prevention Services

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

Statement of Service Performance Output Class 1

Prevention services are designed to protect and promote the health of our population, addressing individual behaviours by targeting population-wide physical and social environments to influence health and wellbeing.

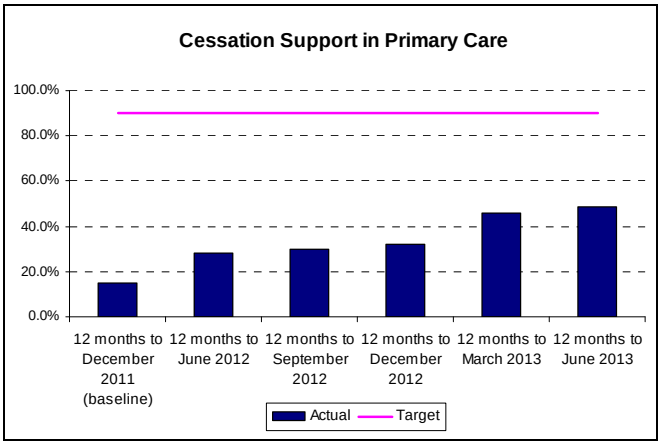
Hawke's Bay DHB's Prevention Services use integrated activities aimed at protecting the general population from harm and keeping them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We recognise inequalities in health outcomes and aim to reduce those disparities as quickly as practicable.

Hawke's Bay DHB's Prevention Services focus strongly on areas of Māori health inequality, long-term conditions and becoming more proactive in advancing health literacy so that more people are aware of health risk, health opportunities and how to support and manage their own care and the care of those for whom they have some responsibility.

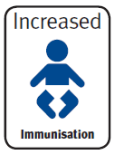
Better

The DHB's 2010 health status review highlights the health risks of smoking and shows that smoking rates in Hawke's Bay are higher than national averages and rates for Māori are higher than non-Māori.

A focus on the national health target - offering advice to quit smoking - is reported below. We also want to track the proportion of people who are being offered and provided with cessation support. The system must be collaborative and co-ordinated If primary care is to be effective at following up quit advice with action [Ef].



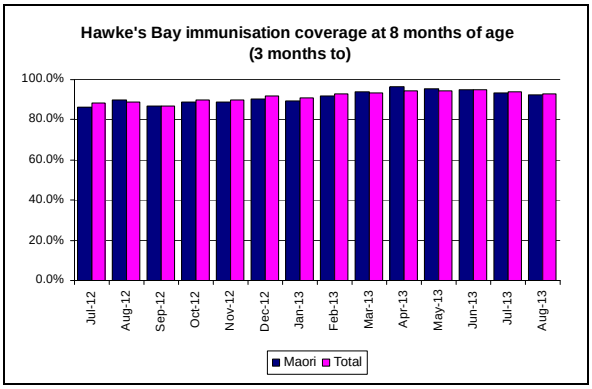
Although we are still some way off the target, there has been a primary care campaign in Hawke's Bay to identify smokers amongst the enrolled population. This has led to a jump in those being offered brief advice. Cessation support is the third step and so, continuing to increase referrals to cessation support in the face of rapidly increasing identification of smokers is commendable. We will continue to work closely with the PHO and primary care to maintain this momentum and achieve the target.



NATIONAL HEALTH TARGET

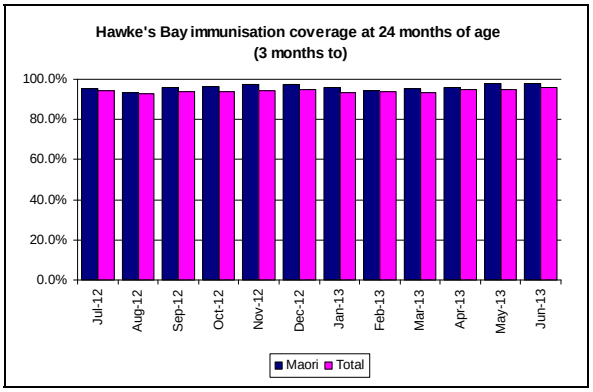
Hawke's Bay DHB supports and promotes immunisation as a key strategy in preventing the outbreak of vaccine preventable diseases.

Evidence shows that children who receive their first scheduled immunisations on time tend to be better engaged with the health sector and are more likely to have all the recommended immunisations by 2 years of age. At 94.8% for our total population [Ef] and 95.5% for our Māori population [Eq], we have eclipsed the national target of 85%.



This level of coverage demonstrates a well-coordinated and targeted service – such success relies on the combined effort of all providers, especially in reaching some of our more transitory population [P].

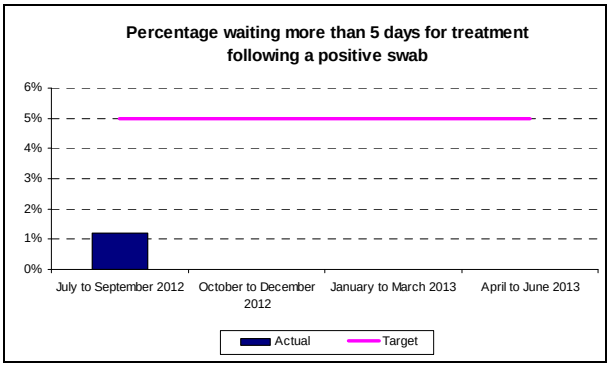
Throughout the year our immunisation services continued to target completion of all scheduled immunisations at 24 months of age too. With a target rate of 95%, we have ended the year on 96.1% for total and 97.8% for Māori. The consistently high rate of coverage is great for children in Hawke's Bay and is a result of having good systems and processes in place, identifying issues and intervening early, tracking and tracing and making personal contact [Ef].



Hawke's Bay immunisation services also focused on its older population offering influenza vaccinations to high-needs people aged 65 and over. Seasonal influenza is a contributory factor in the high number of (preventable) hospitalisations amongst older people, particularly older Māori [Eq]. We have not achieved our target this year and, in fact, we have lower coverage than our baseline (2011 year). However, we are very committed to the objective of reducing avoidable hospitalisation and so, even though we have beaten the national rate for this indicator (63.7%), we will be raising the target for the 2013/14 year.

Percentage of high needs 65 years olds and over influenza immunisation rate			
	Baseline	Target 2012/13	Actual (2012 calendar year)
Overall	*67.1%*	*≥70%*	*66.5% (U)*

A unique health issue for Hawke's Bay is the exceptionally high incidence **rates of acute rheumatic fever** (ARF) in our Flaxmere community. We have been running an active prevention campaign since October 2010 because evidence shows that early treatment of group A streptococcus is one of the most effective primary prevention strategies. With a significant increase in the volume of swabs taken, we have the tools to eliminate this disease – so long as we respond quickly to positive tests [T]. In 2012/13 everyone who had a positive swab was treated well within the targeted limit of 5 days.

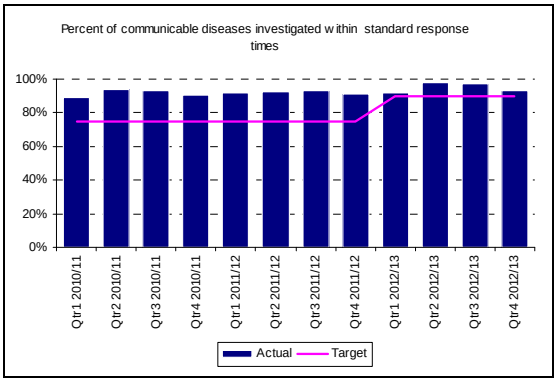


A good prevention campaign will reduce ARF hospitalisation [Ef] and provisional information[4] shows that rate has reduced in Hawke's Bay from 4.3 per 100000 to 2.6 per 100000 for the year to June 2013.

Sooner

Part of the DHB's health protection role includes responding to circumstances that may pose a threat to well-being, health or safety of Hawke's Bay people and communities. Increasing volumes of **communicable disease notifications** to 738 for the year, coupled with a timely response [T] is indicative of an efficient service [Ey]. In 2012/13, having achieved over 92% in the previous year, we raised our target for a timely response[5] from at least 75% to at least 90%. We have consistently come in above the target each quarter, ending up at 93.2% for quarter 4.

Number of communicable disease notifications			
	Baseline	Target 2012/13	Actual (2012/13)
	709	≥*709*	*738 (F)*



[4] Ministry of Health, provisional data. August 2013.
[5] HBDHB Standards: see Appendix One for details.

Successful well child and school health services enhance the health status of currently disadvantaged groups and result in more resilient children living healthy and safe lives. Services must work together across a number of settings to detect and respond to health problems as early as possible in a child's life.

B4 School Checks is a national programme that helps to ensure young people get the best possible start in life. Volumes of B4 Schools checks is determined by the number of 4 year-olds in the population – the service has delivered 1,932 against a target of 1,887 [Ey]. This illustrates good co-ordination and integration of the health sector with early childhood centres, Kohanga Reo and primary care givers. We exceeded our target of numbers in areas of Quintile 5 deprivation index by 195 people (38%). This contributes positively to reducing inequalities [Eq]. At 101%, more than the targeted number of the eligible population received the service. This indicates effective service delivery [Ef] and means that no-one is missing out. *(NB: it is possible to achieve more than 100% because the result is calculated using an estimated population as the denominator.)*

The school environment is a great place for early identification of child health issues that can be responded to with preventative strategies and early intervention [T]. Maintaining a high volume of contacts by Public Health Nurses with school-aged children indicates that School Health Services are user-friendly and patient-centred [P].

Sometimes nurses in schools have to work through quite complex cases and so this year we adjusted target volumes to better reflect productivity related to workload rather than simple case numbers. The service delivered nearly 8% over the target – demonstrating the significant effort and excellent working relationships that exist in this cross-sector service.

Number of Children receiving a B4 school check			
	Baseline	Target 2012/13	Actual (2012/13)
Overall	*2,012*	*≥1887*	*1,932 (F)*
Quintile 5	*667*	*≥514*	*709 (F)*

% of eligible population receiving a B4 school check			
	Baseline	Target 2012/13	Actual (2012/13)
	86%	*≥80%*	*101% (F)*

The number of school contacts by Public Health Nurses			
	Baseline	Target 2012/13	Actual (2012/13)
	20,059	*≥17,225*	*18,577 (F)*

HEADSSS[6] assessments are a validated method of screening teens about their health behaviours or risks. Again, this gives us an opportunity to respond early and so we assess Year 9 students in low decile schools. Maintaining a high rate of completions requires co-ordination, inter-sectoral integration and patient-centeredness [P]. Due to this service only being available in low decile secondary schools, nearly 70% of students receiving a HEADSSS are Māori or Pacific students – this is another area where we are targeting the root cause of inequalities [Eq].

% of year 9's in low decile schools who have a HEADSSS assessment completed			
	Baseline	Target 2012/13	Actual (2012/13)
	92.4%	*≥91%*	*102.5% (F)*

Extra resources were put into this service early in the 2013 school year. As a result, we were able to achieve more than 100% of the target. The service will be extended to cover more schools in 2013/14 because of these encouraging results.

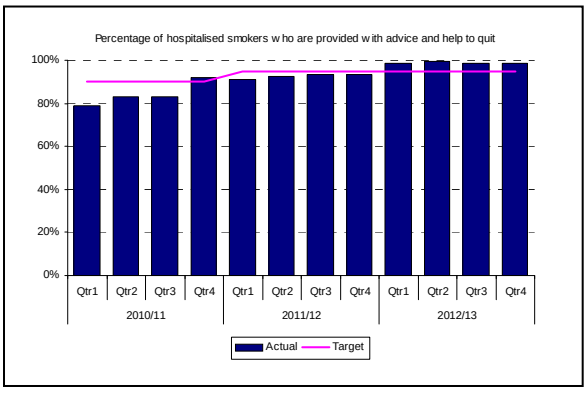
More Convenient

Better help for Smokers to Quit

NATIONAL HEALTH TARGET

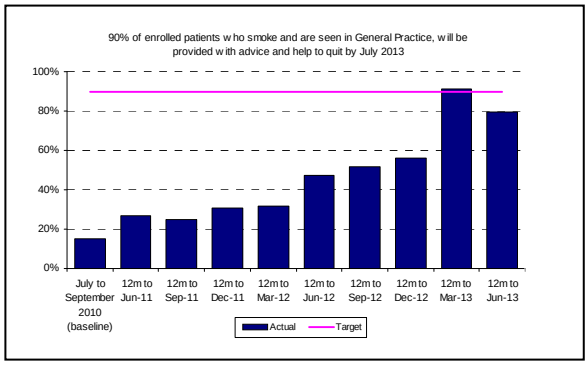
The national health target (better help for smokers to quit) aims to increase the number of times quit advice is offered in health settings. The DHB's smokefree team provide leadership and advice on smokefree systems, training and support across the hospital, primary care and maternity services so that patients can conveniently access regular advice and help to quit.

For hospitalised patients, there has been a steady improvement against this target since it was first introduced. From the first quarter of the year we have exceeded the 95% target, achieving 98.5% in quarter 4. This shows tremendous commitment by hospital-based clinicians [P].



[6] HEADSSS – Home, education, activities, drugs, sex, suicide/depression, safety

The target for **primary care patients** was set at 90% by June 2013. From a low base of 47.3% in quarter 4 last year, primary care has had a surge of effort to embed this practice change [P]. In quarter 3, HBDHB was the first DHB in New Zealand to reach the target. However, as this is a rolling 12-month indicator, the quarter 4 result is still unfavourable against the target at 79.6%. Ongoing focus should see the target reached consistently in 2013/14.



Since July 2012, within this health target, there has been an increased focus on quit advice offered to pregnant women at the time of confirmation of pregnancy. This is because of the significant risks of smoking in pregnancy and of second-hand smoke to babies living in an environment that is not smokefree [Eq]. We targeted 90%. Results for this indicator rely on information compiled by the Ministry of Health. Unfortunately, there is no single source of this information and existing sources are not currently able to be combined. Therefore, we have not been able to assess our progress.

HBDHB continues close monitoring of all aspects of this health target where possible. This includes weekly reporting of results to executive level, and daily audits and feedback of non compliance. Remedial action is taken including:

- Mandatory ABC[7] education for nursing and midwifery staff
- Workshops on Nicotine Replacement Therapy (NRT) use to support clinical practice
- ABC outcome research and summary - and feedback to staff re the positive findings of this research.

The **"Green Prescription" programme** (GRx) is an example of a health promotion initiative that connects people to convenient, publicly funded physical activity and nutrition programmes. The objective is to lower rates of obesity and, thereby, to reduce the risk of long-term conditions such as ischemic heart disease. For 2012/13, we amended the target volume to channel more effort to high-needs individuals [Eq]. There were some challenges during the year regarding appropriate referring and a number of candidates were unable to complete the programme due to ill health. We are disappointed that the targeted volumes were not achieved but we are pleased that a high proportion of Māori continue to participate.

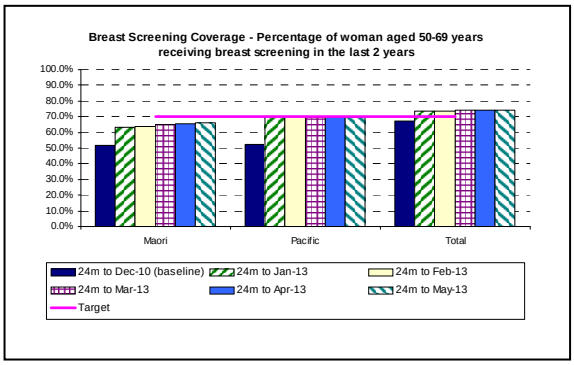
The number of people participating in GRx programmes in primary, secondary care or community settings			
	Baseline	Target 2012/13	Actual (2012/2013)
Total	*1,836*	*≥1,741*	*1,625 (U)*
Māori/Pacific	*NEW*	*≥696*	*670 (U)*

[7] A = ASK all patients if they smoke. B = Provide BRIEF advice to quit to all smokers. C= Offer CESSATION support.

Breast screening - early detection of problems results in better options for treatment and improved survivability. It is important, therefore, to ensure a high up-take of screening programmes [Ef], particularly amongst target groups [Eq]. This can only be achieved if screening opportunities are convenient, easily accessible and culturally responsive.

Screening for breast cancer is offered every two years, free of charge, to all women between the ages of 50 and 69. Overall, we have improved our rate to 74.1% - this is better than the target and shows consistent improvement. However, we are not quite there yet with our Māori women (66.1%) and Pacific women (69.4%). We are keeping up the focus on achieving this important target in 2013/14 through health promotion campaigns and increasing opportunistic identification of those women who are overdue for screening.

Percentage of women aged 50-69 years receiving breast screening in the last 2 years			
	Baseline	Target 2012/13	Actual (24 months to 31 May 2013)
Overall rate:	*69.4 %*	*≥70 %*	*74.1% (F)*
Māori	*55.6%*	*≥70 %*	*66.1% (U)*
Pacific	*64.9 %*	*≥70 %*	*69.4% (U)*



Screening for cervical cancer is offered every 3 years, free of charge, to all women between the ages of 25 and 69 years. Overall we have passed the target of 80% and, after much focused effort, we have achieved 81.9% for Pacific women too. The result for Māori women has improved from a baseline (2011) of 66.4% to 74.1% by March 2013 but is still a little way off the target. We are determined to meet the target for all women in the next year and we will use every opportunity to identify overdue women and support them to access screening services.

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years.			
	Baseline	Target 2012/13	Actual (36 Months to March 2013)
Overall rate:	*78.9 %*	*≥80 %*	*81.7% (F)*
Māori	*66.4 %*	*≥80 %*	*74.1% (U)*
Pacific	*69.5 %*	*≥80 %*	*81.9% (F)*

Prevention Services			
	2013 Actual $'m	2013 Budget $'m	2012 Actual $'m
Ministry of Health	*4.2*	*4.5*	*7.3*
Other Sources	*0.3*	*0.3*	*0.6*
Income by Source	*4.5*	*4.8*	*7.9*
Less:			
Personnel	*1.4*	*1.4*	*1.3*
Clinical supplies	*0.1*	*0.1*	*0.1*
Infrastructure and non clinical supplies	*0.4*	*0.4*	*0.4*
Payments to other providers	*4.7*	*3.4*	*5.5*
Expenditure by type	*6.6*	*5.3*	*7.3*
Net Result	*(2.1)*	*(0.5)*	*0.6*

Early Detection and Management Services

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

Statement of Service Performance Output Class 2

Early detection and management services are delivered in the community by a range of health and allied health professionals to individuals and whānau. To be successful, these services must be well coordinated, integrated to facilitate quick access to a range of care options, and capable of diagnosing and managing health issues in a variety of settings that are appropriate for people who need them.

Better

More Heart and Diabetes Checks

NATIONAL HEALTH TARGET

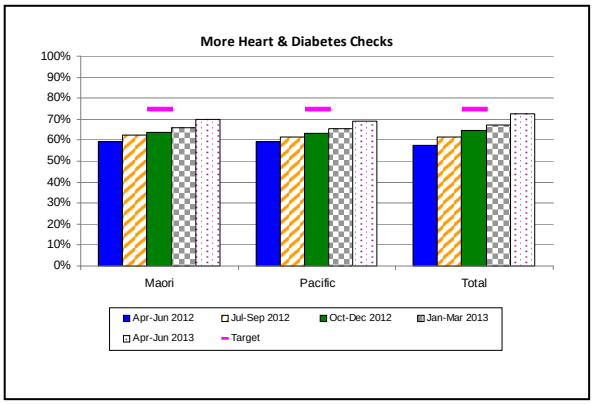
This health target is especially important for Hawke's Bay because of our focus on long-term conditions and Māori health. cardiovascular disease (CVD) and diabetes are identified areas of significant inequality. We want all people who are at risk to be screened in order to provide the earliest-possible [T] opportunities for less-invasive and more cost-effective intervention [P, Ef].

Achieving the target requires a high level of collaboration and co-ordination to arrange and deliver screening for eligible people.

Over the last year the PHO has led two major campaigns to drive people to have heart and diabetes checks. Those campaigns were part of the significant efforts and spend of the PHO, primary health care providers and the DHB. Because of the successful campaigns, the total rate increased from less than 60% at the start of the year 72.4% by year-end. It is very disappointing for everyone who has worked hard on this indicator that the end of year result did not quite meet the target.

Health Target: Better diabetes and cardiovascular services – More heart and diabetes checks		
	Target 2012/13	Actual (April to June 2013)
Total:	≥75%	*72.4% (U)*
Māori:	≥75%	*69.7% (U)*
Pacific:	≥75%	*69.1% (U)*

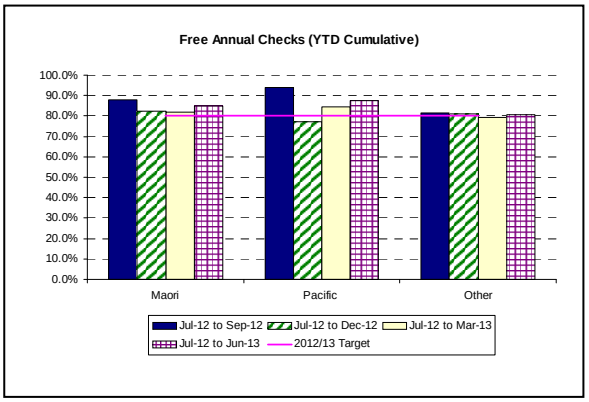
In addition, the Māori and Pacific rates increased by 17% and 16% respectively to end the year at 69.7% and 69.1% respectively. Rates of heart disease and diabetes in our community show significant disparities [Eq] and so we will continue to drive efforts to achieve the target, particularly amongst our Māori and Pacific populations. For 2013/14, the target rate for all population groups will increase to 90% coverage and we will look for innovative ways to encourage our communities to be screened so that health issues or risks can be detected as early as possible.

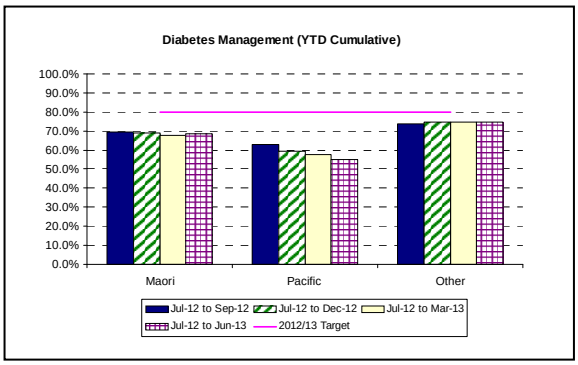


Source: DHB Shared Services

In 2012/13, we have worked closely with the PHO in a service improvement programme that clearly puts primary care in control of managing their enrolled diabetic population. Having at least an annual check is very important for diabetes detection and follow-up.

