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CAPITAL & COAST DISTRICT HEALTH BOARD

Annual Report 2015/2016

Capital & Coast
District Health Board
UPOKO KI TE URU HAUORA

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CCDHB postal address:
Wellington Regional Hospital, Private Bag 7902, Wellington 6242

Wellington Regional Hospital physical address:
Riddiford Street, Newtown, Wellington 6021

Website: www.ccdhb.org.nz
Email: info@ccdhb.org.nz | Phone: 04 385 5999 | Fax: 04 385 5856

Cover photo: Kenepuru Hospital activities coordinator Deepa Chetty reads the paper to patient Gael Hambrook.

COMMS: 0064-1610

CHAIR AND CHIEF EXECUTIVE'S FOREWORD

We are pleased to present Capital & Coast District Health Board (CCDHB)'s Annual Report for the year 1 July 2015 to 30 June 2016. This report outlines what we have achieved, our progress against our key performance measures and details of how the health funding we received has been managed.

Our population continues to increase by more than 2% annually. We have faced greater than expected community and hospital demand for our services during the year and financial challenges. However, we have continued to deliver more efficient, high quality services and to develop new ways of working.

We achieved the average sector level expected efficiency (1.7%). However, greater efficiency is required of CCDHB to close the deficit and manage increasing cost pressures while addressing increasing acute demand and productivity expectations. CCDHB receives 89 cents in the dollar compared with the average DHB because our population is less diverse and younger than others, our population growth, while still relatively high, is not as high as elsewhere, and CCDHB is not a rural DHB. This compels us to focus on greater efficiency and productivity through new models of care and a focus on quality.

Our board has worked assiduously since 2008/09 to sustainably reduce our deficit from $68 million, achieving a $4 million deficit in 2014/15 with the intention of breaking even in 2015/16. However, revenue for both financial years was lower than previously signalled and our end of financial year result was a deficit of $11.9 million, despite measures to produce further savings within the financial year.

This year the board commissioned a high level review of services to identify opportunities to ensure and enhance their clinical and financial sustainability. This review is being undertaken independently by PwC and will be the basis for an ongoing focus on continuing to provide quality services within our budget.

Based on data from the Ministry of Health, CCDHB achieved the lowest length of acute medical hospital stays among the tertiary DHBs, and the second lowest across all DHBs (up to 30% lower than some). This reflects the efficiency of acute health service provision in both the community and in our hospitals.

The board is committed to providing the best quality healthcare possible and continuing to improve health outcomes for our population. 2015/16 has been a busy year heralding a number of major new initiatives and new ways of working.

The board is proud of its work with partners to find ways to deliver healthcare differently. One such initiative is Health Care Homes, which aims to improve healthcare access and focus on managing patients with long-term conditions in the community in partnership with primary health organisations. Around 40,000 people are already benefiting from this programme, which will continue to be rolled out across the region. Online services for patients include requesting prescriptions, making appointments and messaging their GP. Patients can expect improved responses to phone calls and, for urgent appointment requests, a conversation with a GP or nurse may even save a trip to the practice.

In November 2015, we integrated our community and hospital laboratory services. This new service means laboratory equipment has been upgraded across the three DHBs in the lower North Island (Capital & Coast, Hutt Valley and Wairarapa), which will improve patient experiences, turnaround times and access to tests results. The change saves the three DHBs up to $10 million a year which is already being reinvested into services.

In December 2015 we installed what is believed to be the world's first air ambulance simulator, a life sized plane for Life Flight medical staff to train in. This means that Wellington Regional Hospital has the only flight simulation suite in New Zealand (if not Australasia). The flight simulator was purchased by the Wellington Hospitals Foundation using funds raised from the community.

This year we also doubled our MRI capacity, by installing a new MRI scanner at Wellington Regional Hospital in June 2016. The $6.5 million investment means we can deliver a world-class service so patients throughout the region can access the latest technology, get scans faster, and have improved experiences and outcomes.

We also opened New Zealand's first secure forensic inpatient mental health service for young people this year. Called Nga Taiohi, this is a dedicated secure facility providing services for clients who have offended and have complex mental health (or mental health and alcohol or drug) issues. The unit will provide a safe environment with 24-hour care from a specialist multi-disciplinary team. It has an emphasis on Māori cultural therapeutic practices and a strong educational component.

Wellington Regional Hospital's Emergency Department (ED) now has 24/7 support for victims of domestic violence, thanks to a new partnership with Wellington Women's Refuge. In ED all women over the age of 16 are screened for domestic violence and given the option of talking to a support person. During the day this would be a social worker from the hospital and now Wellington Women's Refuge has stepped in to provide an after hour's service.

And this year we launched the final stage of a multimillion dollar makeover of the school dental service in Wellington, Kapiti and Hutt Valley by opening six more fully refurbished and modernised school dental clinics. Since 2010, 13 clinics have been refurbished and 11 dental vans visit most schools that don't have a clinic. The Bee Healthy Regional Dental Service provides free dental examinations and treatment for all children from birth until Year 8 (around age 12), across the Wellington, Hutt Valley and Kapiti Coast regions.

We are continuing to strive to meet the national health targets. This year we exceeded the target for elective surgery, with 10,864 elective surgeries delivered to the DHB population. We were also one of the highest performing DHBs for delivering faster cancer treatment. We continue to strive towards a sustainable future and, to this end, are continuing with our long term systems planning for the year 2030.

We would like to thank our staff and our health and social service sector partners for their hard work in the past year and their ongoing contribution and commitment to improving the health of people in our region. We'd also like to recognise the significant contribution of the Wellington Hospitals Foundation and the time given by our hospital volunteers.

Dr Virginia Hope, BOARD CHAIR MNZM

Debbie Chin, CHIEF EXECUTIVE

STRATEGIC DIRECTION

OUR VISION

Better health and independence for people, families and communities – keeping people well and eliminating health inequalities, everyone will enjoy the best possible health throughout life.

