E83

HAWKE'S BAY DISTRICT HEALTH BOARD

Statement of Intent

2016 – 2019

and

Statement of Performance Expectations

2016/17

HAWKE'S BAY
District Health Board
Whakawāteatia

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

OUR VISION

“HEALTHY HAWKE’S BAY”

“TE HAUORA O TE MATAU-A-MAUI”

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

OUR VALUES / BEHAVIOURS

TAUWHIRO

Delivering high quality care to patients and consumers

RĀRANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

Showing respect for each other, our staff, patients and consumers

ĀKINA

Continuously improving everything we do

Hawke’s Bay District Health Board Annual Plan 2016/17

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STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

Our strategic plan Transform and Sustain is currently being refreshed to ensure we continue to meet the outcomes we set out to achieve. The New Zealand Health Strategy will also inform the Transform and Sustain refresh. The New Zealand Health Strategy is already consistent with this plan.

We continue to build on our excellent relationship with the Primary Healthcare Organisation (PHO): Health Hawke's Bay – Te Oranga Hawke's Bay and other key Organisations to ensure a whole of health system approach. These relationships are key to successfully shifting services into the community and primary care as we have done with District Nursing, Pharmacy Facilitators and Health of Older People Services to name a few examples. This year we will focus on expanding the District nursing and Respiratory programmes in primary care. We will also be increasing primary care capacity to improve access to planned and unplanned care in the community, particularly for vulnerable groups. We will also be celebrating the opening of our new Primary Maternity Unit in July 2016.

Collaboration with other public sector organisations is vital for improving the health of the population. We are working with the intersectoral forum on two key programmes - Economic Development and Social Inclusion.

Heading into the 2016/17 year we are planning to deliver our sixth consecutive surplus. Our baseline funding from the Ministry of Health continues to grow but, in order to fund approved investments along with additional spending needed by our various service directorates, we have a savings plan of $13 million for 2016/17. This is prudent management of resources which allows us to invest in new innovations and services in line with the triple aim that underpins Transform and Sustain.

This annual plan focuses on the 2015/16 year which ends on 30 June 2016. An annual plan is a legal requirement and is the primary accountability document between the Minister of Health and HBDHB.

X_____

Dr Kevin Snee

Chief Executive - Hawke's Bay District Health Board

X_____

Kevin Atkinson

Board Chair – Hawke's Bay District Health Board

X_____

Hon. Dr Jonathan Coleman

Minister of Health

THE PRIMARY HEALTHCARE ORGANISATION

In the 2016 financial year Health Hawke's Bay and Hawke's Bay District Health Board (HBDHB) strengthened our relationship through a number of ways, the secondment of the CEO of Health Hawke's Bay to the role of General Manager Primary Care at HBDHB being one. The purpose of this secondment has been to ensure the focus of both organisations is aligned to the national strategic picture of providing care closer to home.

We take a one team approach toward the achievement of our vision: 'excellent health services working in partnership to improve the health and wellbeing of our people and to eliminate health inequalities within our community'. This 'one team' is not limited to the PHO and the DHB but also includes those from other sectors in our community that influence health outcomes such as social care, education, justice etc.

This plan identifies a number of programmes that will support joint working across the public sector in Hawke's Bay. To enhance the patient journey, uplift our community and support the elimination of inequities we will focus resources on those most in need. By progressing health and social care networks we will be creating people powered community engagement models across Central Hawke's Bay, Te Wairoa, Napier and Hastings

The year ahead, as set out in this plan, will be a tipping point in our development of smarter systems. We will jointly progress the vision of a shared care record and further encourage our population uptake of patient portal.

HBDHB and Health Hawke's Bay are jointly committed to supporting general practice and our community providers. Developing systems and processes that enable them to release time and capacity to continue delivering quality services will maximise value, high performance and sustainability.

We are unified with HBDHB through our common vision and values and will continue to progress our one team agenda. Joint planning is prominent throughout this plan and this approach extends to all strategic planning, governance services and management accountabilities to collectively deliver on the requirements of our population.

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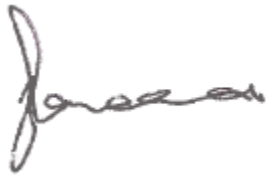
Liz Stockley, Chief Executive Health Hawke's Bay – Te Oranga Hawke's Bay

MĀORI RELATIONSHIP BOARD



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Ngahiwi Tomoana, Chair - HBDHB Māori Relationship Board

ALLIANCE LEADERSHIP TEAM

This plan is agreed to by the Alliance Leadership Team

X_____

Bayden Barber, Member – Hawke's Bay Alliance Leadership Team

1 INTRODUCTION & STRATEGIC INTENTIONS

1.1 Executive Summary

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

Locally, we are guided by a health-sector strategic framework and our five year strategic programme - Transform and Sustain, which was launched in December 2013. Our three priority goals for Transform and Sustain are: responding to our population; delivering consistent high-quality care; and being more efficient at what we do. Through the programme we will contribute to the Government's priorities for the health system, which include fiscal discipline, working across government, shifting and integrating services, improving health information technology, achieving the National Health Targets, and tackling the key drivers of morbidity such as obesity. The refreshed New Zealand Health Strategy will drive new initiatives and the five main themes will be embedded into everyday practice. We also work collaboratively for optimal arrangements by aligning our work to a Regional Services Plan developed on behalf of the six Central Region DHBs - Whanganui, Mid-Central, Wairarapa, Hutt Valley, Capital & Coast, and Hawke's Bay. Fiscal responsibility means that we plan for modest annual operating surpluses that enable us to invest in programmes that will deliver the necessary transformational change for ongoing quality improvement.

Our Statement of Intent outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes. The health system outcomes are defined by the Ministry of Health as New Zealanders living longer, healthier and more independent lives, and a cost effective health system supporting a productive economy. Over time, we will measure progress towards our vision by considering patient and whānau experiences of care, resource sustainability and life expectancy gap as headline system outcomes plus a suite of 21 key supporting dimensions that will be evidence of impact.

Targets for service performance standards for the 2016/17 year and are set out in the Statement of Performance Expectations grouped according to four reportable classes of outputs: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. A set of financial statements for the 2016 to 2020 period are also included. Actual results will be audited against those forecasts by Audit New Zealand after the end of each financial year.

X_____

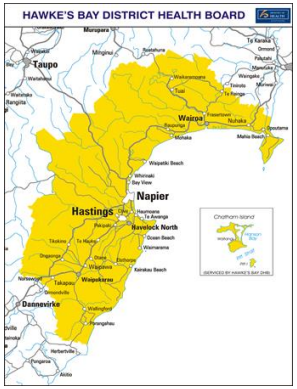
Board Member

X_____

Board Member

1.2 Context

Hawke's Bay District Health Board (HBDHB) is one of 20 District Health Boards (DHBs) that were established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). HBDHB is the Government's funder and provider of public health services for the 161,300[1] people resident in the Hawke's Bay district. A map of the district, which is defined by the NZPHD Act is shown in Figure 1. In 2016/17, HBDHB's allocation of public health funds will be $504 million, including 3.90%[2] of the total health funding that the Government allocates directly to all DHBs.



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

Figure 1: Hawke's Bay District Health Board District

Funding and Provision of Services

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

As a funder, HBDHB buys health and disability services from various organisations right across New Zealand for the benefit of our population. We fund and work very closely with the Primary Healthcare organisation (PHO) Health Hawke's Bay – Te Oranga Hawke's Bay who coordinate and support primary health care services across the district. Health Hawke's Bay brings together General Practitioners (GPs), Nurses and other health professionals in the community to serve the needs of their enrolled populations.

Other organisations we fund may be community-based private entities, such as residential care providers or individual pharmacists, or may be public entities, such as other DHBs. In 2016/17 we will fund over $231 million worth of services from other providers. 78% (2015/16 76.5%) of those services will be from primary care and private providers mostly based in Hawke's Bay communities and the other 22% will be from other DHBs for more specialised care than is provided locally.

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

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

Despite this larger grouping, a small number of specialised services cannot be efficiently provided even at the regional level and these are, therefore, arranged as national services located at one or two provider hospitals for the whole of New Zealand. Examples are clinical

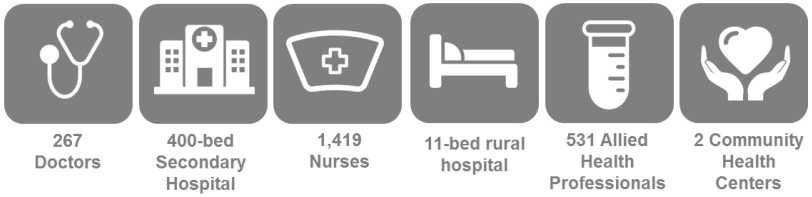
[1] Estimated for 2016 by Statistics New Zealand based on assumptions specified by Ministry of Health
[2] HBDHB share has decreased from 3.96% in 2015/16.
[3] DHB performance objectives are specified in section 22 of the NZPHD Act.

genetics and paediatric cardiology. These services are planned and funded centrally by the National Health Board with all DHBs having access.

Organisational Overview

With over 2,900 employees, HBDHB is the district's largest employer. Our provider arm is known as Health Services and our frontline services are delivered to patients and consumers across the district in a number of settings. For example, we provide public health programmes in schools and community centres, inpatient and outpatient services in leased and owned health facilities, and mobile nursing services in people's homes. The main health facilities include Hawke's Bay Fallen Soldier's Memorial Hospital, Wairoa Hospital and Health Centre, Napier Health Centre and Central Hawke's Bay Health Centre. In addition, we have significant investment in clinical equipment, information technology and other (non-clinical) moveable assets. Corporate and clinical support services are located appropriately to provide effective back-up to our frontline services.