This indicator measures the proportion of the population expected to have diagnosed diabetes who have had an annual check. For the year to 2013, the results was 80.6% against a target of 80%. Because issues related to diabetes are so notably disparate, we analysed this result further and found that the rates for Maori and Pacific were higher than the total, at 85% and 87.5% respectively. This is an excellent result which represents the hard work that general practice and the PHO have undertaken this year. It demonstrates that there is equitable access to diabetes annual reviews too [Eq].





Another important component for diabetics is understanding their condition and how to manage it in order to maximise well-being. For those whose conditions are complex, we need assurance that case management continues to be effective and that ethnic variations are identified and targeted [Ef, Eq]. An increasing proportion of those checked (≥80%) must be meeting a clinical indicator (HBa1C) threshold. At 74.7%, the district has not yet met the target for this indicator and disparities are also apparent.

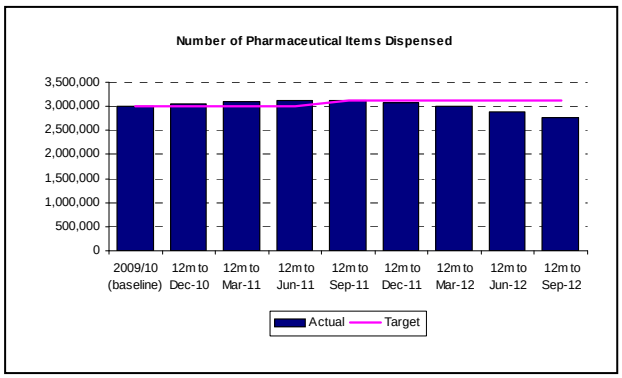
The challenge for 2013/14 will be to ensure that the equity in access to annual checks is matched by equity in outcomes of diabetes management.

Pharmacist services are a significant part of our budget and include provision and dispensing of medicines via the district network of privately owned pharmacies. Good performance in these services contributes to a reduction in the complications of disease, injury and illness.

In anticipation of a new pharmacy agreement that would contribute to greater efficiency [Ey] and a more patient-focused service [P], we targeted a reduction in the volume of dispensed items.

Even though implementation of the new Community Pharmacy contract was significantly delayed, it would appear that the close work with the sector in preparation yielded some early results. Volumes for the year declined by 11.5% to the lowest level in three years. We will continue to hold regular sector workshops aimed at professional support for all those involved in prescribing and dispensing of medicines.

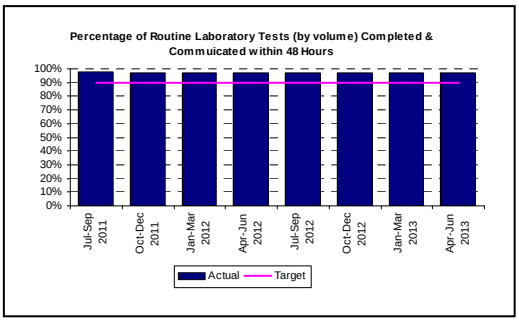
Number of dispensed items			
	Baseline	Target 2012/13	Actual (12 months to June 2013)
	3,120,888	*≤3,120,888*	*2,758,950 (F)*



Source: Pharmaceutical Claims Data Mart, Ministry of Health. Excludes: Pharmaceutical cancer treatment (PCT). Note this data is subject to change over time.

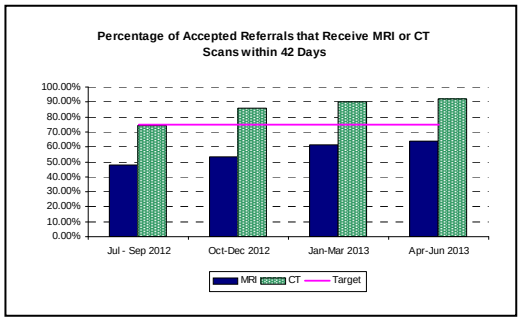
Sooner

People are referred for tests and diagnostic services to help diagnose a health condition or as part of treatment. Demand for community referred tests and diagnostic services are expected to increase as more people engage with health services and more promotional messages about early diagnosis are responded to. What is important is that the system responds to referrals as quickly as possible [T]. Our laboratories have consistently achieved around 97% in each quarter this year – that is 7% better than the acceptable threshold.



Source: Southern Community Laboratories and HBDHB Laboratory

Another important area of diagnostic support for the health sector is radiology. To support the drive for more community-based care delivery, it is crucial that patients do not wait unnecessarily for these services [T, S]. We targeted waiting times for patients referred to two key radiology services – magnetic resonance imaging (MRI) and computed tomography (CT).



For CT, all categories of referrals are receiving their scan within the standard timeframe. Overall, we achieved 92.3% in quarter 4. For MRI, urgent and ACC referrals are being achieved within timeframes but patients for routine scans are waiting up to ten weeks. This means that overall we achieved 63.5% for MRI, which is unfavourable to the 75% target and we have initiated closer monitoring of the system so that impediments to achieving the target can be eliminated.

Good oral health at an early age is a recognised indicator of good lifetime health. Good oral health relies on sound oral hygiene, engagement with the health sector and action around health promotion messages.

Our community oral health service enrols children at school and pre-school to check-up on their teeth. Those identified as needing further examination or treatments are scheduled for a recall. In the last year, only 4% of children were not examined according to their planned schedule. This is a favourable result against a target of less than 5% and it indicates a safe [S] and efficient service [Ey].

Percentage of enrolled preschool and primary school children not examined according to planned recall			
	Baseline	Target 2012/13	Actual (2012 calendar year)
	3.2%	*<5%*	*4% (F)*

A number of improvement initiatives rely on an integrated approach to ensure convenience and accessibility [P]. In 2012/13 we implemented improvements to our sexual health services that aimed at better opportunities for earlier access [T] to contraception, advice and treatment for youth [Eq]. We expected earlier access to preventative measures to reduce the demand for treatment consultations. Better prevention relies on a connected system of quality public health surveillance, laboratories, community-based clinics and responsive school-based services. By being more accessible to people in need, we more than halved our annual target to 550 volumes for the year.

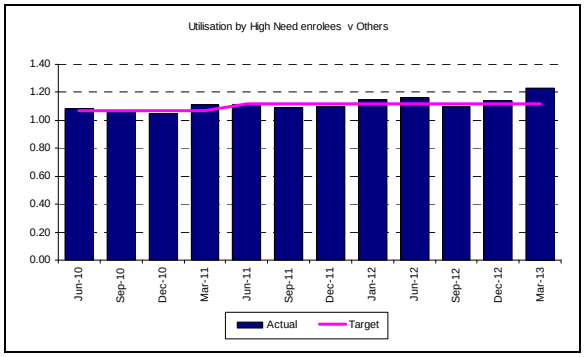
Number of sexual health client contacts – Primary care			
	Baseline	Target 2012/13	Actual (2012/13)
	1,043	*≤1,200*	*550 (F)*

More Convenient

Across New Zealand, people are required to enrol with a GP practice that is affiliated to a Primary Healthcare Organisation (PHO) in order for that practice to receive a subsidy (capitation) for their care. The PHO co-ordinates and manages the targeting of many services to those populations who are known to have the worst health status – Māori, Pacific people and those living in the most deprived neighbourhoods. Use of general practitioner (GP) services by these high-needs patients is now 1.23 times that of others [Eq] with an ongoing upward trend over the last 2 years. This indicates that access to primary care services is improving for those most in need [P].

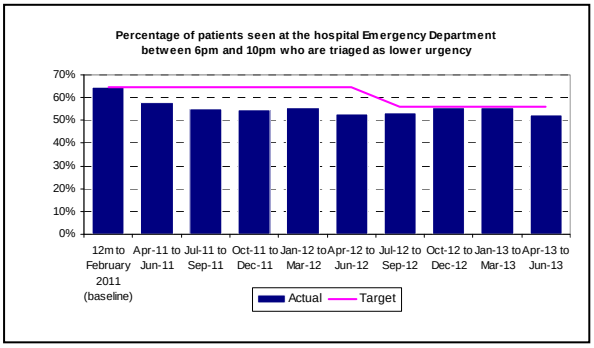
Ratio of high needs enrolees vs others			
	Baseline	Target 2012/13	Actual January to March 2013
	1.09	*≥1.12*	*1.23 (F)*

Source: DHB Shared Services



Use of the hospital emergency department (ED) is seen as a barometer of accessibility of services across the urgent care spectrum. Since 2010 there has been an ongoing effort by the DHB and primary care to ensure that people have access to all urgent care services in the most appropriate place whatever time care is needed [P]. For 2 years, we have seen a gradual reduction in the proportion of people who access the ED between 6pm and 10pm for low-urgency issues. This implies that the system is offering more suitable alternatives for meeting that need and that patients are using them. We will continue to support system improvements that offer appropriate choice to patients for convenient care.

Of patients seen at the hospital emergency department between 6pm and 10pm, percentage who are triaged as lower urgency.			
	Baseline	Target 2012/13	Actual (April to June 2013)
	54.8%	*<56%*	*52.3%*



Co-ordinated Primary Options (CPO) and Sub-acute Community Support (SCS) are initiatives that provide special funding for responding to increasing need with more convenient, community-based pathways [Ef] while still ensuring that all providers are co-ordinated. These initiatives are more patient-centred [P] and lead to reduced hospitalisation [Ey].

Co-ordinated Primary Options (Volumes)			
	Baseline	Target 2012/13	Actual 2012/13
	1,860	*≥2,700*	*3,579 (F)*

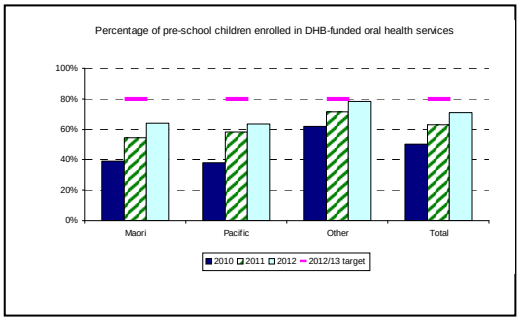
Our CPO programme delivered 3,579 volumes against a target of at least 2,700. Similarly our SCS volumes have increased over the year and 60 volumes were delivered against a target of at least 30.
Both programmes continue to be supported and the results are in line with increasing access to primary care and community services to reduce demand for higher cost hospital services. The DHB and the PHO have to work closely to manage volumes and associated funding.

Sub-acute Community Support (Volumes)			
	Baseline	Target 2012/13	Actual 2012/13
	29	*≥ 30*	*60 (F)*

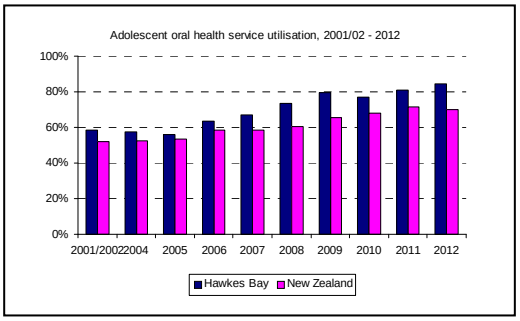
In Hawke's Bay, our information showed a worsening trend and notable disparities in oral health status amongst five year olds. We responded by putting significant investment into our community oral health services to make them more accessible to children and their families [P]. Specifically, we also started a co-ordinated drive to enrol pre-school [T] children into the service with a particular emphasis on Māori and Pacific children [Eq].
Although we still have not hit our target enrolment rate (80%), the whole system is working well and making good progress in the right areas. Since 2010, enrolment of Māori children has increased by 63% and Pacific children by 65%. The programme will continue to be supported so that we can achieve and exceed this target.

Percentage of eligible preschool enrolments in DHB-funded oral health services:			
	Baseline	Target 2012/13	Actual 2012 calendar year
Total:	*50.4%*	*≥80%*	*71.1% (U)*
Māori:	*39.2%*	*≥80%*	*63.8% (U)*
Pacific:	*38.3%*	*≥80%*	*63.3% (U)*

Service enrolment is an important activity indicator that will contribute to improvements in the oral health status indicator for 5-year olds. The results are a reflection of the work that Oral Health Services and the NGO providers have done this year in early enrolment and timely access to services. We expect the trend to continue upwards



We also monitor the use of oral health services provided for adolescents from school-year nine up to and including 17 years of age.



If young people maintain contact with oral health services after they are actively provided in the school environment, we take that as an indication of positive youth health behaviours and of the quality of co-ordination by the private dentists contracted to provide the service [P]. Although the target of 85% has not yet been achieved, we are very close and the trend continues upward with an extra 3.7% of adolescents using the services this year.

Early Detection and Management			
	2013 Actual $'m	2013 Budget $'m	2012 Actual $'m
Ministry of Health	*141.1*	*136.2*	*135.4*
Other District Health Boards	*1.9*	*1.9*	*2.2*
Other Sources	*3.3*	*1.9*	*2.8*
Income by Source	*146.3*	*140.0*	*140.4*
Less:			
Personnel	*22.5*	*22.8*	*22.1*
Outsourced Services	*3.9*	*3.2*	*3.7*
Clinical supplies	*2.4*	*2.7*	*2.1*
Infrastructure and non clinical supplies	*7.4*	*7.3*	*6.8*
Payments to other District Health Boards	*2.5*	*2.3*	*2.4*
Payments to other providers	*104.9*	*100.4*	*104.3*
Expenditure by type	*143.6*	*138.7*	*141.4*
Net Result	*2.7*	*1.3*	*(1.0)*

Intensive Assessment and Treatment Services

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

Statement of Service Performance Output Class 3

Intensive Assessment and Treatment Services include specialist acute and elective services that are usually integrated in hospital settings with co-location of specialist expertise and equipment. Hawke's Bay DHB's provider arm, Health Services, provides or co-ordinates most of these services for the district. Across all of Health Services' work, much of which is done outside the hospital environment, we have maintained a keen focus on links with community based services before people come in to hospital services and after they are discharged – these links must be well-coordinated and work as seamlessly as possible.

Intensive Assessment and Treatment services are continuously assessed against standards of care, benchmarking amongst similar providers and opportunities for improvement. The objective is that the services are:

- Timely, efficient and productive;
- Effective, safe and of high quality; and
- Responsive to need and to other providers of care.

Better

Improved access to Elective Surgery

NATIONAL HEALTH TARGET

Elective services are hospital services for patients that are planned and do not require immediate (acute) hospital treatment. Elective services involve many teams across the organisation including access into outpatients, the surgical booking system, surgical procedures, treatment and delivery of care. Increasing volumes of elective surgery requires good collaboration between all these parts of the system.

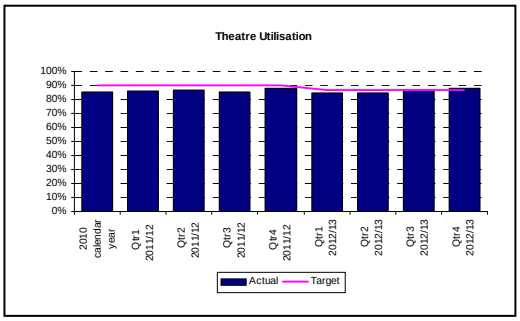
The Government is keen to see **elective surgery volumes** increasing every year and so, along with all DHBs, we agree an annual target with the National Health Board. HBDHB exceeded our targeted volume by 15% [Ey] meaning that there were 949 extra elective surgical discharges in the last year.

Health target: Improved access to elective surgery (discharges)			
	Baseline	Target 2012/13	Actual 2012/13
Number of Elective discharges (volumes)	*5,860*	*≥5,729*	*6,678 (F)*

Source: Ministry of Health

In August 2012, we commissioned a new operating theatre that has been dedicated to acute work so as to reduce the number of scheduled elective surgeries that are cancelled due to a higher priority case [P].
Having more reliable theatre time for elective surgery should improve **theatre utilisation** [Ey] because more unplanned surgery is inherently less efficient.
Since the commissioning of our new theatre, and following some usual "teething" problems, the rate has continued to improve, ending the year at just under 88% for the final quarter.

Theatre utilisation			
	Baseline	Target 2012/13	Actual 2012/13
	86.4%	*≥87%*	*87.9% (F)*



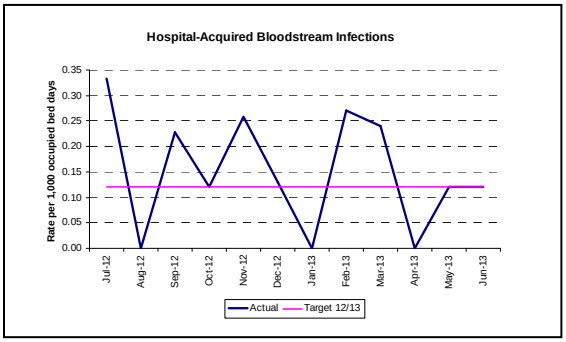
Our targeted rate for **cancellations of elective cases** due to prioritised acute demand was no more than 6% of cases. This is a new indicator for 2012/13 and our data suggests the rate for the last quarter is 19.8%. Considering our achievement of the elective surgery target volumes and almost achieving the theatre utilisation target, we are not confident that this result is accurate. We are auditing the relevant data system and continuing to monitor this target.

Percentage of cancelled elective cases as a result of priorities acute demand			
	Baseline	Target 2012/13	Actual April to June 2013
	new	*≤6%*	*19.8% (U)*

Reducing health-service related harm is a key objective of the Health Quality and Safety Commission. Two important indicators of hospital safety [S] are the **rate of bloodstream infections** and **rate of surgical site infections**. Our hospital has been favourable against target rates for both of these indicators for the duration of the 2012/13 year.

These results show an ongoing commitment to an excellent standard of healthcare in our hospital environment.

Rate of hospital-acquired bloodstream infections per 1000 occupied bed days			
	Baseline	Target 2012/13	Actual April to June 2013
	0.12	*≤0.29*	*0.08 (F)*



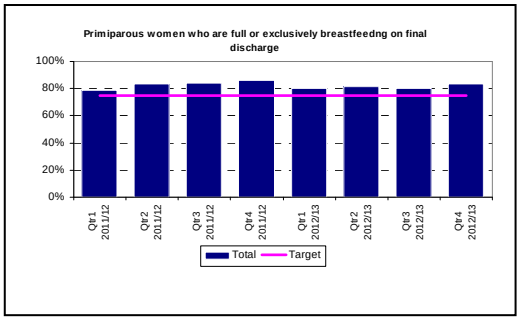
Rate of clean surgical site infections per 100 procedures

	Baseline	Target 2012/13	Actual April to June 2013
	1.2	*≤3.5*	*0.60 (F)*

Maintaining a high **rate of first time mothers breastfeeding** on discharge from maternity services (at 6 weeks) supports other efforts in respect of increasing breastfeeding rates [P], and is an indicator of successfully educating new mothers about the health benefits of this practice [Ef].

Percentage of first time mothers delivering who are breastfeeding (Full or exclusive) at the time of discharge			
	Baseline	Target 2012/13	Actual April to June 2013
	83.3%	*≥75%*	*83.6% (F)*

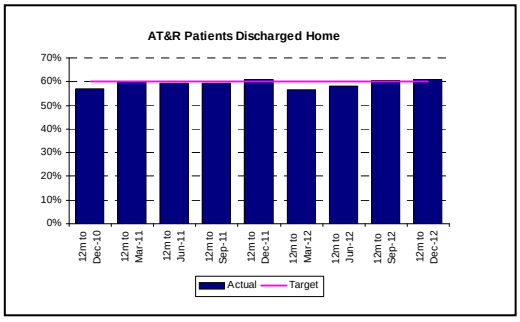
HBDHB consistently achieves above the 2012/13 target of 75% of women who are **full or exclusively breastfeeding at six weeks**. In the fourth quarter of 2012/13 we achieved a rate of 83.6%, which is a good result for the services, the mothers and importantly, for the babies.



Our hospital is part of the 'Baby Friendly Hospitals' initiative so this is a pleasing end of year result.

With an ageing population we expect to see an increase in **Assessment, Treatment and Rehabilitation (AT&R) patients and bed-day volumes**. If our services are successful [Ef], an increasing rate of patients will be discharged home with support [P], if appropriate, rather than into a residential care or hospital environment.
In 2012/13, we have continued to achieve a favourable result of 61% against a minimum target of 60%. Ongoing work with families and patients [P] to ensure safe discharging [S] is paramount. In addition, better links to community-based support systems have been formalised with more collaboration and co-ordination for patients

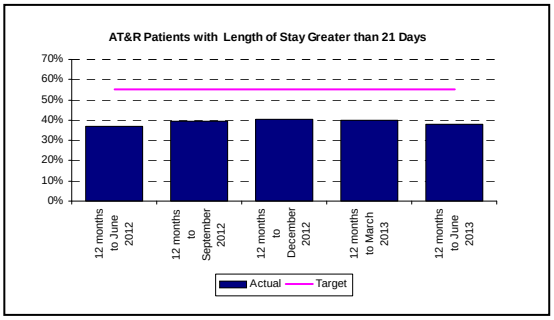
Percentage of AT&R patients discharged home			
	Baseline	Target 2012/13	Actual 2012/13
	59.3%	*≥60%*	*61.0% (F)*



Managing **volumes in AT & R services** appropriately requires close work with community providers and with other agencies, such as ACC. Our aim is to rehabilitate patients using this service as quickly [T] and effectively [Es] as possible, in order for them to return to their usual place of residence.

Percentage of AT&R patients with length of stay greater than 21 days			
	Baseline	Target 2012/13	Actual 2012/13
	57.2%	*≤55%*	*38.2% (F)*

Despite a disappointing result in the previous year, HBDHB again targeted a **decreasing rate of AT&R patients with a length of stay greater than 21 days**. Achieving this measure indicates better care integration [Ef, Ey] with primary/NGO/community services.
We have beaten our target in each quarter of 2012/13 despite delays to discharge caused by some very

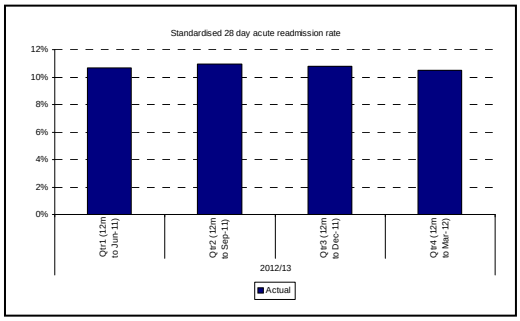


complex patients. The DHB has made use of extra social-worker input to move patients through the system for the best result.

As a measure of safety in AT & R services [S], we have been tracking the rate of inpatient falls. Falls in hospital are a major factor leading to extended length of stay for older people in particular. Against a target of less than 1.1 falls per 100 bed days, AT & R services have managed a favourable result in each quarter and ended up with 0.7 for quarter 4. There has been a step-decrease in the rate of falls due to investment in falls reduction and alert systems.

