HAWKE'S BAY
District Health Board
Whakawāteatia

2020
Annual Report

Contents

Message from the Chair and Chief Executive

The 2019/20 year has been a difficult year where Hawke's Bay DHB's performance has been impacted by a number of factors including COVID-19.

With a new Chief Executive now at the helm the DHB expects to be able to set a stable path for both its staff and community into the future.

One area of particular challenge was financial performance. Hawke's Bay DHB reports a deficit of $32.3 million on normal operations, against a planned deficit of $12.9million. In addition to this, Hawke's Bay DHB has incurred exceptional costs associated with COVID-19 and Holidays Act liability estimate, which takes its overall deficit from $32.3 million to $62.9 million.

Following a review by EY, estimates of the cost to address issues in our interpretation of the Holidays Act, which goes back more than 10 years, has increased from $13m in 2018/19 to $33.9m.

COVID-19 delayed the start of a number of significant construction works this year, which will improve the facilities and services we offer to staff and the Hawke's Bay community.

The facilities projects include an additional theatre as well as the complete refurbishment of radiology, which will begin in earnest in 2021.

Hawke's Bay DHB has also signed off its health strategy, Whānau Ora, Hāpori Ora, for 2019-2029. This strategy sets the scene for the delivery of health services to individuals and communities across Te Matua-a-Māui, the Hawke's Bay region for the next ten years.

The DHB has a committed focus to improve the health of Māori and Pasifika and people with disabilities and is in the process of developing a five-year implementation plan to make this happen.

The implementation plan will prioritise and describe actions, set timelines and budget requirements as well as identify key risks and dependencies.

The Board was pleased to receive additional funding in 2020/2021 to help offset the impact of costs and demand of delivering services as well as some recognition of the population growth the region has experienced. This will help support us on our journey to achieving financial sustainability.

We would like to thank our staff for their commitment and continued focus on delivering safe and quality services to the community despite the challenges of the year. We also extend our thanks to

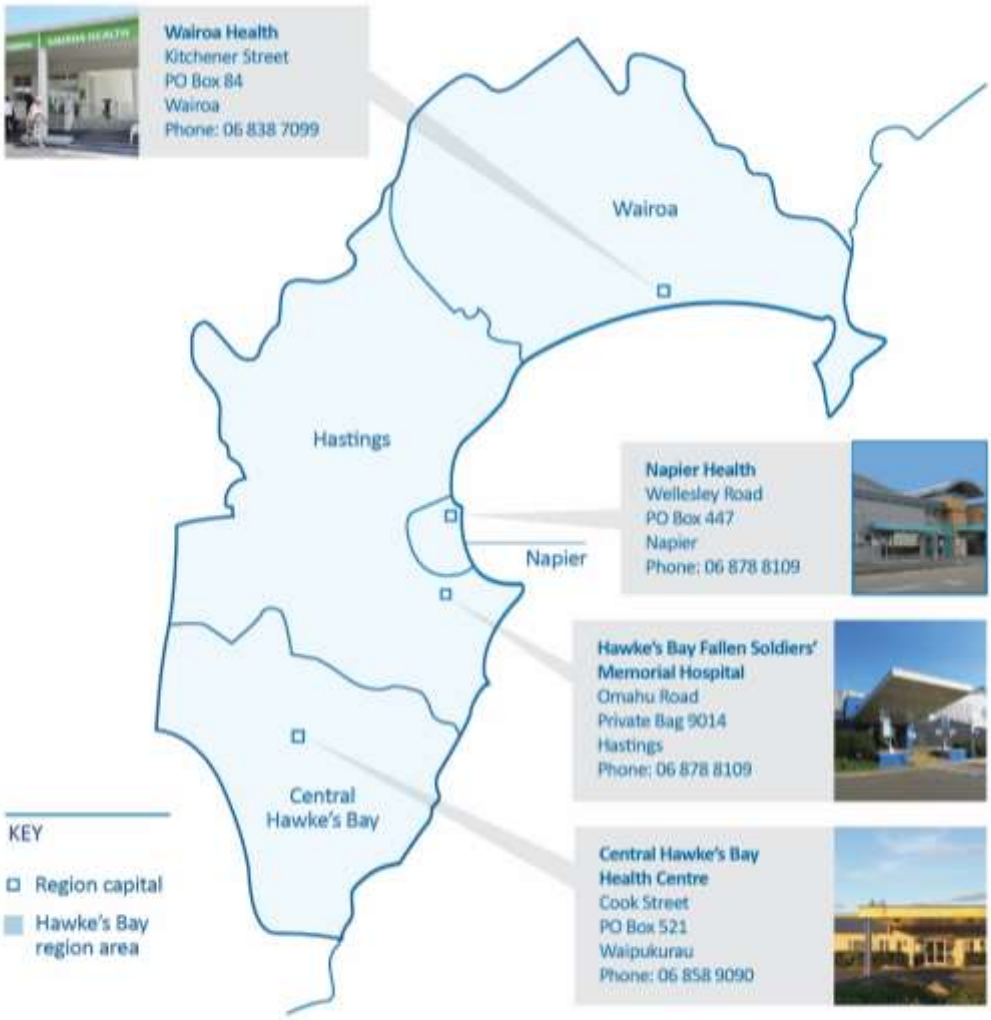
the community, particularly during Covid-19, for being active contributors to living well and looking out for each other.

Keriana Brooking
Chief Executive Officer

Shayne Walker
Board Chair

About Hawke's Bay District Health Board

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district, which includes the Wairoa, Napier, Hastings and Central Hawke's Bay districts.

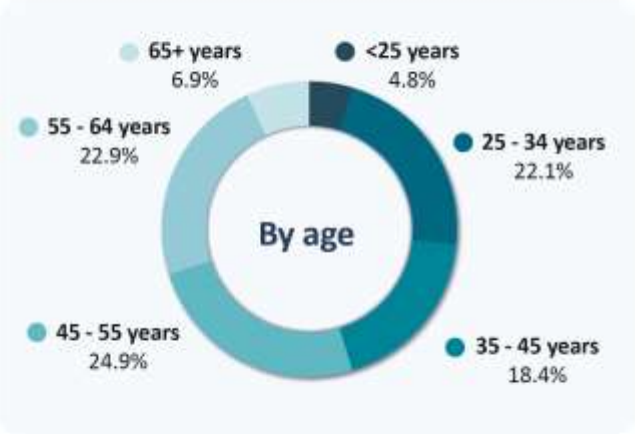


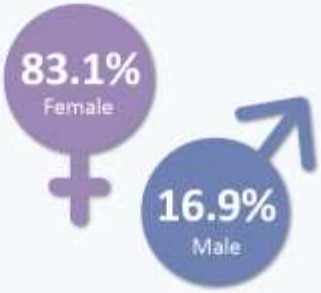
Our values - Our people

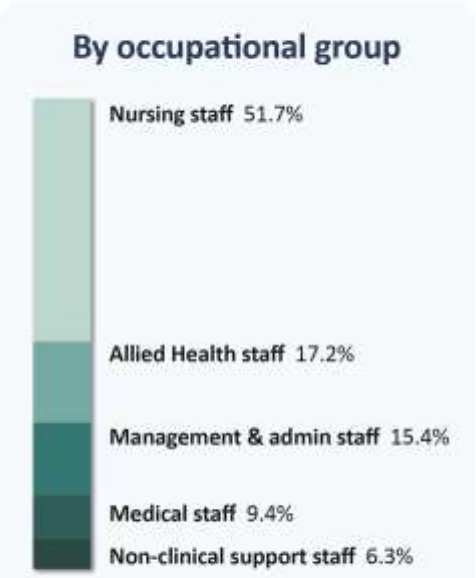
HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

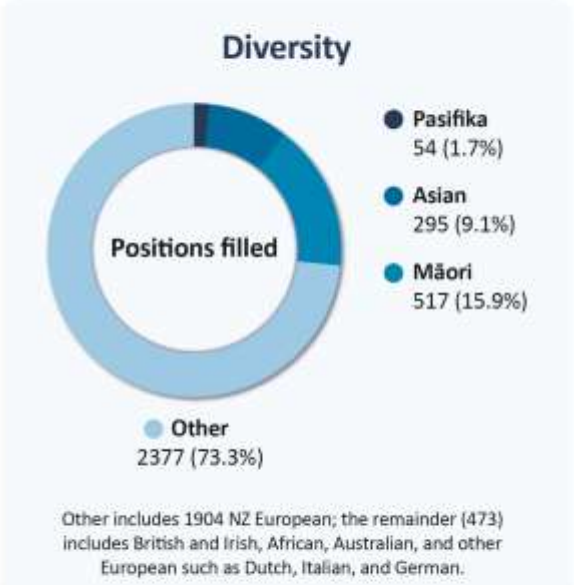
Hawke's Bay DHB currently employs **3243 people**.

A number of the above are multi-jobbed; with **3617 positions** held throughout the organisation. Of these 3617 positions:









Report on good employer obligations

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

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

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

The focus of the People Plan:

- Workforce planning for now and the future.
- Recruiting and building an inclusive representative workforce.
- Embedding the values of the organisation in all we do.
- Ensuring the health and wellbeing of our workforce.
- Taking positive action to build a safe workplace.

Leadership, Accountability and Culture:

Developing leadership capability, remains a priority for Hawke's Bay DHB, as does increasing the capability of our whole workforce. Our focus over the last twelve months has been to develop targeted training programmes to increase our leaders' competence including coaching, supporting and caring for our staff. As an organisation we continue to engage with our staff through established forums including our Joint Consultative Committee, Bipartite and Nursing forums, and through our Safety & Wellbeing committee.

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

The DHB runs an internal pulse survey initiative to identify actions that each team can implement to improve their workplaces and improve their managers.

Recruitment, Selection and Induction:

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

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

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

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

Employee Development, Promotion and Exit:

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

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

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

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

Flexibility and Work Design:

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

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

Remuneration, Recognition and Conditions:

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

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

Harassment and Bullying Prevention:

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

Safe and Healthy Environment:

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

We promote and provide opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via Safety and Wellbeing Representatives and within the Safety and Wellbeing Committee. The Board are committed to ensuring that health and safety is embedded across the organisation and have established a Board Health and Safety Champion role, providing assurance to the Board that the organisation is meeting its obligations. The organisation has also undertaken an assessment through Safe365 online tool to

identify any gaps in health and safety requirements and will continue to build the capability of all and develop a culture whereby health and safety is embedded in everything we do. To further verify our progress we have commenced the accreditation process for ISO 45001.

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

Staff Ethnicity

Increasing the number of Māori employees is a priority 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 percent improvement on previous year with the ultimate aim that the workforce reflects the Hawke's Bay population mix. The aim of this programme is that in the future we will reflect the population within our workforces and therefore the final aim is to have 25 percent Māori represented.

As at the end of the 2019/20 year, significant progress was made, although the target of 16.66 percent of staff identifying as Māori was not reached:

Target 2019/20	16.66% (540)
Actual at 30 June 2020	15.94% (517)
Gap	23 people

Staff Disability

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

Role of the Board

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

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

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

Role of the CEO

The Board delegates to the CEO, on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the Board's agreed strategic direction as set out in the Annual Plan.

Advisory Committees

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

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

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

Finance Risk and Audit Committee:

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

Māori Relationship Board (MRB):

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

Other components of HBDHB's governance structures include:

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

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

Note:

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

Board and Committee Membership

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

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

Board and Committee Member Attendance

Board and committee member attendance for 2019/20 is set out in the following table, with the number of meetings held noted in parentheses.

Board (12 meetings)

FRAC Finance, Risk and Audit Committee (14 meetings)

MRB Māori Relationship Board (10 meetings)

Member	Board	FRAC	MRB
Barbara Arnott (ceased 8/12/19)	4	4	0
Dan Druzianic (ceased 8/12/19)	5	5	0
Hine Flood (ceased 8/12/19)	4	4	6
Helen Francis (ceased 8/12/19)	3	3	0
Diana Kirton (ceased 8/12/19)	4	4	0
Jacoby Poulain (ceased 8/12/19)	0	0	0
Ngahiwi Tomoana (ceased 8/12/19)	3	3	1
Hayley Anderson (started 9/12/19)	7	9	0
Ana Apatu	12	13	10
Kevin Atkinson	11	11	0
David Davidson (started 9/12/19)	6	8	0
Evan Davies (started 9/12/19)	6	8	0
Peter Dunkerley	12	13	0
Joanne Edwards (started 9/12/19)	7	9	1
Charlie Lambert (started 9/12/19)	7	7	2
Anna Lorck (started 9/12/19)	7	8	0
Heather Skipworth	12	12	7
Shayne Walker (started 9/12/19)	7	8	1


Old Macdonald

Improving Outcomes

PERFORMANCE FRAMEWORK

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

The Hawke's Bay Health Strategy Whānau Ora, Hāpori Ora: Healthy Families Healthy Communities (2019-2029) sets out the Hawke's Bay DHB strategic intentions over the next 10 years. The strategy's performance framework focuses on two overall long-term population health outcome objectives:

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

The System Level Measures (SLMs) framework supports the achievement of these overall outcome objectives. Our SLMs in our performance framework are based on those set by the Ministry of Health which align with New Zealand Health Strategy and other national strategic priorities.

Our SLMs recognise that the DHB must work in partnership with primary, secondary and community care and our population health provider to provide services that are high quality, and achieve our strategic intentions.

We also know that we can't achieve the outcomes through the health system alone, but requires the cross-government action to improve socio-economic cultural and environmental conditions, and tackle underlying causes of health inequity.

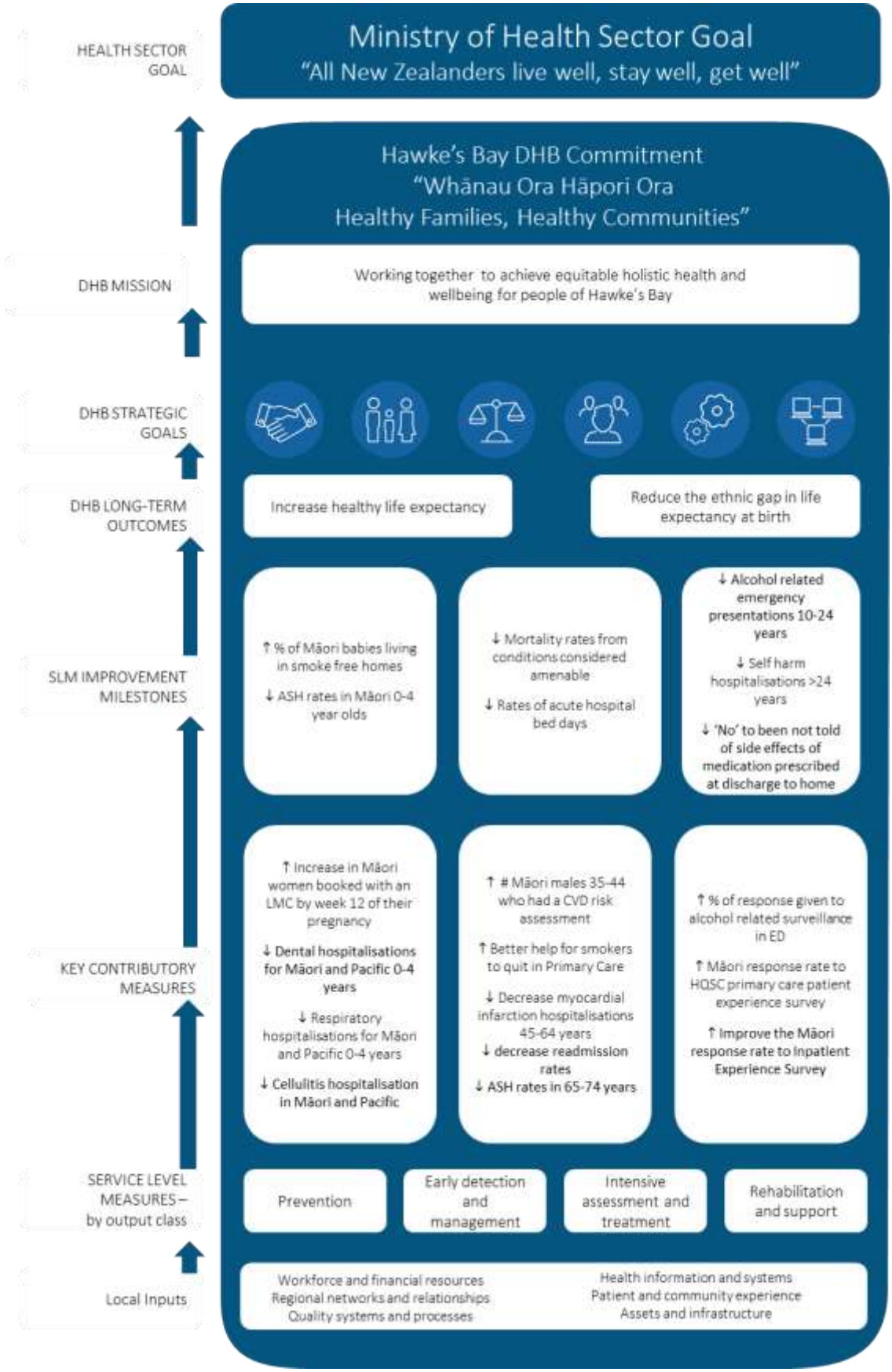
But the DHB has a major part to play. Achieving equitable health outcomes underpin all of our priorities for the Hawke's Bay health system.