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



Icons made by Freepik from www.flaticon.com

Our Population

In 2016/17, the Hawke's Bay district population will grow slightly to just under 162,000 people. Most of our population live in Napier or Hastings, two cities located within 20 kilometres of each other that together account for more than 80% of the total numbers. About 10% of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 10% live in rural and remote locations.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (18% vs 15%) and more people living in areas with relatively high material deprivation (28% vs 20%). The 2013 New Zealand Index of Deprivation (NZDep13)[4] explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms of people's opportunity to access and use the health system. Figure 2, shows the pattern across Hawke's Bay DHB according to NZDep2006 – this is not expected to be markedly different to NZDep2013.

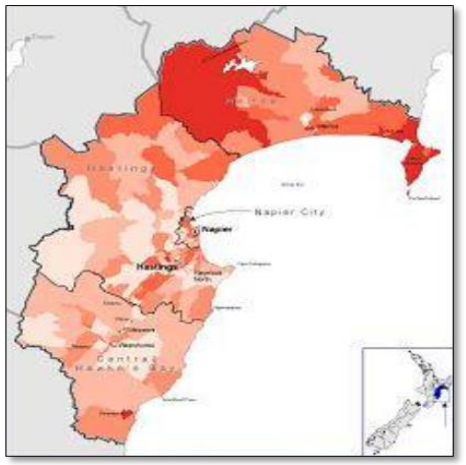


Figure 2: Hawke's Bay District relative deprivation – Darker colour higher deprivation, and lighter colour, lower deprivation

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

Health Status

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

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

Key findings:

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

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum[5] taking a role in putting together an action plan, with nominated sector leads, to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

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

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

1.3 Strategic Intentions

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

National

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

Government's priorities for the health system are communicated to all DHBs through the Minister of Health's annual "Letter of Expectations"[6]. For 2016/17 the Government's investment of an extra $3 billion in health over the past seven years is highlighted alongside a requirement that DHBs operate within allocated funding and drive efficiency in back-office processes and collaboration at national, regional and sub-regional levels. The Minister also expressed expectations regarding working across government, shifting and integrating services, improving health information technology, achieving the National Health Targets, and tackling the key drivers of morbidity.

The refreshed New Zealand Health strategy sets a clear strategic direction for the sector which DHBs will follow to ensure all New Zealanders live well, stay well and get well. The focus for the sector is based on five themes: People Powered, Closer to Home, Value and High Performance, One Team and Smart System.

There is an ongoing focus on the Better Public Services initiatives and the national health targets with a particular emphasis on reducing the incidence of obesity in New Zealand.

Regional:

A Regional Services Plan (RSP)[7] has been developed by the six central region DHBs to provide an overall framework for future planning around optimum arrangements and regionalisation. Working regionally enables us to better address our shared challenges. As a region we are committed to a sustainable health system focussed on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's home as possible.

Local

In 2013, we published Transform & Sustain[8], our strategic plan for 2014 – 2018. Transform & Sustain provides common understanding of our direction and began with sector-wide agreement on a common vision:

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

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

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

[6] Minister of Health's Letter of Expectations, December 22nd 2015.
[7] Regional Services Plan 2016-2017

[8] Available from our website: http://www.hawkesbay.health.nz/

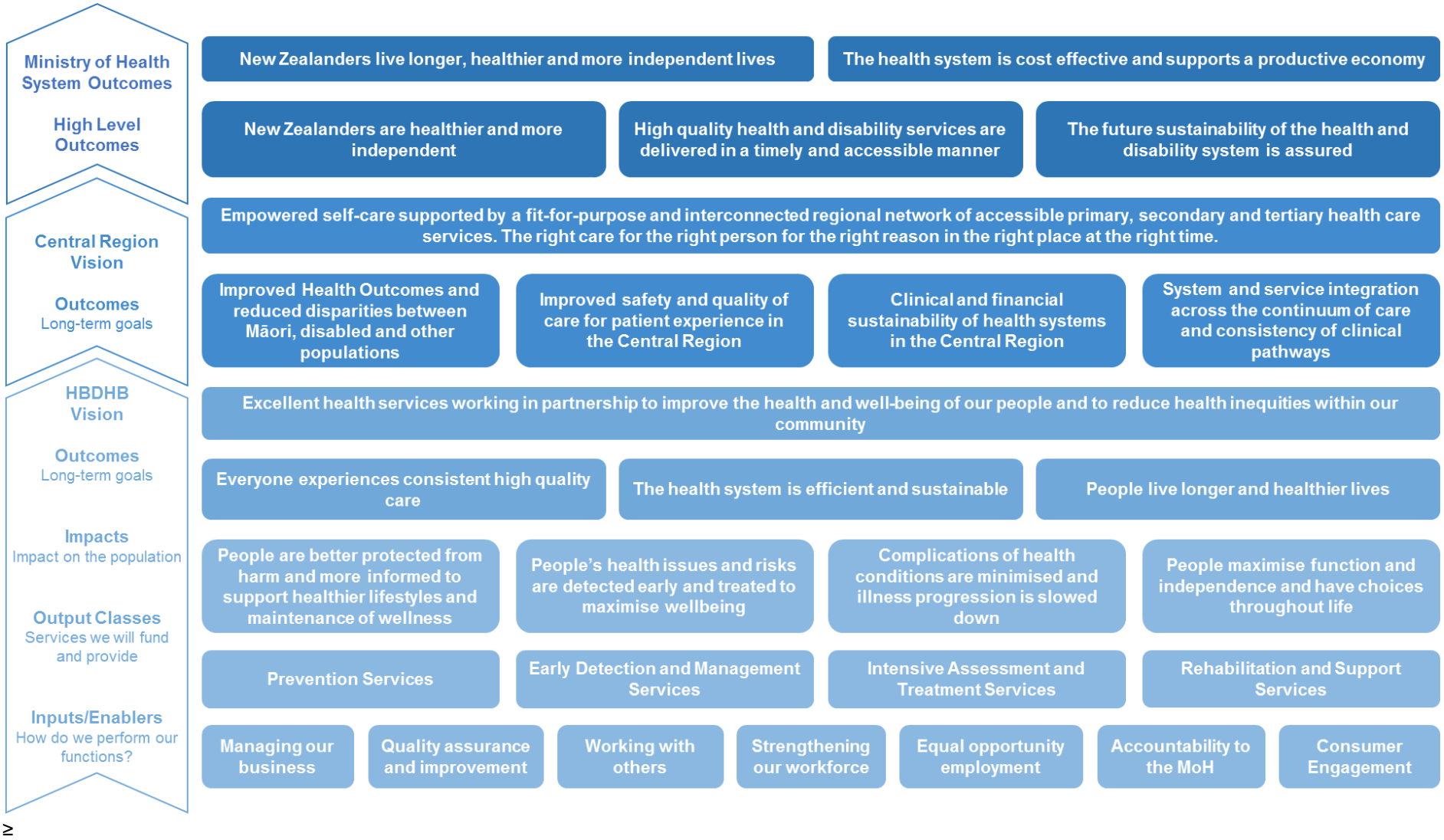


Figure 3: Connecting local activity to local, regional and national objectives

Our Challenges

HBDHB has made significant progress in the recent past. However, we continue to be challenged by ongoing issues, such as the growth in chronic illness, our ageing population and vulnerability in a large proportion of our community. Despite population growth[9] being modest, at about 2.8% in the next 10 years, we will see significant changes in age groups. In our population, the over 65s will grow by 35.6% and the over 85s will increase by 38.6%. The same age group of Māori and Pasifika people will grow even faster at 62% and 69% respectively.

Māori and Pasifika	2016	2026	Growth
0-14	16,220	18,170	12%
15-64	28,480	32,640	15%
65 yrs +	2,900	4,700	62%
85 yrs +	130	220	69%

Total	2016	2026	Growth
0-14	34,350	32,880	-4.3%
15-64	97,680	93,490	-4.3%
65 yrs +	29,270	39,680	35.6%
85 yrs +	3,500	4,850	38.6%

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

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

Risk and Opportunity

The health of our population can be described using the diagram in Figure 4, where everyone in the population fits within one of these categories.

Our focus will be to keep people healthy and well to require less hospital care.

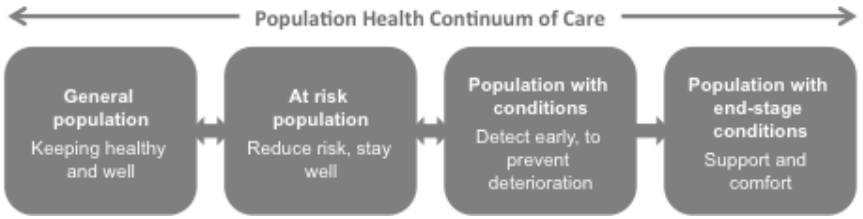


Figure 4: Population Health Continuum of Care

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

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

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

1. Helping people to stay healthy and well and able to live independently in their own home for longer

2. Ensuring that people who have complex long-term illnesses are able to live to their full potential

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

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

In Transform and Sustain, we have summarise these challenges into three priority goals:

Responding to our population

Delivering consistent high-quality health care

Being more efficient at what we do

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

Our Strategic Response

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

Responding to our Population

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

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

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

Recognising that many older people are well, we will develop opportunities for them to contribute valuable consumer support and advice to the care system

We will provide care for our older people in their community with a clear intent to implement key care pathways and integrate service provision across primary and secondary settings

Aiming to begin earlier conversations about care towards the end of life, we will lead open and honest conversations with people and whānau about decisions that affect them. By doing so, we will get a better understanding of what matters to the person and their whānau during this time and will be able to focus on supportive care that is the most appropriate for them.