AT&R Inpatient falls per 100 bed days			
	Baseline	Target 2012/13	Actual April to June 2013
	1.2	*≤1.1*	*0.7 (F)*

In our quest to increase hospital throughput it is important that we measure "error rates". Acute unplanned readmissions occur when treatment has not been effective and a readmission is required urgently. A low rate is an indication of hospital reliability [S, Ef]. While we have not made much progress on this indicator this year, we have been slightly below the target (favourable) in each quarter.



Sooner

Hawke's Bay DHB provides and funds a range of services for people affected by mental illness or addictions. Waiting times across non-urgent drug and alcohol services are monitored so that we can identify and respond to any access issues. Less waiting for treatment [T] is an important aspect of the commitment we have, along with WINZ and the Department of Corrections, to reducing dependency [Ef].

This is a new measure, and we differentiate the targets in 2 ways: firstly, between the mental health services that are delivered by our provider arm and the addiction services that are delivered by our provider and some NGO providers; and secondly, we consider results after 3 weeks of referral and again after 8 weeks of referral.

For our mental health services provided by our provider arm, the waiting time expectations were exceeded at 3 weeks (66%) but not quite reached at 8 weeks (83.7%).

Shorter waits for non-urgent drug and alcohol services			
	Baseline	Target 2012/13	Actual 12 months to March 2013
Mental Health Provider Arm			
Seen within 3 weeks of referral	*new*	*≥60%*	*66% (F)*
Seen within 8 weeks of referral	*new*	*≥90%*	*83.7% (U)*
Addictions (Provider Arm & NGO)			
Seen within 3 weeks of referral	*new*	*≥60%*	*57.7% (U)*
Seen within 8 weeks of referral	*new*	*≥90%*	*83% (U)*

Using a national framework, the services have been making some good progress on getting earlier access for people and this focus will continue.

For addictions services with a range of providers, the waiting times are still a little way off the standard. 57.7% of people are accessing services within 3 weeks and 83% are being seen within 8 weeks. This still needs some improvement and the services are working together to eliminate barriers to achieving the standard.

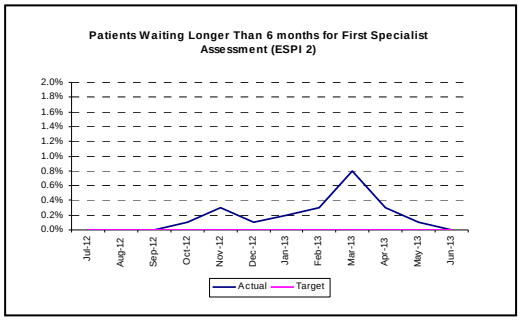
NATIONAL HEALTH TARGET

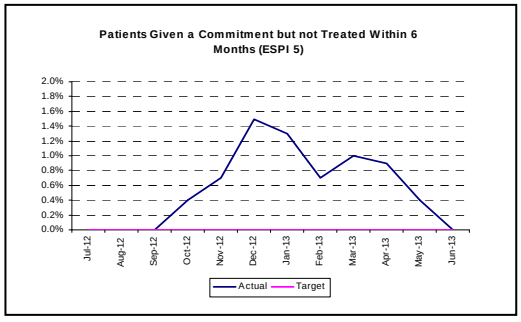
We have been very close to the national target for shorter stays in the emergency department during the whole of 2012/13. Although we ended the year unfavourable at 93.3% (against a target of 95%), we are focused on achieving the intent of the target by supporting a comprehensive, whole-of-system approach to acute care ranging from prior to hospital, through hospital care and on to discharge back to primary care.

Elective Services Patient Flow Indicators (ESPIs) are a national-level monitoring framework for elective services. ESPI2 and ESPI5 are used to show that our elective services are well-coordinated [P] and efficient [Ey].

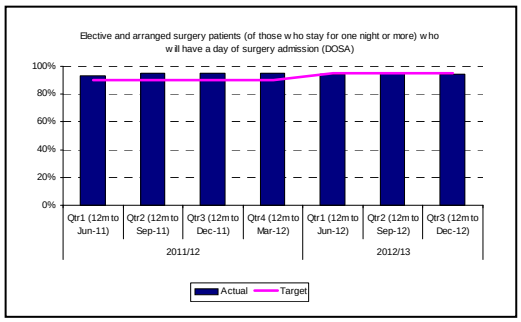
	Baseline	Target 2012/13	Actual June 2013
(ESPI2) % patients waiting longer than 6 months for their First Specialist Assessment (FSA)			
	0.4%	*0%*	*0%*
(ESPI5) % of patients given a commitment but not treated within 6 months			
	0.4%	*0%*	*0%*

With increasing elective surgery being a Government priority, we have had to work extremely hard across the sector to maintain the ESPI targets that we had already achieved by the end of the previous financial year. Despite some non-compliant months in both measures, we have been able to bring them back on track by the end of the year. As from 1 July 2013, the target time reduces from 6 months to 5 months in both cases. Although that may be considered as ambitious, we are committed to the goal because less waiting [T] leads to better outcomes for patients [Ef].





For patients requiring an admission for surgery, a high rate of admissions on the day of surgery (DOSA) is preferred. This is more efficient for the hospital [Ey] and means less unnecessary waiting for patients [T]. Although we have narrowly missed the target (by 0.3%), our DOSA rate has continued to trend upwards from 84.5% in 2010 to 94.7% by March 2013. Last year we achieved 95% but this year's result is an improvement because, in the face of rising surgery volumes, more than 350 extra people had a day of surgery admission. This is a good result and we will continue to improve systems and procedures to enable us to achieve the targeted rate.



Source: Ministry of Health

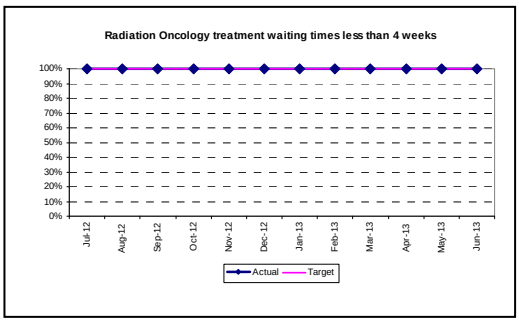
NATIONAL HEALTH TARGET

In a system where people are referred for a number of assessments before treatment is offered, the key principles underlying the system are clarity, timeliness and fairness.

Compliance with the health target shorter waits for cancer treatment confirms that our population is receiving radiation cancer treatments as early as possible [T]. As this is a regional service, maintaining this high rate relies on effective co-ordination, efficient booking and referrals and good patient relationship-management [Ey, P].

The majority of radiation therapy is provided at Palmerston North Hospital for Hawke's Bay district residents.

Health Target: Shorter waits for cancer treatment - Radiation Oncology Treatment Waiting Times less than 4 weeks			
	Baseline	Target 2012/13	Actual 2012/13
	100%	*100%*	*100% (F)*



Source: MidCentral DHB

100% compliance with target waiting times for all intensive cancer treatment is desirable as it ensures that people are having care needs met on time [T]. Meeting treatment need as early as possible supports the increased screening goals (discussed above) and contributes to better survival through reduced morbidity and less premature death [Ef].

Chemotherapy Treatment waiting times less than 4 weeks			
	Baseline	Target 2012/13	Actual April to June 2013
	100%	*100%*	*100% (F)*

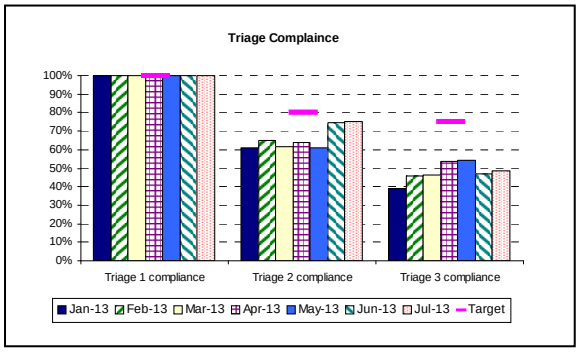
Delivering traditional "hospital" services in community settings is one of the key principles of better, sooner, more convenient health care. Our District Nursing service provides specialised nursing care in people's homes and this often reduces the need for a hospital stay [Ef]. This new indicator measures the timeliness [T] of service response following referral, for which we set a target of 80% within 48 hours. In fact the service has improved across the year from 62% in quarter 1 to nearly 83% by quarter 4. This follows commitment by the service to focus on the target and, through monthly quality meetings, to identify strategies for improving the result.

Initial contact by District Nursing Service within 48 hours of receipt of referral			
	Baseline	**Target** 2012/13	**Actual** April to June 2013
	new	*≥80%*	*82.7% (F)*

Like all Emergency Departments (ED) across New Zealand, we are seeing growth in ED attendance that exceeds population growth. As well as strategies to understand and influence that demand, we have to focus on meeting standard response times for the most urgent cases [T].

Emergency Department Triage compliance rates			
	Baseline	Target 2012/13	Actual April to June 2013
Triage 1	*100.0%*	*100 %*	*100% (F)*
Triage 2	*68.5%*	*≥80 %*	*66.4% (U)*
Triage 3	*58.3%*	*≥75 %*	*51.5% (U)*

Unfortunately, for triage categories 2 and 3 our compliance rates are still some way off the targets. There has been some improvement this year in triage 2, from 63.6% to 66.4%, but triage 3 compliance has declined slightly from 51.8% last year to 51.5% this year. The respective targets are 80% and 75%.

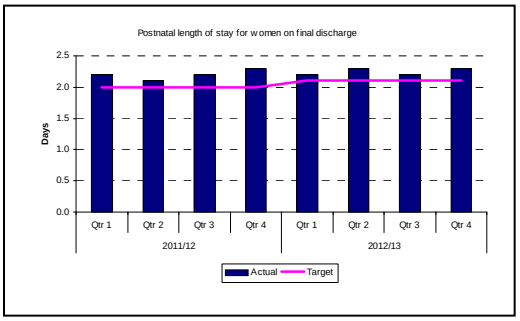


The Ministry of Health has recently studied triage performance across New Zealand and issued some contextual explanations for seemingly poor performance. Compliance with triage rates, which were first introduced in 1993, rely on the time between presenting at an ED and being seen by a doctor. However, recent developments in emergency care focus more on streaming within and outside an ED and more team-based care being provided by a range of health professionals such as specialist nurses, for example. In essence, not being seen by a doctor within the requisite time does not mean that care has not been initiated – stabilisation, tests, diagnostics and pain relief are often well underway before a doctor attends the patient.

Maternity Services are provided to women and their families throughout pregnancy, childbirth and for the first six weeks after birth. The maternity service specifications envisage a post-natal stay of longer than 48 hours only if there are problems or complexities. Mothers and new babies should be ready to go home as soon as possible [T].

Post natal Average length of stay (days)			
	Baseline	Target 2012/13	Actual April to June 2013
	2.1 days	*≤2.1 days*	*2.3 days (U)*

We have not achieved this target. A longer stay is sometimes desirable - first-time mothers [Eq], for example - and can enable better engagement between the health sector and the whānau [Ef]. We are still experiencing some challenges in respect of high rates of caesarean section, premature infants, medical and social complexities and breastfeeding difficulties. Proposals for improvement in primary maternity services are scheduled to come before our Board in the next 12 months and those should help to drive a better result.

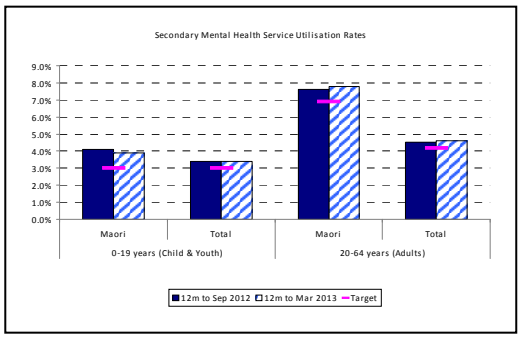


More Convenient

Specialist mental health and addiction services are funded for people who are severely affected by mental illness or addictions. Convenient services must be accessible and HBDHB has criteria in place for prioritising services to those with the highest level of need [Eq]. We also ensure that people from the district have access to regional and national mental health and addiction services [P].

Secondary Mental health services utilisation rate			
	Baseline	Target 2012/13	Actual 12 months to March 2013
0-19 years Child & Youth			
Total	*3.0%*	*≥3.0%*	*3.4% (F)*
Māori	*3.0%*	*≥3.0%*	*3.9% (F)*
20-64 years Adults			
Total	*4.2%*	*≥4.2%*	*4.6% (F)*
Māori	*6.9%*	*≥6.9%*	*7.8% (F)*

In 2012/13 we have continued to see use of these services at rates in excess of targets. That is true for children and youth – total population (3.4%) and Māori population (3.9%) – and for adults – total population (4.6%) and Māori population (7.8%). The trend in the rates is upward, indicating that the service is reaching more people in need [Ef, Ey]. These results are being achieved through a focus on better access by working closely with our NGO partners to smooth the transition of care between services.



Source: Ministry of Health

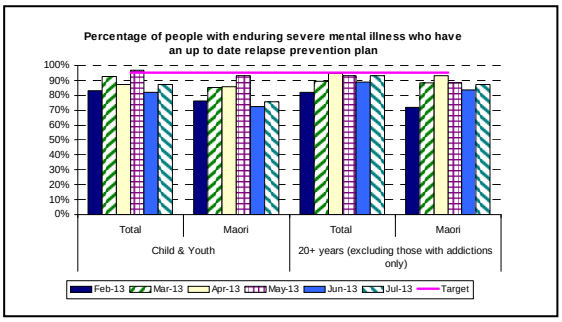
Relapse prevention plans (RPP) are developed for people with enduring mental illness because research shows that RPP are effective at improving outcomes if they are maintained. High rates of "up-to-date" RPP are an indication of service responsiveness [P] and reliability [S].

The target for the year was 95% completion and, although we have seen a consistent improvement since October 2011, we have not quite achieved the goal across the board.

In the final quarter of the year, for the child and youth indicator, we achieved 87.5% for the total population and 75.8% for the Māori population. For adults, the result was 93.1% for the total population and 87.1% for the Māori population.

Even though we are not quite achieving the targets, there has been significant and steady progress in the use of RPP for the total population and for Māori patients. Our NGO partners in these services have recently gone through substantial management changes and we are continuing to offer support for ongoing focus on this service performance measure.

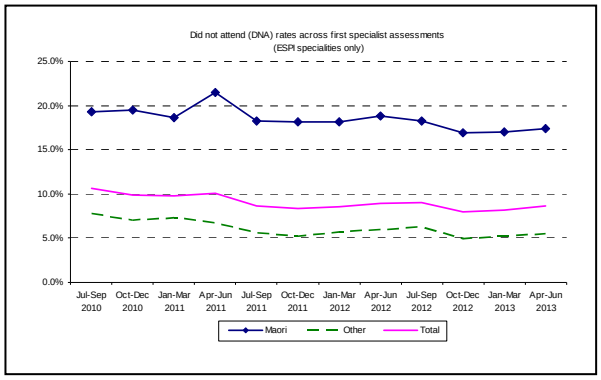
% of people with enduring severe mental illness who have an up to date relapse prevention plan			
	Baseline	Target 2012/13	Actual As at 9th July 2013
0-19 years Child & Youth			
Total	*47.3%*	*≥95%*	*87.5% (U)*
Māori	*40.0%*	*≥95%*	*75.8% (U)*
20 years and over Adults (excluding addictions)			
Total	*77.7%*	*≥95%*	*93.1% (U)*
Māori	*60.1%*	*≥95%*	*87.1% (U)*



An indicator of convenience in respect of elective services is attendance at scheduled first specialist appointments (FSAs). Arranging FSAs requires good communication between patient, referrer and specialist services. A reduction in the rate of patient non-attendance (did not attends – DNAs) is targeted because a high rate is an indication of poor co-ordination [P] and leads to increased unmet need [Eq, Ef].

Did not attend (DNA) rate across first specialist assessments			
	Baseline	Target 2012/13	Actual April to June 2013
Total	*9.8%*	*≤7.5%*	*9.5% (U)*
Māori	*19.4%*	*≤7.5%*	*17.9% (U)*

In 2012/13 we implemented a number of initiatives to reduce DNA rates. However, we have been unable to make any significant gains on this indicator and we are still some way off our target rate of less than 7.5% for Māori and for the total population. We are raising the profile of this indicator for the next year and have made some changes to clinic policies that should lead to better attendance.



Patient convenience [P] and hospital bed utilisation [Ey] is improved if there is a high **rate of day surgery**. This means that the patient is not admitted to a ward for an overnight stay at all.

Percentage of elective and arranged day surgery			
	Baseline	Target 2012/13	Actual 12 months to March 2013
	56.7%	*≥60%*	*58.6 (U)*

Source: Ministry of Health

In 2012/13 our day surgery rate has continued to improve slowly compared to previous results. However, we have not yet achieved the targeted 60%, ending the year slightly lower at 58.6%. We are confident that the target will be surpassed in the next 12 months.

Intensive Assessment and Treatment Services			
	2013 Actual $'m	2013 Budget $'m	2012 Actual $'m
Ministry of Health	*245.0*	*245.7*	*232.5*
Other District Health Boards	*6.5*	*3.9*	*4.4*
Other Sources	*10.1*	*14.2*	*17.8*
Income by Source	*261.6*	*263.8*	*254.7*
Less:			
Personnel	*134.9*	*135.6*	*131.6*
Outsourced Services	*9.7*	*7.9*	*9.2*
Clinical supplies	*32.8*	*39.8*	*31.4*
Infrastructure and non clinical supplies	*32.0*	*31.4*	*29.2*
Payments to other District Health Boards	*46.4*	*42.8*	*44.7*
Payments to other providers	*3.6*	*5.2*	*4.9*
Expenditure by type	*259.4*	*262.7*	*251.0*
Net Result	*2.2*	*1.1*	*3.7*

Rehabilitation and Support Services

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

Statement of Service Performance Output Class 4

Rehabilitation and Support Services support people with enduring conditions and disabilities to live independently. Most of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Needs assessment and service coordination (NASC) services are provided by HBDHB through Options Hawke's Bay.

Other services are provided by Health Services (the DHB's provider arm), General Practice and a number of community-based NGOs and private organisations such as Cranford Hospice, aged-residential care and home-based support services. HBDHB believes all Rehabilitation and Support Services should:

- Be timely, effective and make use of best practices; and
- Be high quality, safe, accessible and well-coordinated according to need.

Better

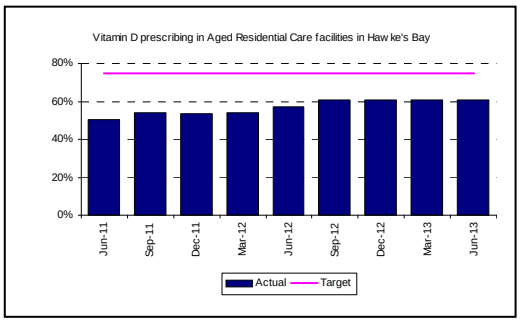
Year 2 (of 3) of our 'health of older persons service improvement' programme (HOPSI) was rolled out in 2012/13. HOPSI aims to deliver better co-ordination of higher quality services to older people. This year, we introduced a new indicator targeting at least 90% of those receiving home-based support services would have a comprehensive clinical assessment and a completed care plan. This is an important component of keeping people safe in their own homes [S] and maintaining their independence [P]. Steady progress throughout the year ended up in quarter 4 with a favourable result of 95.2%.

Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
	Baseline	Target 2012/13	Actual April to June 2013
	new	*≥90%*	*95.2% (F)*

Research has shown that vitamin D deficiency is a common contributor to falls amongst the elderly – falls are a significant driver of hospitalisation for this age group. In a programme across the sector, the DHB targeted a significant increase in vitamin D prescribing [S].

Vitamin D prescribing			
	Baseline	**Target** 2012/13	**Actual** April to June 2013
	53.6%	*≥75%*	*61% (U)*

We have had some difficulty making much progress in this indicator and, at 61% we are still short of our 75% target. However, recent audits of prescribing practices have identified opportunities for amending prescriptions to include vitamin D for some individuals. We will continue to support our primary and community partners in this way to raise the uptake of this preventative measure.



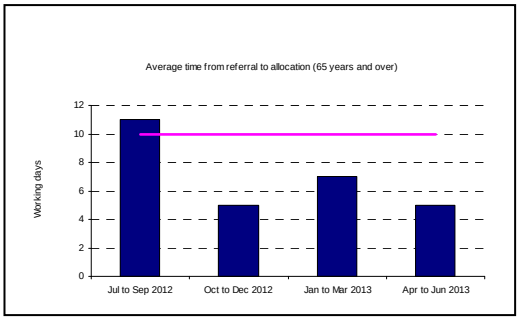
Sooner

Needs Assessment and Service Coordination (NASC) work with people who have support needs to determine eligibility for public funding and to assist the person to define the best mix of supports for themselves. A significant amount of NASC work is with the older population and, as this cohort is increasing, we would expect to see an increase in the number of referrals completed. Referrals processed increased by nearly 13% in the year with 6,888 completed against a forecast of 5,747.

Number of referrals processed (65 years and over)			
	Baseline	Target 2012/13	Actual 2012/13
	5,787	*≥5,787*	*6,888*

To confirm that the DHB are coping with this increase and providing a prompt service [T], we decreased the target for time from referral to assessment [Ey]. We expected to decrease the turnaround time for referrals from 12 days to a maximum of 10 days. That goal was beaten significantly in 3 out of the 4 quarters, ending up at just 5 days for quarter 4.

Average time from referral to allocation (65 years and over)			
	Baseline	Target 2012/13	Actual April to June 2013
	12 days	*≤10 days*	*5 days (F)*



On 1 July 2011, the Ministry of Health devolved NASC services for disability services for people under 65 years of age to DHBs. We started monitoring these volumes separately in the 2012/13 financial year and have delivered 463 assessments against a forecast of 300. The increase in demand has been driven by an upwards trend in new clients plus a rise in requests for reassessments.

Number of needs assessments completed (Disability Services)			
	Baseline	Target 2012/13	Actual 2012/13
	522	*≥300*	*463 (F)*

Being uncertain about the volumes at the beginning of the year meant that we set a cautious target of 13 days for turnaround of referrals. The NASC team have done a superb job in setting up this new service and have delivered more volumes than anticipated in an average turnaround time of just three days [T, Ey].

Average time from referral to assessment (Disability Services)			
	Baseline	Target 2012/13	Actual April to June 2013
	13 days	*≤13 days*	*3 days (F)*

Palliative care is an approach that improves the quality of life [P] of patients and their families facing the problems associated with life-threatening illness. Suffering is prevented and relieved by early identification, assessment and treatment of pain and other problems.