We understand that we must work with our communities to help reduce disparities in health status and reduce the incidence of chronic conditions amongst our population while increasing the independence of the people in our district.

To achieve our health goals, we have developed a range of specific strategies which include:

- focusing on people through integrated care
- supporting and promoting healthy lifestyles
- working with our communities
- developing our workforce
- updating our hospitals
- managing our money

OUR VALUES

As a health care provider, we work according to core values:

- focusing on people and patients
- innovation
- living the Treaty
- professionalism
- action and excellence

STRATEGIC GOALS

We aim to meet the Government's service objectives as well as the needs of our population through:

- improving outcomes for frail elderly
- reduction of health disparities within our population
- integrated delivery of services
- improving the health of children in vulnerable communities, with a particular focus on rheumatic fever, serious skin infection and respiratory conditions
- ongoing quality improvement of planning and reporting processes
- enhancing clinical leadership and communication
- financial and clinical sustainability
- a culture of collaboration with local and regional partners

ABOUT CAPITAL & COAST DHB

We receive funding to improve, promote and protect the health of the people in our communities and ensure health services are available, either by contracting with external providers (such as primary health organisations, general practices, primary care practices/services, non-governmental organisations, rest homes, dentists, pharmacists, and Māori and mental health providers) or providing the services directly (such as hospital services).

Currently just over 300,000 people live within the Capital & Coast DHB district, with just under two thirds of the population in Wellington City, 18% in Porirua and 17% on the Kāpiti Coast. The DHB must assess the health status of the population and determine what funds should be directed to preventing illness and early intervention of illness (via primary health and public health services), while continuing to provide and improve existing hospital and other specialist services.

We are the leading provider of specialist tertiary services for the upper South and lower North Islands, covering a population of over 800,000.

In all, the DHB offers hospital services across a wide range of specialist areas including; cardiology and cardiothoracic surgery, neurosurgery, vascular surgery, renal medicine and transplants, genetics, oncology, paediatric surgery, neonatal intensive care, obstetrics, endocrinology, orthopaedics, urology, and specialised forensic services.

Community-based services provided include both general and specialist district nursing, specialist multi-disciplinary rehabilitation services, occupational therapy, speech language therapy, physiotherapy, dietetics, social work and home support services, mental health, alcohol and drug services.

Our DHB operates Wellington Regional Hospital and Kenepuru Community Hospital, supported by the Kāpiti Health Centre, as well as Ratonga Rua, a large Mental Health campus at Kenepuru, and other community-based services. It is a major employer in the Wellington region with over 4,300 full-time equivalent staff with an additional number of people working on a casual basis.

THE HEALTH OF OUR POPULATION

Our DHB is the seventh largest in New Zealand and spans three territories; Wellington City, Porirua City and part of Kāpiti Coast district. The people of the Wellington region enjoy, on average, better health, longer life spans, and lower rates of morbidity and mortality than many other parts of the country. We have fewer than average Māori (10%) and a higher than average Pacific (7%) and Asian (11%) populations.

Almost a third of our population are aged between 25 and 44, however, age structures differ by ethnicity and between geographic areas:

- Māori and Pacific have a relatively young age structure with more children and fewer people aged over 65.
- Porirua has a large proportion of children under 15 years
- Kāpiti Coast has a large population aged over 65 years.

Overall our district is relatively advantaged in terms of socioeconomic deprivation, with one in five people living in the least deprived areas (NZDep2013 decile 1). However, there are pockets of deprivation in Porirua and south east Wellington and these communities experience poorer health outcomes.

The district population is predicted to increase 8% (23,000 people) by 2026 with the highest growth in Wellington and Kāpiti. Like the country as a whole, our population is ageing and the number of people aged over 65 years is expected to grow by almost 40% (15,000 people) by 2026.

Key health issues for this DHB include:

- Reducing the incidence of long term conditions (such as cardiovascular disease, diabetes and respiratory conditions) and minimising the impact on people's daily lives. Māori and Pacific tend to have earlier onset of long term conditions than other groups.
- The burden of cancer and reducing disparities in survival.
- Experience of mental illness and its unequal impact on younger, disadvantaged population groups.
- Addressing issues for children and youth, including oral health, respiratory, skin infections and injuries, mental health and youth suicide, as well as sexual health.
- Health of older people, including management of long term conditions, cancer, musculoskeletal disease (for example, arthritis, osteoporosis), injury from falls, the impact of dementia, home and community support needs and end of life care.
- Responding to the needs of the 23% of the district population estimated to have a disability.

GOVERNANCE OF CAPITAL & COAST DHB

ROLE OF THE BOARD

The Board of Capital & Coast DHB is responsible for the governance of the organisation and is accountable to the Minister of Health. The DHB governance structure is set out in the New Zealand Public Health and Disability Act 2000.

The Board consists of 11 members who have overall responsibility for the organisation's performance. Seven members are elected as part of the three-yearly local body election process and four are appointed by the Minister of Health. A Crown Monitor was appointed in August 2014.

ROLE OF THE CEO

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

GOVERNANCE PHILOSOPHY

Over the past few years, the three Boards have taken a 'whole-of-health system' approach, including integrating clinical and support services where this provides benefits across the system. Each Board continues to provide governance of local services and all three Boards provide collective governance over services that are shared or integrated, ensuring local accountability. Integrated service approaches are intended to deliver:

- Preventative health and empowered self-care
- Provision of relevant services close to home; and
- Quality hospital care, including highly complex care, for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

BOARD STRATEGY

IMPROVE CHILD HEALTH AND CHILD HEALTH SERVICES IN THE WELLINGTON REGION

Improve the environment, and the quality of healthcare, in the children's ward at Wellington hospital:

- Develop integrated, fit-for-purpose child health services for the sub-region and region.
- Use schools as hubs for health education and nutrition advice.
- Provide better monitoring and evaluation of child health outcomes in Wellington.