Tracking our performance against these system level measures and contributory measures helps us evaluate our success in areas that are important to the community and the Hawke's Bay DHB.

2019/20 is the foundation year in our long term strategy. The nature of population health is such that it may take a number of years to see marked improvement against key outcome measures. Our focus here is on maintaining positive trends over time and reducing inequities.

These measures set alongside our Statement of Performance Expectations SPE (outlined in the following section of this report) outlines the services we planned to deliver and the targets we expected to meet in the 19/20 year.

Outcomes Framework Diagram



Long Term Outcomes

Improving healthy life expectancy for all and half the gap in life expectancy between Māori and non-Māori

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

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

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

> Life expectancy at birth has increased in all regions in New Zealand since 2005–07, with Hawke's Bay increasing the most

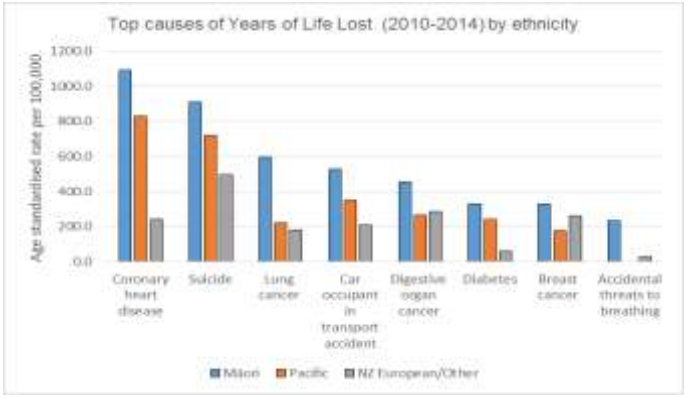
Life expectancy increased 1.5 years for Hawke's Bay males between 2005-07 and 2012-14 and 1.2 years for females. Male life expectancy is 78.6 years and female life expectancy is 82.4 years in Hawke's Bay.

> Māori males and Māori females in Hawke's Bay had the largest life expectancy gain across New Zealand between 2005-07 and 2012-14

Although the gap in life expectancy is decreasing between Māori and non-Māori it remains high 8.2 years for males and 7.7 years for females. Hawke's Bay Māori males life expectancy at birth is 71.7 years and Māori females 75.9 years.

Coronary heart disease, Lung cancer and diabetes are the largest contributor to the gap in life expectancy between Māori and non-Māori.

Smoking is a major contributing factor to these conditions and smoking rates for Māori are 31% compared to 12% for non-Māori (2018 Census).



NOTE: Updated life expectancy data has been delayed due to COVID-19. Life expectancy is based on updated 2018 estimated resident population data.

System Level Measures

Healthy Start

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

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

The desirable outcome is for babies to live in a smokefree environment. This includes adults smoking in the house receiving support to stop smoking.

More babies living in smoke-free homes at six weeks of age

Well Child Tamariki Ora (WCTO) providers ask about household smoking starting at babies six week post-natal check.

49.1% of six week old babies in Hawke's Bay lived in a smoke-free house in the 19/20 year. There was no difference in the proportion of six week olds living in smoke-free homes compared to the previous 2018/19 year. The overall results for 19/20 was impacted by COVID-19 with less WTCO visits undertaken particulalrly in the Alert level 4 period.

More Māori and Pasifika babies are exposed to smoking in their homes, with 31% of Māori and 44.3% Pasifika babies living in smoke-free homes compared to Other ethnicities babies 64.3%. This is a large inequity gap for Māori in particular.

A contributory measure is to increase the % of wāhine Māori booked with an LMC by week 12 of their pregnancy. Booking as early as possible with an LMC in a pregnancy can increase opportunities to support expectant māmā and whānau into smoking cessation services. 52% of Māori māmā were booked with an LMC by week 12 in the first two quarters of 2019/20. This is well below the target of 80%. COVID-19 has also had an impact on the final result and the rate of bookings declined to 48% for Māori māmā by years end (369 booked in the 12 week time frame out of a total 773 Māori māmā).

A key improvement activity this year was to equip midwives working with vulnerable women with a carbon monoxide monitor to help initiate/support the smoking cessation conversation and evaluate the impact of this initiative on smoking cessation referrals.

Keeping Children out of Hospital

Ensuring that children have the best start in life is crucial to the health and wellbeing of the population. The first 1000 days of life having the biggest impact. Many challenges in later life have their roots in the early years of life, including problems such as obesity, heart disease and mental

health problems. Well integrated, quality primary and community services can prevent health problems and improved health outcomes in these early years.

In Hawke's Bay, 37% of all child 0-4 year olds acute admissions to hospital are for conditions that are potentially avoidable through prevention and management in primary care - Ambulatory Sensitive Hospitalisations (ASH). These conditions are predominantly respiratory illnesses, dental, gastroenteritis, and skin infections.

Primary care access as well as underlying determinants of health (housing quality and crowding), exposure to secondhand cigarette smoke, and poverty) contribute to ASH. ASH rates are higher in Māori and Pasifika children

6,436 Total Ambulatory Sensitive Hospitalisations (0-4yrs) per 100,000 population	17% ↓

In the 12 months to June 2020, there were 6,436 ASH admissions per 100,000 in the 0-4 year old population (715 events) a 17% decrease in rates since 12 months to June 2019. Pacific rates decreased 25% but remain nearly three times as high as the Other ethnicity group. Māori rates decreased 19% which was below the target of 5%.

7,323 Māori (0-4 years) Ambulatory Sensitive hospitalisations per 100,000 population (372 admission events)	19% ↓

Māori and Pasifika remain a focus of our SLM plan in 2020/21.

Dental conditions

120 children were admitted for ASH dental conditions or (1,080 per 1000,000 population).	9.4 % ↑

77% of children admitted for dental condition were Māori and Pasifika children. Māori and Pasifika children remain a focus of the DHB-funded child oral health service in 2020/21.

Respiratory Conditions

387 children admitted for avoidable respiratory conditions (3,483 per 100,000 population	26% ↓

71 less Māori children were admitted for avoidable respiratory conditions in the 12 months to June 2020 compared to the previous 12 month period (a 26 percent decrease). Māori and Pasifika children remain the focus as Māori rates of respiratory admissions remain 1.7 times and Pasifika children nearly 3.5 times Other ethnicity children. Immunisation cases remain high.

Skin infections (cellulitis and dermatitis/eczema)

84 children admitted for skin infections (cellulitis and dermatitis/eczema)	8.0% ↑
44 Māori children admitted for skin infections	5.0 % ↑

73% of children admitted for skin infections are Māori and Pasifika children. This population group remains the focus of the DHB skin programme.

Youth are healthy, safe and supported

The Hawke's Bay's Youth Health Strategy conveys a shared vision for young people having access to youth-appropriate health services. The Strategy aligns with a youth development approach forming a balance between services designed to prevent, intervene and treat health problems as well as promoting youth development through preparation, participation and leadership experiences in the design of services.

The youth SLMs consist on five domains reflecting the complexity and range of issues impacting youth health and wellbeing: youth experiences of the health system; sexual and reproductive health; mental health; alcohol and drugs; and access to preventative services.

Hawke's Bay DHB through its Youth Consumer Council identified alcohol and drugs and mental health and wellbeing as their main priorities.

Fewer young people seen in Emergency Departments (ED) because of alcohol.

The indicator is the % of young people presenting to ED with alcohol 'yes and unknown' associated with the event. The rationale here is to improve the data collection and reduce the numbers of 'unknowns' making the data more accurate to use to support population health programmes to reduce the harm caused by alcohol. The proportion of young people (under 24 years of age) presenting to ED where it was coded unknown if alcohol was involved has decreased slightly from 9.2% in the 12 months to June 2019 to 8.6% in the 12 months to June 2020.

There continues to be a quality improvement focus for alcohol data collection in ED.

The focus and target of the measure has been Māori young people rates of alcohol related ED presentations. The Māori rate of 'yes' and 'unknown' if alcohol was involved in the presentaton to the ED was 13.3 percent, which achieved the target of ≤ 14.3 percent.

Fewer young people admitted to hospital because of self-harm.

A total of 170 young people (10 to 24 years old) were admitted to hospital due to self-harm in the 12 months to June 2020. This was a 23 percent decrease over the previous year. (Rate: 54.5 per 10,000 population).

There were fewer Māori young people admitted to hospital because of self-harm. A total of 82 young Māori people were admitted to hospital because of self-harm. The rate was 67.3 per 100,000 which was 21.9 percent less than the previous year and within the target rate of 75 per 10,000 population.

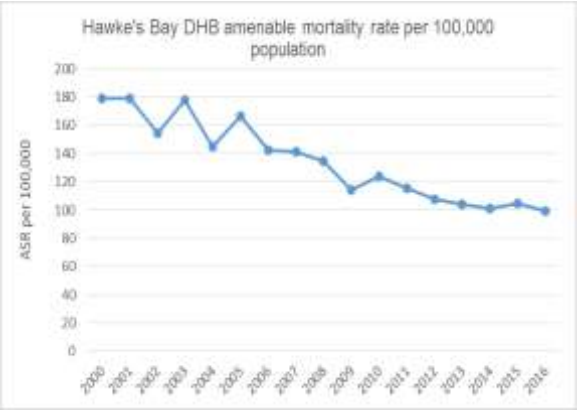
Prevention and Early Detection

Preventative care is centered on keeping people healthy – through providing access to quality health services and medical care by identifying and treating problems quickly, and empowering people to manage their own health. Our aim is for fewer people to die prematurely from potentially avoidable

conditions, such as cardiovascular disease, some cancers and diabetes. Population health approaches and lifestyle behaviours are also equally as important in the prevention of potentially avoidable conditions.

The amenable mortality rate measures the number of deaths under age 75 years that could be avoided through effective health prevention, detection and management interventions.

In 2016 our overall amenable mortality rate is 99.3 per 100,000 population or 226 deaths. (This is the most up-to-date mortality data available to DHBs). Overall amenable mortality rates have reduced by 8 percent over the five years 2012 to 2016. Top amenable mortality conditions are coronary heart disease, diabetes, female breast cancer, stroke, chronic obstructive pulmonary disease and suicide.



Large inequities exist in Hawke's Bay DHB amenable mortality rates. Māori rates were 2.45 times the rates of Non-Māori (in 2015 baseline SLM improvement plan data). The number of Pasifika deaths are too small to assess for inequity in this indicator.

Amenable mortality rates for Māori have not reduced at the same rate as Non-Māori and in 2016 Māori rates are 2.7 times the non- Māori amenable mortality rates.

The top causes of amenable mortality for Māori is coronary heart disease (CVD), using a Cardio Vascular Disease Risk Assessment (CVDRA) is one way to identify the risks of CVD early; lifestyle and drug interventions can reduce the risks and severity of the disease.

A contributory measure to this outcome area is to increase the number of Māori males 35 to 44 years of age who have had a CVDRA.

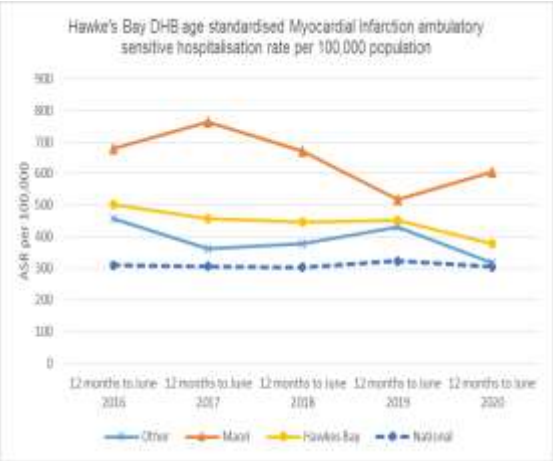
As at June 2020, 57.7 percent (1109) of eligible 35 to 47 year old Māori (1923) had received a CVDRA in the last five years. This rate was lower than previous years and would have been impacted by COVID-19. Increasing CVD risk assessments for at risk population groups is a focus for 2020/21.

Better help to quit smoking

Tobacco smoking is related to a number of life-threatening diseases, including CVD, chronic obstructive pulmonary disease and lung cancer. This outcome is for more primary care patients who smoke been offered help to quit smoking by a health care practitioner

Māori adults are disproportionately impacted by smoking. Disappointingly there has been a decrease in the proportion of Māori been given advice in primary care to quit smoking in the 2019/20 year.

Decreased Myocardial Infarction hospitalisation rates



Māori myocardial infarction hospitalisation rates have increased 17 percent in the 12 months to June 2020, over the previous 12 month period. (An increase of 10 events).

Māori rates are 1.9 times the rates of the Other ethnicity group and Hawke's Bay has higher rates than national rates. The increased focus on improving CVD risk assessments in 2020/21 will support improvements in this measure.

Using Health Resources Effectively

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

Acute bed days per capita is a measure of the use of acute services in secondary care.

The demand for acute hospital care could be reduced by effective patient management in primary care, optimising patient flow within the hospital, discharge planning, community support services and good communication between health care providers.This includes access to diagnostics.

Our standardised rate of acute bed days is trending downwards and the rates decreased from 417.2 per 1,000 population in the 12 months to June 2019 to 375.3 per 1,000 population in the 12 months to June 2020.

The rate of acute bed days use is 1.8 times higher for Māori and 1.4 times higher for Pasifika compared to Other ethnicities.

Reducing acute bed days for Pasifika and Māori is a focus for 2020/21.

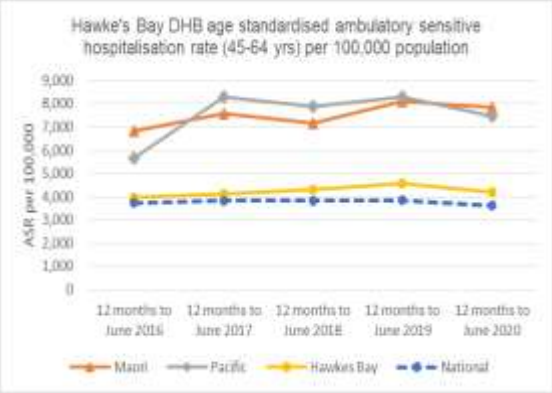
Decreased acute 28 day hospital readmission rate

Hawke's Bay's acute readmission rate was 12.0 percent in the 12 months to June 2020, this is the same as the previous year. Hawke's Bay DHB is the 10th highest of the 20 DHB's in regards to this measure.