Cranford Hospice is the district's community-based palliative care provider and we measure the waiting time [T] for contact from the hospice as a measure of services responsiveness. Over the last 12 months a response within 48 hours of referral has been achieved in 90% of cases, up from 85% in the 12 months prior.

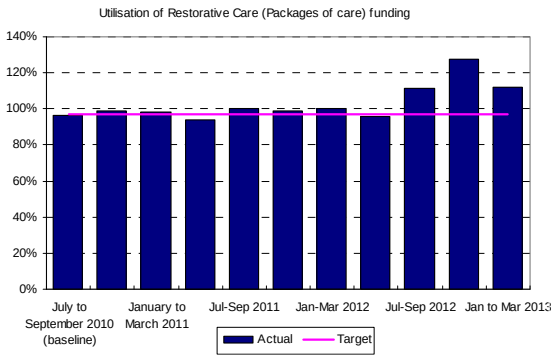
Time from referral receipt to initial Cranford Hospice contact within 48 hours			
	Baseline	Target 2012/13	Actual April to June 2013
	47%	*≥80%*	*90% (F)*

More Convenient

Rehabilitation services are usually enduring in nature and are delivered by a variety of health and allied health specialists in hospital, community and home settings. Funding by way of "packages of care" (POC) allows, enables and encourages the contracted provider to co-ordinate a range of treatments and or therapies according to need [Ef, Eq]. This means that a service can be more tailored to the individual patient [P].

Access to restorative care is governed by strict criteria and it is important that funding available is only used by those that can benefit. All clients are first assessed as requiring rest home level care. The service provides flexible support aimed at improving client confidence and function so that they can safely remain at home instead. The DHB purchases up to 120 packages of care. In quarter 4, provider monitoring reports show that 134 people have benefited from the service this year (112% compared to target).

Utilisation of restorative care (packages of care) funding			
	Baseline	Target 2012/13	Actual January to March 2013
	100%	*≥97.0%*	*111.7 (F)*



More people than planned were considered appropriate for restorative rehabilitation and this raises a challenge of prioritisation of this model. We have confirmed that the service is delaying entry to rest home and hospital level residential care and helping to maintain people independently at home [Ef]. Therefore, we will increase capacity in 2013/14 as we continue to seek best value for our community. The provider expects to be able to increase capacity for another 30 clients by September. Actual numbers will depend on referrals to rest home level of care.

Respite and day services are supplied to people to provide them with a break from a routine or regimented programme, so that crises can be averted [Ef]. Services are short-term or temporary in nature and may include support and respite care for families, whānau, care givers and others affected.

This year, we committed extra resources to significant increases in respite and day services to give better support to people with specialised or high needs [Eq] and their carers. However, we found that some of the respite services that we were funding were used less than 50% of the time. Services were rearranged so that we ended up funding fewer respite days than targeted but more day services. We believe that this was more in line with demonstrated preferences [P] and need.

We expect use of day services to continue growing. This is in line with increasing access to primary care and community services to reduce demand for higher cost hospital and aged residential care services.

Number of respite days and day services			
	Baseline	Target 2012/13	Actual 2012/13
Number of respite days	*4,919*	*≥7,274*	*4,514 (F)*
Number of day services	*9,600*	*≥13,837*	*15,696 (F)*

Rehabilitation and Support Services	2012 Actual $'m	2012 Budget $'m	2011 Actual $'m
Ministry of Health	*60.0*	*61.5*	*58.6*
Other District Health Boards	*2.0*	*2.0*	*2.3*
Other Sources	*0.5*	*0.4*	*0.5*
Income by Source	*62.5*	*63.9*	*61.4*
Less:			
Personnel	*5.9*	*6.0*	*5.8*
Clinical supplies	*0.7*	*0.7*	*0.6*
Infrastructure and non clinical supplies	*1.6*	*1.7*	*1.6*
Payments to other District Health Boards	*3.9*	*3.6*	*3.7*
Payments to other providers	*51.1*	*50.8*	*50.9*
Expenditure by type	*63.2*	*62.8*	*62.6*
Net Result	*(0.7)*	*1.1*	*(1.2)*

Financial Report for the year ended 30 June 2013

The board members are pleased to present the Financial Statements of Hawke's Bay District Health Board for the year ended 30 June 2013.

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

Kevin Atkinson
Chair

Peter Dunkerley
Board Member

24 October 2013

2012/13 Financial Performance

Result

Total comprehensive income for 2012/13 is a $2.1 million surplus on income of $474.9 million. This is in comparison to the $2.0 million surplus reported last year. The underlying result was a $3 million surplus before recognition of $1.3 million of unbudgeted expenditure relating to income recognised in prior years, and $0.4 million of unbudgeted income relating to expenditure that will be incurred in later years, in compliance with *IPSAS-23 Revenue from Non-Exchange Transactions*.

Income was $3.5 million ahead of plan. This included $2.4 million from the Ministry of Health for additional services provided, additional income of $0.8 million from Wairoa GP practices, $0.5 million from Mid Central DHB for oncology clinics and $0.4 million from Tairawhiti DHB for cytotoxic drugs, and donations and clinical trial revenue of $0.7 million, partly offset by a reduction in ACC income of $1.0 million, and a provision against non-resident income of $0.3 million.

Performance by Arm

The funding arm surplus is $4.9 million which is $0.5 million better than plan. The variance from plan includes the elimination of $4.4 million of pharmaceutical expenditure resulting from claims by the provider arm, that was not adjusted in the plan. Otherwise the result would have been $3.9 million unfavourable to plan due mainly to: increased payments to other district health boards for Hawke's Bay domiciled patients treated outside the district resulting from higher presentations in other districts where increased capacity has enabled more patients to be treated; the higher cost of that treatment; and an expansion of the inter district scheme to include patients waiting more than three hours in emergency departments. Increased home care and other personal health costs also contribute to the adverse result.

The governance and funding administration surplus is close to plan.

The provider arm deficit of $3.4 million is $1.5 million unfavourable to plan, this includes the $4.4 million of pharmaceutical claims as mentioned above, that was not adjusted in the plan. Otherwise the result would have been $1.9 million favourable to plan due to: increased revenue from other district health boards; unbudgeted donations and clinical trial income; and lower allied health and administration personnel costs.

A breakdown of income and the surplus/(deficit) is tabled below:

	Achieved $'millions	Plan $'millions	Variance $'millions
Income			
Funding health services	446.7	443.6	3.1
Governance and funding administration	3.4	3.4	-
Providing health services	255.5	255.0	0.5
Eliminations	(230.8)	(230.6)	(0.2)
	474.8	471.4	3.4
Surplus/(Deficit)			
Funding health services	4.9	4.4	0.5
Governance and funding administration	0.6	0.5	0.1
Providing health services	(3.4)	(1.9)	(1.5)
	2.1	3.0	(0.9)

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

2012/13 Financial Performance (continued)

Cash flow

The operating cash surplus of $16.1 million, together with proceeds from the sale of surplus property of $0.3 million, and a reduction of cash holdings by $4.8 million, was sufficient to fund the $16.3 million spend on property, plant and equipment, and intangible assets, invest $4.2 million in Health Benefits Limited (HBL) and the Central Region Information Systems Plan (CRISP), and repay debt of $0.3 million and equity of $0.4 million.

Auditors

The Auditor-General is required under section 14 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2012/13 financial statements, amount to $111,163.

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	2013	2012	2011	2010	2009
Return on net funds employed	11.4%	9.4%	9.6%	14.5%	(1.3)%	(1.6)%
Operating margin to revenue	1.5%	1.2%	1.1%	1.7%	(0.7)%	(0.9)%
Revenue to net funds employed	5.8	5.6	5.9	6.5	6.0	6.0
Debt:debt plus equity ratio	46.1%	48.2%	49.4%	47.2%	57.9%	52.9%
Net result before financing and abnormals	9.3m	8.1m	7.5m	10.0m	(0.9)m	(1.1)m
Net result	3.0m	2.1m	2.0m	5.3m	(5.5)m	(6.1)m
Debt servicing coverage ratio	7.8	7.5	7.5	8.5	3.4	2.8
Ratio of earnings to revenue	4.8%	4.5%	4.3%	4.9%	2.3%	2.3%
Average cost per paid FTE	$81,755	$80,772	$79,093	$76,947	$74,847	$72,224
Average revenue per paid FTE	$232,442	$234,014	$228,359	$223,878	$212,102	$203,670

Statement of comprehensive income

For the year ended 30 June 2013

	Notes	30 June 2013 $'000	Budget 30 June 2013 $'000	30 June 2012 $'000
Patient care revenue	1	468,373	466,130	454,047
Interest income		1,022	1,016	987
Other operating income	2	5,360	4,246	3,569
Gain on sale of surplus properties		62	-	5,650
Total income		474,817	471,392	464,253
Employee benefit costs	3	163,299	165,799	160,796
Outsourced services		13,597	11,070	12,901
Clinical supplies		39,480	38,696	38,364
Infrastructure and non-clinical expenses		21,164	20,793	18,016
Payments to other district health boards		52,750	49,194	51,558
Payments to non-health board providers		158,417	159,311	157,331
Other operating expenses	4	4,882	3,954	5,385
Depreciation and amortisation expense	12,13	13,251	13,318	12,580
Financing costs		2,357	2,400	2,234
Capital charge	5	3,624	3,857	3,204
Total expenses		472,821	468,392	462,369
Share of associate surplus/(deficit)	15	85	-	133
Surplus/(deficit) for the year	7,21	2,081	3,000	2,017
Revaluation of land and buildings		-	-	-
Total comprehensive income for the year		2,081	3,000	2,017

Explanations of major variance against budget are provided in note 30.

District Health Boards 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 2013 was underspent by $2.2 million (2012: $1.1 million). The surplus for 2013 has been transferred to the asset replacement reserve, reflecting that along with previous year surpluses it would be used for the development of the mental health intensive care unit. Consequently mental health payments in excess of funding since 1 July 2001, remains at the 30 June 2012 level of $0.3 million.

Statement of changes in equity

For the year ended 30 June 2013

	Notes	30 June 2013 $'000	Budget 30 June 2013 $'000	30 June 2012 $'000
Balance at 1 July		44,554	47,897	41,927
Total comprehensive income for the year				
Surplus/(deficit) for the year		2,081	3,000	2,017
Revaluation of land and buildings		-	-	-
Equity contributions from the Crown		-	-	967
Equity repayments to the Crown		(357)	(357)	(357)
Balance at 30 June	21	46,278	50,540	44,554

Explanations of major variance against budget are provided in note 30.

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 2013

	Notes	30 June 2013 $'000	Budget 30 June 2013 $'000	30 June 2012 $'000
Assets				
Cash and cash equivalents	6	9,549	17,738	14,372
Trade and other receivables	8	16,495	13,800	16,201
Loans (Hawke's Bay Helicopter Rescue Trust)	9	11	10	10
Inventories	10	3,466	3,325	3,192
Non current assets held for sale	11	-	-	188
Total current assets		29,521	34,873	33,963
Property, plant and equipment	12	112,668	113,882	109,109
Intangible assets	13	2,980	5,440	3,634
Investment property	14	153	249	222
Investment in associate	15	884	666	799
Other investments	16	4,663	3,892	553
Loans (Hawke's Bay Helicopter Rescue Trust)	9	78	79	88
Total non-current assets		121,426	124,208	114,405
Total assets		150,947	159,081	148,368
Liabilities				
Interest-bearing loans and borrowings	17	5,344	5,374	5,345
Trade and other payables	18	30,219	33,957	29,593
Employee benefits	19	28,913	28,706	28,280
Provisions	20	253	255	262
Total current liabilities		64,729	68,292	63,480
Interest-bearing loans and borrowings	17	37,799	37,768	38,142
Employee benefits	19	2,141	2,481	2,192
Total non current liabilities		39,940	40,249	40,334
Total liabilities		104,669	108,541	103,814
Net assets		46,278	50,540	44,554
Equity				
Crown equity	21	37,943	37,931	38,300
Land and building revaluation reserves	21	31,744	31,744	31,744
Asset replacement reserve	21	12,411	10,408	10,048
Retained earnings/(accumulated deficit)	21	(35,820)	(29,543)	(35,538)
Total equity		46,278	50,540	44,554

Explanations of major variance against budget are provided in note 30.

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 2013

		30 June 2013 $'000	Budget 30 June 2013 $'000	30 June 2012 $'000
Cash flows from operating activities				
Receipts from patient care		466,275	471,090	451,297
Receipts from donations, bequests and clinical trials		780	-	105
Other receipts		5,485	-	3,623
Payments to suppliers		(288,888)	(283,383)	(285,241)
Payments to employees		(163,641)	(164,428)	(159,296)
Goods and services tax (net)		1,023	-	(2,025)
Cash generated from operations		21,034	23,279	8,463
Interest received		1,022	1,016	987
Interest paid		(2,405)	(2,400)	(2,137)
Capital charge paid		(3,624)	(3,858)	(3,774)
Net cash inflow/(outflow) from operating activities	7	16,027	18,037	3,539
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		309	-	4,850
Acquisition of property, plant and equipment		(15,899)	(16,944)	(10,846)
Acquisition of intangible assets		(449)	(1,556)	(734)
Acquisition of investments		(4,110)	(3,891)	(553)
Net cash inflow/(outflow) to investing activities		(20,149)	(22,391)	(7,283)
Cash flows from financing activities				
Proceeds from borrowings		-	-	6,500
Proceeds from equity injections from the Crown		-	-	967
Repayment of borrowings		-	-	(201)
Repayment of finance lease liabilities		(344)	(344)	(446)
Repayment of equity to the Crown		(357)	(357)	(357)
Net cash inflow/(outflow) from financing activities		(701)	(701)	6,463
Net increase/(decrease) in cash and cash equivalents		(4,823)	(5,055)	2,719
Add: opening cash		14,372	22,793	11,653
Cash and cash equivalents at end of year	6	9,549	17,738	14,372

The Cash paid to suppliers 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 30.

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

Statement of significant accounting policies

For the year ended 30 June 2013

REPORTING ENTITY

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

The Hawke's Bay District Health Board's primary objectives are the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly the District Health Board is a public benefit entity, as defined under NZ IAS 1.

The financial statements of the Hawke's Bay District Health Board comprise the District Health Board, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited which is jointly controlled by the six district health boards in the central region.

The financial statements for the Hawke's Bay District Health Board are for the year ended 30 June 2013, and were approved by the Board on 24 October 2013.

BASIS OF PREPARATION

Statement of compliance

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

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

Measurement base

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

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

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

Judgements made by management in the application of NZ IFRSs that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in the notes to the accounts.

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($'000) unless otherwise specified. The functional currency of the District Health Board is New Zealand dollars (NZ$).

Changes in accounting policy

There have been no changes in accounting policies during the year.

Early adopted amendments to standards

No new standards or amendments to standards have been early adopted since the issue of XRB A1 Application of Accounting Standards (see Standards not applicable to public benefit entities below).

Standards, amendments and interpretations issued but not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the District Health Board, are:

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets.

  The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2016. However as a new accounting standards framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied to public benefit entities.

Standards, amendments and interpretations issued and effective, that have been deferred

Standards, amendments and interpretations issued and effective that the District Health Board has elected to defer, and which are relevant to the District Health Board, are:

- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction, or production of a qualifying asset. In November 2008, the mandatory adoption of NZ IAS 23 *(revised 2007)* by public benefit entities was deferred pending the completion of the Financial Reporting Standard Board's research project into the application of NZ IAS 23 *(revised 2007)* by public benefit entities. The District Health Board has elected to defer the adoption of the revised IAS 23. Accordingly, all borrowing costs that are directly attributable to the acquisition, construction, or production of a qualifying asset continue to be recognised as an expense.

Standards not applicable to public benefit entities

The Minister of Commerce has approved a new accounting standards framework (incorporating a tier strategy) developed by the External Reporting Board (XRB). Under this accounting standards framework, Hawke's Bay District Health Board is classified as a Tier 1 reporting entity and it will be required to apply full public benefit entity accounting standards (PAS). These standards are being developed by the XRB and are mainly based on current international Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the District Health Board expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the District Health Board is unable to assess the implications of the new accounting standards framework at this time.

The External Reporting Board (XRB) issued XRB A1 Application of Accounting Standards in August 2011, as an interim step towards the new accounting standards framework. This general (accounting) standard defines the NZ IFRS to be applied by public benefit entities. XRB A1 effectively means that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not apply to public benefit entities. Hawke's Bay District Health Board has applied XRB A1 since 1 July 2011, and as a result there has been no impact on the District Health Board's accounting policies for the years ended 30 June 2012 and 30 June 2013, from new or amended NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012.

Basis for consolidation

Subsidiaries
Hawke's Bay District Health Board has no subsidiaries.

Associates
Associates are those entities in which Hawke's Bay District Health Board has significant influence, but not control, over the financial and operating policies.

The financial statements include Hawke's Bay District Health Board's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. The investment in an associate is initially recognised at cost and the carrying amount is increased or decreased to recognise the District Health Board's share of the surplus or deficit of the associate after the date of recognition as an associate. When the District Health Board's share of losses exceeds its interest in an associate, the carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that the District Health Board has incurred legal or constructive obligations or made payments on behalf of an associate. If the associate subsequently reports surpluses, the District Health Board will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised. Distributions received from the associate reduce the carrying amount of the investment.

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

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

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

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

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

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

Crown funding
The Hawke's Bay District Health Board is primarily funded through revenue received from the Crown under a Crown Funding Agreement. The funding is restricted in its use for the purpose of meeting the District Health Board's objectives as specified in the statement of intent.

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

Revenue from other DHBs
Inter district patient inflow revenue occurs when a patient treated within the Hawke's Bay District Health Board region is domiciled outside of Hawke's Bay. The Ministry of Health credits Hawke's Bay District Health Board 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 Hawke's Bay District Health Board.

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

Sale of goods
Revenue from goods sold is recognised when Hawke's Bay District Health Board has transferred to the buyer the significant risks and rewards of ownership of the goods and the District Health Board does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

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

Vested assets
Where a physical asset is gifted to or acquired by the Hawke's Bay District Health Board for nil or nominal cost, the fair value of the asset received is recognised as income when control over the asset is obtained.

The activities of the Hawke's Bay District Health Board are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the District Health Board due to the difficulty of measuring their fair value with reliability.

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

Interest income
Interest income comprises interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains on hedging instruments that are recognised in the surplus or deficit.

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

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

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

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

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

Cash and cash equivalents

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

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

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

Equity investments

The District Health Board designates equity investments at fair value through other comprehensive income, which are initially measured at fair value plus transaction costs. After initial recognition, these investments are measured at their fair values with gains and losses recognised in other comprehensive income, except for impairment losses which are recognised in the surplus or deficit. On derecognition, the cumulative gain or loss previously recognised in other comprehensive income is reclassified to the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss (measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in the surplus or deficit) recognised in other comprehensive income is reclassified from equity to the surplus or deficit. Impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

Derivative financial instruments

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

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

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

Inventories

Inventories held for distribution

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

Inventories held for sale

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

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

Non-current assets held for sale

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

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

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

The Hawke's Bay District Health Board transferred the Napier Hill property from surplus properties within property, plant and equipment to non-current assets held for sale during the year ended 30 June 2011. The property was subsequently sold in August 2011.

Property, plant and equipment

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

- freehold land
- freehold buildings
- surplus property
- clinical equipment
- information technology
- motor vehicles
- other equipment
- work in progress.

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

Revaluations

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

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

Additions

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

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying value of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

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 Hawke's Bay District Health Board and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

Class of Asset	Estimated Life	Depreciation Rate
• Buildings	3 to 40 years	2.5% to 33%
• Clinical equipment	2 to 32 years	3.1% to 50%
• Information technology	2 to 10 years	10% to 50%
• Motor vehicles	2 to 20 years	5% to 50%
• Other equipment	2 to 33 years	3% to 50%

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the District Health Boards website are recognised as an expense when incurred.

Amortisation

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

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

Type of Asset	Estimated Life	Amortisation Rate
• Acquired computer software	3 to 15 years	6.7% to 33%
• Developed computer software	3 to 15 years	6.7% to 33%

Impairment of property, plant and equipment and intangible assets

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

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

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

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

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

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

Investment properties

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. An external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, values the portfolio every twelve months. 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 Hawke's Bay District Health Board begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

Interest-bearing loans and borrowings

Interest-bearing loans and borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, interest-bearing loans and borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Hawke's Bay District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date. Borrowings where the District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date are classified as current liabilities if the District Health Board expects to settle the liability within 12 months of the balance date.

Creditors and other payables

Creditors and other payables are recorded at their face value.

Employee benefits

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

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

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Provisions

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

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

Restructuring

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

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

ACC Partnership Programme

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

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

Goods and services tax

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hawke's Bay District Health Board is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 2007.

Income and cost allocation

Output classes

Income and expenditure for each output class funded or provided by the Hawke's Bay District Health Board and reported in the statement of service performance, has been derived using the allocation system outlined below.

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

Direct income and costs are charged directly to output classes. Indirect costs are charged to output classes using appropriate cost drivers such as actual usage.

Critical accounting estimates and assumptions

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

Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $4.318 million (2012: $4.296 million). Refer note 19.

Workplace accident self insurance

Note 20a provides information about estimates and assumptions applied in determining the District Health Board's liability under the ACC Partnership Programme.

Critical judgements in applying accounting policies

In the process of applying Hawke's Bay District Health Board's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. Management has exercised the following critical judgements in applying accounting policies for the year ended 30 June 2013.

Revaluation of land and buildings

The revaluation of land and buildings as at 30 June 2008, included assumptions relating to the timing of the redevelopment of the Hastings hospital campus, in accordance with the site redevelopment plan under discussion at that time. Site redevelopment has not proceeded due to a re-evaluation of the District Health Board's requirements and the availability of funding. A valuation of land and buildings as at 30 June 2011 was commissioned due to the change in circumstances and the passage of time.

Management determined that re-development of the Hastings hospital campus was likely in the medium term and would have a significant effect on the values of the existing buildings. Ahead of the planning process to determine the District Health Board's requirements going forward, the assumptions made regarding the lives of certain buildings were subject to high uncertainty. Nevertheless management decided to accept the valuation as at 30 June 2011 as the valuations provided the best estimate of fair value available at that time.

The circumstances that applied at 30 June 2011, continue to be the case at 30 June 2013. As there have been no other factors that have caused a material change in the valuation of land and buildings during the year ended 30 June 2013, management considers the valuation as at 30 June 2011 continues to provide the best estimate of fair value available at this time.