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

Improve consumer engagement and put patients and whānau at the centre of care

Create better working relationships that influence Māori and Pasifika health and well-being, acknowledging the formal and informal roles that community-based entities can bring to a partnership. These include iwi, hapū, Treaty settlement entities, Māori providers, individual marae, Pasifika community churches and key Government agencies

Provide good cultural responsiveness training based on advice and support from experts in Māori and Pasifika cultural practices. We will ensure that the health system workforce is well prepared and responsive and that resource allocation and service monitoring are informed through effective engagement, especially with Māori

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

Delivering Consistent High Quality Care

We generally deliver care to a high standard and we have seen some significant improvements in recent years. However, there are still too many examples where patient experience is inadequate and where mistakes that cause harm are made. Delivering high-quality care is about making sure we use all our resources in the best way, with the patients and their family/ whānau at the centre of that care.

The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible and without error or undue waiting.

Every staff member should be aware of their own responsibilities in quality improvement and safety when delivering day-to-day care. Clinicians are not only responsible for the provision of high-quality patient care, their leadership is also important. Clinical participation in the leadership and governance of health services is essential for creating a culture of effective quality and safety.

Being More Efficient at What We Do

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

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

Achieving Regular Financial Surpluses

The DHB is responsible for most of the Government's spending on health in Hawke's Bay – surpluses are planned and must be delivered according to statutory obligations. This will allow us to invest in our infrastructure and services. Over the past five years, through hard work and good management, we have managed to generate an additional investment in our infrastructure with $77.4 million capital investment planned over the next four years.

Where to Next?

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

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

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

How we will Assess Performance

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

Measuring Progress towards Our Vision

The implementation of Transform and Sustain is monitored through a programme of work which is reported monthly. The programme focusses on the 11 key intentions that will support us to address our challenges. These are:

- **Transforming our engagement with Māori**
- **Transforming patient involvement**
- **Transforming health promotion and health literacy**
- **Transforming multi-agency working**
- **Transforming clinical quality through clinical governance**
- **Transforming patient experience through better clinical pathways**
- **Transforming through integration of rural services**
- **Transforming primary health care**
- **Transforming urgent care**
- **Transforming out-of-hours hospital inpatient care**
- **Transforming business models**

Appendix 2 gives a good overview of the implementation of Transform and Sustain. It outlines the programmes that are completed, in progress and planned against each of the intentions. A refresh of the programme is currently underway to ensure we are meeting the outcomes set out in Transform & Sustain and where needed, generate new work to achieve these outcomes.

To measure the impact of Transform and Sustain we have developed the Hawke's Bay Health Sector Performance Framework (figure 5). Our "Vital Signs" represent the outcomes that we expect to see improving over the longer term. We measure the intended outcomes of our work as changes over time and we recognise that the health sector is not solely responsible for achieving them. However, they are all measurable and are aligned to Transform and Sustain objectives as well as NZ Triple Aim dimensions of quality improvement.

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

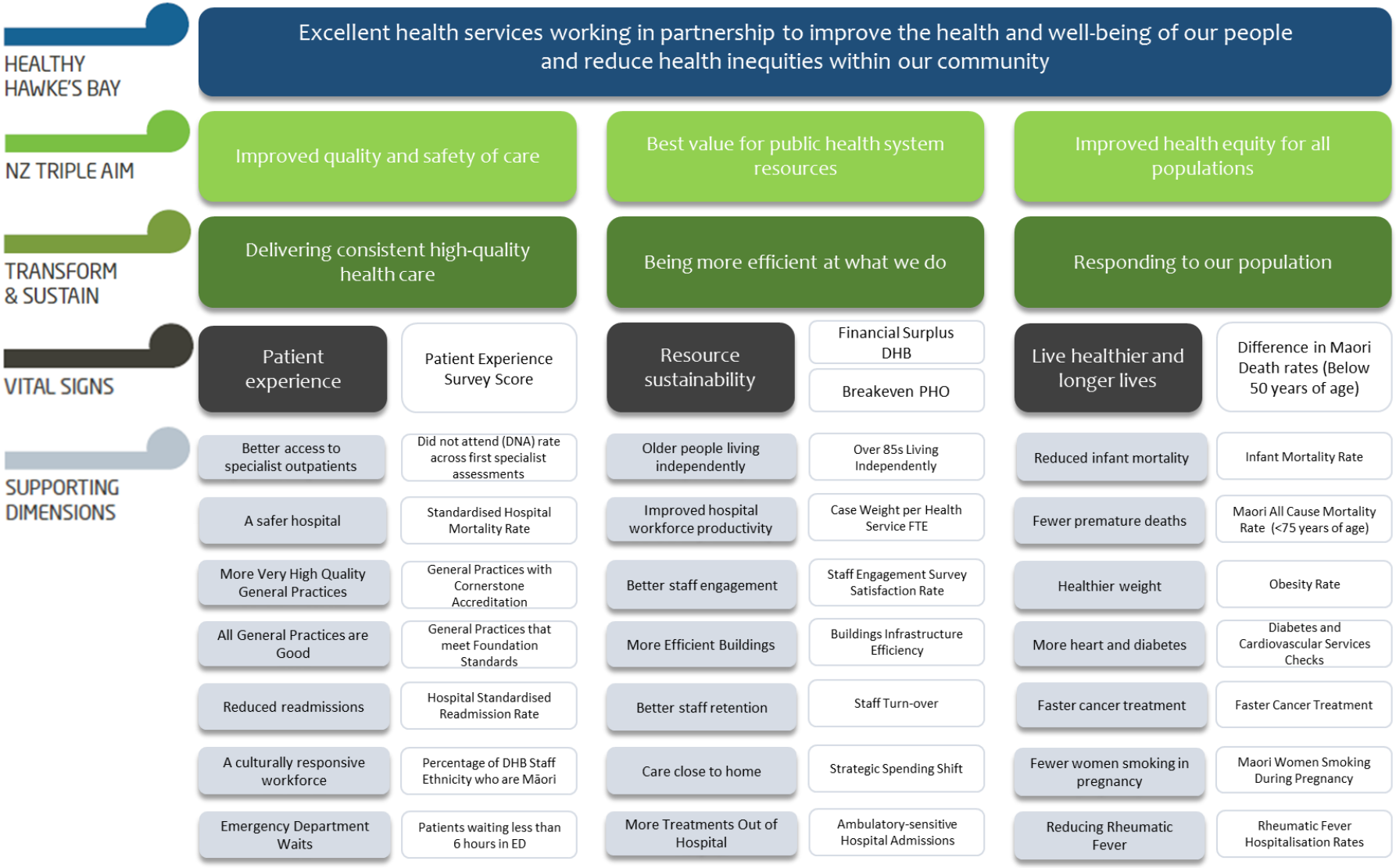


Figure 5: The Hawke's Bay Health Sector Performance Framework

2 STATEMENT OF PERFORMANCE EXPECTATIONS

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

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

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

Service Performance

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

The system dimension: Best value for public health system resources

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

The population dimension: Improved health and equity for all populations

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

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

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

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

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

X_____

Board Member

X_____

Board Member

Code		Description
MH		Māori Health Plan Targets
HT		Health Targets
MoH Performance Measures	**PP**	Policy Priorities
	SI	System Integration
	OP	Outputs
	OS	Ownership
	DV	Developmental

2.1 OUTPUT CLASS 1: Prevention Services

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

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

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

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

System Dimension

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

Prevention Services	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	6.4	10.7	10.2	10.3	10.5	10.7
Other District Health Boards (IDF)	-	-	-	-	-	-
Other sources	0.4	0.2	0.2	0.2	0.2	0.2
Income by Source	**6.8**	**10.9**	**10.4**	**10.5**	**10.7**	**10.9**
Less:						
Personnel	1.5	1.6	1.7	1.7	1.8	1.8
Outsourced services	-	-	-	-	-	-
Clinical supplies	0.1	0.1	0.1	0.1	0.1	0.1
Infrastructure and non clinical supplies	0.4	0.4	0.5	0.5	0.5	0.5
Payments to other District Health Boards	-	-	-	-	-	-
Payments to other providers	8.0	8.7	8.3	8.4	8.5	8.4
Expenditure by type	**10.0**	**10.8**	**10.6**	**10.7**	**10.9**	**10.8**
Net Result	**(3.2)**	**0.1**	**(0.2)**	**(0.2)**	**(0.2)**	**0.0**

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 6 - Funding and Expenditure for Output Class 1: Prevention Services

Population and Individual Dimensions

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	PP31	Oct 2015 to Dec 2015	99.1%	100%	99%	99.1%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	HT	Jul 2014 to Sep 2015	80.8%	75.7%	75.7%	81.2%	≥90%
	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	HT	Oct 2015 to Dec 2015	95.2%	-	-	96.5%	≥90%
	% of pregnant Māori women that are smokefree at 2 weeks postnatal	SI5 / MH	Jul 2014 to Dec 2014	53.0%	81.0%	-	73.0%	≥95%
Increase Immunisation coverage in Children	% of 8 month olds who complete their primary course of Immunisations	HT / MH	Oct 2015 to Dec 2015	92.6%	100%	93.3%	93.3%	≥95%
	% of 2 year olds fully immunised	PP21	Oct 2015 to Dec 2015	95.1%	96.2%	92.9%	93.9%	≥95%
	% of 4 year olds fully immunised by age 5	PP21	Oct 2015 to Dec 2015	94.2%	96.4%	91.1%	92.7%	≥95%
Increase HPV immunisation rates	% of girls that have received HPV dose three	PP21	Jun 2016	87.8%	73.3%	54.9%	68.4%	≥70%
Increase the rate of seasonal influenza immunisations in over 65 year olds	% of high needs 65 years olds and over influenza immunisation rate	MH	Jan 2014 to Dec 2014	68.0%	70.7%	67.6%	67.9%	≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	PP28/MH	Jul 2014 to Jun 2015	2.48	-	-	0.6	≤1.5
More women are screened for cancer	% of women aged 50-69 years receiving breast screening in the last 2 years	MH	Jan 2014 to Dec 2014	68.4%	66.5%	76.0%	74.7%	≥70%
	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	MH / SI6	Jan 2013 to Dec 2015	74.1%	71.2%	76.5%	75.8%	≥80%

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	Rate of SUDI deaths per 1,000 live births	MH	2010 - 2014	2.09	-	-	1.16	≤0.4
	% of caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1	MH	2014/15	72.8%	78.6%	-	80.7%	100%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 6 weeks of age	MH	Jul 2014 to Dec 2014	58%	74%	-	68%	75%
	% of infants that are exclusively or fully breastfed at 3 months of age	MH	Jan 2015 to Jun 2015	46%	62%	-	54%	60%
	% of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	MH	Jan 2015 to Jun 2015	46%	57%	-	56%	65%

2.2 OUTPUT CLASS 2: Early Detection and Management Services

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

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

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

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

How will we assess performance?