Decreased Māori Ambulatory Sensitive Hospitalisations (ASH) 45-64 years per 100,000 population

Ambulatory Sensitive Hospitalisations (ASH) in the 45-64 year age group also contributes to acute bed days but it is also a measure in its own right of the whole system working effectively. ASH are hospitalisations that could

be avoided if patients accessed primary care or have good management of chronic conditions.



Māori ASH rates in the 45-64 year age group have declined 3 percent in the 12 months to June 2020. However large inequities exist, with Māori rates 2.5 times higher, and Pasifika rates 2.4 times higher than ASH rates in the Other ethnicity group.

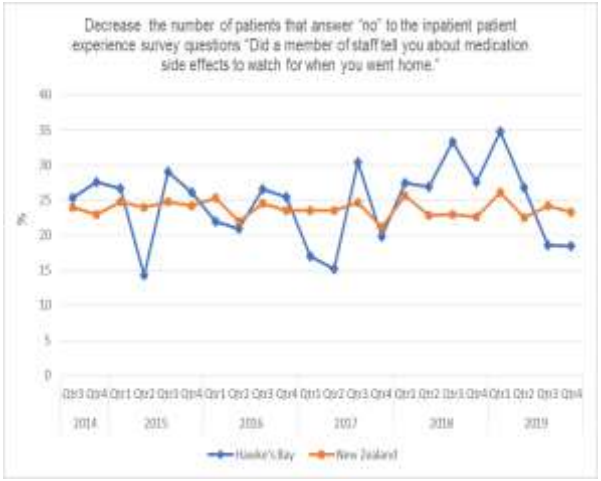
Person and Whānau-centred care

A person and whānau-centred care approach focus is on people, their whānau, friends and carers; understanding their needs and aspirations and what matters to them. If people experience good care, evidence suggests that they will be more engaged with the health system and have better health outcomes. The purpose here is to ensure that patients are receiving quality, effective and integrated health services.

Measuring primary care and inpatient consumer experience is one area of focus in the wider person and whānau-centred care outcome area. This is a calendar year indicator.

Decreasing the number of patients that answer 'no' to the inpatient survey questions 'Did a member of staff tell you about medication side effects to watch for when you went home' has been an improvement focus in the 2019/20 year. We have seen significant reduction in the percentage of patients who responded 'no' to this question.

There has been a 47 percent decrease since Quarter two 2019 (April- May 2019) which has seen the percentage decrease to 18.5 percent in Quarter 3 and 4 of 2019 which has been pleasing and Hawke's Bay rates dropped below national rates. There is no updated data for the 2020 year as the national consumer experience survey was temporarily stopped and a new survey company engaged to run a rebranded survey nationally.



A key system goal of the Hawke's Bay Health Strategy Whānau Ora, Hapori Ora is equity for Māori as a priority; also equity for Pasifika and those with unmet need.

Gathering whānau voice and consumer feedback from Māori is vital to understand experiences with the health system and to help reduce inequities. An improvement activity in 2019/20 was to increase the Māori response rate to the primary care and inpatient experience survey.

Disappointingly we have not been successful and feedback from focus groups; research suggests that an electronic format survey is unlikely to engage Māori and Pasifika participants. We are developing alternative strategies to give effect to the DHB strategic intention of a community led health system. This includes the introduction of valuing whānau voice through our Pātaka Korero programme.

Hawke's Bay DHB have developed an equity framework in the 2019/20 year which clearly requires us to listen to whānau and community in our planning, design, implementation and performance monitoring of our services.

Statement of Responsibility

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

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

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

In the opinion of the board and management of Hawke's Bay District Health Board the financial statements and statement of performance for the year ended 30 June 2020, fairly reflect the financial position and operations of the Hawke's Bay District Health Board.

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

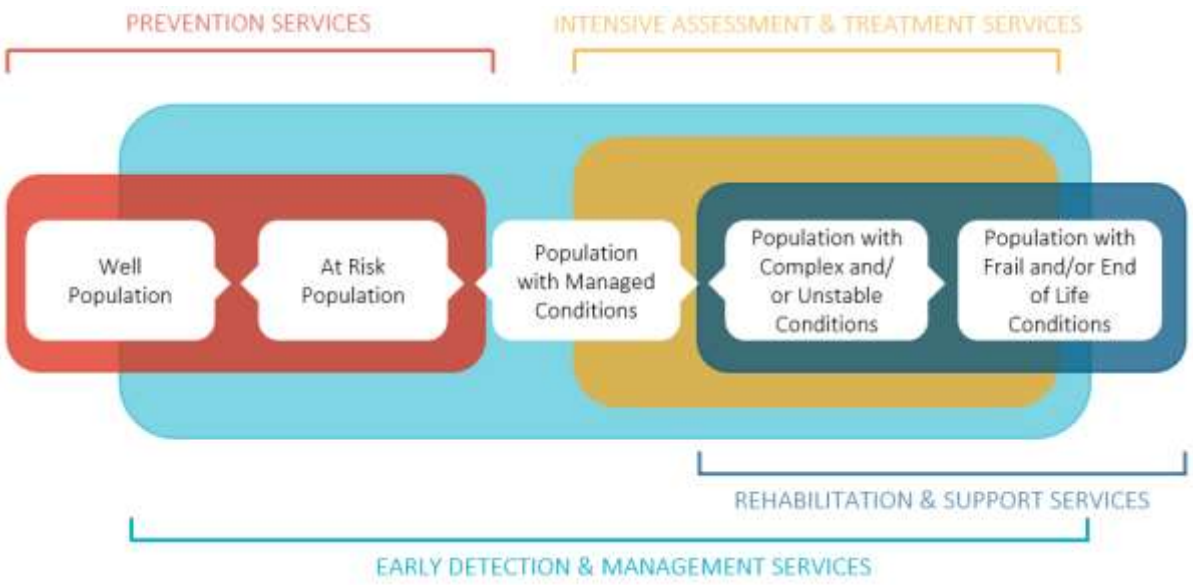
Shayne Walker
Chair

Evan Davies
Board Member

18 December 2020

Statement of Performance

Output Overview



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

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

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

The performance measures chosen are not an exhaustive list of all our activity, but they provide a good representation of the range of outputs that we fund and/or provide. They also have been chosen to reflect outputs which contribute to the achievement of national, regional, and local outcomes. Where possible, we have included with each measure past performance as a baseline data to support evaluation of our performance. Baseline information provided matches those published in the HBDHB Annual Plan 19/20.

Where our results have not been disaggregated into the quarters; this is due to the frequency of information collection/availability, e.g. it may be annual, or seasonal.

Some new measures have been added for the 19/20 year, compared to our previous year. These new measures may not contain comparative or baseline information.

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

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

Impact of COVID-19 on the Services we provide

The unprecedented challenge of COVID-19 on the health sector in the 2019/20 year saw HBDHB respond quickly to the rapidly evolving pandemic situation.

There were significant disruptions within the health sector as rapid service delivery changes were made to reduce the risk of health care associated outbreaks and to prepare for potential additional demand on medical and intensive care services.

Hawke's Bay Hospital's and primary and community health's service capacity was significantly reduced, particularly in the April and May 2020 period.

The reduction in services impacted on our ability to meet performance targets because of the need to re-deploy and re-purpose, staff and facilities, to COVID-19 functions. For example the establishment of: additional hospital ICU capacity and respiratory and isolation ward areas; and community-based testing centres.

To demonstrate the impact of COVID-19 on our 2019/20 performance, we report the cumulative Quarters 1-3 'pre-COVID-19' result, and the Quarter 4 'COVID-19-affected' result, as well as the full year result for each indicator.

In some cases we can only report the annual result as the data did not allow us to break this down. In these instances we have made comment, through our own intelligence, of the impact of COVID-19 on the overall performance of those measures.

The operational impact of COVID-19 is significant and led to changes in existing services and implementation of new or enhanced services.

Change in existing services:

- Repurposing facilities to be able to manage any potential surge in demand on hospital and Intensive care services.
- Postponing planned care, such as outpatient first specialist assessments, follow-up appointments and surgical treatments. This was undertaken to both reduce the risk of COVID-19 spreading and creating capacity in preparation for potential increased numbers of COVID-19 infected patients in an outbreak scenario.
- Face-to-face care was significantly impacted in mental health services, in both intensive inpatient and community-based settings.
- There was significant disruption in the model of care in General Practice. For example, practice capacity for routine face-to-face consultations was reduced and impacted screening rates, such as CVD risk assessments, cervical screening.

- Breast screening services were disrupted during Alert Level 4.
- Reduced face-to-face Well Child Tamariki Ora visits.

Implementation of new/enhanced services:

- Telehealth services were implemented quickly to support ongoing outpatient assessments and clinical follow-up across all inpatient and community-based services; including mental health and allied health.
- Implementation of an innovative change to the delivery of our immunisation programme to increase immunisation coverage of people aged 65 years and over. This population was particularly vulnerable in the event of any widespread local COVID-19 transmission.
- The set-up and repurposing/redeployment of clinical staff to community-based testing centres.
- Implementation in both hospital and general practice settings of additional triage and screening of all patients and visitors including screening stations.
- Investment in, and support of, local COVID-19 laboratory testing.
- Preparedness assessments were conducted in aged care, mental health and disability care facilities; and subsequently responding to outbreaks in facilities, including deploying staff to support.
- Deployment of non-clinical staff and non-acute staff to work in community and within the regional response effort.

As part of the regional response we worked with other Government and NGO entities, and with Ngāti Kahungunu Iwi Inc to set up and manage Hawke's Bay's response to COVID-19, for example:

- Establishment of the Tihei Mauri Ora Emergency Response Centre. This was set up rapidly by Ngāti Kahungunu Iwi as a pandemic coordination unit for Māori and Pasifika whānau residing in the region.
- Community testing centres.
- Border assessment and testing services.
- Personal Protective Equipment (PPE) logistics.
- Intelligence and Digital Enablement support.
- Communication services.
- Welfare and wellness services.

Prevention services help to protect and promote health in our population. Prevention services include health promotion to help prevent the development of disease, statutorily-mandated health protection services to protect the public from toxic environmental risk and communicable diseases, and population health protection services, such as immunisation and screening services.

Statement of Service Performance Output Class 1

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

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

Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise they often arise out of issues that originate outside of the health system.

Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health.

Better Help for Smokers to Quit

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	Jan 18 – Dec 18	96%	96.3%	≥ 95%	97.1%	97.5%	97.1%	●

The performance target was exceeded this year.

Output Measure	Baseline		2018/19	2019/20	2019/20 Result			Rating
			Previous Year	Target	Q 1, 2, 3	Q4	Total	
Percentage of PHO enrolled patients who smoke and who have been offered help to quit smoking by a health care practitioner in the last 15 months	Jan 18 - Dec 18	85%	79%	≥ 90%	67%	61%	61%	

The Smoking Brief Advice (SBA) programme has a cessation focus and provides brief advice and smoking cessation support. The provision of professional advice and support is shown to increase both the likelihood of smokers making; quit attempts, and their success rate. A remuneration Fee for Service (FFS) plan was introduced in November 2019 to incentivise General Practice to provide SBA. Monthly evaluation of performance was reinstated in June 2020 with benchmark reporting. The target this year has not been achieved. COVID -19 impacted on the final result as General Practices' capacity for routine consultations significantly reduced during Alert Level 4. In the 20/21 year, the PHO's Māori Health Team will take an active role in pushing SBA as a priority across general practice and the community.

Output Measure	Baseline		2018/19	2019/20	2019/20 Result			Rating
			Previous Year	Target	Q 1, 2, 3	Q4	Total	
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer (LMC) are offered brief advice and support to quit smoking	Jan 18 - Dec 18	85%	84%	≥ 90%	85%	88%	82%	

We are disappointed we have not met target. However we increased our coverage in the last quarter of the year which was pleasing.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Number of Māori babies who live in a smoke-free household at 6 weeks post-natal	Jan 18 - Jun 18	20.90%	22.20%	≥ 21.90%			30.50%	●

The performance target was exceeded this year.

Increase Immunisation

Immunisation contributes to our health system outcome of developing a healthy population and achieving health equity for Māori and other groups by reducing rates of vaccine-preventable disease. When equitable immunisation coverage is achieved, the health gains are greatest for the most vulnerable groups who would have been at a higher risk of serious complications if they had contracted the vaccine-preventable disease.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of 8 month olds will have their primary course of immunisation (6 weeks, 3 months and 5 month events) on time	Jan 18 - Dec 18	92%	91%	≥ 95%	93%	90%	91%	●

The Ministry of Health have acknowledged the understandable reluctance within the community to expose young babies during the COVID-19 outbreak as well as the disruption to General Practice services, hence the drop in rates. This is a national issue which is likely to persist until December 2020 when catch up has been completed. In Hawke's Bay, General Practice are catching up on the overdue immunisations and are being encouraged to do so. In addition newborn enrolment rates dropped over the quarter 4 period (enrolment and immunisations are closely linked) with an 8.2 percent drop for Māori. Newborn enrolment work has recommenced to ensure hapu Māmā and babies 6 weeks to 12 months are registered with a General Practitioner.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of 4 year olds fully immunised	Jan 18 - Dec 18	90%	90%	≥ 95%	93%	90%	91%	●

The number of 4 year old children fully immunised has improved this year over previous years. The disruption in routine service provided by General Practice during the COVID-19 period impacted on the final result.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of boys and girls fully immunised – HPV vaccine	Jul 17 - Jun 18	76%	64%	≥ 75%			61%	●

The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV related cancer later in life. It is disappointing to see a decrease in performance compared to the previous year's result. COVID-19 impacted on this result due to the disruption of school based health services.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of 65+ year olds immunised – flu vaccine	Mar 18 - Sep 18	58%	60%	≥ 75%			60%	●

The measure is reporting vaccinations delivered between March and September 2019 (the influenza season). Indications are that next year we will meet target due to the significant effort that has gone into increasing the immunisation rates in our 65 years and over population as part of the overall COVID-19 health response. The objective is to protect this vulnerable population against flu and reduce avoidable hospitalisations.

Reduced Incidence of First Episode of Rheumatic Fever

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Acute rheumatic fever initial hospitalisation rate per 100,000	Jul 16 - Jun 17	2.5	5.0	≤ 1.5 per 100,000			1.7	🔴

Acute rheumatic fever rates have not meet target this year. However we are pleased to have made an improvement compared to the previous year. The baseline was amended from TBC to 2.5 per 100,000.

Improve Breast Screening Rates

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of women aged 50-69 years receiving breast screening in the last 2 years	2y to Dec 18							
- Māori		70%	70%	≥ 70%			69.9%	🔵
- Pasifika		67%	69%	≥ 70%			95.8%	🟢
- Others		76%	74%	≥ 70%			74.8%	🟢
- Total		74%	73%	≥ 70%			72.4%	🟢

Primary health prevention, includes screening those at risk and is a key strategy in early detection of cancer to improve survival rates. Māori rates are slightly below target but all other population groups achieved target of 70% screened within the last two years.

COVID-19 has impacted this output measure; as all routine mammograms were halted during COVID-19 Alert Level 4 from March 2020 and did not return until mid-June 2020. Mammograms have recommenced at our fixed site in Hastings. The BreastScreen Coast to Coast (BSCC) mobile service is returning to Central Hawke's Bay and Flaxmere. We are working with four General Practices' in Hastings and have identified Māori and Pasifika women who are unscreened and who will be invited to have a mammogram over a six month period in 2020/21.

Improve Cervical Screening Coverage

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of women aged 25–69 years who have had a cervical screening event in the past 36 months	3y to Dec 18							
- Māori		76%	74%	≥ 80%			74%	●
- Pasifika		72%	75%	≥ 80%			76%	●
- Others		78%	75%	≥ 80%			75%	●
- Total		76%	74%	≥ 80%			74%	●

Screening for cervical cancer is offered every three years to all women 25-69 years. All routine cervical smears were halted during COVID-19 Alert Level 4. Screening did not recommence until COVID-19 Alert Level 3, and at this point numbers were very low. We will be identifying unscreened Māori and Pasifika women in Wairoa and offering additional options for screening. We will have an additional nurse join the Screening team in October 2020, which will assist us to offer more clinic days for the unscreened and under-screened. We will be working with General Practices to encourage and implement on time screening, recalling to commence at 32 months.