Notes to the financial statements

For the year ended 30 June 2013

	Notes	30 June 2013 $'000	30 June 2012 $'000
Note 1 Patient care revenue			
Ministry of Health contracted revenue		450,349	433,724
Revenue from other district health boards		10,402	12,210
Other Crown entity contracted revenue		6,492	6,427
Other patient care related revenue		1,130	1,686
		468,373	454,047
Note 2 Other operating income			
Donations and bequests received		529	165
Rental income		558	529
Cafeteria and food sales		934	994
Other operating income		3,299	1,837
Gain on sale of property, plant and equipment		40	44
Release of unused provisions		-	-
		5,360	3,569
Note 3 Employee benefit costs			
Wages and salaries		159,332	158,277
Employer contributions to defined contribution plans		3,384	1,399
Increase/(decrease) in employee benefit provisions		583	1,120
		163,299	160,796
Note 4 Other operating expenses			
Impairment of trade receivables (bad and doubtful debts)		25	139
Loss on disposal of property, plant and equipment		203	395
Fees to auditor for the audit of the financial statements		111	111
Fees to board members and commissioners		276	281
Operating lease expenses		3,564	3,713
Increase/(decrease) in provisions		588	368
Koha		2	3
Restructuring expenses		113	375
		4,882	5,385

Note 5 Capital charge

District Health Boards pay a capital charge every six months to the Crown. The charge is based on actual closing equity as at 30 June and 30 December each year. The capital charge rate for the year ended 30 June 2013 was 8% (2012: 8%).

	Notes	30 June 2013	30 June 2012
Note 6 Cash and cash equivalents			
Cash		8	8
Bank balances		8	196
Credit balance (Health Benefits Limited)		6,683	-
Call deposits – surplus cash		-	11,148
Call deposits – special funds	6b	1,576	1,657
Call deposits – clinical trials	6c	1,274	1,363
Cash and cash equivalents in the statement of financial position		9,549	14,372
Debit balance (Health Benefits Limited)		-	-
Cash and cash equivalents for the purposes of the cash flow statement		9,549	14,372

Note 6b Special funds		
Opening balance	1,657	1,662
Donations and bequests	278	99
Interest received	36	29
Expenditure during the year	(395)	(133)
	1,576	1,657

Special funds include funding from the Ministry of Education for early childhood education purposes. Receipts in 2013 amounted to $152,000 (2012: $148,000), and the balance of funds as at 30 June 2013 amounted to $306,000 (30 June 2012: $250,000).

Note 6c Clinical Trials		
Opening balance	1,363	1,378
Receipts	261	270
Interest received	27	27
Expenditure during the year	(377)	(312)
	1,274	1,363

DHB Treasury Services Agreement

The Hawke's Bay District Health Board is a party to the DHB Treasury Services Agreement under which Health Benefits Limited (HBL) has been mandated by its shareholding ministers, to put in place a sweep facility amongst the DHBs to reduce the overall cost of their banking arrangements. The DHBs have appointed Westpac as their preferred supplier of the banking arrangements. The DHB has undertaken as follows:

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

Prior to joining the DHB Treasury Services Agreement the District Health Board had a $10 million working capital facility (bank overdraft) with the Bank of New Zealand.

Credit card facility

Hawke's Bay District Health Board has a $200,000 BNZ Business Visa Card facility.

Note 7 Reconciliation of surplus for the period with net cash flows from operating activities

	Notes	30 June 2013 $'000	30 June 2012 $'000
Surplus/(deficit) for the year	21	2,081	2,017
Add back non-cash items:			
Share of associate surplus		(85)	(133)
Depreciation and amortisation		13,251	12,580
Disposal costs previously expensed		-	2,373
Add back items classified as investing activity:			
Net loss/(gain) on disposal of surplus property		-	(5,650)
Net loss/(gain) on disposal of investment property		(65)	-
Net loss/(gain) on disposal of property, plant and equipment		203	351
Debt forgiven (Hawke's Bay Helicopter Rescue Trust)		10	9
Interest attributed to Energy Efficiency Conservation Authority borrowings		-	9
Interest attributed to Finance Leases		(48)	98
Movements in working capital:			
(Increase)/decrease in trade and other receivables		(295)	(3,213)
(Increase)/decrease in inventories		(273)	(17)
Increase/(decrease) in trade and other payables		899	(7,048)
Increase/(decrease) in employee benefits		846	2,095
Increase/(decrease) in provisions		(10)	7
Net movement in working capital		1,252	(8,176)
Other movements not in working capital			
Increase/(decrease) in employee benefits		(487)	61
Net cash inflow/(outflow) from operating activities		16,027	3,539

Note 8 Trade and other receivables

	Notes	30 June 2013	30 June 2012
Ministry of Health receivables		2,422	2,166
Trade receivables		2,280	2,128
Ministry of Health accrued income		7,269	6,550
Other accrued income		4,146	4,601
Prepayments		378	756
		16,495	16,201

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 $111,000 (2012: $117,000)

Trade receivables are shown net of impairments amounting to $487,000 (2012: $140,000) recognised in the current year and arising from non-resident fees and small service charges which can be uneconomic to collect.

As at 30 June 2013 and 2012, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below.

	Gross 30 June 2013	Impairment 30 June 2013	Net 30 June 2013	Gross 30 June 2012	Impairment 30 June 2012	Net 30 June 2012
Not past due or past due <30 days	4,173	(32)	4,141	3,445	(14)	3,431
Past due 31-60 days	109	(7)	102	167	(8)	159
Past due 61-90 days	188	(10)	178	317	(7)	310
Past due >90 days	698	(438)	260	448	(111)	337
	5,168	(487)	4,681	4,377	(140)	4,237

The provision has been calculated based on expected losses for Hawke's Bay District Health Board's pools of debtors. Expected losses have been determined based on an analysis of the District Health Board'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:

	Notes	30 June 2013 $'000	30 June 2012 $'000
Balance at beginning of year		140	205
Additional provisions made during the year		349	139
Receivables written-off during period		(2)	(204)
Balance at end of year		487	140

Note 9 Loans

	Notes	30 June 2013 $'000	30 June 2012 $'000
Non current			
Loan to Hawke's Bay Helicopter Rescue Trust		78	88
Current			
Loan to Hawke's Bay Helicopter Rescue Trust		11	10
		89	98

Note 10 Inventories

	30 June 2013 $'000	30 June 2012 $'000
Pharmaceuticals	714	865
Surgical and medical supplies	1,818	1,445
Other supplies	934	882
	3,466	3,192

Write-down of inventories amounted to nil for 2013 (2012: $16,150). The amount of inventories recognised as an expense during the year ended 30 June 2013 was $34.9 million (2012: $29.0 million). No reversal of previously recognised write-down was made in the current year. No inventories were held at current replacement cost at 30 June 2013 (30 June 2012: 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.

Note 11 Non current assets held for sale

The are no non current assets held for sale as at 30 June 2013 (2012: $188,000). The Napier property owned by the District Health Board and used by the Alzheimers Society, Napier was sold during the year, and the proceeds net of costs gifted to the Society.

Note 12 Property, plant and equipment

30 June 2013 Owned assets	Cost/Valuation 1 July 2012 $'000	Accumulated Depreciation 1 July 2012 $'000	Carrying Amount 1 July 2012 $'000	Acquisitions $'000	Transfers $'000	Disposals $'000	Depreciation Expense $'000	Depreciation written back on disposal/transfer $'000	Revaluations/ Impairment charges $'000	Depreciation written back on revaluation $'000	Cost/Valuation 30 June 2013 $'000	Accumulated Depreciation 30 June 2013 $'000	Carrying Amount 30 June 2013 $'000
Land	6,658	-	6,658	-	-	-	-	-	-	-	6,658	-	6,658
Buildings	81,712	(5,771)	75,941	-	8,507	-	(6,443)	-	-	-	90,219	(12,214)	78,005
Clinical equipment	27,853	(13,138)	14,715	-	3,503	(1,563)	(3,466)	1,431	-	-	29,793	(15,173)	14,620
Information technology	5,973	(3,130)	2,843	-	973	(148)	(1,152)	148	-	-	6,798	(4,134)	2,664
Motor vehicles	1,735	(458)	1,277	-	53	(34)	(176)	24	-	-	1,754	(610)	1,144
Other equipment	6,810	(2,410)	4,400	-	1,397	(112)	(674)	63	-	-	8,095	(3,021)	5,074
	130,741	(24,907)	105,834	-	14,433	(1,857)	(11,911)	1,666	-	-	143,317	(35,152)	108,165
Leased assets													
Buildings	3,525	(2,899)	626	-	26	-	(237)	-	-	-	3,551	(3,136)	415
	3,525	(2,899)	626	-	26	-	(237)	-	-	-	3,551	(3,136)	415
Work in Progress													
Buildings	1,595	-	1,595	10,202	(8,533)	-	-	-	-	-	3,264	-	3,264
Clinical equipment	226	-	226	3,599	(3,503)	-	-	-	-	-	322	-	322
Information technology	345	-	345	923	(973)	-	-	-	-	-	295	-	295
Motor vehicles	-	-	-	59	(53)	-	-	-	-	-	6	-	6
Other equipment	483	-	483	1,115	(1,397)	-	-	-	-	-	201	-	201
	2,649	-	2,649	15,898	(14,459)	-	-	-	-	-	4,088	-	4,088
	136,915	(27,806)	109,109	15,898	-	(1,857)	(12,148)	1,666	-	-	150,956	(38,288)	112,668

Restrictions

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 District Health Board has declared surplus and wishes to sell, to be sold to it for use in the redress of Treaty of Waitangi claims. The District Health Board may also be required to assist the Crown to meet its obligations over Māori sites of significance.

Valuation

Re-valued land and buildings are stated at net current value as determined by John Reid (MPropertyStudies BCom(VPM) ANZIV SNZPI) of Logan Stone as at 30 June 2011. The board believes that the net book value of plant and equipment is the fair value at 30 June 2013.

30 June 2012 Owned assets	Cost/Valuation 1 July 2011 $'000	Accumulated Depreciation 1 July 2011 $'000	Carrying Amount 1 July 2011 $'000	Acquisitions $'000	Transfers $'000	Disposals $'000	Depreciation Expense $'000	Depreciation written back on disposal $'000	Revaluations/ Impairment charges $'000	Depreciation written back on revaluation $'000	Cost/Valuation 30 June 2012 $'000	Accumulated Depreciation 30 June 2012 $'000	Carrying Amount 30 June 2012 $'000
Land	6,798	-	6,798	-	(140)	-	-	-	-	-	6,658	-	6,658
Buildings	76,720	-	76,720	-	4,992	-	(5,773)	2	-	-	81,712	(5,771)	75,941
Clinical equipment	25,359	(10,622)	14,737	-	3,446	(952)	(3,312)	796	-	-	27,853	(13,138)	14,715
Information technology	6,752	(3,815)	2,937	-	1,174	(1,953)	(1,268)	1,953	-	-	5,973	(3,130)	2,843
Motor vehicles	1,399	(347)	1,052	-	412	(76)	(142)	31	-	-	1,735	(458)	1,277
Other equipment	6,312	(2,119)	4,193	-	1,006	(508)	(549)	258	-	-	6,810	(2,410)	4,400
	123,340	(16,903)	106,437	-	10,890	(3,489)	(11,044)	3,040	-	-	130,741	(24,907)	105,834
Leased assets													
Buildings	3,525	(2,662)	863	-	-	-	(237)	-	-	-	3,525	(2,899)	626
	3,525	(2,662)	863	-	-	-	(237)	-	-	-	3,525	(2,899)	626
Work in Progress													
Buildings	1,280	-	1,280	5,357	(5,042)	-	-	-	-	-	1,595	-	1,595
Clinical equipment	443	-	443	3,229	(3,446)	-	-	-	-	-	226	-	226
Information technology	386	-	386	1,133	(1,174)	-	-	-	-	-	345	-	345
Motor vehicles	-	-	-	412	(412)	-	-	-	-	-	-	-	-
Other equipment	396	-	396	1,093	(1,006)	-	-	-	-	-	483	-	483
	2,505	-	2,505	11,224	(11,080)	-	-	-	-	-	2,649	-	2,649
	129,370	(19,565)	109,805	11,224	(190)	(3,489)	(11,281)	3,040	-	-	136,915	(27,806)	109,109

One property was transferred to non current assets available for sale during the year ended 30 June 2012.

Note 13 Intangibles assets

30 June 2013 Owned assets	Cost/Valuation 1 July 2012 $'000	Accumulated Amortisation 1 July 2012 $'000	Carrying Amount 1 July 2012 $'000	Acquisitions $'000	Transfers $'000	Disposals $'000	Amortisation Expense $'000	Amortisation written back $'000	Revaluations/ Impairment charges $'000	Cost/Valuation 30 June 2013 $'000	Accumulated Amortisation 30 June 2013 $'000	Carrying Amount 30 June 2013 $'000
Software	8,792	(5,270)	3,522	-	359	-	(1,103)	-	-	9,151	(6,373)	2,778
	8,792	(5,270)	3,522	-	359	-	(1,103)	-	-	9,151	(6,373)	2,778
Work in Progress												
Software	112	-	112	449	(359)	-	-	-	-	202	-	202
	112	-	112	449	(359)	-	-	-	-	202	-	202
	8,904	(5,270)	3,634	449	-	-	(1,103)	-	-	9,353	(6,373)	2,980

30 June 2012 Owned assets	Cost/Valuation 1 July 2011 $'000	Accumulated Amortisation 1 July 2011 $'000	Carrying Amount 1 July 2011 $'000	Acquisitions $'000	Transfers $'000	Disposals $'000	Amortisation $'000	Amortisation written back $'000	Revaluations/ Impairment charges $'000	Cost/Valuation 30 June 2012 $'000	Accumulated Amortisation 30 June 2012 $'000	Carrying Amount 30 June 2012 $'000
Software	7,970	(3,952)	4,018	-	793	29	(1,299)	(19)	-	8,792	(5,270)	3,522
	7,970	(3,952)	4,018	-	793	29	(1,299)	(19)	-	8,792	(5,270)	3,522
Work in Progress												
Software	209	-	209	725	(793)	-	-	-	-	112	-	112
	209	-	209	725	(793)	-	-	-	-	112	-	112
	8,179	(3,952)	4,227	725	-	29	(1,299)	(19)	-	8,904	(5,270)	3,634

Note 14 Investment property

	30 June 2013 $'000	30 June 2012 $'000
Balance at beginning of year	222	249
Disposals	(69)	-
Fair value adjustments	-	(27)
Balance at end of year	153	222

Investment properties are valued to fair value annually as at 30 June. Analysis of the investment properties and the property market performed within the DHB indicated valuation changes were immaterial, and no valuation adjustment has been made. The previous valuation as at June 2012 were performed by John Reid (MPropertyStudies BCom(VPM) ANZIV SNZPI) of Logan Stone. The fair value of investment property has been determined using market based evidence.

Note 15 Investments in associates

Hawke's Bay District Health Board had the following investments in associates:

General information

Name of entity	Principal activities	Interest held at 30 June 2012	Balance date
Allied Laundry Services Limited	Laundry services	25%	30 June
Te Matau a Maui Health Trust	PHO Governance	No reliable measure	30 June

The Te Matau a Maui Health Trust (the Trust) holds all the shareholding of the Hawke's Bay Primary Health Organisation (PHO). The Hawke's Bay District Health Board appoints four of the ten trustees to represent the general community in consultation with all of the territorial local authorities within the Hawke's Bay region. One of these trustees must be ordinarily resident in the Wairoa District and one of these trustees must be ordinarily resident in the Central Hawke's Bay District. Through its association with the Trust in appointing four of the ten trustees, and its association with the Hawke's Bay PHO as the PHO's primary funder, the District Health Board has significant influence over both the Trust and the PHO. Significant influence is the power to participate in the financial and operating policy decisions of the Trust and the PHO, but is not control over those policies.

The District Health Board is required to equity account for its associate organisations, recording the initial investment at cost and adjusting it thereafter for any changes in the District Health Board's share of the net assets/equity of the associate. However the equity structure of the Trust is not clearly defined from an equity accounting perspective, and it is not possible to obtain a reliable measure of the ownership interest. Consequently the Trust is excluded from the remainder of this note.

Movements in the carrying amount of the investment in Allied Laundry Services Limited	30 June 2013 $'000	30 June 2012 $'000
Balance at 1 July 2012	799	666
New investments during the year	-	-
Disposal of investments during the year	-	-
Dilution gain/(loss)	-	-
Share of total comprehensive income	85	89
Other movements (adjustment for 2010 and 2011 surpluses not previously recognised)	-	44
Dividend	-	-
Balance at 30 June 2013	884	799

There are no significant restrictions on the ability of the associate to transfer funds to Hawke's Bay District Health Board in the form of cash dividends.

Summarised financial information of Allied Laundry Services Limited Presented on a gross basis	30 June 2013 $'000	30 June 2012 $'000
Assets	4,831	4,852
Liabilities	1,175	1,374
Revenue	6,941	6,622
Surplus/(deficit)	340	360
Hawke's Bay District Health Board ownership interest	25%	25%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Contingent liabilities that arise because of several liability	-	-
Contracted capital commitments	-	-
Other contracted commitments	-	170

This information is from the unaudited management accounts of theCompany as at 30 June 2013.

Allied Laundry Services Limited is an unlisted company. Accordingly, there are no published price quotations for this investment.

Summarised financial information of Te Matau a Maui Health Trust Presented on a gross basis	30 June 2013 $'000	30 June 2012 $'000
Assets	10,209	11,701
Liabilities	4,820	5,392
Revenue	32,670	33,002
Total comprehensive Income	(790)	1,642
Share of trust's contingent liabilities incurred jointly with other investors	-	-
Contingent liabilities that arise because of several liability	-	-
Contracted capital commitments	-	-
Other contracted commitments	-	232

This information is from the unaudited management accounts of the Trust as at 30 June 2013.

Note 16 Other investments

	30 June 2013 $'000	30 June 2012 $'000
Balance at beginning of year	553	-
New investments during the year	4,110	553
	4,663	553
Investments		
Class B shares in Health Benefits Limited	999	-
Central Region Technical Advisory Services	3,664	553
	4,663	553

Health Benefits Limited (HBL) issued 2,504,000 Class B shares to Hawke's Bay District Health Board in December 2012, and are using the proceeds of the share issue to fund the Finance, Procurement and Supply Chain Shared Services Programme it is implementing on behalf of all the district health boards. As at 30 June 2013 a total of 999,000 shares had been called at $1 per share. The shares confer a right to use the shared service and carry no voting rights.

Hawke's Bay District Health Board has an interest in the Central Region Information Systems Plan (CRISP) which is a co-operative venture involving the district health boards in the central region. The legal structure of CRISP is yet to be determined, and the contributions to CRISP by the District Health Board have been treated as an investment until the legal structure is resolved.

Note 17 Interest-bearing loans and borrowings

	30 June 2013 $'000	30 June 2012 $'000
Non-current		
Secured bank loans (Ministry of Health)	37,500	37,500
Finance lease liabilities	299	642
	37,799	38,142
Current		
Secured bank loans (Ministry of Health)	5,000	5,000
Finance lease liabilities	344	345
	5,344	5,345

Secured Bank Loans

Hawke's Bay District Health Board has a secured bank loan with the Crown. The details of terms and conditions are as follows:

	30 June 2013 $'000	30 June 2012 $'000
Weighted average interest rate		
Ministry of Health	5.39%	5.42%
Repayable as follows:		
Less than one year	5,000	5,000
One to two years	10,000	5,000
Two to three years	-	10,000
Three to fours years	-	-
Four to five years	6,000	-
Later than five years	21,500	22,500
Term loan facility limits:		
Ministry of Health	42,500	42,500

Security and Terms

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

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

The Government of New Zealand does not guarantee term loans.

Unsecured Bank Loans

Hawke's Bay District Health Board had an unsecured bank loan with the Energy Efficiency Conservation Authority. The loan was repayable in quarterly instalments of $49,000, with the final instalment of $54,000 repaid on 15 May 2012. No interest was payable on the loan and the amount amortised as interest expense for 2013 was nil (2012: $8,907)

Finance Lease Liabilities

Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance lease are disclosed on note 12. Finance lease liabilities are payable as follows:

	Total 2013 Actual	Interest 2013 Actual	Principal 2013 Actual	Total 2012 Actual	Interest 2012 Actual	Principal 2012 Actual
Minimum Lease payments payable:						
Less than one year	415	40	375	415	70	345
Between one and five years	276	8	268	690	48	642
	691	48	643	1,105	118	987
Future finance charges	(29)	(1)	(28)	(33)	(2)	(31)
	662	47	615	1,072	116	956
Present value of minimum lease payments payable:						
Less than one year	400	38	362	410	69	341
Between one and five years	262	9	253	662	47	615
	662	47	615	1,072	116	956

Hawke's Bay District Health Board leases a building under a lease classified as a finance lease. The lease is for the Central Hawke's Bay Health Centre which is leased for a period of fifteen years ending February 2015, with right of renewal for a further three periods of six years each, and an escalation clause allowing for increases in line with the inflation rate. Under the terms of the lease agreements, no contingent rents are payable.

Note 18 Trade and other payables

	30 June 2013 $'000	30 June 2012 $'000
Trade payables	3,848	4,880
ACC levy payable	792	887
Goods and services tax	2,017	696
Income in advance relating to contracts with specific performance obligations	2,091	2,674
Other non-trade payables and accrued expenses	21,471	20,456
	30,219	29,593

Trade and other payables 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 trade and other payables approximates their fair value.

Note 19 Employee benefits

	30 June 2013 $'000	30 June 2012 $'000
Non-current liabilities		
Long service leave	1,991	1,995
Retirement gratuities	150	197
	2,141	2,192
Current liabilities		
Accrued salaries and wages	5,509	5,295
Annual leave	17,279	17,125
Sick leave	240	265
Continuing medical education leave and expenses	3,948	3,756
Sabbatical leave	505	491
Long service leave	1,299	1,271
Retirement gratuities	133	77
	28,913	28,280

Actuarial valuations

An external independent actuarial valuer, Paul Dalebroux (BSc(Hons), FIA, FNZSA) has calculated the Hawke's Bay District Health Board's liability for long service leave, retirement gratuities, sabbatical leave and sick leave, and the valuations are effective 30 June 2013.

Note 20 Provisions

	ACC Partnership Programme
30 June 2013	
Balance at 1 July 2012	262
Additional provisions made	587
Amounts used	(596)
Unused amounts reversed	-
Balance at 30 June 2013	253
30 June 2012	
Balance at 1 July 2011	255
Additional provisions made	368
Amounts used	(361)
Unused amounts reversed	-
Balance at 30 June 2012	262

All provisions are classified as current.

a. ACC Partnership Programme

Liability valuation

The liability for the ACC Partnership Programme is measured at the value of anticipated future payments to be made in respect of the employee injuries and claims 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.