System Dimension

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

Early Detection and Management	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	118.1	121.9	120.3	121.5	123.7	125.9
Other District Health Boards (IDF)	1.9	1.8	1.8	1.8	1.9	1.9
Other sources	4.2	2.8	2.7	2.6	2.7	2.7
Income by Source	**124.2**	**126.5**	**124.8**	**125.9**	**128.2**	**130.5**
Less:						
Personnel	24.6	25.8	27.3	27.9	28.7	29.7
Outsourced services	3.8	3.7	3.1	3.2	3.3	3.3
Clinical supplies	2.9	2.5	2.0	1.9	1.8	1.6
Infrastructure and non clinical supplies	7.9	7.9	9.0	9.2	9.4	9.6
Payments to other District Health Boards	2.4	2.5	2.4	2.5	2.5	2.9
Payments to other providers	84.3	91.4	92.1	93.2	94.6	93.0
Expenditure by type	**125.9**	**133.8**	**135.9**	**137.8**	**140.3**	**140.0**
Net Result	**(1.7)**	**(7.3)**	**(11.1)**	**(11.9)**	**(12.1)**	**(9.5)**

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 7 –Funding and Expenditure for Output Class 2: Early Detection and Management Services

Population and Individual Dimensions

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	MH	Dec 2015	97.2%	88.7%	96.5%	96.4%	100%
Avoidable hospitalisation is reduced	Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	SI1 / MH / SI5	Oct 2014 to Sep 2015	5,336	-	3,768	4,725	TBC[10]
	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	SI1 / MH		6,310	-	2,812	3,510	≤3,510
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy		Jun 2015 to Sep 2015	50.7%	40.6%	58.5%	54.5%	≥80%
Hospital service users are reconnected with primary care	Rate of high intensive users of hospital ED as a proportion of Total ED visits		Oct 2015 to Dec 2015	6.13%	6.89%	5.27%	5.57%	≤5.4%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	PP13 / MH	2014*	65.3%	71.7%	81.3%	73.9%	≥95%
	% of children who are carries free at 5 years of age	PP11 / SI5	2015*	36.0%	30.5%	70.1%	54.4%	≥67%
	% of enrolled preschool and primary school children not examined according to planned recall	PP13	2014*	5.1%	7.4%	2.9%	4.0%	≤4.8%
	% of adolescents using DHB-funded dental services	PP12	2014*	-	-	-	78.3%	≥85%
	Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8	PP10	2015*	1.43	1.04	0.70	0.96	≤0.92
Improved management of long-term conditions	Proportion of people with diabetes who have good or acceptable glycaemic control	PP20	12 months - Dec 2015	37.8%	45.5%	42.9%	41.4%	≥55%
	% of the eligible population having had a CVD risk assessment in the last 5 years	PP20	5 years to Dec 2015	86.3%	87.0%	91.7%	90.3%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days	PP29	Dec 2015	84%	-	-	84.4%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 6 weeks	PP29	Dec 2015	31%	-	-	31.0%	≥85%
More pre-schoolers receive Before School Checks	% of 4-year olds that receive a B4 School Check		Jan 2015	52%	54%	56%	54%	≥90%

[10] *This target will be set as part of the System Level Measures process*

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	HT / SI5	Sep 2015	30%	-	23%	27%	≥95%

*Calendar Year

2.3 OUTPUT CLASS 3: Intensive Assessment and Treatment Services

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

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

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

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

How will we assess performance?

System Dimension

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

Intensive Assessment and Treatment	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	*273.9*	*286.8*	*307.9*	*311.0*	*316.6*	*322.3*
Other District Health Boards (IDF)	*4.0*	*3.7*	*3.7*	*3.8*	*3.8*	*3.9*
Other sources	*14.7*	*13.7*	*13.6*	*13.0*	*13.4*	*13.7*
Income by Source	***292.6***	***304.2***	***325.2***	***327.8***	***333.9***	***339.9***
Less:						
Personnel	*146.6*	*153.8*	*162.8*	*166.5*	*171.2*	*177.0*
Outsourced services	*9.4*	*9.1*	*9.1*	*9.3*	*9.5*	*9.7*
Clinical supplies	*42.2*	*36.6*	*32.0*	*30.1*	*28.9*	*25.2*
Infrastructure and non clinical supplies	*34.3*	*34.0*	*38.4*	*39.2*	*40.0*	*40.9*
Payments to other District Health Boards	*43.2*	*45.4*	*44.1*	*45.7*	*46.6*	*53.4*
Payments to other providers	*9.4*	*12.2*	*15.8*	*16.0*	*16.2*	*15.9*
Expenditure by type	***285.1***	***291.1***	***302.2***	***306.7***	***312.5***	***322.1***
Net Result	***7.5***	***13.1***	***23.0***	***21.1***	***21.3***	***17.8***

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 8 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Services

Population and Individual Dimensions

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	HT	Oct 2015 to Dec 2015	94.8%	94.8%	91.6%	94.7%	≥95%
Faster cancer treatment	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks from Q1 2016/17	HT	6 months to Dec 2015	78.6%		76.7%	77.6%	≥85%
More elective surgery	Number of elective surgery discharges[11]	HT	Jul 14 to Jun 15	NA	NA	NA	6,154	7374
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of high-risk patients will receiving an angiogram within 3 days of admission.	PP20	Oct 2015 to Dec 2015	60.0%	100%	71%	68.7%	≥70%
	% of angiography patients whose data is recorded on national databases	PP20	Oct 2015 to Dec 2015	71.4%	50%	88.5%	84.1%	≥95%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed	PP20	Oct 2015 to Dec 2015	0%	0%	4.1%	4.1%	≥6%
	% of patients admitted to the demonstrated stroke pathway	PP20	Oct 2015 to Dec 2015	100%	-	78.8%	78.4%	≥80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	PP20	Oct 2015 to Dec 2015	80.0%	-	78.2%	77.4%	≥80%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SI4	Oct 2015 to Dec 2015	-	-	-	17.6	≥21.0
	Cataract procedures			-	-	-	51.2	≥27.0
	Cardiac surgery			-	-	-	6.3	≥6.5
	Percutaneous revascularisation			-	-	-	12.4	≥12.5
	Coronary angiography			-	-	-	39.5	≥34.7

[11] Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Shorter stays in hospital	Average length of stay Elective (days)		OS3	12 months - Dec 2015	-	-	-	1.66	1.55
	Average length of stay Acute (days)		OS3	12 months - Dec 2015	-	-	-	2.55	2.35
Fewer readmissions	Acute readmissions to hospital		OS8	12 months - Sep 2015				7.7%	TBC
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days		PP29	Oct 2015 to Dec 2015	60.0%	100%	71.0%	68.7%	≥95%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks		PP29	Dec 2015	66.7%	-	85.7%	82.4%	≥85%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 30 days		PP29	Dec 2015	100%	-	100%	100%	100%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)		PP29	Dec 2015	82.4%	100%	86.6%	87.1%	≥70%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 90 days		PP29	Dec 2015	100%	100%	99.2%	99.3%	100%
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		PP29	Dec 2015	66.7%	-	80.8%	79.3%	≥70%
	70% of people waiting for a surveillance colonoscopy will wait no longer than 120 days beyond the planned date?		PP29	Dec 2015	66.7%	-	88.5%	86.2%	100%
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Oct 2015 to Dec 2015	14.9%	18.3%	5.3%	8.1%	≤7.5%
Better mental health services Improving access Better access to mental health and addiction services	Proportion of the) population seen by mental health and addiction services	Child & youth (0-19	PP6	12 months - Sep 2015	4.62%	2.95%	3.70%	4.07%	≥4%
		Adult (20-64)	PP6	12 months - Sep 2015	8.75%	2.95%	3.79%	4.94%	≥5%
		Older adult (65+)	PP6	12 months - Sep 2015	0.96%	0.97%	1.05%	1.04%	≥1.15

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of 0-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	PP8	12 months - Dec 2015	63.2%	75.0%	56.9%	60.1%	≥80%
		Addictions (Provider Arm and NGO)	PP8	12 months - Dec 2015	90.5%	-	61.5%	84.2%	≥80%
	% of 0-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	PP8	12 months - Dec 2015	86.5%	91.7%	85.3%	81.5%	≥95%
		Addictions (Provider Arm and NGO)	PP8	12 months - Dec 2015	100%	-	92.3%	99.5%	≥95%
Improving mental health services using discharge planning	% children and youth with a transition (discharge) plan		PP7	12 months - Dec 2015	35.9%	37.0	36.3%	36.2%	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		MH / SI5	Oct 2015 to Dec 2015	196.0	-	93.4	97.0	≤81.5

2.4 OUTPUT CLASS 4: Rehabilitation and Support Services

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 9.