BETTER ELDER CARE

Plans are under way to establish better pathways for managing the 'frail elderly' so that older citizens have access to better quality services in the community. We would like these services expanded to include:

- A Regional Elder Care Centre of Excellence, based in Kenepuru.
- Better monitoring and oversight of aged care facilities.
- A system of continuous quality improvement for home and community support for our elderly population.

INTEGRATED CARE

So that health services can be provided as close to home as possible, and unnecessary hospital admissions can be avoided.

CCDHB has been working with primary health organisations to integrate primary, secondary, tertiary and public health care. We want to encourage the more rapid development of integrated care pathways that can prevent unnecessary admissions and adverse events.

We want to expand these services to include:

- Integrated family health care centres that provide access to a variety of services in one location and eventually focus on keeping people well, as well as treating people when they are sick. We would like to begin with a pilot for an integrated family care centre in Porirua.
- Better access to information that promotes wellness and good personal health, at all points across the health continuum.
- Better access to mental health services.

EMPOWERED SELF-CARE

As chronic diseases become more prevalent, it is important that patients are actively engaged in their care. We want to see greater recognition of the capacity of the patient in guiding and managing their own care, as well as better sharing of information and decision-making, and more opportunities for preventive care.

We want to assess the increasing evidence for the impact of preventative activities in primary care. Other initiatives we would like to see include:

- The progressive availability and promotion of access to advance care planning throughout the health system.

- Schools as community hubs for education, physical wellbeing and activity and nutrition advice.
- RPH to develop a community care pilot with a group of cluster schools within its current mandate.
- Measuring patient experience/outcome to ensure that better health outcomes are achieved.
- Improved access to green prescriptions and nutrition advice.

ENHANCED CLINICAL LEADERSHIP

We want clinical leaders to have greater and more coordinated input into decision-making within CCDHB. We also want to see:

- More and better communication between the Board and clinical leaders.
- More innovative delivery of our health services, including more effective use of telemedicine, telehealth, and Skype.

CONTINUOUS OUTCOME EVALUATION AND MONITORING

We want continuous outcome evaluation and monitoring against our strategic goals and targets. For example the Board would like to be able to track the relationship between CVD assessment, and health outcomes, including using the assessments to identify those with pre-diabetic conditions and give them access to more intensive input and treatment to prevent their transition to diabetes.

BOARD & COMMITTEE MEETING ATTENDANCE

July 2015 - June 2016

Board member	**Board** (6 meetings)	**CPHAC** (5 meetings)	**DSAC** (5 meetings)	**HAC** (6 meetings)	**FRAC** (10 meetings)
Dr Virginia Hope++	6	4	4	6	10
Dr Derek Milne	6	5	5	3	6
Dr Judith Aitken	6	-	-	5	6
Mr David Choat	4	4	4	3 *	-
Mr Peter Douglas++	4	1 **	1 **	-	8
Ms Helene Ritchie	6	3	3	-	-
Mr Darrin Sykes++	3	-	-	-	7
Ms Sue Kedgley	5	-	-	6	-
Mr Chris Laidlaw	5	3	3	-	-
Mr Nick Leggett +	6	2 *	2 *	3 *	4 *
Mr Roger Jarrold	4	-	-	-	10
Dr Margaret Wilsher *(Crown Monitor)*	2	2	2	3	9

Note:
- \- not a member
- * new member of the committee from Feb 2016
- ** ceased committee membership
- \+ Board representative, Sub-Regional Pacific Strategic Health Advisory Group
- ++ Board representatives, Māori Partnership Board

OUR PEOPLE

Delivering expert health care requires the right mix of trained and qualified people. In order for us to do this we work hard to attract and retain a skilled and responsive workforce that can deliver a sustainable service that looks to continually improve patient care.

A key priority for us is improving clinical workforce retention by continuing to support and grow clinical leadership, by supporting clinical governance of the patient journey across primary and secondary services.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level; controlling the growth of hospital labour costs; maintaining and where possible, improving hospital productivity: and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians.

The DHB continues to ensure local clinicians take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and optimal clinical arrangements for securing specialised hospital capacity with neighbouring DHBs. This strengthened clinical leadership was assisted through the activity of the Alliance Leadership Team, the Strategic Clinical Governance Group and involvement of clinicians in the development of collaborative service models at a sub-regional and regional level.

The Strategic Clinical Governance Group is responsible for providing clinical leadership; leading the development of clinical governance across all of the services provided by the DHB; overseeing the quality and safety of services delivered by DHB providers and the clinical quality programme; and providing advice and recommendations to the DHB Board, Chief Executive and management.

GOOD EMPLOYER OBLIGATIONS REPORT

A key value of the DHB is to be a good employer. Capital & Coast DHB embraces the seven key elements of 'the Good Employer' as prescribed by the EEO Commissioner. The elements are:

- Leadership, accountability, and culture
- Recruitment, selection, and induction
- Employee development, promotion, and exit
- Flexibility and work design
- Remuneration, recognition, and conditions
- Harassment and bullying prevention
- Safe and healthy environment.

A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity and we have an equal employment opportunities focus within the relevant polices. Training and development opportunities are offered to all staff, and personal performance and development plans are done annually.

Several forums are in place comprising of employees from across the DHB. These forums meet to consider workplace practices. Topics include health and safety, and professional practices for nursing, clerical, and administration staff.

One of the DHB's three priorities is building capability. As a good employer the DHB values professionalism through leadership. Therefore unacceptable employee behaviour is not tolerated. Last year we updated HR policies and guidelines related to discipline, performance, and code of conduct, harassment prevention, and protected disclosures. We are taking other actions to reduce the incidence of bullying and harassment within our organisation for example this year we have established roles as contact people for staff in relation to bullying and harassment prevention and provided external expert training for this. We have other policies including the EEO Policy which will be reviewed this year.