Better Rates of Breastfeeding

Children who are exclusively breastfed for around three months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and middle ear infections. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of Sudden Unexplained Death in Infancy (SUDI), asthma and childhood obesity.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of infants that are exclusively or fully breastfed at 3 months	6m to Dec 18	57%	57%	≥ 60%			58%	●

In 2018-2019 we developed and implemented a new community-based Māori breastfeeding support service with all Well Child Tamariki Ora providers across Hawke's Bay. There has been a positive response to this service which is reflected in the slight increase in breastfeeding rates at three months of age. We continue to make a concentrated effort in this area and are investigating opportunities to provide culturally responsive breastfeeding support to new māmā from the ante-natal period through to six months.

Statement of Service Performance Output Class 2

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

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

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

Improved Access to Primary Care

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of the population enrolled in the PHO	Jan 18	98%	98%	≥ 90%	99%	99%	99%	●

The performance target was exceeded this year.

Reduce the Difference Between Māori and Other Rate for ASH Zero-Four Years- SLM

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - four years								
- Māori	12m to Dec 18	8,750	8,710	≤ 8,313			7,323	●

Ambulatory Sensitive hospitalisations (ASH) are hospital admissions which could have been avoided through access and interventions in primary care. This measure was focussed to improve the Māori result. Results for; Pacific 13,472, Other 4,633, and Total 6,436 (per 100,000). We achieved this target as less children presented with respiratory illness during the COVID-19 Alert Level 4 period.

Reduce ASH 45-64 years

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
ASH rate per 100,000 45-64 years								
- Māori	12m to Dec 18	9,328	9,833	≤ 9,341			7,843	●

The target was focussed to improve the Māori result. Results for; Pacific 7,454, Other 3,121, and Total 4,209 (per 100,000). The performance target was exceeded this year.

More Pregnant Women Under the Care of a Lead Maternity Carer (LMC)

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of women booked with an LMC by week 12 of their pregnancy	Jul 18 - Sep 18	64%	63%	80%	64%	34%	57%	●

Early registration with an LMC is encouraged to promote the good health and wellbeing of mother and the developing baby. COVID-19 impacted on the performance of the final result. There was no face to face LMC contact unless it was clinically critical or urgent, over Alert Level 4. Achievement of this output measure remains a focus in 2020/21.

Improving New-Born Enrolment in General Practice

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of new-borns enrolled in general practice by 6 weeks of age			76%	≥ 55%	72%	63%	69%	●

A PHO representative has worked actively with all midwives in the area to ensure that enrolment with a primary care provider is facilitated and timely.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of new-borns enrolled in general practice by 3 months of age	Dec 19 - Feb 19	90%	91%	≥ 85%	88%	76%	85%	●

There was some deterioration in performance during Q4, as some staff facilitating this process were moved into the COVID-19 Incident Management Team.

Better Oral Health

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of children who are carries free at 5 years of age (Yr1)	12m to Dec 18	62%	62%	≥ 61%			63%	●

This measure indicates the prevalence of oral disease experienced in children of pre-school age, measured at five years of age. The performance target was exceeded this year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Mean 'DMFT' score at year 8 (Yr1)	12m to Dec 18	0.76	0.76	≤ 0.73			0.7	●

This measure indicates the prevalence of oral disease and severity of dental decay experienced in children at the end of their primary schooling (Year 8, 12/13-year olds). Improvements in this measure will show the effectiveness of publicly-funded child oral health services, in particular the Community Oral Health Service, and of oral health promotion activities. The performance target was exceeded this year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of preschool children enrolled in and accessing community oral health services (Yr1)	12m to Dec 17	91%	95.70%	≥ 95%			91%	●

Increasing enrolment of pre-school children in publicly funded child oral health programmes enables early engagement and provides opportunities for oral health promotion and interventions aimed at prevention of oral disease, and reduces the prevalence of dental decay.

The baseline is 91% for 2017 calendar year. This baseline was not set in the 19/20 Statement of Performance Expectations. The data is now available and is reflected in the table above.

Preschool children enrolled in and accessing Community Oral Health Service is an area that has been targeted by the service – with pleasing results from 'engagement' initiatives, such as phoning to make appointments at a time / place that works for whānau.

We have also introduced telehealth contacts for the first dental contact for tamariki aged 9 – 15 months. We would anticipate seeing improvements in this measure in the future.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of enrolled preschool and primary school children overdue for their scheduled examinations (Yr1)	12m to Dec 18	10%	10%	≤ 10%			14%	●

This measure indicates the coverage and timeliness of publicly-funded child oral health services delivered by the Community Oral Health Service.

We did not meet target in this measure which is reflective of a service capacity issue i.e., the number of Dental Therapist FTE against number of tamariki needing to be seen, and the volume of work required for each tamariki. We have initiated a number of actions to improve the efficiency of the service in the future. For example, digital radiography is been rolled out this year and will reduce the overall number of visits individual tamariki need to make.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage utilisation of DHB-funded dental services by adolescents for school Year 9 up to and including 17 years (Yr1)	12m to Dec 16	69%	68%	≥ 85%			61.1%	●

Increasing the proportion of adolescents (from School Year 9, 13/14-year olds, up to and including 17 years of age) who have accessed DHB-funded oral health services will impact on the prevalence and severity of oral disease in adolescents.

The baseline data was provided to us from the Ministry of Health during the 19/20 year. Subsequently the baseline was amended from TBC to 69% and the 18/19 previous year result (68%) has also been added.

Hawke's Bay DHB acknowledges the unmet target in this group; there has been gradual decline in utilisation year on year. As a DHB we will work with our contracted providers on strategies to improve engagement of this group and increase utilisation.

Improved Management of Long- Term Conditions (CVD, Acute Heart Health, Diabetes, and Stroke)

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	12m to Dec 18	42%	33%	≥ 60%			66%	●

Diabetes is a leading long term condition and contributor to many other conditions. An annual HbA1c test (of a patient's blood glucose levels) is a means of assessing the management of people's condition.

A level of less than 64mmol/mol reflects an acceptable blood glucose level. The diabetes clinical nurse specialist (CNS) team is strong and community-facing having changed its delivery model to spend more time in General Practice and we have exceeded our target this year.

COVID-19 has had little impact as our diabetes specialist nurse was able to work remotely.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of the eligible population will have had a CVD risk assessment in the last five years	5y to Dec 18	86%	82%	≥ 90%			81.2%	●

Cardiovascular disease (CVD) is one of the leading causes of death in Hawke's Bay. By identifying those at risk of CVD early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event. This measure performance was impacted due to COVID-19 as General Practice capacity for routine consultations was significantly reduced over the period.

Less Waiting for Diagnostic Services

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	Dec 18	92%	92%	≥ 95%	76%	62%	72%	●

This measure excludes patients that have been referred for a planned procedure. CT diagnostic measures are national DHB performance measures and refer to non-urgent scans. Demand has exceeded capacity across both the public and private sectors and wait times have increased across the country. A number of factors are driving this pressure including new drug and treatment programmes and increased surgical volumes, along with population growth and ageing.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	Dec 18	90%	92%	≥ 90%	76%	42%	67%	●

This measure excludes patients that have been referred for a planned procedure. MRI diagnostic measures are national DHB performance measures and refer to non-urgent scans. Demand has exceeded capacity across both the public and private sectors and wait times have increased across the country. A number of factors are driving this pressure including new drug and treatment programmes and increased surgical volumes, along with population growth and ageing.

Increase Referrals of Obese Children to Clinical Assessment and Family Based Nutrition, Activity and Lifestyle Interventions

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	6m to Nov 18	96%	97%	≥ 95%	99.5%	100%	99.6%	●

This activity occurs automatically following identification during the B4 School Check (B4Sc). B4Sc is a nationwide programme offering a free health and development check for 4 year olds.

Improved Youth Access to Health Services - SLM

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	12m to Dec 18							
- Māori		79.8	69.7	≤ 75.0			67.3	●

The target was focussed to improve the Māori result. Results for; Pacific 21.7, Other 48.7, and Total 54.5 (per 10,000). The performance target was exceeded this year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of ED presentations for 10-24 year olds which are alcohol related - Māori	12m to Dec 18	14.60%	14.00%	< 14.30%			13.3%	●

The target was focussed to improve the Māori result. Results for; Pacific 8.9%, Asian 9.2%, Other 11.1%, and Total 11.9%. The performance target was exceeded this year.

Amenable Mortality - SLM

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Relative rate between Māori and Non-Māori Non-Pasifika (NMNP)	2015	2.45 relative rate	2.5	< 2.5 relative rate			2.7	●

There is a deteriorating relative rate between Māori and Non-Māori Non-Pasifika aged standardised amenable mortality rate. Māori rates are 2.7 times those of Non-Māori Non-Pasifika ethnicity group and below target.

Impact

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

Statement of Service Performance Output Class 3

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

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

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

Less Waiting for ED Treatment

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of patients admitted, discharged or transferred from an ED within 6 hours	Jan 18 - Dec 18	88%	86%	≥ 95%	78%	83%	79%	●

Growth in acute demand has put significant pressure on the ED and flow into hospital services which is reflected in the deteriorating performance of our results. High occupancy rates create long delays in inpatient bed requests to allocation. This includes the Intensive Care Unit (ICU) and High Dependency Unit (HDU) bed availability. We have continued with our focus on a new digitally-enabled programme Emergency

Q to refer appropriate patients to primary care/urgent care rather than ED, and we continue to work with inpatient areas to improve access to inpatient beds.

Faster Cancer Treatment (FCT)

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	6m to Dec 18	95%	79%	≥ 90%	81.3%	82.3%	81.5%	

At least 90% of patients are expected to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer. This indicator looks across the whole cancer pathway to ensure people have prompt access to cancer services. Prior to COVID-19, we were on a trajectory to realise improvements in our results, however COVID-19 negatively impacted our overall trajectory.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat	6m to Dec 18	85%	84%	≥ 85%	87%	87%	87%	

The performance target was exceeded this year.

Patients with Acute Coronary Syndrome (ACS) Receive Seamless, Coordinated Care across the Clinical Pathway

To provide a nationally consistent reporting framework, all regions are required to report agreed indicators from New Zealand Acute Coronary Syndrome Improvement programme (ANZACS QI)

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of ACS patients undergoing coronary angiogram, door to catheter lab (cath), within 3 days	Jan 18 - Dec 18	61%	59%	> 70%	54%	54%	54%	●

Factors influencing our performance include: limited facility capacity (shared facility with an active interventional Radiology department) and limited staff resource. We are advertising for a Senior Medical Officer (SMO). This position is yet to be filled despite active recruitment.

Cath lab capacity remains limited due to the shared facility within Radiology. We continue to work with Capital & Coast DHB (CCDHB), via their Capacity Planner, to manage this.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF	Jan 18 - Dec 18	66%	67%	≥ 85%	71%	77%	73%	●

Currently our Echo department has two FTE vacancies, the impact of this has seen a reduction in capacity to one third ($^1/_3$). Additionally, as above (in the previous output measure), constraints in the Angio department also impact this measure.

We have now engaged a locum for two days per week for outpatient lists. Once the Echo department staffing levels improve a subsequent improvement in performance against this measure is expected. COVID-19 did not have an impact on our performance.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication / intolerance all ACS patients who undergo coronary angiogram should be prescribed at discharge aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)	Jan 18 - Dec 18	55%	57%	> 85%	60%	62%	61%	

This indicator is under review by the regional network. Our performance is consistent within the central region. While we remain under review for this measure, practice will stay consistent with international guidelines and clinical judgement. COVID-19 did not have an impact on our performance.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within: a) 30 days of discharge	Sep 18 - Nov 18	97%	99%	> 95%	91%	99%	93%	

We have experienced staffing capacity issues, as a result we have not reached target this year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within: b) within 3 months	Sep 18 - Nov 18	100%	100%	> 99%	97%	96%	97%	●

We typically meet this target with adequate staffing resource available. COVID-19 did not have an impact on our performance.

Equitable Access to Care for Stroke Patients

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of potentially eligible stroke patients who are thrombolysed 24/7	Jan 18 - Dec 18	9%	11%	≥ 10%			9%	●

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Jan 18 - Dec 18	80%	79%	80%			74%	●

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	Jan 18 - Dec 18	73%		≥ 80%				

We are currently unable to report on this measure as no process has been developed, and as a consequence no data is captured within our Patient Management system.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	N/A	tbc		≥ 60%				

This is a new measure. No process has been developed to capture this information within our Patient Management System. As a consequence, we do not have a baseline or any results.

Planned Care

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of services that report Yes (that more than 90 percent of referrals within the service are processed in 15 calendar days or less) ESPI1	Dec 18	68%	63%	100%	68%	95%	74%	●

There has been some improvement in our performance since last year but we have not meet target. Early in the year there were capacity issues to triage referrals within time frames. A more robust booking process of

review and escalation has been put in place with booking staff and we have seen an improvement in performance.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of patients waiting over four months for FSA ESPI2	Dec 18	30%	30%	0%	31%	45%	45%	●

Due to capacity issues in Ophthalmology / Ear Nose and Throat / Maxillofacial / General Surgery, we did not meet wait times. A plan has been put in place driven by our Chief Operating Officer in partnership with Service Directors, and Digital Enablement to negate the negative impact on ESPI2. While there was significant disruption in our outpatient services over the COVID-19 affected period this did not impact materially on our final result.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of patients in Active Review with a priority score above the actual Treatment Threshold (aTT) ESPI3				0%				

No process has been developed to capture this information within our Patient Management System. As a consequence, we do not have a baseline or any results.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of patients waiting over 120 days for treatment ESPI5	Dec 18	27%	27%	0%	31%		44%	●

We experienced insufficient surgical capacity; due to reduced staff resources. Plans have been put in place to negate the negative impact on ESPI5. COVID-19 affected period did impact on this result as there was significant disruption to Planned Care intervention delivery over the period.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of patients prioritised using an approved national or nationally recognised prioritisation tool ESPI8			100%	100%	100%	100%	100%	●

Prioritisation tools are part of the surgical referral process.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Ophthalmology: Number of patients waiting more than or equal to 50 percent longer than the intended time for their appointment.				0	367	1098	1098	●

The intent of this measure is that no patient will wait more than or equal to 50 percent longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service. This is a new measure and no baseline or previous year's data was available.

COVID-19 impacted this measure due to a disruption in our ophthalmology outpatient department services over the COVID-19 affected period. We also had a shortage of staff, and the result was that we were unable to see all overdue patients.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Acute readmissions to hospital	12m to Dec 18	11.90%	11.90%	≤ 11.80%			12.00%	●

Reduced presentations were experienced during Alert Level 4. A proactive approach was taken to contact patients with chronic illnesses during this time to ensure they did not delay seeking the healthcare they needed.

Shorter Stays in Hospital

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
LoS Elective (days)	12m to Dec 18	1.59		tbc				

No target was established during 2019/20. The Ministry of Health subsequently removed the requirement to report on this measure. We are unable to report on this measure as no data has been provided by the Ministry of Health.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
LoS Acute (days)	12m to Dec 18	2.31		tbc				

No target was established during 19/20. The Ministry of Health subsequently removed the requirement to report on this measure. We are unable to report on this measure as no data has been provided by the Ministry of Health.