Rehabilitation and Support	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	70.4	68.7	69.6	70.3	71.6	72.8
Other District Health Boards (IDF)	2.1	2.0	2.0	2.1	2.1	2.1
Other sources	0.1	0.3	0.2	0.2	0.2	0.2
Income by Source	**72.6**	**71.0**	**71.8**	**72.5**	**73.8**	**75.2**
Less:						
Personnel	6.5	6.8	7.2	7.4	7.6	7.8
Outsourced services	-	-	-	-	-	-
Clinical supplies	0.8	0.7	0.5	0.5	0.5	0.4
Infrastructure and non clinical supplies	1.8	1.8	2.1	2.1	2.2	2.2
Payments to other District Health Boards	3.6	3.8	3.7	3.8	3.9	4.5
Payments to other providers	59.4	59.8	65.0	65.8	66.8	65.6
Expenditure by type	**72.1**	**72.9**	**78.5**	**79.6**	**80.9**	**80.5**
Net Result	**0.5**	**(1.9)**	**(6.7)**	**(7.0)**	**(7.0)**	**(5.4)**

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 9 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Services

Population and Individual Dimensions

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years		Oct 2015 to Dec 2015	144.4	-	-	136.5	≤139.5
		80-84 years		Oct 2015 to Dec 2015	208	-	-	178.9	≤183.1
		85+ years		Oct 2015 to Dec 2015	153.8	-	-	229.2	≤231.0
Better community support for older people	Acute readmission rate: 75 years +			12 months - Sep 2015	-	-	-	11.1%	<10%
	% of people receiving home support who have a comprehensive clinical assessment and a completed care plan		PP23	Jul 2015 to Sep 2015	100%	100%	100%	100%	≥95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.		PP23	Oct 2015 to Dec 2015	-	-	-	63%	77%
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.		PP23	Oct 2015 to Dec 2015	-	-	-	-	improve on current performance
Increased capacity and efficiency in needs assessment and service coordination services	Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment			Oct 2015 to Dec 2015	-	-	-	13.8%	<13.8%
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours			Oct 2015 to Dec 2015	-	-	-	91.0%	>80%
More day services	Number of day services			12 months – Jun 2015	-	-	-	21,546	≥21,791
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan			Oct 2015 to Dec 2015	-	-	-	90.5% 78.4%	90% 98%

3 FINANCIAL PERFORMANCE

Planning regulations require the DHB's Annual Plan to contain detailed financial budgets, and information on how the DHB's performance both as a funder and as a provider of services will be demonstrated. This module contains audited financial statements for the 2014/15 financial year, forecast financial statements for 2015/16, and projected financial statements for the 2016/20 period. Separate financial performance statements for the funding of services, providing of services, and governance and funding administration are also included for each of these periods. Performance against the 2016/17 financial year projections will be reported in the 2016/17 Annual Report.

3.1 PROJECTED FINANCIAL STATEMENTS

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $5 million this year. This is consistent with the DHB's recent track record, and enables us to fund a proportionate capital programme, including in the plan period the completion of major mental health, maternity, endoscopy and renal facilities associated with service redesign.

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

Projected Financial Statements

Reporting Entity

The financial statements of the District Health Board comprise the District Health Board, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The District Health Board has no subsidiaries.

Cautionary Note

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

The underlying assumptions were adopted on 25 May 2016.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). They projected financial statements have been prepared in accordance with tier 1 Public Benefit Entity Standards (PBE) accounting standards.

The accounting policies applied in the projected financial statements are included as an appendix.

Projected Statement of Revenue and Expense

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Ministry of Health - devolved funding	454,822	484,024	504,227	509,208	518,463	527,744
Ministry of Health - non devolved contracts	14,180	4,039	3,732	3,805	3,886	3,969
Other District Health Boards	11,821	11,598	11,549	11,774	12,024	12,283
Other government and Crown agency sourced	6,421	5,680	6,394	6,519	6,658	6,801
Patient and consumer sourced	1,484	1,211	1,377	1,403	1,433	1,464
Other	7,691	5,964	4,920	4,113	4,201	4,291
Operating revenue	496,420	512,517	532,199	536,822	546,665	556,552
Employee benefit costs	179,099	188,050	199,028	203,507	209,309	216,375
Outsourced services	13,233	12,812	12,248	12,488	12,754	13,029
Clinical supplies	45,967	39,758	34,619	32,523	31,184	27,241
Infrastructure and non clinical supplies	44,937	44,110	50,042	51,016	52,101	53,224
Payments to non-health board providers	210,131	223,798	231,261	235,288	239,317	243,683
Operating expenditure	493,366	508,527	527,199	534,822	544,665	553,552
Surplus for the period	3,054	3,990	5,000	2,000	2,000	3,000
Revaluation of land and buildings	37,444	(1,795)	-	-	-	-
Other comprehensive revenue and expense	37,444	(1,795)	-	-	-	-
Total comprehensive revenue and expense	**40,498**	**2,195**	**5,000**	**2,000**	**2,000**	**3,000**

Table 1 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Movements in Equity

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Equity as at 1 July	**49,140**	**87,626**	**89,465**	**94,108**	**95,750**	**97,393**
Total comprehensive revenue and expense:						
Funding of health and disability services	7,481	5,186	5,000	2,000	2,000	3,000
Governance and funding administration	148	478	0	-	-	-
Provision of health services	(4,575)	(1,675)	(0)	-	-	-
Gain on disposal of assets held for sale	-	-	-	-	-	-
Revaluation of land and buildings	37,444	(1,795)	-	-	-	-
	40,498	2,195	5,000	2,000	2,000	3,000
Contributions from the Crown (equity injections)	-	-	-	-	-	-
Repayments to the Crown (equity repayments)	(357)	(356)	(358)	(357)	(357)	(357)
Transfer of the Chatham Is. to Canterbury DHB	(1,655)	-	-	-	-	-
Equity as at 30 June	**87,626**	**89,465**	**94,107**	**95,750**	**97,393**	**100,036**

Table 2 - Projected Statement of Movements in Equity

Projected Statement of Financial Position

in thousands of New Zealand Dollars

As at 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Equity						
Paid in equity	35,573	35,216	34,859	34,502	34,145	33,788
Asset revaluation reserve	69,187	67,392	67,392	67,392	67,392	67,392
Asset replacement reserve	15,253	-	-	-	-	-
Trust and special funds (no restricted use)	3,125	3,125	3,125	3,125	3,125	3,125
Accumulated deficit	(35,511)	(16,268)	(11,269)	(9,269)	(7,269)	(4,269)
	87,626	**89,465**	**94,107**	**95,750**	**97,393**	**100,036**
Represented by:						
Current assets						
Cash	9	7	7	7	7	7
Short term investments	13,538	3,146	7,661	2,259	1,926	1,832
Short term investments (special funds/clinical trials)	3,124	3,095	3,095	3,095	3,095	3,095
Receivables and prepayments	17,855	18,225	18,607	18,969	19,371	19,788
Loans (Hawke's Bay Helicopter Rescue Trust)	10	11	11	12	13	13
Inventories	3,881	3,961	4,044	4,123	4,211	4,301
Assets classified as held for sale	1,220	1,220	-	-	-	-
	39,637	29,665	33,425	28,465	28,622	29,036
Non current assets						
Property, plant and equipment	148,303	157,877	166,028	173,575	174,177	176,699
Intangible assets	2,298	1,213	665	58	(620)	(1,325)
Investment property	131	131	131	131	131	131
Investment in NZ Health Partnerships Limited	2,504	2,504	2,504	2,504	2,504	2,504
Investment in associates	4,742	5,804	6,943	8,082	8,481	8,481
Loans (Hawke's Bay Helicopter Rescue Trust)	55	42	29	15	-	-
	158,033	167,572	176,299	184,365	184,673	186,490
Total assets	**197,670**	**197,237**	**209,724**	**212,829**	**213,295**	**215,525**
Less:						
Current liabilities						
Payables and accruals	29,953	30,582	31,194	31,826	29,573	27,511
Employee entitlements	35,248	32,317	34,485	35,260	36,265	37,859
Loans and borrowings	-	-	6,000	11,500	-	10,000
	65,201	62,900	71,679	78,586	65,838	75,370
Non current liabilities						
Employee entitlements	2,342	2,372	2,438	2,493	2,564	2,619
Loans and borrowings	42,500	42,500	41,500	36,000	47,500	37,500
	44,842	44,872	43,938	38,493	50,064	40,119
Total liabilities	**110,044**	**107,772**	**115,617**	**117,079**	**115,902**	**115,489**
Net assets	**87,626**	**89,465**	**94,108**	**95,750**	**97,393**	**100,036**