The DHB also has an HR Plan centred around building a positive workplace. The plan includes actions being undertaking in relation to engagement of staff and leadership. It includes building on the leadership development already provided. There will shortly be a pilot for a course for all managers called "What Leaders Need to Know" that is built from the leadership ethos that was agreed by the executive for all 3 DHBs in our sub region. The sub region has also agreed a leadership capability profile and is looking to develop or purchase leadership development that is aligned with that.

Approximately 92% of employees are covered by Collective Employment Agreements (CEA). All the CEAs have remuneration, recognition and conditions clauses. We also take a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the organisation.

The DHB has provided training for all managers and union representatives on the new health and safety legislation.

The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the employee assistance programme.

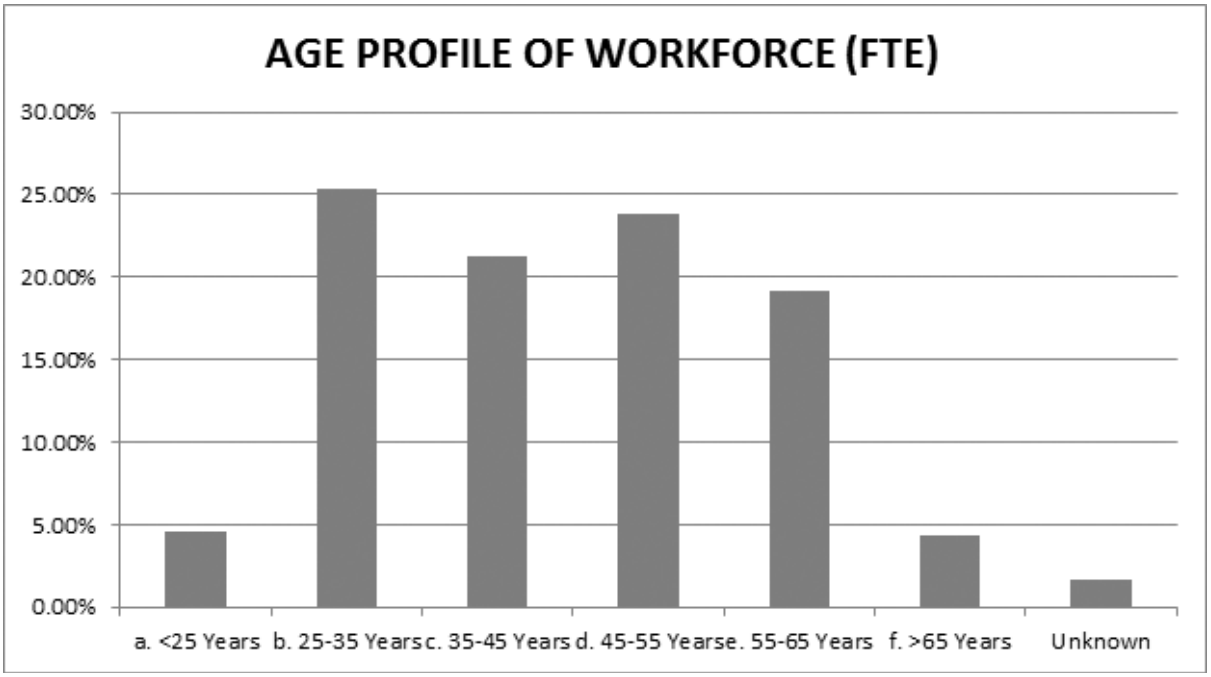
WORKFORCE PROFILE

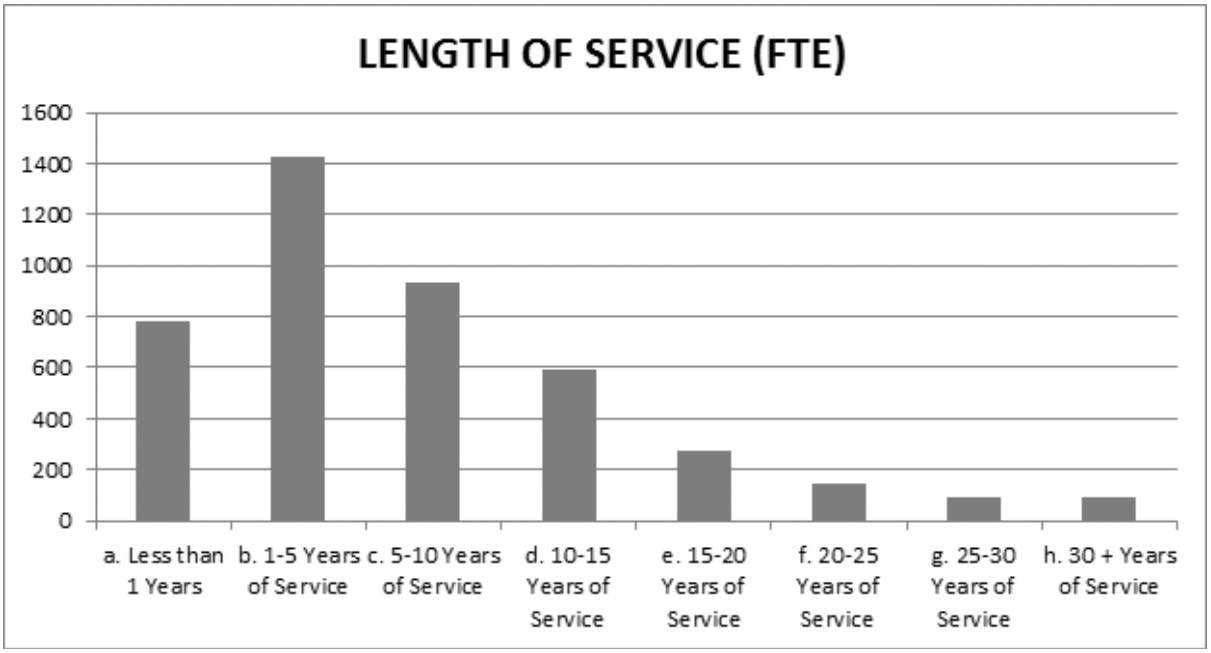
Full Time Equivalent (FTE) staff numbers