Quicker Access to Diagnostics

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

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage accepted referrals for elective coronary angiography completed within 90 days	As at Dec 18	100%	99%	≥ 95%	88%	89%	88%	

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),	As at Dec 18	95%	93%	≥ 90%	91%	74%	88%	●

We experienced a reduction in our specialist resources. To improve our performance we are looking to recruit a consultant workforce, and utilise a locum workforce as available. We are also looking to increase delivery of service to six days a week, when resources are available. COVID-19 had a negative impact on this measure due to the loss of resource capacity.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)	As at Dec 18	69%	53%	≥ 70%	39%	21%	34%	●

The COVID-19 affected period exacerbated a poor performance result. The Endoscopy service was disrupted due to repurposing the facility for the anticipated COVID-19 response. The service has also had capacity issues due to staff shortages throughout the 19/20 year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	As at Dec 18	55%	54%	≥ 70%	46%	33%	42%	●

The COVID-19 affected period exacerbated a poor performance result. The Endoscopy service was disrupted due to repurposing the facility for the anticipated COVID-19 response. The service has had capacity issues due to staff shortages throughout the 19/20 year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of participants to have received their colonoscopy within 45 calendar days of their FIT result being recorded in the NBSP information system		NA	99.60%	≥ 95%	94%	92%	94%	●

COVID-19 negatively impacted this measure. Patients that were previously booked (and within target) had procedures postponed (during Alert Level 4) and subsequently rescheduled outside of the target time frame. While we experienced a loss of resourced capacity, all outstanding colonoscopies have now been completed.

This is a new measure and the baseline was omitted in the Statement of Performance Expectations.

Fewer Missed Outpatient Appointments

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Did not attend (DNA) rate across first specialist assessments	Jan 18 - Dec 18							
- Māori		11.30%	11.70%	≤ 9%	12%	12%	12%	●
- Pasifika		13.30%	14.20%	≤ 9%	14%	14%	13%	●
- Total		5.90%	5.60%	≤ 5%	6%	6%	6%	●

Results for the Other ethnicity as follows; Q1, 2, 3 = 4.1%, Q4 = 3.1%, and Total = 3.9%. The Did Not Attend (DNA) rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not. When patients fail to turn up to appointments, it is costly for the DHB and can negatively affect the patient's recovery and long term outcomes.

Outpatient bookers continue to work with Kaitakawaenga and Navigators and review the DNA rates on a monthly basis. Information is reviewed with an ethnicity equity lens across all outpatient bookings to identify what specialties require more focus to support both Māori and Pasifika. We are exploring how to better assist those that are struggling with the Outpatient process including a partnership with PHO to support this work.

Better Mental Health Services Improving Access

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Proportion of the population seen by MH&A services child & youth services (CAFS) (zero -19 years)	12m to Sep 18	5.30%	3.80%	≥ 4.30%			3.70%	●

This measure is a national DHB performance measure and standards are set nationally based on the expectation that over 4.3 percent of the population (under 20 years) will need access to specialist mental health support. Demand exceeds capacity. Contributing factors are; vacancies within the service, capacity within mild to moderate youth services, and increased demand associated with COVID-19. Active recruitment in place to fill vacancies. We are working with youth services to ensure they are open to

referrals from the CAFs team. COVID-19 has had a negative impact; with increased demand and a reduction in staff due to resignations over the COVID-19 period.

Better Access to Mental Health & Addiction (MH&A) Services

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Proportion of the population seen by MH&A services Adult (20-64 years)	12m to Sep 18	5.30%	5.40%	≥ 5.40%			5.60%	●

This measure is a national DHB performance measure and standards are set nationally based on the expectation that over 5.4 % of the population (20-64 years) will need access to specialist mental health support. Community Mental Health team continue to actively support whaiora in the community. All mental health services have been impacted by COVID-19 and have seen increased demand in the months following COVID-19 Alert Level 4.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Proportion of the population seen by MH&A services Older adult (65+ years)	12m to Sep 18	1.05%	1.00%	≥ 1.15%			1.00%	●

Traditionally Hawke's Bay is low in this indicator; our interpretation is that clients are well managed in community settings, however we continue to monitor and address any indicators of an escalation in need.

Reducing Waiting Times Shorter Waits for Non-Urgent Mental Health and Addiction Services for Zero-19 Year Olds

These are secondary services for those most severely affected by mental illness and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of an efficient and responsive service. A continued focus on earlier intervention in the community is a key strategy in reducing the number of people requiring specialist care and the wait times for treatment.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of zero-19 year olds seen within 3 weeks of referral to Mental Health provider arm	12m to Dec 18	75%	78%	≥ 80%			74%	

The service is actively managing referrals using a range of options including non-face-to-face when appropriate. All mental health services were impacted by COVID-19 and seeing increased demand in the months following Alert Level 4.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Percentage of zero-19 year olds seen within 3 weeks of referral to Addictions (provider arm and NGO)	12m to Dec 18	67%	74%	≥ 80%			78%	

CAPA (Choice and Partnership Appointments) has been trialled and this has resulted in an improved capacity to complete choice/initial appointments and increasing appointments from 14 per week to 25 per week. COVID-19 had a negative impact; limited access to appointments and increased staff turnover as a result of COVID-19. Performance has improved over the previous year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of zero-19 year olds seen within 8 weeks of referral Mental health provider arm	12m to Dec 18	92%	92%	≥ 95%			93%	

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of zero-19 year olds seen within 8 weeks of referral Addictions (provider arm and NGO)	12m to Dec 18	89%	90%	≥ 95%			96%	

Improving Mental Health Services Using Discharge Planning

Maintaining and improving patient engagement through the use of a transition/discharge plan will ensure that services are responsive to patient needs and that people are better able to manage their mental health condition.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Community services transition (discharge) plans: Percentage of clients discharged from community MH&A will have a transition (discharge) plan	Jan 18 – Dec 18	78.50%	78.20%	≥ 95%			80%	

Issues with current MH&A services electronic template has been reviewed to improve its functionality and formatting. The intention is to improve uptake of the form within the electronic system. Central Region DHBs work is underway to agree on a centrally used template to improve access to plans via clinical portal. Some client contact and planning was impacted by COVID-19. Performance has improved this year over the previous year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Community services transition (discharge) plans: Percentage of audited files have a transition (discharge) plan of acceptable standard	Jan 18 - Dec 18	97.00%		≥ 95%	95%	93%	94%	

Issues with current MH&A services electronic template has been reviewed to improve its functionality and formatting. The intention is to improve uptake of the form within the electronic system. Central Region DHBs work is underway to agree on a centrally used template to improve access to plans via clinical portal.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Wellness plans: Percentage of clients with an open referral to MH&A services of greater than 12 months have a wellness plan.	Jan 18 - Dec 18	99.30%	98.50%	≥ 95%			99%	

Recording of plans within our Patient Management System and auditing of these plans, has seen an improvement in results.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Wellness plans: % of audited files meet accepted good practice – wellness plans	Jan 18 - Dec 18	89.00%		≥ 95%	85%	80%	84%	

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Inpatient services transition (discharge) plans: Percentage of clients discharged from adult inpatient MH&A services have a transition (discharge) plan	Jan 18 - Dec 18	64.30%	72.40%	≥ 95%			64.7%	

Issues with current MH&A services electronic template has been reviewed to improve its functionality and formatting. The intention is to improve uptake of the form within the electronic system. Central Region DHBs work is underway to agree on a centrally used template to improve access to plans via clinical portal.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of audited files have a transition (discharge) plan of acceptable standard		-		≥ 95%	85%	88%	86%	

This is a new measure and no baseline was set. Recording of plans within our Patient Management System and auditing of this being completed shows a modest improvement during the year.

Increasing Consumer Focus More Equitable Use of Mental Health Act: Section 29 Community Treatment Orders

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Rate of s29 orders per 100,000 population - Māori	12m to Dec 18	395	407	≤ 356			439	

The target was focussed to improve the Māori result. The Non-Māori result was 119. Stress on the system has had an impact that has been recognised - resulting in a specific piece of work being developed around responding to whānau in crisis. Mental Health has teamed up with Police on this approach. Crisis response project underway with Model of Care change being developed.

Better Patient Experience - SLM

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Number of patients that answer 'no' to the inpatient experience survey question 'Did a member of staff tell you about medication side effects to watch for when you went home'	Jan 16 - Mar 16	22%	27.6%	≤ 17%			18.5%	

There has been some improvement in performance in this indicator but we did not achieve target.

Better aligned services - SLM

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Total acute hospital bed days per capita (per 1,000 population)	Jan 18 - Dec 18	410	420	≤ 390			375.3	

More Appropriate Elective Surgery

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Number of publicly funded case mix included, elective and arranged discharges for people living within the DHB region	12m to Jun 18	7,467	6907	TBC			6,009	●

During the 2019/20 year, the target was agreed with the Ministry of Health and was updated from TBC to 7,298.

Improving the Quality of Identity Data within the National Health Index (NHI) and Data Submitted to National Collections

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
New NHI registrations in error	3m to Dec 18	5.10%	1.70%	>1% and ≤3%			3.90%	●

Our typical on-boarding process did not allow for variation in server performance, this resulted in an adverse performance to target. Our on-boarding practices were reviewed and updated, as a result, errors relating to duplicates have now been resolved.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Recording of non-specific ethnicity in new NHI registrations	3m to Dec 18	1.30%	2.00%	>0.5% and ≤2%			1.70%	●

Two factors contributed to meeting this target. They were: a) an increase in training opportunities delivered and b) the introduction of monthly spot auditing, to identify and reduce and procedural issues.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Update of specific ethnicity value in existing NHI records with a non-specific value	3m to Dec 18	0.10%	0.00%	≤ 2%			0%	●

Two factors contributed to meeting this target. They were: a) an increase in training opportunities delivered and b) the introduction of monthly spot auditing, to identify and reduce and procedural issues.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Invalid NHI data updates	3m to Dec 18	NA		tbc				

No target or baseline was established during 2019/20. The Ministry of Health subsequently removed the requirement to report on this measure. We are unable to report on this measure as no data has been provided by the Ministry of Health.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures	3m to Dec 18	NA		≥90% and <95%				

This is a new measure. We are unable to report on this measure as no data has been provided by the Ministry of Health.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
National collections completeness	3m to Dec 18	NA		≥94.5% and <97.5%				

This is a new measure. We are unable to report on this measure as no data has been provided by the Ministry of Health.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Assessment of data reported to the national minimum set (NMDS)	3m to Dec 18	84.10%		≥ 75%				

We are unable to report on this measure as no data has been provided by the Ministry of Health.

Statement of Service Performance Output Class 4

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults.

Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. Hawke's Bay DHB provides NASC services through NASC Hawke's Bay.

Other services are provided by our Provider Arm, general practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or frail and/or end of life conditions.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence.

For people in our population who have end-stage conditions, it is important that they and their family or whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

Better Access to care for Older People

Age specific rates of non- urgent and semi- urgent attendances to the ED are monitored for ages 75-79, 80-84 years and 85 + years. A decrease in these rates is an indicator of our services working effectively to keep our older people out of hospital.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	2019/20 Result Q4	2019/20 Result Total	Rating
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years	12m to Dec 18	127.5	122.8	≤ 130			131.3	●

Disappointingly, we have seen an increase in our 75-79 years ED utilisation rates for non–urgent and semi-urgent presentations in this age group.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	12m to Dec 18	169.1	156	≤ 170			177.1	

Disappointingly we have seen an increase in our 80-84 years ED utilisation rates for non-urgent and semi urgent presentations in this age group.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	12m to Dec 18	227.5	221	≤ 225			221.5	

There has been a slight increase in our 85 years and over ED utilisation rates for non-urgent and semi-urgent presentations over the previous year. We are pleased that we have achieved target.

Better Community Support for Older People

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Acute readmission rate: 75 years +	12m to Dec 18	12.30%	12.40%	≤ 11%			12.0%	

We have seen an improvement over time in our readmission rates in older people 75 years and over however we did not meet the target of 11% this year.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Rate of carer stress: informal helper expresses feelings of distress = YES, expressed as a % of all home care assessments	Oct 17 - Dec 17	tbc		≤ 26%				

While this measure has been reflected in previous Statement of Performance Expectations' we continue to experience data access issues with interRAI, which has resulted in not being able to report a baseline or results. Work is underway to source interRAI data extracts on an ongoing basis.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of people having homecare assessments who have indicated loneliness	Oct 17 - Dec 17	tbc		≤ 23%				

While this measure has been reflected in previous Statement of Performance Expectations' we continue to experience data access issues with interRAI, which has resulted in not being able to report a baseline or results. Work is underway to source interRAI data extracts on an ongoing basis.

Increased Capacity and Efficiency in Needs Assessment and Service Coordination Services

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Conversion rate of contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency	Oct 17 – Dec 17	tbc		tbc				

While this measure has been reflected in previous Statement of Performance Expectations' we continue to experience data access issues with interRAI, which has resulted in not being able to report a baseline or results. Work is underway to source interRAI data extracts on an ongoing basis.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Clients with a Change in Health, End-stage Disease, Signs and Symptoms (CHESS) score of four or five at first assessment	Oct 17 – Dec 17	tbc		≤ 11%				

While this measure has been reflected in previous Statement of Performance Expectations' we continue to experience data access issues with interRAI, which has resulted in not being able to report a baseline or results. Work is underway to source interRAI data extracts on an ongoing basis.

More Older Patients Receive Falls Risk Assessment and Care Plan

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of older patients given a falls risk assessment	12m to Dec 18	93%	92%	≥ 90%	91%	92%	91%	●

Reducing harm from falls is one of our priority Quality and Safety markers and in 2019/20 we met the target with 91% of our elderly patients having a falls risk assessment completed.

Output Measure	Baseline		2018/19 Previous Year	2019/20 Target	2019/20 Result Q 1, 2, 3	Q4	Total	Rating
Percentage of older patients assessed as at risk of falling receive an individualised care plan	12m to Dec 18	90%	92%	≥ 90%	93%	88%	92%	●

If an older patient is assessed at risk of falling, they need an individualised care plan to minimise the risk. 92% of our patients assessed at risk received an individualised care plan which was above target.

The table below shows the revenue and expenditure information for prevention services, early detection and management services, intensive assessment and treatment services, and rehabilitation support output classes.

Cost of service statement by output class for the year ended 30 June 2020.

Prevention Services

	Actual 30 June 2020 $'m	Budget 30 June 2020 $'m	Actual 30 June 2019 $'m
Ministry of Health	9.2	9.1	8.4
Other District Health Boards	-	-	-
Other sources	0.2	0.4	0.3
Income by Source	**9.4**	**9.5**	**8.7**
Less:			
Personnel	2.3	2.1	2.0
Clinical supplies	0.1	0.1	0.1
Infrastructure and non clinical supplies	0.4	0.5	0.3
Payments to other providers	7.1	6.9	6.4
Expenditure by type	**9.9**	**9.6**	**8.8**
Net Result	(0.5)	(0.1)	(0.1)

Note: The net result to 30 June 2020 was significantly affected by the additional provisioning for Holidays Act remediation, and the COVID-19 response and recovery.

Early Detection and Management

	Actual 30 June 2020 $'m	Budget 30 June 2020 $'m	Actual 30 June 2019 $'m
Ministry of Health	146.1	145.2	121.2
Other District Health Boards	2.1	2.1	2.1
Other sources	2.7	3.1	3.7
Income by Source	**150.9**	**150.4**	**127.0**
Less:			
Personnel	37.2	33.9	20.4
Outsourced services	7.1	4.9	2.6
Clinical supplies	3.6	3.3	3.5
Infrastructure and non clinical supplies	3.6	9.3	3.5
Payments to other District Health Boards	2.9	2.9	2.9
Payments to other providers	101.2	100.0	98.8
Expenditure by type	**155.6**	**154.3**	**131.7**
Net Result	(4.7)	(3.9)	(4.7)

Note: The net result to 30 June 2020 was significantly affected by the additional provisioning for Holidays Act remediation, and the COVID-19 response and recovery.