An external independent actuarial valuer, Peter Davies (B.Bus.Sc, FIA, FNZSA) has calculated the Hawke's Bay District Health Board's liability, and the valuation is effective 30 June 2013. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

The key assumptions used in determining the outstanding claims liability are:

- that the number of reopening claims are similar to those derived from other valuations of entities that are members of the Full Self Cover Plan;
- that claims incurred but not reported (IBNR) will be similar to past claim reporting patterns of weekly compensation and 'medical only' claims, and that further approximate additions for weekly compensation claims to allow for the possibility of long term gradual process claims will be sufficient;
- that a 7.5% factor will be sufficient for future claim management expenses; and
- that liabilities can be carried at their face value as there are insufficient long-term claims to be able to carry out any meaningful discounting.

Risk margin

A risk margin of 12.5% (2012 12.5%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. The risk margin has been determined after consideration of past claims history, costs and trends. The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Insurance risk

The District Health Board operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibilities for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.

The District Health Board is responsible for managing claims for a period of up to five years following the lodgement date. At the end of five years, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis. A stop loss limit of 250% of risk (levy rate x total liable payroll x loss ratio) is used. The stop loss limit means the District Health Board will carry the total cost of all claims only up to a total of $1.2 million per annum. The Hawke's Bay District Health Board is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee. The value of the liability is not material for the District Health Board's financial statements; therefore, any changes in assumptions will not have a material impact on the financial statements.

b. Other provisions

There are no provisions for site restoration or onerous contracts as at 30 June 2013 (30 June 2012: Nil).

Note 21 Equity

	Crown Equity	Land Revaluation Reserve	Buildings Revaluation Reserve	Asset Replace Reserve	Accumulated Deficit	Total Equity
	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2012	38,300	5,410	26,334	10,048	(35,538)	44,554
Surplus/(deficit) for the year	-	-	-	-	2,081	2,081
Transfers between reserves	-	-	-	2,363	(2,363)	-
Contribution from the Crown	-	-	-	-	-	-
Repayment to the Crown	(357)	-	-	-	-	(357)
Balance at 30 June 2013	37,943	5,410	26,334	12,411	(35,820)	46,278
Balance at 1 July 2011	37,690	5,410	26,334	3,000	(30,507)	41,927
Surplus/(deficit) for the year	-	-	-	-	2,017	2,017
Transfers between reserves	-	-	-	7,048	(7,048)	-
Contribution from the Crown	967	-	-	-	-	967
Repayment to the Crown	(357)	-	-	-	-	(357)
Balance at 30 June 2012	38,300	5,410	26,334	10,048	(35,538)	44,554

Asset Replacement Reserve

The asset replacement reserve includes cash proceeds from the sale of the Napier Hill site of $4.850 million in the year ended 30 June 2012 and $3.000 million in prior years, and underspends relating to mental health funding from the Ministry of Health of $2.363 million including an adjustment of $0.149 million (prior years: $2.198 million). These funds have been reserved for the development of a mental health intensive care unit.

Land and Buildings Revaluation Reserves

Where land and buildings are reclassified as investment property, the cumulative increase in the fair value of the land and buildings at the date of reclassification in excess of any previous impairment losses is included in the revaluation reserve.

Note 22 Commitments

	30 June 2013 $'000	30 June 2012 $'000
Capital commitments		
Property, plant and equipment	1,096	953
Health Benefits Limited – Class B shares	1,505	-
Central Region Information Systems Plan (CRISP)	1,831	-
	4,432	953

Capital commitments include orders issued for property, plant and equipment, and future agreed contributions to Health Benefits Limited and CRISP.

	30 June 2013 $'000	30 June 2012 $'000
Non-cancellable commitments – operating leases		
Not more than one year	2,353	2,204
One to two years	2,027	1,824
Two to five years	3,502	3,709
Later than five years	5,455	6,851
	13,337	14,588

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

Note 23 Financial instruments

a. Financial instrument categories

	30 June 2013 $'000	30 June 2012 $'000
Financial Assets		
Loans and receivables		
Cash and cash equivalents	9,549	14,372
Loans	89	98
Trade and other receivables	16,495	16,201
	26,133	30,671

	30 June 2013 $'000	30 June 2012 $'000
Financial Liabilities		
Financial liabilities at amortised cost		
Secured bank loans (Ministry of Health)	42,500	42,500
Finance lease liabilities	643	987
Trade and other payables	30,219	29,593
	73,362	73,080

b. Fair value hierarchy disclosures

The Hawke's Bay District Health Board recognises no financial instruments at fair value in the statement of financial position.

c. Financial instrument risks

The Hawke's Bay District Health Board's activities expose it to a variety of financial instrument rate risks, including market risk, credit risk and liquidity risk. The District Health Board 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. The Hawke's Bay District Health Board's exposure to fair value interest rate risk is limited to its bank deposits which are held at fixed rates of interest.

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 the Hawke's Bay District Health Board to cash flow interest rate risk.

The Hawke's Bay District Health Board's investment policy requires a spread of investment maturity dates to limit exposure to short-term interest rate movements. The District Health Board currently has no variable interest rate investments.

The Hawke's Bay District Health Board's borrowing policy requires a spread of interest rate repricing dates on borrowings to limit the exposure to short-term interest rate movements.

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

	Effective Interest Rates	Total $'000	6 months or less $'000	6-12 months $'000	1-2 years $'000	2-5 years $'000	> 5 years $'000
30 June 2013							
Cash and cash equivalents							
Bank balances	-	16	16				
Credit balance (HBL)	4.02%	6,683	6,683	-	-	-	-
Short term deposits	2.17%	2,850	2,638	-	212	-	-
Secured bank loans:							
NZD fixed rate loans	5.39%	(42,500)	-	(5,000)	(10,000)	-	(27,500)
Finance lease liabilities	8.40%	(642)	-	-	(642)	-	-
Repricing gap		(33,593)	9,337	(5,000)	(10,430)	-	(27,500)

No borrowings matured and no borrowings were drawn in the year ended 30 June 2013.

	Effective Interest Rates	Total $'000	6 months or less $'000	6-12 months $'000	1-2 years $'000	2-5 years $'000	> 5 years $'000
30 June 2012							
Cash and cash equivalents							
Bank balances	-	204	204	-	-	-	-
Call deposits	2.50%	5,448	5,448	-	-	-	-
Short term deposits	2.77%	8,720	8,711	9			
Bank overdraft	5.54%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loans	5.42%	(42,500)	(5,000)	-	(5,000)	(10,000)	(22,500)
Finance lease liabilities	8.40%	(987)	-	-	-	(987)	-
Repricing gap		(29,115)	9,363	9	(5,000)	(10,987)	(22,500)

Foreign Currency risk

Hawke's Bay District Health Board is exposed to foreign 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.

Hawke's Bay District Health Board hedges all capital asset purchase orders greater than $100,000 denominated in foreign currencies. The District Health Board uses forward exchange contracts to hedge its foreign currency risk. Usually the forward exchange contracts have maturities of less than one year after the 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 District Health Board's bankers. The District Health Board does not hold any other monetary assets and liabilities in currencies other than NZD.

Credit risk

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 95% (30 June 2012: 93%) of the District Health Board's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Liquidity risk

Liquidity risk is the risk that the Hawke's Bay District Health Board 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 District Health Board aims to maintain flexibility in funding by keeping committed credit lines available. In meeting its liquidity requirements the Hawke's Bay District Health Board maintains a target level of investments that must mature within specified time frames.

Contractual maturity analysis of financial liabilities

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

	Carrying amount	Contractual cash flows	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
30 June 2013							
Trade and other payables	30,219	30,219	30,219	-	-	-	-
Secured loans (Ministry of Health)	42,500	52,351	1,154	6,083	11,900	9,890	23,324
Finance lease liabilities	643	788	236	237	315	-	-
	73,362	83,358	31,609	6,320	12,215	9,890	23,324
30 June 2012							
Trade and other payables	29,593	29,593	29,593	-	-	-	-
Secured loans (Ministry of Health)	42,500	53,331	6,063	1,038	7,041	14,047	25,142
Finance lease liabilities	987	1,248	234	234	468	312	-
	73,080	84,172	35,890	1,272	7,509	14,359	25,142

Contractual maturity analysis of financial assets

The table below analyses the Hawke's Bay District Health Board's financial assets into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest receipts.

	Carrying amount	Contractual cash flows	6 months or less	6-12 months	1-2 years	2-5 years	> 5 years
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
30 June 2013							
Cash and cash equivalents							
Bank balance	16	16	16	-	-	-	-
Credit balance (Health Benefits Ltd)	6,683	6,683	6,683				
Term deposit	2,850	2,850	2,638	212	-	-	-
Trade and other receivables	16,495	16,495	16,495	-	-	-	-
	26,044	26,044	25,832	212	-	-	-
30 June 2012							
Cash and cash equivalents							
Bank balance	204	204	204	-	-	-	-
Term deposit	14,168	14,185	14,176	9	-	-	-
Trade and other receivables	16,201	16,201	16,201	-	-	-	-
	30,573	30,590	30,581	9	-	-	-

Forecasted transactions

Hawke's Bay District Health Board does not hedge forecasted transactions.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of comprehensive income. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of interest income or financing costs in the Statement of Comprehensive Income. The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2013 was nil (2012: nil) recognised in fair value derivatives.

Sensitivity analysis

In managing interest rate and currency risks Hawke's Bay District Health Board aims to reduce the impact of short-term fluctuations in the District Health Boards earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on earnings.

At 30 June 2013, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2013/14, as most of the District Health Board's term debt is at fixed rates, and only the net interest from cash holdings would be affected. 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, with no major items planned for 2013/14.

Fair value

The fair values together with the carrying amounts shown in the statement of financial position are as follows:

	30 June 2013		30 June 2012	
	Carrying amount $'000	Fair value $'000	Carrying amount $'000	Fair value $'000
Loans and receivables				
Loans	89	99	98	111
Trade and other receivables	16,495	16,495	16,201	16,201
Cash and cash equivalents	9,549	9,549	14,372	14,372
Secured bank loans	(42,500)	(44,717)	(42,500)	(47,237)
Finance lease liabilities	(643)	(656)	(987)	(1,072)
Trade and other payables	(30,219)	(30,219)	(29,593)	(29,593)
	(47,229)	(49,449)	(42,409)	(47,218)

No interest rate swap and forward exchange contract assets or liabilities were in place on 30 June 2013 (2012: Nil)

Estimation of fair values analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

a. Interest bearing loans and borrowings

Fair value has determined using contractual cash flows, discounted using a rate based on market quoted Government stock at balance date plus a margin for District Health Board risk .

b. Finance lease liabilities

The fair value is estimated as the present value of future cash flows, discounted at market interest rates for homogeneous lease agreements. The estimated fair values reflect changes in interest rates.

c. Trade and other receivables/payables

For receivables/payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables/payables are discounted to reflect the fair value.

d. Interest rates used for determining fair value

The entity uses the government yield curve as of 30 June 2013 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows

	30 June 2013 %	30 June 2012 %
Loans and borrowings	2.84% - 4.15%	2.37% - 4.24%
Leases	2.89%	2.38%

Note 24 Contingent Assets

The Hawke's Bay District Health Board has a guarantee from Honeywell that energy efficiency and conservation measures managed by Honeywell will result in significant savings within a four year time period. Savings have not been achieved as quickly or to the extent expected and as a result payments were received from Honeywell between 2009 and 2011. No payments were received in 2012 or 2013, however it is likely that further payments will be received from Honeywell relating to the guarantee, although the value of the payments, if any, cannot be measured reliably.

Note 25 Contingent Liabilities

Lawsuits against the District Health Board

Hawke's Bay District Health Board 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 District Health Board or some other party. An assessment of the financial effect of the disputes and grievances cannot be made. The District Health Board was exposed to the same type of contingent losses last year, and no assessment of the financial effect could be made.

Superannuation schemes

The District Health Board 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 District Health Board could be responsible for any deficit of the scheme. Similarly, if a number of employers ceased to participate in the scheme, the District Health Board could be responsible for and increased share of any deficit.

As at March 2013, the scheme had a past service surplus of $17.4 million (7.7% of the liabilities) exclusive of employer superannuation contribution tax. This surplus was calculated using a discount rate equal to the expected return on assets, but otherwise the assumptions and methodology are consistent with the requirements of NZ IAS 19 *Employee Benefits.* The actuary to the scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report the actuary recommended employer contributions remain suspended.

Note 26 Related party transactions

Hawke's Bay District Health Board has a related party relationship with its associates, board members and executive officers. The District Health Board has no subsidiaries. All related party transactions have been entered into on an arms' length basis.

Hawke's Bay District Health Board is a wholly owned entity of the Crown. The Government significantly influences the role of the District Health Board as well as being its major source of revenue.

Significant transactions with government-related entities

Hawke's Bay District Health Board has been provided with funding from the Crown of $450.3 million (2012: $433.7 million) for specific purposes as set out in the New Zealand Health and Disability Act 2000 and the Crown Funding Agreement entered into with the Ministry of Health. The District Health Board provides services to, and receives revenue of $6.1 million (2012: $6.1 million) from the Accident Compensation Corporation (ACC), which is also a wholly owned entity of the Crown.

The Ministry of Health administers the inter-district flows regime on behalf of the all the District Health Boards in New Zealand. The regime compensates each district health board for the treatment of patients domiciled in other districts. The Hawke's Bay District Health Board received $7.8 million (2012: $8.9 million) and paid $52.8 million (2012: $51.5 million) under the regime.

Collectively, but not individually, significant, transactions with government related entities

In conducting its activities, Hawke's Bay District Health Board is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The District Health Board is exempt from paying income tax.

The District Health Board also purchase goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government related entities for the year ended 30 June 2013 totalled $6.1 million (2012: $6.2 million). These purchases include blood products from the New Zealand Blood Service, operational costs of Health Benefits Limited, air travel from Air New Zealand, operational costs of Pharmac and contributions to their discretionary pharmaceutical fund, electricity from Meridian Energy, and educational courses from the Eastern Institute of Technology.

Related party transactions with associated entities and joint ventures

	30 June 2013		30 June 2012	
	Transaction amount Payments/(Receipts) $'000	Outstanding amount Owed/(Owing) $'000	Transaction amount Payments/(Receipts) $'000	Outstanding amount Owed/(Owing) $'000
Allied Laundry Services Limited				
Laundry services	1,485	-	2,024	-
Consumables	(16)	1	(31)	(1)
Te Matau a Maui Health Trust				
Primary health services	32,748	-	37,751	-
Primary health services	(532)	(546)	(681)	(305)
Central Region's Technical Advisory Services Limited				
Health information, service planning and external service audits	2,956	-	788	-

Allied Laundry Services Limited and the Te Matau a Maui Health Trust are associate entities of the District Health Board. Central Region Technical Advisory Services is a joint venture with other district health boards. Te Matau a Maui Health Trust operates through Health Hawke's Bay – Te Oranga Hawke's Bay which is a Primary Health Organisation. The Trust became an associate of the District Health Board from 1 April 2011.

The outstanding amount for the Te Matau a Maui Health Trust is owing to the District Health Board as it relates to refunds from Health Hawke's Bay Limited for services the PHO does not provide.

Related party transactions involving key management personnel (or their close family members)
The following transactions were entered into during the year with key management personnel:

- The District Health Board has a contract with Unison Networks Limited (Unison), an electricity lines company in which board chairman Kevin Atkinson is the chairman, and board member Helen Francis is a trustee of the Hawke's Bay Power Consumers Trust which holds all the shares in Unison. The contract is to lease a generator for a fixed fee per annum plus a CPI adjustment until 30 November 2020. During the year the lease cost $58,854 including $158 for maintenance (2012: $60,358 including a catch-up of prior year CPI adjustments). There was a balance of nil (2012: nil) outstanding at year end. During the year ended 30 June 2013 the District Health Board paid Unison a second installment of $30,198 for the procurement and building of switchgear (2012: $30,198). There was a balance of nil outstanding at year end.

- During the year ended 30 June 2013 the District Health Board provided support for a number of health related programmes run by Ngati Kahungunu Iwi Inc of which deputy chairman Ngahiwi Tomoana is a Chairman. The services cost $59,191 (2012: $13,043) and there was a balance of nil (2012: nil) outstanding at year end. During the year the District Health Board purchased health services from Te Taiwhenua o Heretaunga of which Ngati Kahungunu Iwi Inc is the titular head. The services cost $5,287,543 (2012: $6,751,938) and there was a balance of nil (2012: nil) outstanding at year end. During the same period the District Health Board provided training services and seconded a staff member to Te Taiwhenua o Heretaunga. The services cost $26,998 (2012: $76,864) and there was a balance of nil (2012: nil) outstanding at year end.

- During the year ended 30 June 2013 the District Health Board paid for rates, aquatic centre concession cards, training workshops, building consents and building warrants of fitness, from the Napier City Council of which board member Barbara Arnott is the Mayor. During the year these services cost $6,348 (2012: $7,194). There was a balance of nil (2012: nil) outstanding at year end.

- During the year the year ended 30 June 2013 the District Health Board purchased helicopter transfer services from the Hawke's Bay Helicopter Rescue Trust, in which board member Peter Dunkerley, and Ken Foote, company secretary, are trustees. These services cost $363,420 (2012: $469,936). There was a balance of nil (2012: nil) outstanding at year end. During the same period the District Health Board supplied patient escorts for ACC patients, electricity and telecommunication services, and a defibrillator and a ventilator to the trust. The charge for this service was $17,572 (2012: $26,984) and there was a balance of $3,709 (2012: $2,246) outstanding at year end. In February 2013 the District Health Board forgave $15,790 (2012: $15,790) of the advance to the trust that was used for the construction of the helicopter hanger. There is a balance of $110,520 outstanding on the advance at year end.

- During the year ended 30 June 2013 the District Health Board purchased water and paid for rates and various regulatory functions from the Wairoa District Council, of which board member Denise Eaglesome is deputy mayor. These services cost $48,376 (2012: $34,643). There was a balance of nil (2012: nil) outstanding at year end.

- During the year ended 30 June 2013 the District Health Board purchased dementia specific day care and community services from the Alzheimers Society Napier Incorporated, of which board member Helen Francis is a committee member. These services cost $292,640 (2012: $395,806), and there was a balance of nil (2012: nil) outstanding at year end. During the same period, the District Health Board provided meals to the society that cost $16,904 (2012: $6,386) and there was a balance of $2,416 (2012: nil) outstanding at year end. The District Health Board also gifted the $250,548 proceeds from the sale of one of its properties used by the Society. The gift is subject to a specific trust.

- During the year ended 30 June 2013 the District Health Board purchased study courses from the Eastern Institute of Technology (EIT), in which board member Diana Kirton is Assistant Head of School / Practium manager for School of Health and Sport Science, and Tracee TeHuia, director of Māori health, is a member of the Council. These services cost $237,371 (2012: $347,067). There was a balance of nil (2012: nil) outstanding at year end. During the same period the District Health Board accepted clinical placements from EIT and supplied clinical goods to EIT for a total charge of $136,086 (2012: $134,993). There was a balance outstanding of $34,982 (2012: $6,523) at year end.

- During the year ended 30 June 2013 the District Health Board rented accommodation from Little Elms operated by Trucking for Hawke's Bay Child Cancer Charitable Trust, in which Ken Foote, company secretary, is the District Health Board's representative on a management committee making recommendations to the trust board. The accommodation cost $34,256 (2012: $29,298), and there was a balance of nil (2012: $174) outstanding at year end.

- There are close family members of key management personnel employed by Hawke's Bay District Health Board. The terms and conditions of these arrangements are no more favourable than the District Health Board would have adopted if there were no relationship to key management personnel.

- No provision has been required, nor any expense recognised for the impairment of any loans or other receivables to related parties (2012: Nil).

Key management personnel compensation

	30 June 2013	30 June 2012
	$'000	$'000
Salaries and other short term employment benefits	2,931	2,608
Post-employment benefits	-	-
Other long term benefits	9	-
Termination benefits	101	-
	3,041	2,608

Key management personnel includes board members, the Chief Executive Officer, and the 13 (2012: 10) senior management staff and advisors who were members of the executive management team during the year.

Note 27 Remuneration

Remuneration – Board members

	30 June 2013		30 June 2012	
	Board	Committees	Board	Committees
	$'000	$'000	$'000	$'000
Board Members *from December 2010*				
Kevin Atkinson *Chair*	40,000	3,500	40,000	4,000
Ngahiwi Tomoana *Deputy Chair (appointed member*)	25,000	1,937	25,000	2,000
Barbara Arnott (*appointed member)*	20,000	4,125	20,000	4,125
David Barry	20,000	4,125	20,000	4,000
David Davidson	20,000	1,500	20,000	2,250
Dan Druzianic *(appointed member)*	20,000	4,125	20,000	4,375
Peter Dunkerley	20,000	4,063	20,000	4,000
Denise Eaglesome *(appointed member)*	20,000	1,250	20,000	2,000
Helen Francis	20,000	2,062	20,000	2,500
Diana Kirton	20,000	1,374	20,000	3,622
Kirsten Wise	20,000	3,250	20,000	3,500

During the year directors fees of $7,500 were paid to ex-board member David Ritchie (2012: $7,500) as one of the District Health Board's representatives on the Board of Allied Laundry Services Limited.

Remuneration – Committee members who are not board members or employees

	30 June 2013 Committees	30 June 2012 Committees		30 June 2013 Committees	30 June 2012 Committees
	$	$		$	$
Bayden Barber	1,250	250	Kerri Nuku	750	1,500
Lee Bullivant	-	1,500	Eileen Page	1,250	1,500
Heather Campbell	1,000	250	Diana Peterson	750	2,000
Tatiana Greening	4,250	5,250	Desma Ratima	2,000	2,500
Leslie Hokianga	750	1,750	Heather Robertson	-	1,250
Ngatai Huata	2,500	3,750	Rhose Shand	-	1,750
Terry Kingston	1,500	1,500	Frances Smiler-Edwards	1,000	1,000
Amber Logan-Riley	1,750	4,250	Laureen Sutherland	1,000	1,000
Vaun McCormick	250	-	Joan Sye	1,000	1,750
John Newland	1,000	500	Diane Walsh	1,250	-
Graeme Norton	1,750	750			

During the year additional payments of $6,345 were paid to Ngatai Huata for additional work resulting from her membership of advisory committees.