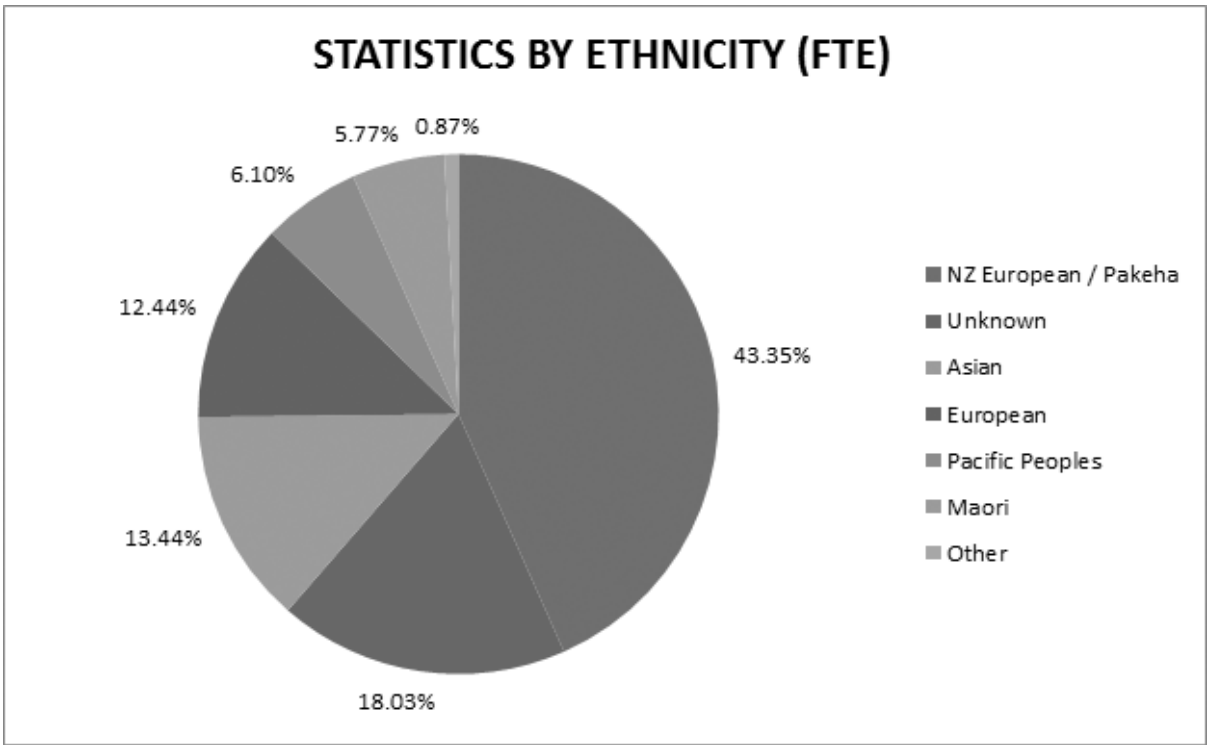
Profession	2016	2015	2014	2013	2012	2011	2010	2009
Medical	658	641	618	588	564	524	510	490
Nursing	2005	1946	1895	1910	1805	1789	1791	1640
Allied Health	707	762	767	760	727	706	685	646
Other	966	998	877	1011	958	957	968	971
Total	4337	4347	4257	4268	4054	3976	3954	3746

Statistics by Gender

Gender	2016	2015	2014	2013	2012	2011	2010	2009
Female	74%	73%	72%	73%	73%	73%	73%	72%
Male	26%	27%	28%	27%	27%	27%	27%	28%


AGE PROFILE OF WORKFORCE (FTE)
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
a. <25 Years
b. 25-35 Years
c. 35-45 Years
d. 45-55 Years
e. 55-65 Years
f. >65 Years
Unknown


LENGTH OF SERVICE (FTE)
1600
1400
1200
1000
800
600
400
200
0
a. Less than 1 Years
b. 1-5 Years of Service
c. 5-10 Years of Service
d. 10-15 Years of Service
e. 15-20 Years of Service
f. 20-25 Years of Service
g. 25-30 Years of Service
h. 30 + Years of Service


STATISTICS BY ETHNICITY (FTE)
5.77%
0.87%
6.10%
12.44%
43.35%
13.44%
18.03%
NZ European / Pakeha
Unknown
Asian
European
Pacific Peoples
Maori
Other

PERFORMANCE HIGHLIGHTS

Capital & Coast DHB continues to provide high quality and timely services for our population. In 2015/16:

- Capital & Coast DHB exceeded the Health Target for the number of elective surgeries delivered with 10,864.
- Capital & Coast DHB achieved the *CVD risk assessment* Health Target with 91% of eligible people receiving an assessment in 2015/16.
- Capital & Coast DHB continues to perform with rates of ambulatory sensitive hospitalisations below the national average.
- Regional Public Health exceeded the target for the percentage of school children receiving Boostrix vaccination and HPV vaccinations in schools.
- Capital & Coast DHB has observed sustained improvement in the proportion of 5 year olds who are cares-free from 2013. These improvements have also been observed amongst Māori and Pacific children.
- In Capital & Coast DHB, the burden of decay (mean DMFT) in twelve year old children has decreased from 2013.
- In Capital & Coast DHB, the proportion of diabetics with good blood glucose control (HbA1c less than 64 mmol/mol) has improved across the DHB's population, Māori and Pacific.
- Capital & Coast DHB achieved the Before School Check screening target for both the total population and the high need population, with 91% high need children and 90% of all children receiving a check.
- All general practices in Capital & Coast DHB have a diabetes care improvement plan. These plans include regular monitoring of diabetes care and outline strategies that will improve diabetes care in the practice.
- Capital & Coast DHB achieved the 85% target for the percentage of children under 5 years of age in DHB-funded dental services.
- Capital & Coast DHB met the target set for hospital quality measures of the number of medication errors causing harm and the percentage of DNA appointments for outpatient first specialist assessments.
- Capital & Coast DHB achieved targets for the proportion of people 65+ who are being supported to live at home.