Intensive Assessment and Treatment

	Actual 30 June 2020 $'m	Budget 30 June 2020 $'m	Actual 30 June 2019 $'m
Ministry of Health	350.4	354.4	351.4
Other District Health Boards	8.2	8.3	4.5
Other sources	8.0	7.6	13.0
Income by Source	**366.6**	**370.3**	**368.9**

Less:			
Personnel	221.8	198.3	197.7
Outsourced services	17.5	11.1	17.6
Clinical supplies	53.1	51.2	51.5
Infrastructure and non clinical supplies	49.3	39.6	61.5
Payments to other District Health Boards	53.3	53.2	52.2
Payments to other providers	23.0	22.9	5.1
Expenditure by type	**418.0**	**376.3**	**385.6**
Net Result	**(51.4)**	**(6.0)**	**(16.7)**

Note: The net result to 30 June 2020 was significantly affected by the additional provisioning for Holidays Act remediation, and the COVID-19 response and recovery.

Rehabilitation and Support

	Actual 30 June 2020 $'m	Budget 30 June 2020 $'m	Actual 30 June 2019 $'m
Ministry of Health	79.5	79.0	79.9
Other District Health Boards	2.2	2.2	2.3
Other sources	0.2	0.1	0.3
Income by Source	**81.9**	**81.3**	**82.5**
Less:			
Personnel	9.8	8.9	8.8
Clinical supplies	1.0	0.9	1.0
Infrastructure and non clinical supplies	1.9	2.2	1.8
Payments to other District Health Boards	4.4	4.4	4.4
Payments to other providers	71.1	67.8	73.4
Expenditure by type	**88.2**	**84.2**	**89.4**
Net Result	**(6.3)**	**(2.9)**	**(6.9**

Note: The net result to 30 June 2020 was significantly affected by the additional provisioning for Holidays Act remediation, and the COVID-19 response and recovery.

Total District Health Board

	Actual 30 June 2020 $'m	Budget 30 June 2020 $'m	Actual 30 June 2019 $'m
Ministry of Health	585.2	587.7	560.9
Other District Health Boards	12.5	12.6	8.9
Other sources	11.1	11.2	17.3
Income by Source	**608.8**	**611.5**	**587.1**
Less:			
Personnel	271.1	243.2	228.9
Outsourced services	24.6	16.0	20.2
Clinical supplies	57.8	55.5	56.1
Infrastructure and non clinical supplies	55.2	51.6	67.1
Payments to other District Health Boards	60.6	60.5	59.5
Payments to other providers	202.4	197.6	183.7
Expenditure by type	**6717**	**624.4**	**615.5**
Net Result	**(62.9)**	**(12.9)**	**(28.4)**

2019/20 Financial Performance

Result

The Operating Result (the result relating to business as usual) for 2019/20 is $32.3 million deficit, against a planned deficit of $12.9 million. The higher than planned deficit Operating Result was driven by higher than planned cost of delivering services, particularly in acute services, pharmaceuticals and services for older populations, driven by demand and mix of services. Recent increases in population have been a contributing factor to this demand, which is expected to be recognised through the Population Based Funding Formula over time. A further factor was lower than planned revenue from MOH revenue agreements relating to planned care performance, wash-up of MOH revenue agreements and pay settlements. In addition to the Operating Result, the DHB incurred costs relating to COVID-19 ($9.7 million net expenditure) and an increase in the Holidays Act liability ($20.9 million), increasing the deficit to $62.9 million on revenue of $608.8 million. This is in comparison to the $28.4 million deficit reported last year.

Cash flow

Equity injections for capital projects and deficit support of $21.3 million, together with draw-downs from the DHB's overdraft facility of $3.8 million, and a $0.4 million reduction in short term investments, provided the funding used for the $15.5 million investment in long term assets, the $9.6 million operating cash deficit and the repayment of $0.4 million of equity.

Auditors

The Auditor-General is required under section 15 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements and performance information presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2019/20 annual report, amount to $153,000.

Ministerial directions

One new direction was issued during the year.

- The COVID-19 Response Direction (2020)

Directions that remain current include:

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

Actions are underway to implement the remaining requirements of the NZBN Directive by the December 2020 milestone date.

Five-year financial performance summary

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

Performance Indicator	Target	2020	2019	2018	2017	2016
Return on net funds employed	(3.7)%	(39.5)%	(12.9)%	(0.1)%	7.3%	9.8%
Operating margin to revenue	(0.9)%	(9.0)%	(3.4)%	0.0%	1.8%	2.2%
Revenue to net funds employed	4.3	4.8	3.8	3.8	3.8	3.8
Net result before financing & abnormal	(5.2)m	(54.6)m	(19.8)m	(0.2)m	10.3m	13.2m
Net result	(12.9)m	(62.9)m	(28.4)m	(8.6)m	3.6m	4.4m
Ratio of earnings to revenue	1.5%	(6.7)%	(1.3)%	2.4%	4.5%	5.2%
Average cost per paid FTE	$98,732	$98,526	$94,114	$89,090	$87,731	$86,563
Average revenue per paid FTE	$248,415	$238,548	$241,417	$238,336	$239,610	$238,939

Statement of comprehensive revenue and expense

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Notes	30 June 2020	Budget 30 June 2020	30 June 2019
Patient care revenue	2.5	604,720	606,762	581,251
Interest revenue		150	84	387
Other operating revenue	2.6	3,776	4,639	5,415
Total revenue		608,646	611,485	587,053
Personnel costs	2.7	250,137	243,178	228,856
Outsourced services		24,557	16,023	20,227
Clinical supplies		54,441	52,225	52,900
Infrastructure and non-clinical expenses		29,352	26,433	27,024
Payments to other DHBs		60,621	60,497	59,532
Payments to non-health board providers		202,411	197,655	183,721
Other operating expenses	2.8	28,259	6,225	19,853
Depreciation and amortisation expense	3.6, 3.7	13,576	14,465	12,272
Financing costs	2.9	244	338	81
Capital charge	2.10	8,103	7,346	8,541
Impairment losses	3.7	-	-	2,638
Total expenses		671,701	624,385	615,645
Share of associate surplus/(deficit)	3.9	152	-	167
Surplus/(deficit)		**(62,903)**	**(12,900)**	**(28,425)**
Other comprehensive revenue and expense				
Revaluation of land and buildings	3.6	-	-	13,399
Total comprehensive revenue and expense		**(62,903)**	**(12,900)**	**(15,026)**

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

DHBs are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2020 was as planned (2019: underspent by $0.2 million). Mental health payments are $0.3 million less than funding over the nineteen years since 1 July 2001 (30 June 2019: $0.3 million less).

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

Statement of changes in equity

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Notes	30 June 2020	Budget 30 June 2020	30 June 2019
Balance at 1 July		143,641	126,778	148,724
Total comprehensive revenue and expense		(62,903)	(12,900)	(15,026)
Owner transactions				
Equity injections from the Crown		21,292	3,450	10,300
Equity repayments to the Crown		(357)	(357)	(357)
Balance at 30 June	**4.5**	**101,673**	**116,971**	**143,641**

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

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

Statement of financial position

As at 30 June 2020

in thousands of New Zealand Dollars

	Notes	30 June 2020	Budget 30 June 2020	30 June 2019
Assets				
Current assets				
Cash and cash equivalents (excluding bank overdraft)	3.1	1,200	840	777
Short term investments	3.1	1,449	1,854	1,872
Receivables and prepayments	3.2	20,897	26,489	29,327
Loans (Hawke's Bay Helicopter Rescue Trust)	3.3	-	-	15
Inventories	3.4	4,626	3,933	4,023
Total current assets		28,172	33,116	36,014
Non-current assets				
Property, plant and equipment	3.6	189,697	176,597	190,255
Intangible assets	3.7	15,743	2,661	13,393
Investment property	3.8	694	610	694
Investment in associate	3.9	1,341	10,398	1,189
Total non-current assets		207,475	190,266	205,531
Total assets		**235,647**	**223,382**	**241,545**
Liabilities				
Current liabilities				
Bank overdraft	3.1	14,433	27,541	10,216
Payables and deferred revenue	4.2	36,672	35,952	32,345
Employee entitlements	4.3	44,856	39,653	38,534
Provisions	4.4	34,724	-	13,808
Total current liabilities		130,685	103,146	94,903
Non-current liabilities				
Employee entitlements	4.3	3,289	2,790	3,001
Lease liabilities		-	475	-
Total non-current liabilities		3,289	3,265	3,001
Total liabilities		**133,974**	**106,411**	**97,904**
Net assets		**101,673**	**116,971**	**143,641**
Equity				
Contributed capital	4.5	112,880	84,738	91,945
Property revaluation reserves	4.5	96,103	82,704	96,103
Restricted funds	4.5	2,163	-	2,636
Accumulated surpluses/(deficits)	4.5	(109,473)	(50,471)	(47,043)
Total equity		**101,673**	**116,971**	**143,641**

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

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

Statement of cash flows

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Notes	30 June 2020	Budget 30 June 2020	30 June 2019
Cash flows from operating activities				
Receipts from patient care		608,413	610,784	575,359
Receipts from donations, bequests and clinical trials		401	-	298
Other receipts		9,765	-	4,774
Payments to suppliers		(376,663)	(356,981)	(350,934)
Payments to employees		(244,336)	(241,246)	(229,156)
Goods and services tax (net)		904	-	(318)
Cash generated from operations		(1,516)	12,557	23
Dividends received		69	-	-
Interest received		150	84	387
Interest paid		(244)	(181)	(81)
Capital charge paid		(8,103)	(7,346)	(8,541)
Net cash inflow/(outflow) from operating activities		**(9,644)**	**5,114**	**(8,212)**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		11	-	494
Acquisition of property, plant and equipment		(12,395)	(16,665)	(15,354)
Acquisition of intangible assets		(3,125)	(1,327)	(2,249)
Acquisition of investments		-	-	(1,519)
Net cash inflow/(outflow) to investing activities		**(15,509)**	**(17,992)**	**(18,628)**
Cash flows from financing activities				
Proceeds from equity injections by the Crown		21,293	740	10,300
Proceeds from movement in short term investments (net)		423	-	(227)
Repayment of finance lease liabilities		-	(34)	-
Repayment of equity to the Crown		(357)	(357)	(357)
Net cash inflow/(outflow) from financing activities		**21,359**	**349**	**9,716**
Net increase/(decrease) in cash and cash equivalents		(3,794)	(12,529)	(17,124)
Add: opening cash		(9,439)	(14,172)	7,685
Cash and cash equivalents at end of year	3.1	**(13,233)**	**(26,701)**	**(9,439)**

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

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

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

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

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Notes	30 June 2020	Budget 30 June 2020	30 June 2019
Surplus/(deficit) for the year		**(62,903)**	**(12,900)**	**(28,425)**
Add back non-cash items:				
Share of associate surplus		152	-	(167)
Depreciation and amortisation		13,576	14,465	12,271
Impairment of investment in FPIM		-	-	2,638
Add back items classified as investing activity:				
Net loss/(gain) on disposal of property, plant and equipment		142	62	111
Debt forgiven (Hawke's Bay Helicopter Rescue Trust)		15	15	14
Dividends from associate		69	-	138
Movement in working capital:				
(Increase)/decrease in receivables and prepayments		7,989	(519)	(3,868)
(Increase)/decrease in inventories		(603)	(77)	(115)
Increase/(decrease) in payables and deferred revenue		5,187	2,135	(4,496)
Increase/(decrease) in employee entitlements		6,796	1,829	(565)
Increase/(decrease) in provisions		19,648	17	13,870
Net movement in working capital		39,017	3,385	4,826
Other movements not in working capital				
Increase/(decrease) in employee entitlements		288	87	382
Net cash inflow/(outflow) from operating activities		**(9,644)**	**5,114**	**(8,212)**

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

Notes to the financial statements

For the year ended 30 June 2020

in thousands of New Zealand Dollars

In preparing the 2020 financial statements, the notes have been grouped into sections under five key categories which are considered to be the most relevant for stakeholders and other users.

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

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

1. Reporting entity and basis of preparation

1.1 Reporting Entity

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

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

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

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

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

The financial statements for HBDHB are for the year ended 30 June 2020, and were approved by the Board on 18 December 2020.

1.2 Basis of preparation

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

Statement of going concern

The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue to operate for the foreseeable future, based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances that it considers likely to affect the DHB during the period of one year from the date of signing the 2019/20 financial statements, and to circumstances that it knows will occur after that date that could affect the validity of the going concern assumption (as set out in its current statement of intent). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort, dated 29 September 2020 from the Ministers of Health and Finance which states that equity support will be provided where necessary to maintain viability.

Borrowing covenants and forecast borrowing requirements

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

Statement of compliance

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

Presentation currency and rounding

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

Standards issued and not yet effective and not early adopted

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

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. HBDHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

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

PBE FRS 48 Service Performance Reporting

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

in thousands of New Zealand Dollars

2. Result for the year

2.1 Performance by Arm

Hawke's Bay DHB's annual plan includes separate operating statements for funding, governance and funding administration and providing health services. The following table compares performance against the plan for the 2019/20 year.

	Achieved $m	Plan $m	Variance $m
Revenue			
Funding health services	573.7	581.8	8.1
Governance and funding administration	3.6	3.6	-
Providing health services	369.8	362.6	(7.2)
Eliminations	(338.3)	(336.5)	1.8
	608.8	611.5	2.7
Surplus/(Deficit)			
Funding health services	(23.8)	(12.9)	(10.9)
Governance and funding administration	(0.1)	-	(0.1)
Providing health services	(39.0)	-	(39.0)
	(62.9)	(12.9)	(50.0)

Notes:

Providing health services includes $9.5 million (2019: $8.2 million) of claims for pharmaceutical expenditure through Ministry of Health Sector Services that are ultimately paid for from the funding health services category. These claims are eliminated in the financial statements, but are included in the above table to provide a more useful comparison.

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

The adverse funding health services result largely arises from lower MOH revenue and higher than anticipated costs for residential care and home support, and loss of planned care revenue due to the lower than planned volume of elective surgery.

Contributing to the providing health services deficit was higher than planned use of locums to cover vacancies and leave for medical personnel, increased use of nursing resources related to patient volume, difficulty achieving savings targets, and higher than anticipated use of blood products and patient transport, partly offset by allied health vacancies.

2.2 Performance against budget

Accounting Policy

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

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

Financial Performance

The result for the year is $50 million adverse to plan, including:

- $20.9 million increase in the provision for Holidays Act remediation;
- $9.7 million net expenditure for COVID-19 response and recovery;
- $7.9 million less revenue than planned (net of additional revenue offset by associated expenditure), including $4.2 million for planned care (elective surgery) and reduced proceeds from the wash-up of MOH revenue agreements;
- $9 million of higher costs to provide health services, driven by higher than planned patient demand that increased staffing, locum costs, some high cost clinical supplies, patient transport and security;
- $5.2 million for funding other providers arising from faster than expected take-up of new pharmaceuticals and the move to a higher cost mix of care relating to the health of older people;
- marginally offset by the release of $2 million of budgeted contingency.

Financial Position

Equity was reduced by the $62.9 million result and the $0.4 million equity repayment to the Crown, and increased by MOH deficit and capital funding of $21.3 million. The remaining difference is the differing opening positions between the plan and actual result, including the unbudgeted $13.4 million gain from the 2018/19 land and building revaluation and the $10.3 million deficit funding in June 2019. Current assets were $4.9 million lower than budget largely due to lower Ministry of Health wash-ups than anticipated in the plan. Non-current assets were $17.2 million higher than budget mostly reflecting the unbudgeted 2018/19 land and building revaluation, and the purchase of property, plant and equipment net of depreciation and amortisation. The reclassification of the Regional Digital Health Service from investments to intangible assets was made after the completion of the Annual Plan, and explains the variances in these items. Liabilities were $27.6 million higher than plan, due to provisioning for Holidays Act remediation and leave balance increases including the cancellation of leave for the COVID-19 response, more than offset the lower than planned bank overdraft that resulted from deficit funding. No provision was made in the plan for Holidays Act remediation, as insufficient information was available at the time the plan was prepared to make a reliable estimate of the liability.