Table 3 - Projected Statements of Financial Position

Projected Statement of Cash Flows

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	494,548	518,808	531,229	537,058	547,169	557,331
Cash paid to suppliers and service providers	(299,064)	(314,352)	(303,309)	(307,582)	(312,624)	(313,221)
Cash paid to employees	(176,194)	(186,766)	(198,449)	(202,914)	(208,698)	(215,741)
Cash generated from operations	**19,289**	**17,690**	**29,471**	**26,562**	**25,847**	**28,369**
Interest received	1,628	1,360	885	-	-	-
Interest paid	(2,419)	(2,236)	(2,476)	(2,562)	(2,397)	(2,476)
Capital charge paid	(3,740)	(3,971)	(7,186)	(7,326)	(7,482)	(7,642)
Cash flow from investing activities	14,757	12,844	20,694	16,674	15,969	18,251
Proceeds from sale of property, plant and equipment	2,236	1,263	1,220	-	-	-
Acquisition of property, plant and equipment	(15,608)	(23,117)	(22,042)	(21,719)	(15,945)	(17,988)
Acquisition of intangible assets	(921)	(1,094)	-	-	-	-
Acquisition of investments	(1,752)	-	-	-	-	-
Cash flow from financing activities	(16,045)	(22,949)	(20,822)	(21,719)	(15,945)	(17,988)
Proceeds from borrowings	-	-	5,000	-	-	-
Proceeds from equity injections	(1,655)	-	-	-	-	-
Repayment of borrowings	-	-	-	-	-	-
Repayment of finance lease liabilities	(268)	-	-	-	-	-
Equity repayment to the Crown	(357)	(357)	(357)	(357)	(357)	(357)
	(2,280)	(357)	4,643	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	(3,567)	(10,462)	4,515	(5,402)	(333)	(94)
Cash and cash equivalents at beginning of year	18,536	14,969	4,507	9,022	3,620	3,286
Cash and cash equivalents at end of year	14,969	4,507	9,022	3,620	3,286	3,192
Represented by:						
Cash	9	7	7	7	7	7
Short term investments	14,960	4,500	9,015	3,612	3,279	3,185
	14,969	4,507	9,022	3,619	3,286	3,192

Table 4 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Ministry of Health - devolved funding	454,822	484,024	504,227	509,208	518,463	527,744
Inter district patient inflows	7,696	7,486	7,545	7,692	7,855	8,024
Other revenue	202	151	30	31	32	33
	462,719	**491,662**	**511,803**	**516,931**	**526,350**	**535,801**
Expenditure						
Governance and funding administration	2,781	3,140	3,220	3,283	3,353	3,425
Own DHB provided services						
Personal health	207,692	214,874	229,142	232,338	236,721	239,766
Mental health	24,366	25,005	24,259	24,732	25,258	25,801
Disability support	9,169	14,701	13,796	14,066	14,367	14,675
Public health	520	4,357	4,523	4,611	4,708	4,811
Maori health	579	601	601	613	626	640
Other DHB provided services (Inter district outflows)	242,326	259,538	272,321	276,360	281,680	285,693
Personal health	45,156	46,843	45,317	46,201	47,183	48,197
Mental health	2,342	2,391	2,410	2,457	2,509	2,563
Disability support	3,210	3,000	3,232	3,295	3,365	3,437
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
Other provider services	50,709	52,234	50,959	51,953	53,057	54,197
Personal health	87,818	99,483	104,187	105,735	107,014	108,539
Mental health	10,888	11,088	11,164	11,383	11,624	11,874
Disability support	56,101	56,071	59,392	60,549	61,833	63,161
Public health	1,248	1,185	1,578	1,608	1,643	1,677
Maori health	3,368	3,737	3,982	4,060	4,146	4,235
	159,422	171,564	180,302	183,335	186,260	189,486
Total Expenditure	**455,238**	**486,476**	**506,803**	**514,931**	**524,350**	**532,801**
Net Result	**7,481**	**5,186**	**5,000**	**2,000**	**2,000**	**3,000**

Table 5 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Funding	2,781	3,140	3,220	3,283	3,353	3,425
Other government and Crown agency sourced	-	-	-	-	-	-
Other revenue	23	39	30	31	32	33
	2,804	3,179	3,250	3,314	3,385	3,458
Expenditure						
Employee benefit costs	677	729	954	975	1,003	1,038
Outsourced services	414	457	472	481	491	501
Clinical supplies	0	1	1	1	1	1
Infrastructure and non clinical supplies	632	580	878	895	914	933
	1,723	1,767	2,305	2,352	2,409	2,473
Plus: allocated from Provider Arm	933	933	945	962	976	985
Net Result	**148**	**478**	**0**	**-**	**-**	**-**

Table 6 - Projected Governance and Funding Administration Operating Results

Projected Provider Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Funding	242,326	259,538	272,241	276,278	281,596	285,607
Ministry of Health - non devolved contracts	14,180	4,039	3,732	3,805	3,886	3,969
Other District Health Boards	4,126	4,112	4,004	4,082	4,169	4,259
Accident Insurance	5,931	5,291	5,980	6,097	6,227	6,361
Other government and Crown agency sourced	490	389	414	422	431	440
Patient and consumer sourced	1,484	1,211	1,377	1,403	1,433	1,464
Other revenue	7,466	5,774	4,859	4,051	4,137	4,225
	276,004	280,355	292,608	296,138	301,879	306,325
Expenditure						
Employee benefit costs	178,422	187,320	198,075	202,532	208,306	215,337
Outsourced services	12,818	12,355	11,696	11,925	12,179	12,442
Clinical Supplies	45,966	39,757	34,618	32,522	31,183	27,240
Infrastructure and non clinical supplies	44,305	43,530	49,163	50,121	51,187	52,291
	281,512	282,963	293,553	297,100	302,855	307,310
Less: allocated to Governance & Funding Admin.	933	933	945	962	976	985
Surplus for the period	**(4,575)**	**(1,675)**	**(0)**	**-**	**-**	**-**
Revaluation of land and buildings	(37,444)	1,795	-	-	-	-
Net Result	**32,869**	**(3,470)**	**(0)**	**-**	**-**	**-**

Table 7 – Projected Provider Arm Operating Results

3.2 SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform solution managed by New Zealand Health Partnerships Limited (NZHPL).
- Allowance has been made for net additional costs arising from the Regional Health Information Project (RHIP) of $1.1 million in each of 2016/17 and 2017/18, and $0.4 million in 2018/19.
- The full year impact of ongoing transformation expenditure has required a $10.8 million efficiency programme for the 2016/17 year. Nominal increases in funding (excluding revenue banking), and inflationary increases in expenditure will require further savings of $2.7 million, $2.0 million and $4.6 million in 2017/18, 2018/19, and 2019/20 respectively. No allowance has been made for a new investment programme in the plan, however such programmes are likely and will require increases in the savings targets. Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the two programmes on financial performance have been recognised in clinical supplies.
- Unless otherwise stated, increases in revenue and expenditure due to changes in price levels have been allowed for at 1.95%, 2.125% and 2.15% for 2017/18, 2018/19 and 2019/20 respectively based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015).
-

Revenue

- Crown funding under the national population based funding formula, including adjustments, will be $472.2 million for 2016/17. Funding for the 2017/18, 2018/19 and 2019/20 years will include nominal increases of $8.5 million per annum.
- Crown funding for non-devolved services of $35.8 million is based on agreements already in place with the appropriate Ministry of Health directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- The remaining $4.2 million of the $5 million of funding left with the Ministry of Health in 2011/12 due to sales proceeds from the Napier Hill site sale, will be drawn down in 2016/17.
- Inter district flows revenue is in accordance with Ministry of Health advice.
- Other income has been budgeted at the District Health Board's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2016/17 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Personnel cost increases have been allowed for at 2.25%, 2.85% and 3.375% for 2017/18, 2018/19 and 2019/20 respectively based on Treasury forecasts for wage inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015).
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2015/16. The District Health Board is managing internally to a cap of 400 FTEs.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the District Health Board's best estimates of likely cost.

- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.

Services Provided by Other DHBs

- Inter district flows expenditure is in accordance with MoH advice.

Other Provider Payments

- Other provider payments have been budgeted at the District Health Board's best estimate of likely costs

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investment in NZHPL gives the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- The drawdown of $5 million of debt funding in June 2016 for the new Mental Health Inpatient Unit (Nga Rau Rakau), as agreed with the Minister of Health as part of the disposal of the Napier Hill site, has an assumed interest rate of 3.42% being 15 points above 10 year government stock rate on 21 January 2016. Interest rates of 4.3%, 4.65% and 4.8% have been applied from the maturity dates of expiring facilities in 2017/18, 2018/19, and 2019/20 respectively based on 15 points above Treasury forecasts for 10 year bonds (30 June Year composite rates based on the 31 March interest rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015. No maturities or new borrowings are expected in 2016/17.
- The capital charge rate remains at 8%.

Investment

- The purchase of class B shares in New Zealand Health Partnerships Limited (NZHPL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- The District Health Board's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- No collaborative regional or sub-regional initiatives have been included other than RHIP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

Investment	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Buildings and Plant	5,710	8,619	4,800	5,500
Clinical Equipment	9,407	6,040	4,500	3,900
Other Equipment	2,800	3,510	3,545	4,588
Information Technology	3,125	2,550	2,100	3,000
Capital Investment	**21,042**	**20,719**	**14,945**	**16,988**
New technologies/Investments	1,000	1,000	1,000	1,000
Investment in RHIP	1,139	1,139	0.399	-
Total Investment	**23,181**	**22,858**	**13,344**	**17,988**

Capital Investment Funding

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

Investment Funding	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Total Investment	23,181	22,858	13,344	17,988
Funded by:				
Depreciation and amortisation	14,440	14,779	16,021	16,433
Operating surplus	5,000	2,000	2,000	3,000
Cash holdings	3,741	6,079	(4,677)	(1,445)
Capital Investment Funding	**23,181**	**22,858**	**13,344**	**17,988**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. The last revaluation was at 30 June 2015, and no adjustment has been made for the effect of any other revaluation over the time horizon of the plan.

Debt and Equity

- Debt will be at the levels in the table below. Loans and borrowings are included in the table at face value.

Debt	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Borrowing	47.5	47.5	47.5	47.5
Finance leases	-	-	-	-
Total debt	**47.5**	**47.5**	**47.5**	**47.5**
Debt/(Debt+Equity) Ratio	*33.5%*	*33.1%*	*32.8%*	*32.2%*

- No debt funding from the Crown is planned for the four year planning period. There are no banking covenants relating to the debt.