MINISTER'S HEALTH TARGETS

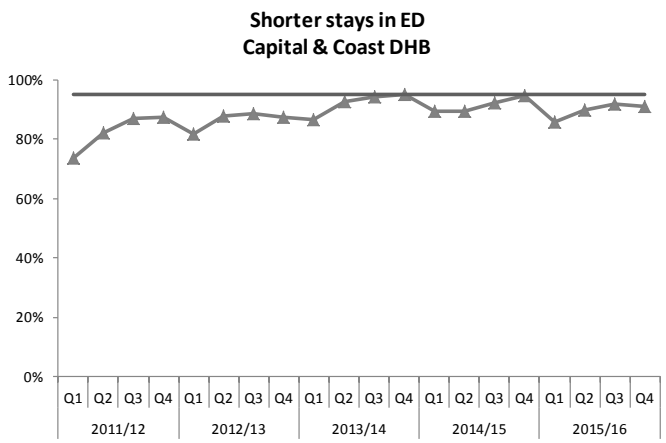
Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. They provide a focus for action.[1] Note the changing vertical (y) axis between graphs.

Shorter stays in Emergency Departments

95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Target: 95%

2015/16 Performance: 91%

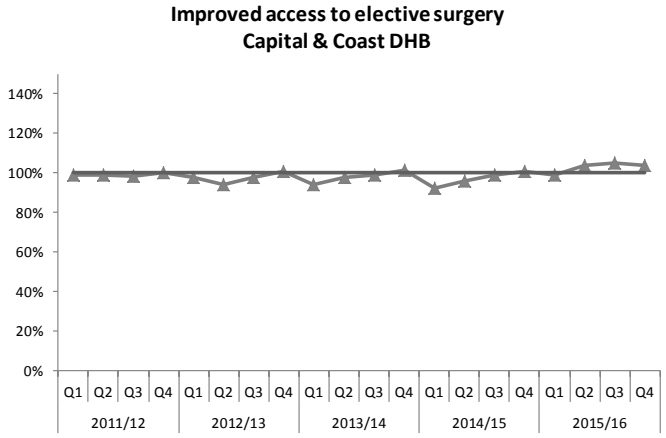


Improved access to elective surgery

More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.

Target: 10,439 (graph - 100%)

2015/16 Performance: 10,864



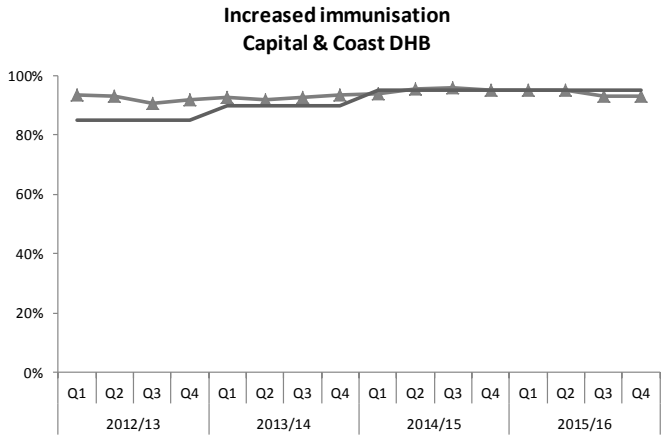
[1] Quoted from the Ministry of Health (http://www.health.govt.nz/new-zealand-health-system/health-targets)

Increased immunisation

85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014.

Target: 95%

2015/16 Performance: 93%

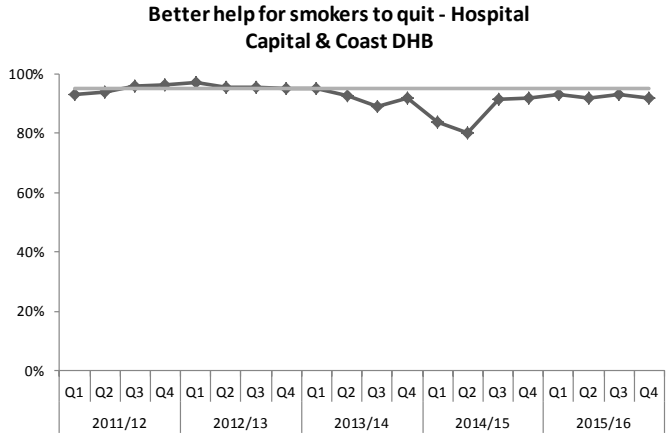


Better help for smokers to quit – Hospital

95 percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.

Target: 95%

2015/16 Performance: 92%

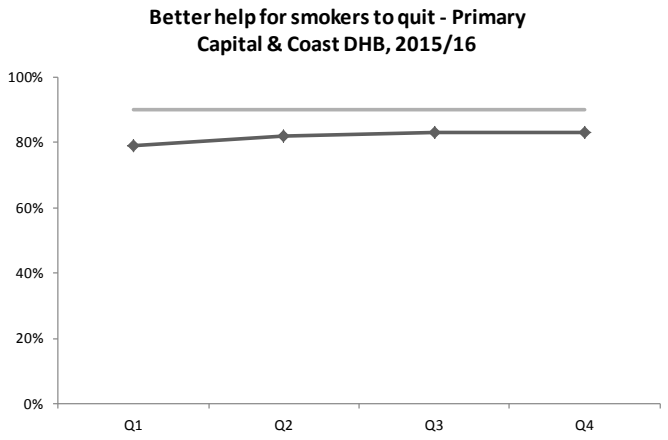


Better help for smokers to quit – Primary care

90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking[2].