Employee Remuneration

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

	30 June 2013	30 June 2012		30 June 2013	30 June 2012
100,000-109,999	42	49	290,000-299,999	4	1
110,000-119,999	27	20	300,000-309,999	1	4
120,000-129,999	19	17	310,000-319,999	5	2
130,000-139,999	9	9	320,000-329,999	1	2
140,000-149,999	11	10	330,000-339,999	1	-
150,000-159,999	6	12	340,000-349,999	2	-
160,000-169,999	9	7	350,000-359,999	-	1
170,000-179,999	7	6	360,000-369,999	1	-
180,000-189,999	10	7	370,000-379,999	-	-
190,000-199,999	9	8	380,000-389,999	-	-
200,000-209,999	6	8	390,000-399,999	-	-
210,000-219,999	6	7	400,000-409,999	-	-
220,000-229,999	8	4	410,000-419,999	-	-
230,000-239,999	5	6	420,000-429,999	-	1
240,000-249,999	5	7	430,000-439,999	1	-
250,000-259,999	2	5	440,000-449,999	-	-
260,000-269,999	6	3	450,000-459,999	1	-
270,000-279,999	4	3	460,000-469,000	-	1
280,000-289,999	4	4			

During the year ended 30 June 2013, eleven (30 June 2012: 12) employees received compensation and other benefits in relation to cessation totalling $246,164 (30 June 2012: $375,246) .

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.

The Hawke's Bay District Health Board has affected 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.

Note 28 Subsequent events

There are no significant events subsequent to balance date.

Note 29 Output class summary

	30 June 2013 $'000	Budget 30 June 2013 $'000	30 June 2012 $'000
Income			
Prevention services	4,514	4,800	7,884
Early detection and management	146,284	140,000	140,367
Intensive assessment and treatment	261,578	263,800	254,757
Rehabilitation and support	62,523	63,900	61,378
Total income	474,899	472,500	464,386
Expenditure			
Prevention services	6,550	5,300	7,293
Early detection and management	143,611	138,700	141,444
Intensive assessment and treatment	259,414	262,700	251,020
Rehabilitation and support	63,243	62,800	62,612
Total expenses	472,818	469,500	462,369
Surplus/(deficit) for the year	2,081	3,000	2,017

Direct income and costs are attributed directly to output classes. Indirect income and costs are allocated to output classes using appropriate cost drivers.

Note 30 Explanation of financial variances from budget

The financial information contained in the statement of intent is prospective financial information in terms of FRS-42 *Prospective Financial Information*. FRS-42 requires the District Health Board 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, which is also a specific requirement of s.41(2)(k) of the Public Finance Act 1989.

Financial Performance

Income for the year is $3.5 million higher than plan reflecting:

- income of $2.4 million for additional services for the Ministry of Health;
- additional income from other DHBs including $0.5 million from Mid Central DHB for oncology clinics and $0.4 million from Tairawhiti DHB for cytotoxic drugs;
- donations and bequests of $0.7 million; including a contribution from Otago University towards additional meeting rooms in the education centre, and funding from the Ministry of Education for early childhood education;
- additional income of $0.8 million from the Wairoa GP practices acquired during the year; offset by:
- lower than budgeted income from ACC of $1.0 million; and
- a provision against non-resident income of $0.3 million.

The result for the year is a $0.9 million lower than planned surplus, and reflects the net amount of income recognised in earlier years than the related expense is incurred, in compliance with *IPSAS-23 Revenue from Non-Exchange Transactions*. The district health board does not budget for the impact of this standard because the amounts are unknown at the time the budget is prepared.

Financial Position

The table below adjusts the projections for assets, liabilities and equity in the 2012/13 Annual Plan, by the difference between the forecasts used for 2011/12 in the Plan, and the results for 2011/12 reported in the 2011/12 Annual Report.

	2012/13 Annual Plan Forecast 2012 Result $'000 A	2011/12 Annual Report Reported 2012 Result $'000 B	Adjustment required to the 2012 Result $'000 C=B-A	2012/13 Annual Plan Projected 2013 Result $'000 D	2012/13 Annual Plan Adjusted for 2012 Result $'000 E=D+C	2012/13 Annual Report Reported 2013 Result $'000 F	2012/13 Annual Plan / Annual Report Variance $'000 G=F-E
Assets	154,583	148,368	(6,215)	159,081	152,866	150,947	(1,919)
Liabilities	(106,686)	(103,814)	2,872	(108,541)	(105,669)	(104,669)	1,000
Equity	(47,897)	(44,554)	3,343	(50,540)	(47,197)	(46,278)	919

Equity is $0.9 million lower than the adjusted plan, reflecting the lower than planned surplus. Assets are $1.9 million lower than the adjusted plan, reflecting lower than planned capital expenditure, mostly relating to projects that will not be going ahead. Liabilities are $1.0 million lower than the adjusted plan reflecting a reduction in trade payables.

Cash Flow

Cash flow from operating activities was $2.0 million lower than plan reflecting the lower surplus, increases in receivables and reductions in payables. Cash flow from investing activities was $2.2 million lower than plan, as a result of lower than planned investment in property, plant and equipment. Cash flow from financing activities was in line with budget.

Appendix one: Technical Results Report

Key for technical results report

Baseline	Latest available data for planning purpose
Target 2012/13	Target 2012/13
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target

OUTPUT CLASS 1: PREVENTION SERVICES

HEALTH PROMOTION AND EDUCATION SERVICES

Health Target: Better help for smokers to quit - Percentage of hospitalised smokers offered advice to quit			
Financial Year	Baseline	Target	Actual to Date
2011/12	*83%* *October – December 2010*	*≥95%*	*91.0% (U) - July to September 2011*
			92.6% (U) – October to December 2011
			93.2% (U) – January to March 2012
			93.3% (U) - April to June 2012
2012/13	*92.6%* *October – December 2011*	*≥95%*	*97.0% (F) - July to September 2012*
			99.4% (F) – October to December 2012
			98.7% (F) – January to March 2013
			98.5% (F) - April to June 2013

Health Target: Better help for smokers to quit - Percentage of PHO enrolled smokers offered advice to quit			
Financial Year *Source: Ministry of Health*	Baseline	Target	Actual to Date
2011/12	*15%* *July – September 2010* *(Source: DHBNZ)*	*≥90%*	*25.0% (U) – 12 months to September 2011*
			30.8% (U) – 12 months to December 2011
			31.9% (U) – 12 months to March 2012
			47.3% (U) – 12 months to June 2012
2012/13	*30.8%* *12 months to December 2011* *(Source: DHBNZ)*	*≥90%*	*51.8% (U) - 12 months to September 2012*
			56.3% (U) – 12 months to December 2012
			91.2% (F) - 12 months to March 2013
			79.6% (U) - 12 months to June 2013

Health Target: Better help for smokers to quit - *% of pregnant women offered advice and support to quit*			
Financial Year *Source: Ministry of Health*	Baseline	Target	Actual to Date
2012/13	*NEW*	*≥90%*	Unable to measure, see note below

For the 2012/13 financial year a new maternity indicator was included in the 'Better Help for Smokers to Quit' health target. To date, the Ministry has explored several options of using existing data sources to report on the Maternity indicator, but there is no single source that captures information about primary maternity services for all pregnant women, and existing sources are not currently able to be combined to do so. Therefore the Ministry is now looking at the option of DHBs capturing data and reporting on this indicators via the booking form, whereby a maternity facility is notified of the estimated due date for a pregnant women registered with an LMC or with DHB Primary Maternity Services. Issues with this newly proposed methodology are still being investigated for introduction in 2013/14 financial year.

Cessation Support in Primary Care			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*15% 12 months to December 2011*	*≥90%*	*29.6% (U) - 12 months to September 2012*
			32.2% (U) -12 months to December 2012
			45.8% (U) - 12 months to March 2013
			48.6% (U) - 12 months to June 2013

The number of people participating in GRx (Green Prescription) programmes in primary, secondary care or community settings			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2011/12	*1,934 2010 calendar year*	*≥1,920*	*1,836 (U) - 2011 calendar year*
2012/13	*1,836 2010 calendar year*	*≥1,741*	*1,625 (U) - July 2012 to June 2013*
MAORI/PACIFIC			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥696*	*670 (U) - July 2012 to June 2013*

Percentage of people waiting more than 5 days for treatment following a positive swab			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*0% 3 months to December 2012*	*≤5%*	*1.2% (F) - July to September 2012*
			0.0% (F) – October to December 2012
			0.0% (F) – January to March 2013
			0.0% (F) - April to June 2013

STATUTORY AND REGULATORY SERVICES

Number of communicable disease notifications			
Financial Year	Baseline	Target	Actual to Date
2011/12	*728 Annual average for the period Jul-05 – Jun-10*	*≥728*	*754 (F) - July 2011 to June 2012*
2012/13	*709 Annual average for the period Jul-05 – Jun-11*	*≥709*	*738 (F) - July 2012 to June 2013*

Percentage of communicable diseases investigated within standard response times[8]			
Financial Year	Baseline	Target	Actual to Date
2011/12	*94% October to December 2010*	*≥75%*	*91.6% (F) - July to September 2011*
			92.6% (F) - October to December 2011
			93.2% (F) - January to March 2012
			91.1% (F) - April to June 2012
2012/13	*92.6% 2010 calendar year*	*≥90%*	*91.6% (F) - July to September 2012*
			97.8% (F) - October to December 2012

[8] HBDHB Standards: One week for haemophilus influenzae type b & meningococcal disease. Two weeks for mumps, non seasonal influenza A (H1N1), paralytic shellfish poisoning, pertussis & rubella. Sixty five weeks for tuberculosis - new cases, relapses or reactivations. Thirty nine weeks for tuberculosis - treatment of latent infections. Eight weeks for lead absorption, legionella & leptospirosis. Four weeks for campylobacter, chemical poisoning from the environment, cryptosporidium, gastroenteritis, giardia, hepatitis A, B & C, listeria, measles, paratyphoid fever, salmonella, shigella, typhoid fever, VTEC/STEC infection and yersinia. A number of notifiable diseases have been omitted from this indicator because they are rare or they are seldom investigated by field officers.

			97.2% (F) - January to March 2013
			93.2% (F) - April to June 2013

POPULATION BASED SCREENING SERVICES

Percentage of women aged 50-69 years receiving breast screening in the last 2 years			
Financial Year *Source: Breast Screen Coast to Coast*	Baseline	Target	Actual to Date
OVERALL RATE			
2011/12	*67.5%* *24 months to December 2010*	*≥70%*	*72.2% (F) - 24 months to 30 April 2012*
2012/13	*69.4%* *24 months to November 2011*	*≥70%*	*74.1% (F) - 24 months to 31 May 2013*
MAORI			
2011/12	*51.8%* *24 months to December 2010*	*≥70%*	*59.3% (U) - 24 months to 30 April 2012*
2012/13	*55.6%* *24 months to November 2011*	*≥70%*	*66.1% (U) - 24 months to 31 May 2013*
PACIFIC			
2011/12	*52.2%* *24 months to December 2010*	*≥70%*	*68.5% (U) - 24 months to 30 April 2012*
2012/13	*64.9%* *24 months to November 2011*	*≥70%*	*69.4% (U) - 24 months to 31 May 2013*

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years			
Financial Year *Source: Breast Screen Coast to Coast*	Baseline	Target	Actual to Date
OVERALL RATE			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*78.9%* *36 months to December 2011*	*≥80%*	*81.7% (F) - 36 months to 31 March 2013*
MAORI			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*66.4%* *36 months to December 2011*	*≥80%*	*74.1% (U) - 36 months to 31 March 2013*
PACIFIC			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*69.5%* *36 months to December 2011*	*≥80%*	*81.9% (F) - 36 months to 31 March 2013*

IMMUNISATION SERVICES

Health Target: Increased immunisation - Percentage of 8 month who complete their primary course of immunisations			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥85%*	*87.0% (F) – 3 months to September2012*
			91.8% (F) – 3 months to December 2012
			93.6% (F) – 3 months to March 2013
			94.8% (F) - 3 months to June 2013
MAORI			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥85%*	*86.8% (F) – 3 months to September2012*
			90.3% (F) – 3 months to December 2012
			94.0% (F) – 3 months to March 2013
			95.5% (F) - 3 months to June 2013

Increased immunisation - Percentage of 2 year olds fully immunised:			
Financial Year	Baseline	Target	Actual to Date
TOTAL			
2011/12	*96.4%* *3 months to December 2010*	*≥95%*	*94.2% (U) – 3 months to September2011*
			93.9% (U) – 3 months to December 2011
			95.8% (F) – 3 months to March 2012
			95.5% (F) - 3 months to June 2012
2012/13	*93.9%* *3 months to December 2011*	*≥95%*	*93.8% (U) – 3 months to September2012*
			94.9% (U) – 3 months to December 2012
			93.6% (U) – 3 months to March 2013
			96.1% (F) - 3 months to June 2013
MAORI			
2011/12	*95.2%* *3 months to December 2010*	*≥95%*	*95.8% (F) – 3 months to September2011*
			94.3% (U) – 3 months to December 2011
			96.3% (F) – 3 months to March 2012
			96.7% (F) - 3 months to June 2012
2012/13	*94.3%* *3 months to December 2011*	*≥95%*	*95.8% (F) – 3 months to September2012*
			97.2% (F) – 3 months to December 2012
			95.2% (F) – 3 months to March 2013
			97.8% (F) - 3 months to June 2013

Percentage of high needs 65 years olds and over influenza immunisation rate			
Financial Year *Source: DHB Shared Services*	Baseline	Target	Actual to Date
2011/12	*63.6%* *January to September 2010*	*≥68%*	*67.09% (U) - January to December 2011*
2012/13	*67.1%* *January to December 2011*	*≥70%*	*66.5% (U) - January to December 2012*

WELL CHILD AND SCHOOL HEALTH SERVICES

Number of Children receiving a B4 school check - Overall			
Financial Year	Baseline	Target	Actual to Date
2011/12	*1,730* *July 2009 to June 2010*	*≥1,887*	*2,045 (F) - July 2011 to June 2012*
2012/13	*2,012* *2010/11*	*≥1,887*	*1,932 (F) - July 2012 to June 2013*

Number of Children receiving a B4 school check – Quintile 5			
Financial Year	Baseline	Target	Actual to Date
2011/12	*567* *July 2009 to June 2010*	*≥514*	*660 (F) - July 2011 to June 2012*
2012/13	*667* *2010/11*	*≥514*	*709(F) - July 2012 to June 2013*

Percentage of eligible population receiving a B4 school check			
Financial Year	Baseline	Target	Actual to Date
2011/12	*76%* *As at March 2010*	*≥80%*	*87% (F) - July 2011 to June 2012*
2012/13	*86%* *2010/11*	*≥80%*	*101% (F) - July 2012 to June 2013*

The number of school contacts by Public Health Nurses			
Financial Year	Baseline	Target	Actual to Date
2011/12	*22,567* *2009/10*	*≥21,351*	*19,293 (U) - July 2011 to June 2012*
2012/13	*20,059* *2010/11*	*≥17,225*	*18,577 (F) - July 2012 to June 2013*

Percentage of year 9's in low decile schools who have a HEADSSS assessment completed			
Financial Year	Baseline	Target	Actual to Date
2011/12	*88.6%* *2010 calendar year*	*≥91%*	*98.3% (F) - July 2011 to June 2012*
2012/13	*92.4%* *2011 calendar year*	*≥91%*	*102.5% (F) - July 2012 to June 2013*

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

PRIMARY HEALTH CARE SERVICES

GP utilisation: ratio of high needs enrolees vs others			
Financial Year *Source: DHB Shared Services*	Baseline	Target	Actual to Date
2011/12	*1.08* *January – June 2010*	*≥1.12*	*1.11 (U) - April to June 2011*
			1.09 (U) - July to September 2011
			1.10 (U) - October to December 2011
			1.15 (F) - January to March 2012
2012/13	*1.09* *July – September 2011*	*≥1.12*	*1.15 (F) - April to June 2012*
			1.16 (F) - July to September 2012
			1.14 (F) - October to December 2012
			1.23 (F) - January to March 2013

Of patients seen at the hospital emergency department between 6pm and 10pm, percentage who are triaged as lower urgency.			
Financial Year	Baseline	Target	Actual to Date
2011/12	*64.7%* *12 months to February 2011*	*<64.7%*	*54.9% (F)- July to September 2011*
			54.8% (F)- October to December 2011
			55.6% (F)- January to March 2012
			52.8% (F)- April to June 2012
2012/13	*54.8%* *October - December 2011*	*<56%*	*53.1% (F) - July to September 2012*
			55.7% (F) - October to December 2012
			55.7% (F) - January to March 2013
			52.3% (F) - April to June 2013

Number of sexual health client contacts – Primary care			
Financial Year	Baseline	Target	Actual to Date
2011/12	*1,043* *2009/10*	*≤1,200*	*1,613 (U) - July 2011 to June 2012*
2012/13	*1,043* *2009/10*	*≤1,200*	*550 (F) - July 2012 to June 2013*

PRIMARY AND COMMUNITY CARE PROGRAMMES

Health Target: More heart and diabetes checks: 75% of the eligible population will have had their cardiovascular disease risk assessed in the last 5 years			
Financial Year *Source: DHB Shared Services*	Baseline	Target	Actual to Date
TOTAL:			
January to June 2012	*-*	*≥60%*	*50.7% (U) - January to March 2012*
			57.5% (U) - April to June 2012
2012/13	*47.9%* *As at 30th June 2011*	*≥75%*	*61.4% (U) - July to September 2012*
			64.7% (U) – October to December 2012
			67.1% (U) – January to March 2013
			72.4% (U) - April to June 2013
MAORI			
January to June 2012	*-*	*≥60%*	*53.4%(U) - January to March 2012*
			59.5% (U) - April to June 2012
2012/13	*48.8%* *As at 30th June 2011*	*≥75%*	*62.2% (U) - July to September 2012*
			63.8% (U) – October to December 2012
			65.8% (U) – January to March 2013
			69.7% (U) - April to June 2013
PACIFIC			
January to June 2012	*-*	*≥60%*	*53.3%(U) - January to March 2012*
			59.4% (U) - April to June 2012
2012/13	*49.1%* *As at 30th June 2011*	*≥75%*	*61.5% (U) - July to September 2012*
			63.4% (U) – October to December 2012
			65.3% (U) – January to March 2013
			69.1% (U) - April to June 2013

More heart and diabetes checks - Better management of long-term conditions: Diabetes detection and follow up			
Financial Year *Source: DHB Shared Services*	Baseline	Target	Actual to Date
TOTAL:			
2012/13	*NEW*	*≥80%*	*80.6% (F) - July 2012 to June 2013*

More heart and diabetes checks - Better management of long-term conditions: Diabetes Case management			
Financial Year	Baseline	Target	Actual to Date
TOTAL::			
2011/12	*71%* *April – September 2010*	*≥80%*	*76.2% (U) - April 2011 – March 2012*
2012/13	*75.8%* *April – September 2011*	*≥80%*	*73.4% (U) – July 2012 to September 2012*
			74.8% (U) – July 2012 to December 2012
			74.7% (U) – July 2012 to March 2013
			74.7% (U) - July 2012 to June 2013
MAORI:			
2011/12	*66%* *April – September 2010*	*≥80%*	*68.6% (U) - April 2011 – March 2012*
2012/13	*69.6%* *April – September 2011*	*≥80%*	*69.3% (U) - July to September 2012*
			69.4% (U) – October to December 2012
			67.7% (U) – January to March 2013
			68.7% (U) - April to June 2013
PACIFIC:			
2011/12	*54%* *April – September 2010*	*≥80%*	*52.2% (U) - April 2011 – March 2012*
2012/13	*52.1%* *April – September 2011*	*≥80%*	*61.1% (U) - July to September 2012*
			58.3% (U) – October to December 2012
			57.7% (U) – January to March 2013
			55.2% (U) - April to June 2013

Co-ordinated Primary Options [9] (Volumes)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*NA*	*≥2,622*	*4,559 (F) - July 2011 to June 2012*
2012/13	*1,860* *July 2010 to June 2011*	*≥2,700*	*3,579 (F) - July 2012 to June 2013*

Sub-acute Community Support (Volumes)			
Financial Year *Please note this data is subject to change over time*	Baseline	Target	Actual to Date
2011/12	*30* *July 2010 – May 2011*	*≥ 30*	*36 (F) - July 2011 to June 2012*
2012/13	*29* *July 2011 – March 2012*	*≥ 30*	*60 (F) - July 2012 to June 2013*

ORAL HEALTH SERVICES

Percentage of enrolled preschool and primary school children not examined according to planned recall			
Financial Year	Baseline	Target	Actual to Date
2011/12	*3.2%* *2010 calendar year*	*<5%*	*2% (F) - 2011 calendar year*
2012/13	*3.2%* *2010 calendar year*	*<5%*	*4% (F) - 2012 calendar year*

Percentage of eligible preschool enrolments in DHB-funded oral health services			
Financial Year	Baseline	Target	Actual to Date
TOTAL:			
2011/12	*50.4%* *2010 calendar year*	*≥80%*	*63.1% (U) - 2011 calendar year*
2012/13	*50.4%* *2010 calendar year*	*≥80%*	*71.1% (U) - 2012 calendar year*
MAORI:			
2011/12	*39.2%* *2010 calendar year*	*≥80%*	*54.4% (U) - 2011 calendar year*
2012/13	*39.2%* *2010 calendar year*	*≥80%*	*63.8% (U) - 2012 calendar year*
PACIFIC:			
2011/12	*38.0%* *2010 calendar year*	*≥80%*	*58.4% (U) - 2011 calendar year*
2012/13	*38.3%* *2010 calendar year*	*≥80%*	*63.3% (U) - 2012 calendar year*

[9] Includes: Standard Acute Packages of Care, High Cost Gynaecological Procedures and Hospital Discharge Pathway

Adolescent [10] Oral Health utilisation rates			
Financial Year *Source: Ministry of Health*	Baseline	Target	Actual to Date
2011/12	*79.4%* *2009 calendar year*	*≥85%*	*80.8% (U) - 2011 calendar year*
2012/13	*77.2%* *2010 calendar year*	*≥85%*	*84.5 %(U) - 2012 calendar year*

COMMUNITY REFERRED TESTS/DIAGNOSTIC SERVICES AND PHARMACIST SERVICES

Percentage of routine laboratory tests [11] (by volume) completed and communicated to referring practitioners within 48 hours from time of receipt			
Financial Year *Source: Southern Community Laboratories and HBDHB Laboratory*	Baseline	Target	Actual to Date
2011/12	*97.3%* *October – December 2010*	*≥90%*	*97.8% (F) – July to September 2011*
			97.2% (F) – October to December 2011
			97.2% (F) – January to March 2012
			97.1% (F) - April to June 2012
2012/13	*97.2%* *October – December 2011*	*≥90%*	*97.3% (F) - July to September 2012*
			97.0% (F) – October to December 2012
			97.2% (F) – January to March 2013
			97.2% (F) - April to June 2013