Cash Flow

Cash from operating activities was $14.8 million lower than plan, reflecting the financial performance discussed above less provisioning for MOH revenue wash-ups and Holidays Act remediation. Cash outflow to investment activities, mainly the purchase of property, plant and equipment, was $2.5 million lower than plan reflecting delays in business case approval. Financing cash flow benefited from the $21.3 million of unanticipated deficit and capital funding.

2.3 Critical accounting estimates and assumptions

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

2.4 Critical judgements in applying accounting policy

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

in thousands of New Zealand Dollars

2.5 Patient care revenue

Accounting policy

Ministry of Health population-based revenue

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

Ministry of Health contract revenue

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

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

Revenue from other DHBs

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

Other Crown entity contracted revenue

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

	30 June 2020	30 June 2019
Ministry of Health population-based revenue	525,266	501,131
Ministry of Health contract revenue	59,970	59,726
Revenue from other DHBs	12,469	13,340
Other Crown entity contracted revenue	5,591	5,760
Other patient care related revenue	1,424	1,294
	604,720	**581,251**

Other Crown entity contract revenue includes funding from the Ministry of Education for early childhood education purposes. Receipts in 2019/20 amounted to $171 thousand (2019: $161 thousand), and the balance of funds as at 30 June 2020, included in Note 4.2 under income in advance, amounted to $54 thousand (30 June 2019: $58 thousand).

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

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

	30 June 2020	30 June 2019
Budget appropriation	524,166	497,215
Supplementary estimates	13,842	3,916
Less: classified under Ministry of Health Contract Revenue		
Pay equity funding devolution	11,662	-
Other funding relating to In-Between-Travel, palliative care, cancer nurse coordination, and Boost Hospice	1,080	-
Ministry of Health population-based revenue	**525,266**	**501,131**

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

in thousands of New Zealand Dollars

2.6 Other operating revenue

Accounting policy

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

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Rental revenue

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

Sale of goods

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

Provision of services

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

Vested assets

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

Donated services

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

	30 June 2020	30 June 2019
Donations and bequests received	252	145
Rental revenue	685	690
Cafeteria and food sales	979	1,065
Other operating revenue	2,301	3,336
Gain on sale of property, plant and equipment	39	179
Clinical trials income transferred to an independent charitable trust	(480)	-
	3,776	**5,415**

2.7 Personnel costs

	30 June 2020	30 June 2019
Salaries and wages	237,663	218,752
Employer contributions to defined contribution plans	7,626	7,039
Increase/(decrease) in employee entitlements	4,848	3,065
	250,137	**228,856**

in thousands of New Zealand Dollars

2.8 Other operating expenses

Accounting policy

Operating lease payments

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

	30 June 2020	30 June 2019
Impairment of receivables (bad and doubtful debts)	62	170
Loss on disposal of property, plant and equipment	148	259
Fees to auditor for the audit of the financial statements	153	135
Fees to board members	307	289
Operating lease expenses	5,368	4,879
Increase/(decrease) in provisions	22,218	14,117
Koha	3	4
	28,259	**19,853**

2.9 Financing costs

Accounting Policy

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

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

Overdraft interest expense was $244 thousand (2019: $81 thousand). The DHB had no other borrowings or finance leases at balance date.

2.10 Capital charge

Accounting policy

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

DHBs pay a capital charge to the Crown on their taxpayers' funds as at 30 June and 31 December each year. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2020 was 6% (2019: 6%).3.1

in thousands of New Zealand Dollars

3. Resourcing the DHB's activities

3.1 Cash and cash equivalents and short-term investments

Accounting policy

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

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

Cash and cash equivalents	30 June 2020	30 June 2019
Cash	4	4
Bank balances	2	9
30 day deposits – special funds	414	392
30 day deposits – clinical trials	780	372
Cash and cash equivalents (excluding bank overdraft)	**1,200**	**777**
Bank overdraft	(14,433)	(10,216)
Cash and cash equivalents	**(13,233)**	**(9,439)**

Short term investments		
Term deposits – special funds	1,207	1,186
Term deposits – clinical trials	242	686
	1,449	**1,872**

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

Financial assets recognised subject to restrictions

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

Special funds		
Opening balance	1,578	1,719
Donations and bequests	138	66
Interest received	37	43
Transfer to operating funds	-	(127)
Expenditure during the year	(132)	(123)
	1,621	**1,578**

in thousands of New Zealand Dollars

Clinical Trials	30 June 2020	30 June 2019
Opening balance	1,058	1,122
Receipts	256	284
Interest received	17	28
Expenditure during the year	(310)	(376)
	1,021	**1,058**

DHB Treasury Services Agreement

Hawke's Bay DHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHP) and all DHBs. This agreement enables NZHP to sweep DHB bank account balances and invest the pool of surplus funds on their behalf. The agreement also allows individual DHBs to borrow from the pool of surplus funds at the on-call interest rate earned on the pool plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's provider arm funding plus GST. As at 30 June 2020 this limit for HBDHB was $32 million (2019: $29.3 million).

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

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

Credit card facility

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

3.2 Receivables and prepayments

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. HBDHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.
In measuring expected credit losses, short-term receivables have been assessed on a collective basis for customer categories that possess shared credit risk characteristics. They have been grouped based on the days past due.
Short-term receivables are written off when there is no reasonable expectation of recovery

Receivables with no allowances for credit losses	30 June 2020	30 June 2019
Ministry of Health receivables	1,975	2,413
Ministry of Health accrued revenue	8,429	13,114
Other accrued revenue	8,207	9,676
Prepayments	997	536
	19,608	**25,739**
Receivables with allowances for credit losses		
Trade receivables (gross)	1,671	4,000
Less: Allowance for credit losses	(382)	(412)
	1,289	**3,588**
Receivables and prepayments	**20,897**	**29,327**

in thousands of New Zealand Dollars

Receivables and prepayments comprise	30 June 2020	30 June 2019
Receivables from the sales of goods and services (exchange transactions)	10,493	13,800
Less: Receivables from devolved funding (non-exchange transactions)	10,404	15,527
	20,897	**29,327**

The expected credit loss rates for receivables are based on the payment profile of revenue on credit over a number of years, and the historical credit losses experienced over that period for a number of customer categories.

The allowance for credit losses at 30 June 2020 and 30 June 2019 was determined by applying the expected credit loss rates for each days past due bracket (i.e. current, 30 days, 60 days and 90days) within each customer category (e.g. dental treatment, loan equipment, and meals on wheels) to the gross carrying amount for that classification at 30 June.

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

	30 June 2020	30 June 2019
Opening allowance for credit losses as at 1 July	412	334
Increase in loss allowance made during the year	62	179
Receivables written-off during the year	(92)	(101)
Balance at 30 June	**382**	**412**

The aggregated allowance for credit losses across all customer categories at 30 June 2020 and 30 June 2019 are as follows:

30 June 2020	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.4%	38.9%	21.4%	36.2%	10.5%
Gross carrying amount	2,618	36	14	978	3,646
Lifetime expected credit loss	11	14	3	354	382

30 June 2019	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.4%	2.4%	4.9%	23.3%	6.4%
Gross carrying amount	4,007	253	611	1,542	6,413
Lifetime expected credit loss	16	6	30	360	412

in thousands of New Zealand Dollars

3.3 Loans

Accounting policy

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

Loan to Hawke's Bay Helicopter Rescue Trust	30 June 2020	30 June 2019
Non-current	-	-
Current	-	15
	-	**15**

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

3.4 Inventories

Accounting Policy

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

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

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

Inventories held for distribution	30 June 2020	30 June 2019
Pharmaceuticals	951	776
Surgical and medical supplies	2,158	2,144
Other supplies	1,517	1,103
	4,626	**4,023**

Write-down of inventories amounted to $138 thousand (2019: $46 thousand). No reversal of previously recognised write-downs was made in the current year. The amount of inventories recognised as an expense during the year was $44.1 million (2019: $45.1 million). No inventories were held at current replacement cost at 30 June 2020 (30 June 2019: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

3.5 Non-current assets held for sales

Accounting policy

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.
Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

HBDHB has no non-current assets held for sale.

in thousands of New Zealand Dollars

3.6 Property, plant and equipment

Accounting policy

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

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

Revaluations

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

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

Additions

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

Disposals

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

Subsequent costs

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

Depreciation

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

Class of asset	Estimated life	Depreciation rate
Buildings	5 to 60 years	1.6% to 20%
Clinical equipment	2 to 20 years	5% to 50%
Information technology	2 to 10 years	10% to 50%
Motor vehicles	7 to 20 years	5% to 14%
Other equipment	3 to 30 years	3% to 33%

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

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

Impairment of property, plant and equipment

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

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

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

Critical accounting estimates and assumptions

Estimating useful lives of property, plant and equipment

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

Notes to the financial statements (continued)

For the year ended 30 June 2020

in thousands of New Zealand Dollars

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

Valuation

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid MPropertyStudies BCom FNZIV FPINZ of Added Valuation Limited. The valuation was effective as at 30 June 2019. The valuations of land and buildings were updated to reflect the movement in building costs in Hawke's Bay over that year, and the useful lives of buildings were updated to recognise the impact of the National Asset Management Plan and the DHB's cash position on the timing of buildings upgrades and replacement. Movement in the value of land and the replacement value of buildings during 2019/20 is not considered material enough to require a further revaluation this year.

Land

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

Buildings

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

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

Non-specialised buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.
The Board believes that the net book value of plant and equipment is the fair value at 30 June 2020.

Impairment

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

Restrictions

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

Notes to the financial statements (continued)

For the year ended 30 June 2020

in thousands of New Zealand Dollars

30 June 2020	1 July 2018									30 June 2019		
	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions	Transfers from work in progress	Revaluation of land and buildings	Disposals/ transfers to investment properties	Depreciation expense	Depreciation write back on disposal/ revaluation	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Owned assets												
Land	9,745	-	9,745	-	-	2,382	-	-	-	12,127	-	12,127
Buildings	130,307	-	130,307	-	19,477	3,952	(87)	(7,065)	7,065	153,649	-	153,649
Clinical equipment	36,252	(23,086)	13,166	-	2,648	-	(2,656)	(3,159)	2,493	36,244	(23,752)	12,492
Information tech.	7,333	(5,775)	1,558	-	2,368	-	(1,354)	(914)	1,338	8,347	(5,351)	2,996
Motor vehicles	1,844	(1,304)	540	-	38	-	(6)	(156)	5	1,876	(1,455)	421
Other equipment	3,542	(1,910)	1,632	-	1,161	-	(317)	(344)	244	4,386	(2,010)	2,376
	189,023	(32,075)	156,948	-	25,692	6,334	(4,420)	(11,638)	11,145	216,629	(32,568)	184,061
Leased assets												
Alterations	1,658	(483)	1,175	-	25	-	-	(161)	-	1,683	(644)	1,039
	1,658	(483)	1,175	-	25	-	-	(161)	-	1,683	(644)	1,039
Work in Progress												
Buildings	14,094	-	14,094	8,537	(19,502)	-	-	-	-	3,129	-	3,129
Clinical equipment	277	-	277	3,818	(2,648)	-	-	-	-	1,447	-	1,447
Information tech.	1,147	-	1,147	1,618	(2,368)	-	-	-	-	397	-	397
Motor vehicles	-	-	-	38	(38)	-	-	-	-	-	-	-
Other equipment	-	-	-	1,343	(1,161)	-	-	-	-	182	-	182
	15,518	-	15,518	15,354	(25,717)	-	-	-	-	5,155	-	5,155
	206,199	(32,558)	173,641	15,354		6,334	(4,420)	(11,799)	11,145	223,467	(33,212)	190,255

3.7 Intangible assets

Accounting policy

Software acquisition and development

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

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

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

Amortisation

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

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

Type of asset	Estimated life	Amortisation rate
Acquired computer software	3 to 25 years	4% to 33%
Developed computer software	3 to 10 years	10% to 33%
RHIP assets (PACS Archive)	10 years	10%

Impairment of intangible assets

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

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

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

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

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

Critical accounting estimates and assumptions

Estimating useful lives of intangible assets with definite lives

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

Critical judgements in applying accounting policies

Impairment of intangible assets with indefinite lives

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

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

Notes to the financial statements (continued)

For the year ended 30 June 2020

in thousands of New Zealand Dollars

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

RDHS assets are the DHB's share of the assets comprising the Regional Digital Health Service (RDHS) facilitated by Central Region's Technical Advisory Services Limited (CRTAS). The intangible asset recognises the DHB's right to use the RDHS clinical information systems, and its ownership of a proportion of the systems assets. RDHS is substantially complete, and the right to use the assets has been transferred to software work in progress and will be amortised as each part of the system is completed. The RDHS work in progress at 30 June 2020 is considered to be fit for purpose, and the DHBs in the central region continue to support the project. HBDHB considers the carrying amount of the assets (the cost of the system build), is equivalent to the recoverable service amount using depreciated replacement cost, and consequently no impairment of the assets, is necessary.

in thousands of New Zealand Dollars

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

The FPIM rights were fully impaired on 30 June 2019 – see the "Impairment of intangible assets with indefinite lives" section of this note above.

in thousands of New Zealand Dollars

3.8 Investment property

Accounting policy

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

Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above). When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to retained earnings. Any loss arising in this manner is recognised immediately in the surplus or deficit.

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

	30 June 2020	30 June 2019
Balance at beginning of year	694	960
Transfers from property, plant and equipment	-	84
Transfers from non-current assets held for sale	-	-
Fair value adjustments	-	-
Disposals	-	(350)
Balance at end of year	694	694

No revaluation was completed for investment properties as at 30 June 2020 due to the minimal value of the property. The property were last revalued as at 30 June 2018 by John Reid MPropertyStudies BCom FNZIV FPINV of Added Valuation, who holds an annual practicing certificate and has held registration since 1985. The fair value of the investment properties was determined using market based evidence.

3.9 Investment in associates

Accounting policy

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

If the share of deficits of an associate equals or exceeds the DHB's interest in the associate, further deficits are not recognised. After the DHB's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that the DHB has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the DHB will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

in thousands of New Zealand Dollars

Hawke's Bay DHB has an investment in one associate entity, Allied Laundry Services Limited (ALSL), whose principal activity is the provision of laundry services. The interest held at 30 June 2020 was 16.67% (30 June 2019: 16.67%). ALSL has been treated as an associate entity because its shares are held equally by six DHB shareholders, who appoint one director each, and contribute 90% of the company's income. The associates balance date is 30 June. There are no significant restrictions on the ability of the associate to transfer funds to HBDHB in the form of cash dividends.

Summarised financial information of Allied Laundry Services Limited	30 June 2020	30 June 2019
Presented on a gross basis		
Assets	9,867	9,918
Liabilities	2,233	2,634
Revenue	11,761	10,924
Surplus/(deficit)	764	558
HBDHB ownership interest	16.67%	16.67%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Capital commitments	-	-

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited draft accounts as at 30 June 2020, and their audited financial statements as at 30 June 2019.

4. Financing the DHB's activities

4.1 Borrowings and finance leases

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

4.2 Payables and deferred revenue

Accounting policy

Payables and deferred revenue are recorded at their face value.

Payables and deferred revenue under exchange transactions	30 June 2020	30 June 2019
Trade payables	3,281	5,620
Income in advance relating to contracts with specific performance obligations	1,281	502
Other non-trade payables and accrued expenses	29,473	22,976
	34,035	29,098
Payables and deferred revenue under non exchange transactions		
ACC levy payable	233	1,027
Goods and services tax	2,404	2,220
	2,637	3,247
Total payables and deferred revenue	**36,672**	**32,345**

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

in thousands of New Zealand Dollars

4.3 Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Critical accounting estimates and assumptions

Employee entitlement provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $6,352 million (2019: $5.830 million).