Target: 90%

2015/16 Performance: 83%



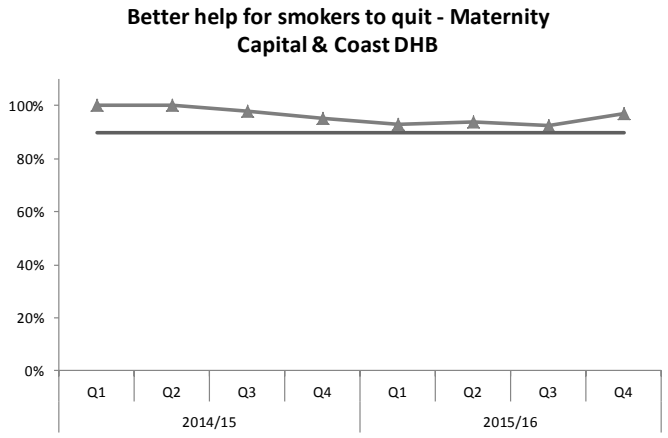
[2] From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking.

Better help for smokers to quit – Maternity

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

Target: 90%

2015/16 Performance: 97%

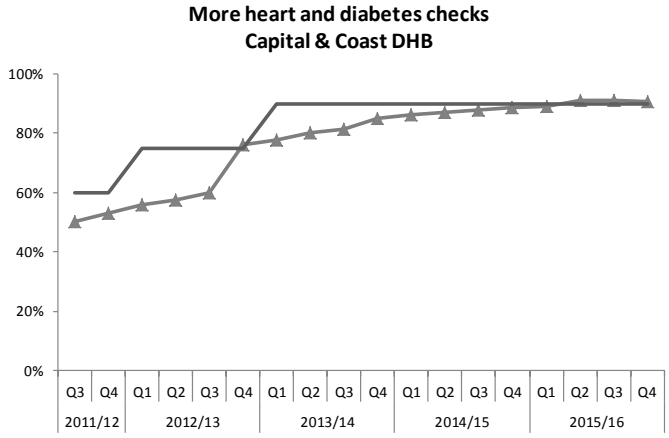


More heart and diabetes checks

90 percent of the eligible population[3] will have had their cardiovascular risk assessed in the last five years.

Target: 90%

2015/16 Performance: 91%

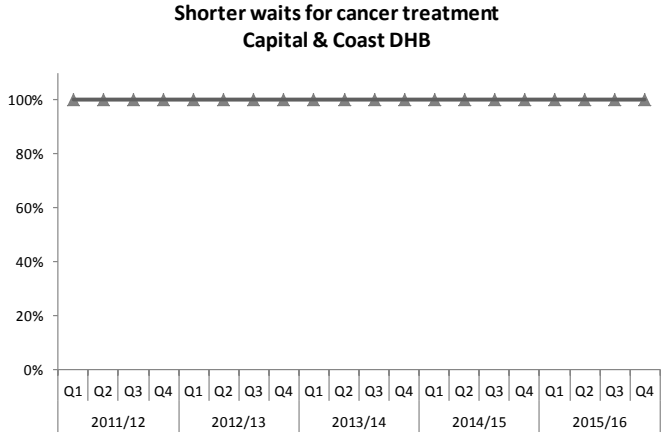


Shorter waits for cancer treatment

All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. The Ministry of Health has transitioned from this target to the 'Faster cancer treatment' health target.

Target: 100%

2015/16 Performance: 100%



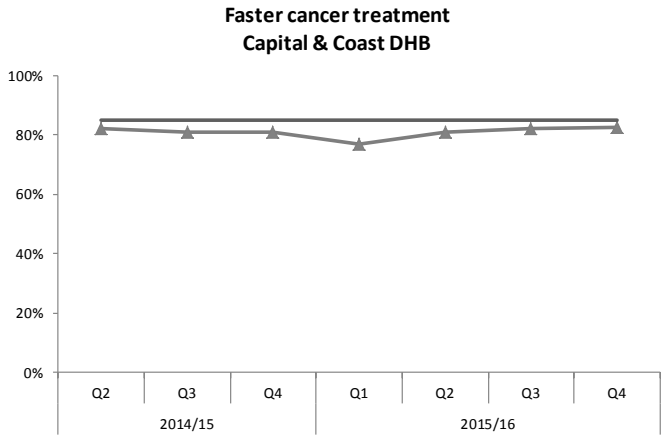
[3] Males of Māori, Pacific or Indian ethnicity aged 35-74 years at then end of the reporting period and enrolled with a PHO; Females of Māori, Pacific or Indian ethnicity aged 45-74 years at the end of the reporting period and enrolled with a PHO; Males of any other ethnicity aged 45-74 years at the end of the reporting period and enrolled with a PHO; Females of any other ethnicity aged 55-74 years at the end of the reporting period and enrolled with a PHO.

Faster cancer treatment

85 percent 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 by July 2016, increasing to 90 percent by June 2017.

Target: 85%

2015/16 Performance: 83%



OUTCOMES AND IMPACTS

As the major funder and provider of health, wellbeing, and disability services in our district, we work to make and maintain positive changes in the health of our population. Our decisions about which services to fund and deliver have a significant impact on the health of our population, and contribute to the effectiveness of our entire health system.

In the following section, we present our nine intended outcomes and their associated impact measures. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas our DHB is making a positive difference and in which areas our DHB should seek to improve. It is important to note that these outcomes are progressed not just through the work of DHBs, but also through the work of all of those across the health system and wider health and social services.