Percentage of accepted referrals that receive MRI or CT scans within 42 days			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
CT			
2012/13	*NEW*	*≥75%*	*74.2% (U) - July to September 2012*
			85.8% (F) – October to December 2012
			90.2% (F) – January to March 2013
			92.3% (F) - April to June 2013
MRI			
2012/13	*NEW*	*≥75%*	*47.6% (U) - July to September 2012*
			53.1% (U) – October to December 2012
			61.6% (U) – January to March 2013
			63.5% (U) - April to June 2013

Number of dispensed items			
Financial Year *Source: Pharmaceutical Claims Data Mart, Ministry of Health. Excludes: Pharmaceutical cancer treatment (PCT). Note this data is subject to change over time.*	Baseline	Target	Actual to Date
2011/12	*2,771,649* *2009/10*	*≤3,000,000*	*3,114,000 (U) - 12 months to March 2012*
2012/13	*3,120,888* *12 months to February 2012*	*≤3,120,888*	*2,758,950 (F) - 12 months to June 2013*

[10] Adolescents are defined as people from Year 9 up to and including age 17 years

[11] Hematology (routine) – complete blood count (CBC). Prothrombin time (INR – International Normalised Ratio)
Biochemistry (routine) – Electrolytes (Sodium), Liver functions tests (LFT), Lipids, Beta gonadotropin hormone (BHCG)
Microbiology (routine) – Urine microscopy and culture

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

MENTAL HEALTH SERVICES

Secondary Mental health services utilisation rate			
Financial Year *Source: Ministry of Health*	Baseline	Target	Actual to Date
0-19 YEARS CHILD AND YOUTH			
TOTAL			
2011/12	*3.0%* *12 months to September 2010*	*≥2.9%*	*3.0% (F) - 12 months to September 2011*
			3.0% (F) - 12 months to March 2012
2012/13	*3.0%* *12 months to September 2011*	*≥3.0%*	*3.4% (F) - 12 months to September 2012*
			3.4% (F) - 12 months to March 2013
MAORI			
2011/12	*2.9%* *12 months to September 2010*	*≥2.9%*	*3.0% (F) - 12 months to September 2011*
			3.4% (F) - 12 months to March 2012
2012/13	*3.0%* *12 months to September 2011*	*≥3.0%*	*4.1% (F) - 12 months to September 2012*
			3.9% (F) - 12 months to March 2013
20-64 YEARS ADULTS			
TOTAL			
2011/12	*4.1%* *12 months to September 2010*	*≥4.1%*	*4.2% (F) - 12 months to September 2011*
			4.2% (F) - 12 months to March 2012
2012/13	*4.2%* *12 months to September 2011*	*≥4.2%*	*4.5% (F) - 12 months to September 2012*
			4.6% (F) - 12 months to March 2013
MAORI			
2011/12	*6.6%* *12 months to September 2010*	*≥6.6%*	*6.9% (F) - 12 months to September 2011*
			6.9% (F) - 12 months to March 2012
2012/13	*6.9%* *12 months to September 2011*	*≥6.9%*	*7.6% (F) - 12 months to September 2012*
			7.8% (F) - 12 months to March 2013

Percentage of people with enduring severe mental illness who have an up to date relapse prevention plan			
Financial Year	Baseline	Target	Actual to Date
0-19 YEARS CHILD AND YOUTH			
TOTAL			
2011/12	*11.5%* *As 10th January 2011*	*≥95%*	*63.4% (U) – As at 25th October 2011*
			47.3% (U) – As at 5th January 2012
			59.3% (U) – As at 7th April 2012
			80.6% (U) – As at 9th July 2012
2012/13	*47.3%* *As January 2012*	*≥95%*	*85.5% (U) – As at 25th October 2012*
			82.1% (U) – As at 5th January 2013
			87.4% (U) – As at 7th April 2013
			87.5% (U) – As at 9th July 2013
MAORI			
2011/12	*0.0%* *As 10th January 2011*	*≥95%*	*39.3% (U) – As at 25th October 2011*
			40.0% (U) – As at 5th January 2012
			66.7% (U) – As at 7th April 2012
			68.4% (U) – As at 9th July 2012
2012/13	*40%* *As January 2012*	*≥95%*	*75.8% (U) – As at 25th October 2012*
			64.0% (U) – As at 5th January 2013
			85.7% (U) – As at 7th April 2013
			75.8% (U) – As at 9th July 2013

20 YEARS AND OVER ADULTS (EXCLUDING ADDICITONS)			
TOTAL			
2011/12	*45.6%* *As 10th January 2011*	*≥95%*	*73.4% (U) – As at 25th October 2011* *77.7% (U) – As at 5th January 2012* *80.6% (U) – As at 7th April 2012* *80.2% (U) – As at 9th July 2012*
2012/13	*77.7%* *As January 2012*	*≥95%*	*82.5% (U) – As at 25th October 2012* *83.6% (U) – As at 5th January 2013* *94.8% (U) – As at 7th April 2013* *93.1% (U) – As at 9th July 2013*
MAORI			
2011/12	*30.8%* *As 10th January 2011*	*≥95%*	*47.3% (U) – As at 25th October 2011* *47.3% (U) – As at 25th October 2011* *60.1% (U) – As at 5th January 2012* *55.3% (U) – As at 7th April 2012*
2012/13	*60.1%* *As January 2012*	*≥95%*	*68.9% (U) – As at 25th October 2012* *62.9% (U) – As at 5th January 2013* *93.0% (U) – As at 7th April 2013* *87.1% (U) – As at 9th July 2013*

Shorter waits for non-urgent drug and alcohol services			
Financial Year *Please note data is subject to change over time*	Baseline	Target	Actual to Date
PERCENTAGE OF PEOPLE SEEN WITHIN 3 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥60%*	*64.6% (F) - October 2011 to September 2012* *66.0% (F) – April 2012 to March 2013*
ADDICTIONS (PROVIDER ARM AND NGO)			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥60%*	*61.3% (F) – October 2011 to September 2012* *57.7% (U) – April 2012 to March 2013*
PERCENTAGE OF PEOPLE SEEN WITHIN 8 WEEKS OF REFERRAL			
MENTAL HEALTH PROVIDER ARM			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥90%*	*87.7% (U) – October 2011 to September 2012* *83.7% (U) – April 2012 to March 2013*
ADDICTIONS (PROVIDER ARM AND NGO)			
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥90%*	*88.6% (U) - October to September 2012* *83.0% (U) – April 2012 to March 2013*

ELECTIVE SERVICES (inpatient, outpatient and cancer treatment)

Health target: Improved access to elective surgery (discharges)[12]			
Financial Year *Please note data is subject to change over time*	Baseline	Target	Actual to Date
NUMBER OF ELECTIVE DISCHARGES (VOLUMES)(Source: Ministry of Health)			
2011/12	*5,586*	*≥5,709*	*6,207 (F) – July 2011 to June 2012*
2012/13	*5,860* *2010/2011*	*≥5,729*	*6,678 (F) - July 2012 to June 2013*

(ESPI2) Percentage patients waiting longer than 6 months for their First Specialist Assessment (FSA)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*1.7%* *March 2011*	*0%*	*0.4% (U) – September 2011*
			0.3% (U) – December 2011
			0.3% (U) – March 2012
			0.0% (F) - June 2012
2012/13	*0.4%* *January 2012*	*0%*	*0.0% (F) – September 2012*
			0.1% (U) – December 2012
			0.8% (U) – March 2013
			0.0% (F) - June 2013

(ESPI5) Percentage of patients given a commitment but not treated within 6 months			
Financial Year	Baseline	Target	Actual to Date
2011/12	*4.4%* *March 2011*	*0%*	*1.6% (U) – September 2011*
			0.2% (U) – December 2011
			0.1% (U) – March 2012
			0.0%(F) - June 2012
2012/13	*0.4%* *January 2012*	*0%*	*0.0% (F) – September 2012*
			1.5% (U) – December 2012
			1.0% (U) – March 2013
			0.0% (F) - June 2013

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

Did not attend (DNA) rate across first specialist assessments[13]			
Financial Year *Please note data is subject to change over time*	Baseline	Target	Actual to Date
TOTAL			
2011/12	*9.1%* *January to March 2011*	≤7.5%	*9.7% (U) – July to September 2011*
			9.8% (U) - October to December 2011
			9.9% (U) – January to March 2012
			9.5% (U) - April to June 2012
2012/13	*9.8%* *October to December 2011*	≤7.5%	*7.9% (U) - July to September 2012*
			8.8% (U) – October to December 2012
			10.2% (U) – January to March 2013
			9.5% (U) - April to June 2013
MAORI			
2011/12	*18.6%* *January to March 2011*	≤7.5%	*19.7% (U) – July to September 2011*
			19.4% (U) - October to December 2011
			20.6% (U) – January to March 2012
			17.8% (U) - April to June 2012
2012/13	*19.4%* *October to December 2011*	≤7.5%	*16.1% (U) - July to September 2012*
			18.5% (U) – October to December 2012
			20.9% (U) – January to March 2013
			17.9% (U) - April to June 2013

Percentage elective and arranged day of surgery admissions (DOSA)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*84.5%* *12 months to September 2010*	≥90%	*93.4% (F) - 12 months to June 2011*
			95.0% (F) - 12 months to September 2011
			95.0% (F) - 12 months to December 2011
			95.0% (F) - 12 months to March 2012
2012/13	*92.6%* *2010/11*	≥95%	*94.4% (U) - 12 months to June 2012*
			95.3% (F) - 12 months to September 2012
			94.7% (U) - 12 months to December 2012
			94.7% (U) - 12 months to March 2013

Percentage of elective and arranged day surgery			
Financial Year	Baseline	Target	Actual to Date
2011/12	*58%* *12 months to September 2010*	≥60%	*56.9% (U) - 12 months to June 2011*
			56.7% (U) - 12 months to September 2011
			56.7% (U) - 12 months to December 2011
			56.6% (U) - 12 months to March 2012
2012/13	*56.7%* *12 months to September 2011*	≥60%	*57.2% (U) - 12 months to June 2012*
			59.2% (U) - 12 months to September 2012
			58.3% (U) - 12 months to December 2012
			58.6% (U) - 12 months to March 2013

Theatre utilisation			
Financial Year	Baseline	Target	Actual to Date
2011/12	*85.2%* *2010 calendar year*	≥90%	*86.1% (U) – July to September 2011*
			86.4% (U) – October to December 2011
			85.3% (U) – January to March 2012
			88.3% (U) - April to June 2012

[13] ESPI specialities only

2012/13	*86.4%* *October to December 2011*	*≥87%*	*84.8% (U) - July to September 2012*
			85.0% (U) - October to December 2012
			86.7% (U) - January to March 2013
			87.9% (F) - April to June 2013

Percentage of cancelled elective cases as a result of prioritised acute demand			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≤6%*	*11.1% (U) - July to September 2012*
			14.4% (U) – October to December 2012
			13.6% (U) – January to March 2013
			19.8% (U) - April to June 2013

Health Target: Shorter waits for cancer treatment - Radiation Oncology Treatment Waiting Times less than 4 weeks			
Financial Year *Source: MidCentral DHB*	Baseline	Target	Actual to Date
2011/12	*100%* *October – December 2010*	*100%*	*100% (F) - July to September 2011*
			100% (F) - October to December 2011
			100% (F) – January to March 2012
			100% (F) - April to June 2012
2012/13	*100%* *October – December 2011*	*100%*	*100% (F) - July to September 2012*
			100% (F) – October to December 2012
			100% (F) – January to March 2013
			100% (F) - April to June 2013

Chemotherapy Treatment waiting times less than 4 weeks			
Financial Year	Baseline	Target	Actual to Date
2011/12	*100%* *October – December 2010*	*100%*	*100% (F) - July to September 2011*
			100% (F) - October to December 2011
			100% (F) - January to March 2012
			100% (F) - April to June 2012
2012/13	*100%* *October – December 2011*	*100%*	*100% (F) - July to September 2012*
			100% (F) - October to December 2012
			100% (F) - January to March 2013
			100% (F) - April to June 2013

Initial contact by District Nursing Service within 48 hours of receipt of referral			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥80%*	*61.9% (U) - July to September 2012*
			78.1% (U) – October to December 2012
			81.0% (F) – January to March 2013
			82.7% (F) - April to June 2013

ACUTE SERVICES (emergency department, inpatient, outpatient)

Health Target: Shorter stays in Emergency Departments - Percentage of attendances to Emergency Department with Length of Stay within 6 hours			
Financial Year	Baseline	Target	Actual to Date
2011/12	*91%* *October to December 2010*	*≥95%*	*92.4% (U) – July to September 2011*
			**94.5% (F) – October to December 2011*
			**94.8% (F) – January to March 2012*

			95.8% (F) - April to June 2012
2012/13	*94.5%* *October to December 2011*	*≥95%*	*94.0% (U) - July to September 2012*
			94.3% (U) – October to December 2012
			93.1% (U) – January to March 2013
			93.3% (U) - April to June 2013

** Shorter stays in emergency department – HBDHB is reporting this as achieved in line with the Ministry of Health.*

Emergency Department Triage compliance rates			
Financial Year	Baseline	Target	Actual to Date
TRIAGE 1[14]			
2011/12	*100.0%* *October to December 2010*	*100%*	*100% (F) – July to September 2011*
			100% (F) – October to December 2011
			100% (F) – January to March 2012
			100% (F) - April to June 2012
2012/13	*100.0%* *October to December 2011*	*100%*	*100% (F) - July to September 2012*
			100% (F) – October to December 2012
			100% (F) – January to March 2013
			100% (F) - April to June 2013
TRIAGE 2[15]			
2011/12	*69.0%* *October to December 2010*	*≥80%*	*68.3% (U) – July to September 2011*
			68.5% (U) – October to December 2011
			61.2% (U) – January to March 2012
			63.6% (U) - April to June 2012
2012/13	*68.5%* *October to December 2011*	*≥80%*	*64.5% (U) - July to September 2012*
			59.8% (U) – October to December 2012
			62.4% (U) – January to March 2013
			66.4% (U) - April to June 2013
TRIAGE 3[16]			
2011/12	*60.6%* *October to December 2010*	*≥75%*	*55.6% (U) – July to September 2011*
			58.3% (U) – October to December 2011
			47.8% (U) – January to March 2012
			51.8% (U) - April to June 2012
2012/13	*58.3%* *October to December 2011*	*≥75%*	*45.4% (U) - July to September 2012*
			43.3% (U) – October to December 2012
			43.8% (U) – January to March 2013
			51.5% (U) - April to June 2013

[14] Definition of Triage 1: seen immediately
[15] Definition of Triage 2: seen within 10 minutes
[16] Definition of Triage 3: seen within 30 minutes

Standardised 28 day acute readmission rate			
Financial Year *Source: Ministry of Health*	Baseline	Target	Actual to Date
2011/12 NEW DEFINITION	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*11.3%* *2010/2011*	*≤11.2%*	*10.96% (F) - 12 months to June 2012*
			10.98% (F) - 12 months to September 2012
			10.81% (F) - 12 months to December 2012
			10.5% (F) - 12 months to March 2013

The results in the table are provided by the MoH however when validating the data we have identified events that were flagged as a 28 day acute readmission but linked to events outside of the 28 day period. The data quality issues make it difficult to get a true understanding of our Acute Readmission rate. However results from Quarter 1, 2, 3 & 4 (with data quality issues) are stable.

Rate[17] of hospital-acquired bloodstream infections[18]			
Financial Year	Baseline	Target	Actual to Date
2011/12	*0.21 per 1000 occupied bed days* *2010 calendar year*	*≤0.21*	*0.08 per 1000 occupied bed days (F) – July to September 2011*
			0.22 per 1000 occupied bed days (U) – October to December 2011
			0.17 per 1000 occupied bed days (F) – January to March 2012
			0.13 per 1000 occupied bed days (F) – April to June 2012
2012/13	*0.12 per 1000 occupied bed days* *2011calendar year*	*≤0.29*	*0.19 per 1000 occupied bed days (F) – July to September 2012*
			0.17 per 1000 occupied bed days (F) – October to December 2012
			0.17 per 1000 occupied bed days (F) – January to March 2013
			0.08 per 1000 occupied bed days (F) – April to June 2013

[17] Per 1000 occupied bed days
[18] Only those with an Acute admission type

Rate of clean site surgical site infections per 100 procedures			
Financial Year *Source: Ministry of Health*	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13-*		
2012/13	*1.2* *2011 calendar year*	*≤3.5*	*1.67 per 100 procedures (F) - July to September 2012*
			0 per 100 procedures (F) - October to December 2012
			0.01 per 100 procedures (F) - January to March 2013
			0.60 per 100 procedures (F) - April to June 2013

MATERNITY SERVICES

Post natal Average length of stay (days)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*2.2 days* *October – December 2010*	*≤2 days*	*2.2 days (U) – July to September 2011*
			2.1 days (U) – October to December 2011
			2.2 days (U) – January to March 2012
			2.3 days (U) - April to June 2012
2012/13	*2.1 days* *October – December 2011*	*≤2.1 days*	*2.2% (U) - July to September 2012*
			2.3% (U) – October to December 2012
			2.2% (U) – January to March 2013
			2.3% (U) - April to June 2013

Percentage of first time mothers delivering who are breastfeeding (Full or exclusive) at the time of discharge			
Financial Year *Please note this data is subject to change over time*	Baseline	Target	Actual to Date
2011/12	*84.5%* *October – December 2010*	*≥75%*	*78.6% (F) – July to September 2011*
			83.4% (F) – October to December 2011
			84.4% (F) – January to March 2012
			86.3% (F) - April to June 2012
2012/13	*83.3%* *October – December 2011*	*≥75%*	*80.2% (F) - July to September 2012*
			81.5% (F) – October to December 2012
			80.1% (F) – January to March 2013
			83.6% (F) - April to June 2013

ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)

Percentage of AT&R patients discharged home			
Financial Year	Baseline	Target	Actual to Date
2011/12	*62%* *12 months to December 2010*	*≥60%*	*61.0% (F) - 12 months to June 2012*
2012/13	*59.3%* *12 months to December 2011*	*≥60%*	*61.0% (F) - 12 months to June 2013*

Percentage of AT&R patients with length of stay greater than 21 days			
Financial Year	Baseline	Target	Actual to Date
2011/12	*56.1%* *3 months to February 2011*	*≤50%*	*59.1% (U) - April to June 2012*
2012/13	*57.2%* *October – December 2011*	*≤55%*	*39.6% (F) – 12 months to September 2012*
			40.3% (F) – 12 months to December 2012
			39.9% (F) – 12 months to March 2013
			38.2% (F) - 12 months to June 2013

Inpatient falls per 100 bed days			
Financial Year	Baseline	Target	Actual to Date
2011/12	*1.3* *2010 calendar year*	*≤1.3*	*1.3 per 100 bed days (F) - April to June 2012*
2012/13	*1.2* *October – December 2011*	*≤1.1*	*0.9 per 100 bed days (F) - July to September 2012*
			0.6 per 100 bed days (F) – October to December 2012
			0.8 per 100 bed days (F) – January to March 2013
			0.7 per 100 bed days (F) - April to June 2013

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

NEEDS ASSESSMENT AND SERVICE COORDINATION (NASC) SERVICES

Number of referrals processed (65 years and over)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*5,358* *2010 calendar year*	*≥5,584*	*6098 (F) - July 2011 to June 2012*
2012/13	*5,787* *2010/11*	*≥5,787*	*6,888 (F) - July 2012 to June 2013*

Average time from referral to allocation (65 years and over)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*13 days* *October – December 2010*	*≤10 days*	*8 days (F) – April to June 2012*
2012/13	*12 days* *January – March 2012*	*≤10 days*	*11 days (U) - July to September 2012*
			5 days (F) - October to December 2012
			7 days (F) - January to March 2013
			5 days (F) - April to June 2013

Number of needs assessments completed (Disability Services)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*522* *2010/11*	*≥300*	*463 (F) July 2012 to June2013*

Average time from referral to assessment (Disability Services)			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*13 days* *2010/11*	*≤13 days*	*12 days (F) - July to September 2012*
			4 days (F) - October to December 2012
			6 days (F) - January to March 2013
			3 days (F) - April to June 2013

REHABILITATION SERVICES AND PALLIATIVE CARE SERVICES

Utilisation of restorative care (packages of care) funding[19]			
Financial Year	Baseline	Target	Actual to Date
2011/12	*96.7%* *July – September 2010*	*≥97.0%*	*94.2% (U) – April to June 2011*
			100% (F) – July to September 2011
			99.2% (F) – October to December 2011
			100% (F) - January to March 2012
2012/13	*100%* *July – September 2011*	*≥97.0%*	*111.7% (U) – April to June 2012*
			106.7% (F) – July to September 2012
			127.5% (F) – October to December 2012
			111.7% (F) - January to March 2013

Time from referral receipt to initial Cranford Hospice contact within 48 hours			
Financial Year	Baseline	Target	Actual to Date
2011/12	*NA*	*100%*	*85% (U) - April to June 2012*
2012/13	*47%* *January to March 2012*	*≥80%*	*90% (F) - April to June 2013*

HOME BASED SUPPORT SERVICES AND AGED RESIDENTIAL CARE BED SERVICES

Percentage of people receiving home support who have a comprehensive clinical assessment and a completed care plan			
Financial Year	Baseline	Target	Actual to Date
2011/12	*New indicator in the Statement of Service Performance for 2012/13*		
2012/13	*NEW*	*≥90%*	*93.8% (F) - July to September 2012*
			93.3% (F) – October to December 2012
			95.7% (F) – January to March 2013
			95.2% (F) - April to June 2013

Vitamin D prescribing			
Financial Year	Baseline	Target	Actual to Date
2011/12	*54%* *October – December 2010*	*≥75%*	*54.0%(U) – July to September 2011*
			53.6% (U) - October to December 2011
			54.0% (U) – January to March 2012
			57.3% (U) - April to June 2012
2012/13	*53.6%* *October – December 2011*	*≥75%*	*57.3% (U) - July to September 2012*
			61.0% (U) – October to December 2012
			61.0% (U) – January to March 2013
			61.0% (U) - April to June 2013

RESPITE CARE AND DAY SERVICES

Number of respite days			
Financial Year	Baseline	Target	Actual to Date
2011/12	*3,501* *July 2009 – June 2010*	*≥3,362*	*4,242 (F) - July 2011 to June 2012*
2012/13	*4,919* *July 2010 – June 2011*	*≥7,274*	*4,514 (U) - July 2012 to June 2013*

[19] Percentage of high level clients

Number of day services			
Financial Year	Baseline	Target	Actual to Date
2011/12	*9,853* *July 2009 – June 2010*	≥*11,869*	*13,510 (F) - July 2011 to June 2012*
2012/13	*9,600* *July 2109 – June 2011*	≥*13,837*	*15,696 (F) - July 2012 to June 2013*

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