Non-current liabilities	30 June 2020	30 June 2019
Long service leave	3,192	2,892
Retirement gratuities	97	109
	3,289	**3,001**

in thousands of New Zealand Dollars

Current liabilities	30 June 2020	30 June 2019
Accrued salaries and wages	8,709	6,947
Annual leave	27,229	23,865
Sick leave	465	438
Continuing medical education leave and expenses	5,855	4,893
Sabbatical leave	638	637
Long service leave	1,844	1,658
Retirement gratuities	116	96
	44,856	**38,534**

Key assumptions in measuring employee entitlements

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 0.22% (2019: 1.26%) in year one to 3.77% (2019: 4.30%) after 52 (2019: 52) years. The salary inflation factor is the DHB's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates are 1% lower, or salary increases 1% higher, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $287 thousand higher (2019: $277 thousand higher). Conversely if the discount rates are 1% higher, or salary increases 1% lower, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $259 thousand lower (2019: $249 thousand lower).

4.4 Provisions

Accounting policy

Provisions

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

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

Critical accounting estimates and assumptions

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

in thousands of New Zealand Dollars

	30 June 2020	30 June 2019
Balance at beginning of year	13,808	936
Additional provisions made	22,218	14,117
Amounts used	(1,302)	(1,245)
Unused amounts reversed	-	-
Balance at end of year	**34,724**	**13,808**

All provisions are classified as current.

ACC Accredited Employers Programme

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

Liability valuation

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

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

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

Hawke's Bay DHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will carry the total cost of claims up to $2.2 million (2019: $2.2 million) for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceed the stop loss limit, the DHB will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

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

An independent consulting actuary, Peter Davies B.Bus.Sc, FIA, FNZSA has calculated the DHB's liability, and the valuation is effective 30 June 2020. The actuary has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the consulting actuary's report.

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

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

in thousands of New Zealand Dollars

Holidays Act remediation

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue into the 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Hawke's Bay DHB has reassessed the likely liability at $33.9 million (2019: $13 million), based on a draft Holidays Act Financial Liability Assessment Report prepared by the remediation project. The financial liability assessment has been developed based on identified areas of non-compliance with the Holidays Act and the subsequent sample recalculations performed based on an agreed sample of current and former employees.

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

4.5 Equity

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

in thousands of New Zealand Dollars

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

Property Revaluation Reserves

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

	30 June 2020	30 June 2019
Land	10,657	10,657
Buildings	85,446	85,446
	96,103	**96,103**

Restricted Funds

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

5. Other disclosures

5.1 Taxes

Accounting policy

Goods and services tax

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

in thousands of New Zealand Dollars

5.2 Capital commitments and operating leases

Capital commitments	30 June 2020	30 June 2019
Property, plant and equipment		
Buildings	1,674	457
Clinical equipment	741	883
Plant	10	14
Information technology	80	23
Intangible assets		
Software	38	66
Regional Digital Health Service (RDHS)	1,051	971
	3,594	2,414

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

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

Non-cancellable commitments – operating leases	30 June 2020	30 June 2019
Not more than one year	3,178	3,184
One to five years	9,670	11,189
Later than five years	1,732	2,350
	14,580	16,723

5.3 Financial instruments

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

- The Napier Health Centre lease was extended from the December 2011 expiry date for a further twelve years ending December 2023, with a right of renewal for a further two periods of six years each, and an escalation clause allowing for increases in line with the inflation rate.
- The lease of the administration building at 100 McLeod Street was varied in February 2018, for a ten year period, with two right of renewal periods of four years each. The lease is reviewed to market every two years.
- The lease of the store building on Omahu Road was renewed in December 2014, for the first of three right of renewal periods of two years each, with a review to market on each renewal date.
- The Central Hawke's Bay Health Centre was renewed from July 2015, for four years, with a right of renewal for a further two periods of four years each.

a. Financial instrument categories

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

in thousands of New Zealand Dollars

Financial Assets

Financial assets measured at amortised cost (2018: Loans and receivables)	30 June 2020	30 June 2019
Cash and cash equivalents	1,200	777
Short term investments	1,449	1,872
Loans	-	15
Receivable and prepayments	21,118	29,327
	23,767	**31,991**

Financial Liabilities

Financial liabilities measured at amortised cost		
NZ Health Partnerships	14,433	10,216
Payables and deferred revenue	36,672	32,345
	51,105	**42,548**

b. Fair value hierarchy disclosures

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

c. Financial instrument risks

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

Market risk

Fair value interest rate risk

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

Cash flow interest rate risk

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

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

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

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

in thousands of New Zealand Dollars

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

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

Currency risk

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

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

Sensitivity analysis

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

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor at 96% (30 June 2019: 95%) of the DHB's revenue. The Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

in thousands of New Zealand Dollars

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

Sensitivity analysis

At 30 June 2020, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2020/21, as the DHB has no term debt, and only the net interest from cash holdings would be affected.

Credit quality of financial assets

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

	30 June 2020	30 June 2019
Counterparties with credit ratings		
Cash, cash equivalents and investments		
AA-	2,642	2,636
Total cash and cash equivalents	2,642	2,636
Counterparties without credit ratings		
Cash and cash equivalents		
NZ Health Partnerships – no defaults in the past	-	-
Receivables and prepayments		
Receivables and prepayments with no defaults in the past	20,974	29,184
Receivables and prepayments with defaults in the past	144	143
Total receivables and prepayments	21,118	29,327
Loans		
Hawke's Bay Helicopter Rescue Trust - no defaults in the past	-	15

Liquidity risk

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

Contractual maturity analysis of financial liabilities

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

Forecasted transactions

Hawke's Bay DHB does not hedge forecasted transactions.

5.4 Contingent assets

There are no contingent assets at 30 June 2020 (2019: Nil).

in thousands of New Zealand Dollars

5.5 Contingent liabilities

Lawsuits against the DHB

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

Superannuation schemes

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

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

As at 31 March 2020, the scheme had a past service deficit of $2.8 million (4.1% of the liabilities). This amount was exclusive of employer superannuation contribution tax. This deficit was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

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

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

The key assumptions in the review were:

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

The Scheme had 110 members (2019: 141) at 31 March 2020, two (2019: three) of whom were employees of the DHB.

5.6 Related party transactions

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

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

in thousands of New Zealand Dollars

Key management personnel compensation

	30 June 2020	30 June 2019
Board Members		
Remuneration	307	289
Full time equivalent members	*1.3*	*1.3*
Executive management team		
Remuneration	3,603	3,306
Full time equivalent members	*13.3*	*13.2*
Total key management personnel remuneration	**3,910**	**3,595**
Total full time equivalent personnel	**14.6**	**14.5**

The full time equivalent for Board members has been determined based on the frequency and length of board meetings and the estimated time for Board members to prepare for meetings. Three executive positions covered by contractors on an interim basis for parts of the year are in the table, including accommodation and transport valued at the cost incurred by the DHB. One executive position was held by an employee of Health Hawke's Bay, the Hawke's Bay PHO, and has been excluded from the table.

5.7 Remuneration

Remuneration – Board members

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

	30 June 2020		30 June 2019	
in whole New Zealand Dollars	Board	Committees	Board	Committees
Appointed December 2019				
Shayne Walker *Chair*	26,771	2,000	-	-
Evan Davies *Deputy Chair*	16,710	2,313	-	-
Joanne Edwards	13,368	2,000	-	-
Charlie Lambert	13,368	1,500	-	-
Elected October 2019				
Hayley Anderson	13,368	2,250	-	-
Ana Apatu	21,999	5,250	20,400	5,000
Kevin Atkinson Chair until October 2019	31,862	2,500	42,000	2,500
David Davidson	13,368	1,750	-	-
Peter Dunkerley	21,999	2,686	20,400	2,500
Anna Lorck	13,368	2,000	-	-
Heather Skipworth	21,999	5,250	20,400	5,313
Retired October 2019				
Barbara Arnott	9,416	1,250	20,400	3,750
Ngahiwi Tomoana *Deputy Chair*	11,769	1,250	25,500	3,750
Dan Druzianic	9,416	1,560	20,400	3,120
Hine Flood	9,416	3,250	20,400	4,250
Helen Francis	9,416	750	20,400	2,500
Diana Kirton	9,416	1,000	20,400	2,500
Jacoby Poulain (resigned July 2019)	1,569	-	20,400	2,500
	268,598	38,559	251,100	37,683

in thousands of New Zealand Dollars

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

Board members Hayley Anderson and Ana Apatu were remunerated for their work as Incident Controller and Intersectional and Iwi Liaison respectively during the COVID-19 response and recovery. Their remuneration was what would be paid in a normal supplier relationship on terms and conditions no more favourable than those the DHB would have adopted if dealing with those individuals at arm's length in the same circumstances.

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

Remuneration – Committee members who are not board members or employees

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

Employee Remuneration

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

	30 June 2020	30 June 2019		30 June 2020	30 June 2019
100,000-109,999	142	123	320,000-329,999	5	2
110,000-119,999	83	65	330,000-339,999	4	3
120,000-129,999	38	29	340,000-349,999	1	4
130,000-139,999	32	22	350,000-359,999	1	1
140,000-149,999	23	13	360,000-369,999	3	2
150,000-159,999	9	18	370,000-379,999	7	1
160,000-169,999	15	9	380,000-389,999	1	1
170,000-179,999	12	10	390,000-399,999	1	2
180,000-189,999	12	8	400,000-409,999	1	1
190,000-199,999	5	7	410,000-419,999	1	3
200,000-209,999	5	10	420,000-429,999	-	1
210,000-219,999	11	8	430,000-439,999	1	2
220,000-229,999	8	8	440,000-449,999	2	1
230,000-239,999	14	13	460,000-469,999	1	-
240,000-249,999	6	12	470,000-479,999	1	-
250,000-259,999	7	8	490,000-499,999	-	3
260,000-269,999	7	2	500,000-509,999	1	-
270,000-279,999	11	4	520,000-529,999	1	-
280,000-289,999	4	9	530,000-539,999	-	2
290,000-299,999	6	6	540,000-549,999	-	1
300,000-309,999	7	5	570,000-579,999	-	1
310,000-319,999	7	5	610,000-619,999	1	-

The above table includes $2.1 million of payments made in the 2018/19 financial year, to senior medical officers during the Resident Doctors Association strikes. This affects comparison between the two years.

During the year, nine (30 June 2019: one) employee received compensation and other benefits in relation to cessation totalling $262,236 (30 June 2019: $22,745).

Compensations

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

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

5.8 Capital management

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

5.9 Events after balance date

There are no significant events after balance date.

5.10 Extensions of time – 2020/21 Statement of Performance Expectations

The Minister of Health granted an extension of time to 15 August 2020 for finalising and publishing HBDHB's 2020/21 Statement of Performance Expectations (SPE). The reason the extension was granted was to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and ensure quality SPE documents were produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

This disclosure is in accordance with s.149CA(3)(e) of the Crown Entities Act 2004.

5.11 COVID-19

Hawke's Bay had a relatively low incidence of COVID-19 with 44 people infected and no fatalities. However the need to prepare for a possible severe outbreak required significant expenditure on:

- the renovation of a number of buildings to allow the separation of COVID-19 and non-COVID-19 patients;
- the stand-up of a number of community based assessment centres (CBACs);
- agreements with primary care providers to staff the CBACs;
- the procurement of clinical equipment and supplies such as ventilators and masks;
- the testing, contact tracing and treatment of a number of patients;
- ensuring the availability of capacity including the cancellation of elective procedures; and
- ensuring the availability of staff including the cancellation of annual leave.

Expenditure at 30 June 2020 amounted to $14.9 million, of which $5.2 million was funded by MOH, for a $9.7 million impact in the statement of comprehensive revenue and expense.

Independent Auditor's Report

To the readers of the Hawke's Bay District Health Board's financial statements and performance information for the year ended 30 June 2020

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

We have audited:

- the financial statements of the Hawke's Bay DHB on pages 74 to 113, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Hawke's Bay DHB on pages 18 to 25 and 28 to 72.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements to the Hawke's Bay DHB on pages 74 to 113:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Unmodified opinion on the performance information

In our opinion, the performance information of the Hawke's Bay DHB on pages 18 to 25 and 28 to 72:

- present fairly, in all material respects, the Hawke's Bay DHB's performance for the year ended 30 June 2020, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

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

Our audit of the financial statements and the performance information was completed on 18 December 2020. This is the date at which our opinion is expressed.

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

Basis for our qualified opinion on the financial statements and unmodified opinion on the performance information

As outlined in Note 4.4 on page 104, the Hawke's Bay DHB has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

During the 2019 financial year-end audit, we were unable to obtain sufficient appropriate audit evidence to determine whether the amount of the Hawke's Bay DHB's provision of $13 million as at 30 June 2019 was reasonable, because of the work that was yet to be completed to remediate these issues. We accordingly expressed a qualified opinion on the financial statements for the year end 30 June 2019.

The Hawke's Bay DHB made progress during the 30 June 2020 year in estimating the amount of the provision and we have been able to obtain sufficient appropriate audit evidence that the provision of $33.9 million as at 30 June 2020, is reasonable. However, until the process is completed, there are uncertainties surrounding the amount of the provision.

Our opinion on the current period's financial statements is qualified because of the possible effects of the matter on the comparability of the current period's provision and the 2019 provision.

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

We have fulfilled out responsibilities in accordance with the Auditor-General's Auditing Standards. We believe that the audit evidence we have obtained is sufficient and appropriate to provide the basis for our qualified opinion on the financial statements and the basis for our unmodified opinion on the performance information.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements.

The Hawke's Bay DHB is reliant on financial support from the Crown

Note 1.2 on page 79 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Hawke's Bay DHB will be able to settle this liability, if it becomes due within one year of approving the financial statements. To support the Board's ongoing concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Hawke's Bay DHB over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Note 5.11 on page 113 outlines the impact of Covid-19 on the Hawke's Bay DHB.

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

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

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

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

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hawke's Bay DHB's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Hawke's Bay DHB's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Hawke's Bay DHB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Hawke's Bay DHB to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial

statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 17, 26, 27, 73, 117 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than the audit, we have no relationship with, or interests in, the Hawke's Bay DHB.

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

Glossary of Acronyms

ACE	Angiotensin Converting Enzyme
ACS	Acute Coronary Syndrome
ARB	Angiotensin II Receptor Blockers
ASH	Ambulatory Sensitive Hospitalisation
AT&R	Assessment Treatment and Rehabilitation
B4SC	Before School Check
BSCC	Breast Screen Coast to Coast
CAPA	Choice and Partnership Approach
CBAC	Community Based Assessment Centre
CE ACT	Crown Entities Act
CEO	Chief Executive Officer
CHESS	Changes in Health, End-stage disease, Signs and Symptoms Scale
COO	Chief Operating Officer
CPHAC	Community Public Health Advisory Committee
CNS	Clinical Nurse Specialist
CVD	Cardiovascular Disease
CVDA	Cardiovascular Disease Assessment
DNA	Did Not Attend
DSAC	Disability Support Advisory Committee
ED	Emergency Department
FFA	Fee for Service
FRAC	Finance Risk and Audit Committee
FTE	Full Time Equivalent
HAC	Hospital Advisory Committee
HBDHB	Hawke's Bay District Health Board
HDU	High Dependency Unit
HPV	Human Papillomavirus
HQSC	Health Quality and Safety Commission
HR	Human Resources
ICU	Intensive Care Unit
LMC	Lead Maternity Carer
LOS	Length of Stay
LVEF	Left Ventricular Ejection Fraction
MH&A	Mental Health and Addiction Service
MoH	Ministry of Health
MRB	Māori Relationship Board
NASC	Needs Assessment Service Coordination
NGO	Non Government Organisation
NHI	National Health Index
NZPHD Act	New Zealand Public Health and Disability Act
PBFF	Population Based Funding Formula
SBA	Smoking Brief Advice
SLM	System Level Measures
SP	Statement of Performance
SPE	Statement of Performance Expectations
SUDI	Sudden Infant Death in Infancy
TBC	To be confirmed
WCTO	Well Child Tamariki Ora

HAWKE'S BAY DISTRICT HEALTH BOARD

PRIVATE BAG 9014

HASTINGS 4156