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

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

Equity	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Opening equity	89.5	94.1	95.8	97.4
Surplus	5.0	2.0	2.0	3.0
Equity repayments (FRS3)	(0.4)	(0.3)	(0.4)	(0.4)
Closing equity	**94.1**	**95.8**	**97.4**	**100.0**

Additional Information and Explanations:

Disposal of Land

- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

4 STEWARDSHIP & ORGANISATIONAL CAPABILITY

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

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

A health system that is responsive to need

Consistent high-quality health care

A more efficient health system

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

TAUWHIRO: delivering high-quality care to patients and consumers

RĀRANGA TE TIRA: working together in partnership across the system

HE KAUANANU: showing respect for each other, our staff, patients and consumers

ĀKINA: continuously improving everything we do.

QUALITY

Transform and Sustain is providing:

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

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

Creating Headroom for Change

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

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

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

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

4.1 Organisational Development

Workforce

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

Organisational development programmes are focusing on the following:

- Further advancing our Service Directorate structure of Service Director,

  Medical/Surgical Director and Nurse Director
- Clinical leadership and engagement of staff bottom up in our Transform and Sustain priorities
- Talent Management Programme including succession planning
- Transformational management and leadership capability
- Increasing staff engagement, health and well-being
- High performing teams, including re-skilling and up-skilling of staff
- New roles and capabilities to support new models of care and new ways of working
- Building capability, through structured development of current staff and recruitment of high calibre individuals
- Increasing Māori staff representation and increasing effective engagement with Māori
- Maintaining high levels of Union engagement
- Continued development of smart systems and reporting
- Full implementation of the new Health and Safety at Work Act including our new risk management approach to health and safety management.
- Enhanced blended and on-line learning and development programmes for clinicians and staff

Development of a new workforce development framework and strategy focussing on our medical, nursing, allied, support and management and administration workforces.Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications

The communications team is committed to looking at new and fresh ways to engage successfully with our community and our staff. We challenge our staff to think about effective strategies and how best to communicate them so people can better manage their way through the complexities of the health system. We are always looking to help staff promote new ideas and new initiatives through more effective and compelling communication.

Health Information

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

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

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

Capital

Regional capital investment approaches are outlined in RSP and individual sections contain capital investment plans. HBDHB is committed to working with the regional capital planning committee on the development of our local plans and assisting our regional colleagues in development of the regional capital plan and its implementation.

Formal asset management planning is undertaken at HBDHB. Our asset values were last updated by a Registered Valuer as at the 30 June 2015. Our Asset Management Plan has also been updated in 2014-15 incorporating a ten year plan for expenditure on our assets. Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

Nga Rau Rākau, the new mental health inpatient unit, opened in February 2016, and Waioha, the primary maternity unit, will open for use in July 2016. The new stand-alone endoscopy unit and the renal centralised development were approved in principle by the DHB Board in July 2015 and September 2015 respectively.

Major Strategic Asset Expenditure 2016-20

	2016-17	2017-18	2018-19	2019-20
	-	-	-	-
Mental Health Inpatient Unit	2,210	-	-	-
Maternity Development	100	-	-	-
New stand-alone endoscopy	3,000	5,000	900	-
Renal centralised development	1,000	389	-	-
Oncology upgrade	-	200	800	-
Upgrade old MHIU	400	2,000	3,000	2,500
Central Region IS Programme	650	7	-	-

Procurement

The Ministry of Business, Innovation and Employment (MBIE) Government Rules of Sourcing (Rules) became mandatory for the public health sector on 1 February 2015. HBDHB intends to comply with the requirements set out in the Rules to the greatest extent that is practicable. Compliance with the Rules is subject to any statutory or similar obligation applying in respect to procurement e.g. pharmaceuticals from the pharmaceutical schedule (PHARMAC), being a requirement of s23(7) of the NZ Public Health and Disability Act; in-scope procurement via Health Alliance (hA), being procurement covered by arrangements consented to by the Minister under s24 of the NZPH&D Act.

4.2 Key Intentions

We have described what our core challenges are:

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

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

- **Transforming our engagement with Māori**
- **Transforming patient involvement**
- **Transforming health promotion and health literacy**
- **Transforming multi-agency working**
- **Transforming clinical quality through clinical governance**
- **Transforming patient experience through better clinical pathways**
- **Transforming through integration of rural services**
- **Transforming primary health care**
- **Transforming urgent care**
- **Transforming out-of-hours hospital inpatient care**
- **Transforming business models**

Processes for Achieving Regular Financial Surpluses

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

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

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

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

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

Shifting Resources

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

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not about shifting resources from one provider to another, but rather it is about changing the service model.

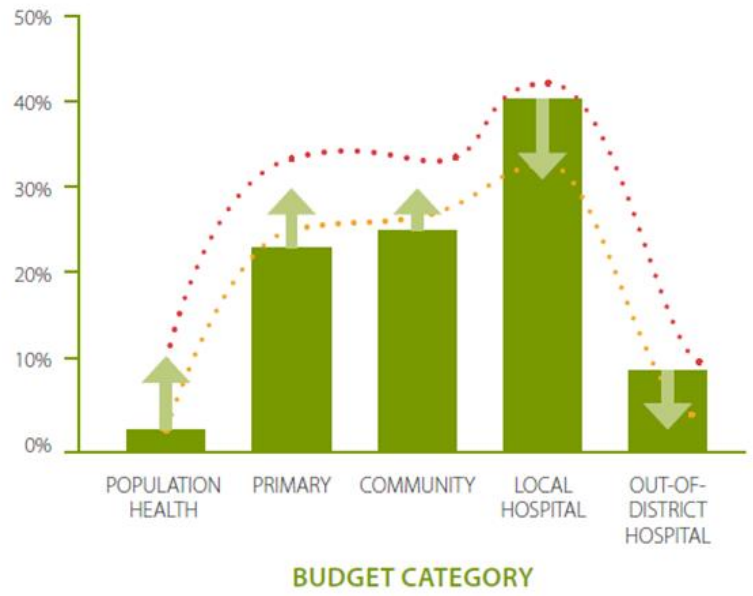


Figure 10: A model for changing resource deployment in a health system

Summary

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

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[12] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

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

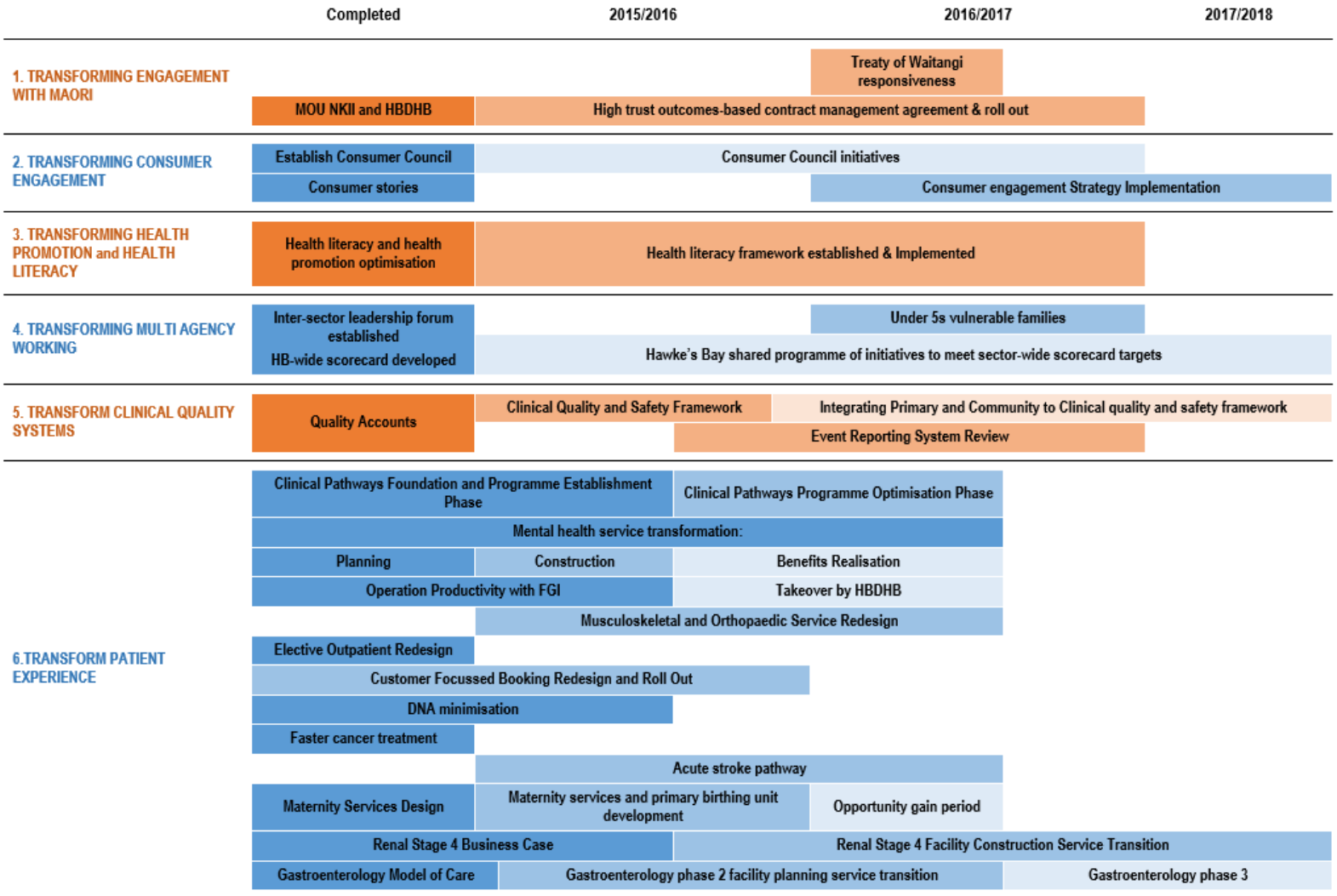
Note C: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement which is reviewed every two years. The last review was in April 2014.

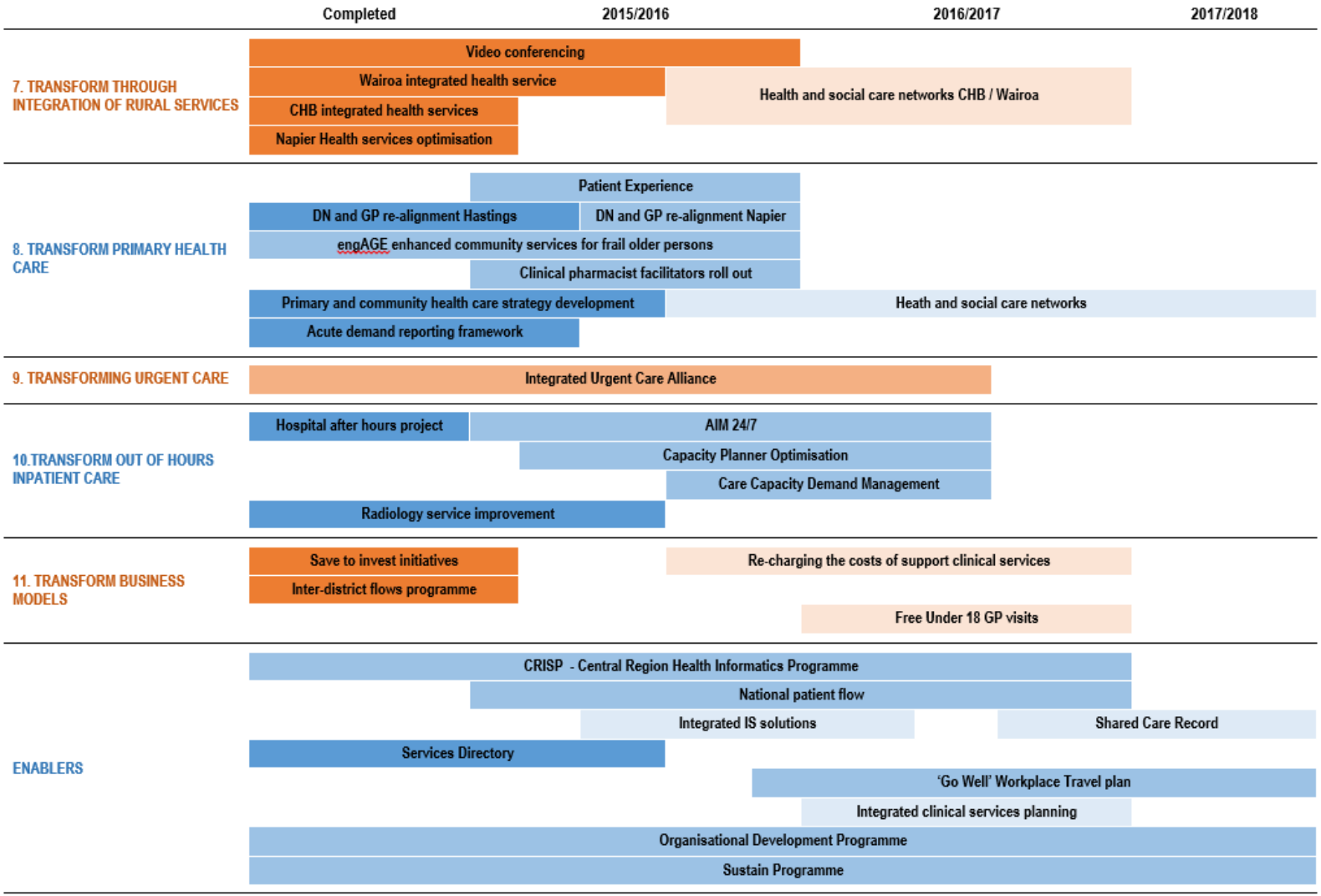
[12] As defined in section 58 of the Companies Act 1993

5 APPENDICES

5.1 APPENDIX 1 Our Strategic Framework

5.2 APPENDIX 2 Transform and Sustain Programme Overview




Completed
2015/2016
2016/2017
2017/2018
7. TRANSFORM THROUGH INTEGRATION OF RURAL SERVICES
Video conferencing
Wairoa integrated health service
CHB integrated health services
Napier Health services optimisation
Health and social care networks CHB / Wairoa
8. TRANSFORM PRIMARY HEALTH CARE
Patient Experience
DN and GP re-alignment Hastings
DN and GP re-alignment Napier
engAGE enhanced community services for frail older persons
Clinical pharmacist facilitators roll out
Primary and community health care strategy development
Heath and social care networks
Acute demand reporting framework
9. TRANSFORMING URGENT CARE
Integrated Urgent Care Alliance
10.TRANSFORM OUT OF HOURS INPATIENT CARE
Hospital after hours project
AIM 24/7
Capacity Planner Optimisation
Care Capacity Demand Management
Radiology service improvement
11. TRANSFORM BUSINESS MODELS
Save to invest initiatives
Inter-district flows programme
Re-charging the costs of support clinical services
Free Under 18 GP visits
ENABLERS
CRISP - Central Region Health Informatics Programme
National patient flow
Integrated IS solutions
Shared Care Record
Services Directory
'Go Well' Workplace Travel plan
Integrated clinical services planning
Organisational Development Programme
Sustain Programme

5.3 APPENDIX 3 Notes to the Financial Statements

Reporting Entity

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

The Hawke's Bay District Health Board's primary objectives are the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly the District Health Board is a public benefit entity for financial reporting purposes.

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

Basis of Preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently to all periods.

Statement of Compliance

The financial statements of the district health board 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 Public Benefit Entity (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 unless otherwise specified.

Income and Cost Allocation

Output Classes

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

Direct revenue and costs are allocated directly to output classes. Indirect costs are allocated to output classes using appropriate cost drivers such as volumes provided.

The purchase units that comprise an output class change over time as clinical practice and medical technology develop. Consequently while the figures prepared for each year reported in the annual report will be consistent with the figures for each year reported in its associated annual plan, they are not necessarily consistent with the annual reports and annual plans of other years.

Performance against Budget

The budget figures are those approved by the District Health Board in its annual plan. The budget figures are prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the District Health Board for the preparation of the financial statements.

Patient Care Revenue

Ministry of Health Population-based Revenue

The Hawke's Bay District Health Board receives annual funding from the Ministry of Health based on Hawke's Bays share of the national population. Revenue is recognised in the year it is received.

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 District Health Boards

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

Other Crown Entity Contracted Revenue

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

Other Operating Revenue

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 Income

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

Sale of Goods

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

Provision of Services

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 the Hawke's Bay District Health Board for nil or nominal cost, the fair value of the asset received is recognised as income when control over the asset is obtained.

Donated Services

The activities of the Hawke's Bay District Health Board are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the District Health Board.

Other Operating Expenses

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.

Financing Costs

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.

Capital Charge

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

Cash and Cash Equivalents

Cash and cash equivalents include 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.

Debtors and Other Receivables

Receivables and prepayments are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that the Hawke's Bay District Health Board will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Loans

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

Inventories

Inventories held for Distribution

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost 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.

Non-current Assets held for Sale

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

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

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

Property, Plant and Equipment

Property, plant and equipment consists of the following asset classes: 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 District Health Board and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired 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 value of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in 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 Hawke's Bay District Health Board and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

Class of Asset	Estimated Life	Depreciation Rate
Buildings	5 to 40 years	2.5% to 20%
Clinical equipment	2 to 32 years	3% to 50%
Information technology	3 to 10 years	10% to 33%
Motor vehicles	3 to 20 years	5% to 33%
Other equipment	3 to 30 years	3.3% to 33%

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

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

Impairment of Property, Plant and Equipment and Intangible Assets

Hawke's Bay District Health Board 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 amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is 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

Software Acquisition and Development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include 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 district health board 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 assets is available for use and ceases at the date the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

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

Type of Asset	Estimated Life	Amortisation Rate
Acquired computer software	3 to 15 years	6.7% to 33%
Developed computer software	3 to 15 years	6.7% to 33%
NZ Health Partnerships Ltd Class B shares	Indefinite	Nil
Interest in CRISP	Work in progress	Nil

Impairment of Intangible Assets

Hawke's Bay District Health Board 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 annually for impairment.

Investment Properties

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value, an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, will provide an assessment of the fair 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 accumulated surpluses/(deficits). Any loss arising in this manner is recognised immediately in the surplus or deficit.

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

Investments in Associates

Investments in associate entities are accounted for using the equity method. An associate is an entity over which the district health board 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 district health board's share of the surplus or deficit of the associate after the date of recognition. Distributions received from an associate reduce the carrying amount of the investment.

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

Borrowings and Finance Leases

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method. Borrowings are classified as current liabilities unless Hawke's Bay District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date.

Finance leases transfer to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased asset or the present value of the minimum lease payments. The finance component is 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. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the district health board will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the leased term and its useful life.

Employee Entitlements

Short-term Employee Entitlements

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

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

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

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation 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 linked service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on: likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlements information; and the present value of the estimated future cash flows.

Superannuation Schemes

Defined Contribution Schemes

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

Defined Benefit Schemes

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

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

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present 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.

Taxes

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 (IRD) is included as part of receivables or payables in the statement of financial position.

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income Tax

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