POPULATION HEALTH OUTCOME: IMPROVED HEALTH EQUITY

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and current models of care. Patients can find it hard to access services or to know how to manage their health if services are not culturally competent. We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

The DHB measures progress through:

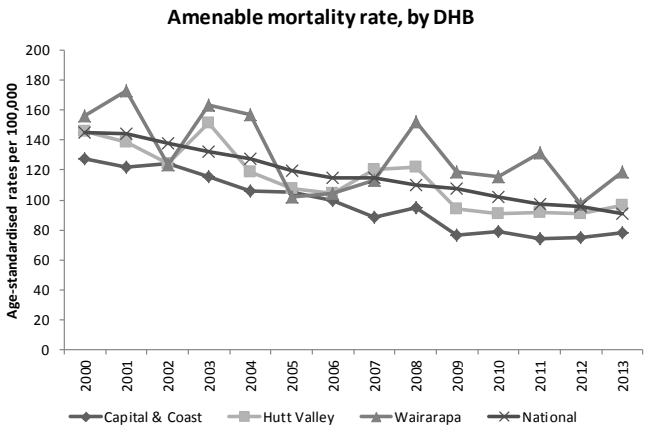
Impact measure: A reduction in amenable mortality rates

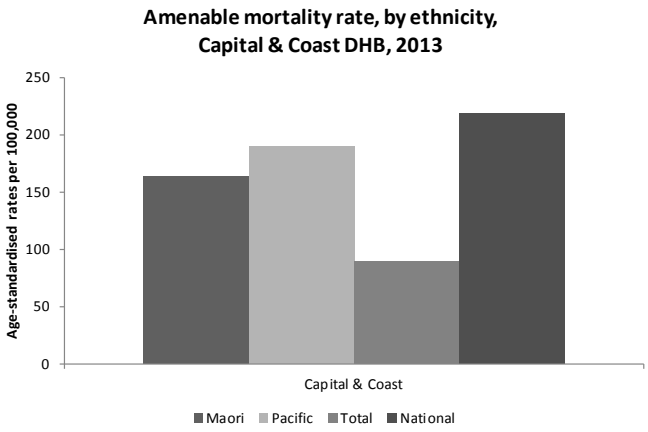
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them.

Māori and Pacific amenable mortality rates are higher than all ethnicities, indicating that Māori and Pacific are not receiving equitable coverage or quality of healthcare. Māori and Pacific amenable mortality rates in Capital & Coast DHB are lower than the national rate.

The Ministry of Health's Mortality Collection data up to year end 2013 was released in June 2016.





Source: Ministry of Health

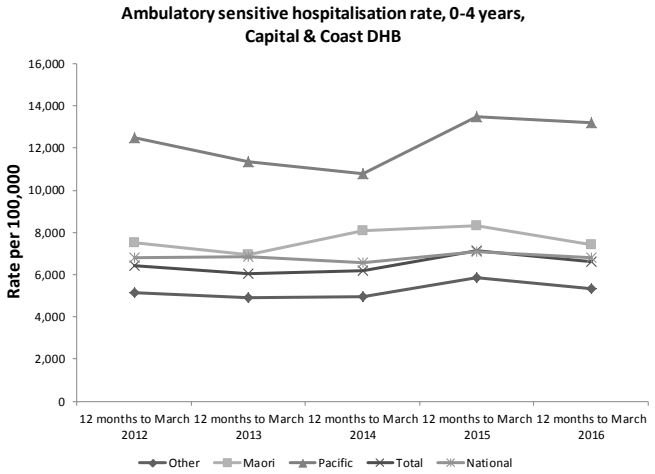
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates[4]

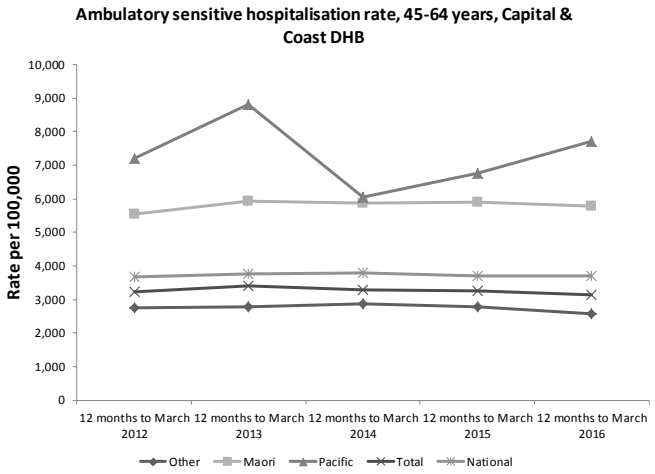
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include, for example, skin infections, dental conditions, asthma, pneumonia, cardiovascular disease and diabetes.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

In Capital & Coast DHB, ASH rates amongst Māori and Pacific children (0-4 years) are 1.3 and 2.5times higher, respectively, compared to Other ethnicities. The ASH rates amongst Māori and Pacific adults (45-64 years) are 2.2 and 3.0 times higher compared to Other adults.

Note that the methodology for this measure was revised by the Ministry of Health in 2015/16. These figures use the revised methodology.





Source: Ministry of Health

[4] ASH rate for 0-74 years as published in the Annual Plan is no longer available. ASH rates are now calculated for the 0-4 and 45-64 years age groups only.

POPULATION HEALTH OUTCOME: IMPROVED ENVIRONMENTAL AND DISEASE HAZARD MANAGEMENT

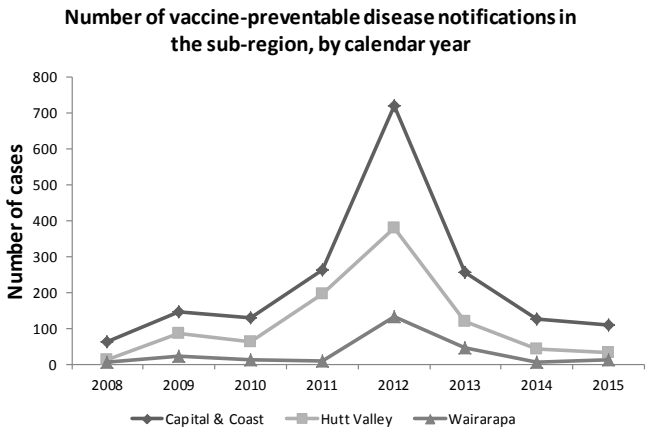
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised.

Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this Regional Public Health works with Police, councils, and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use.

Impact measure: A decrease in vaccine-preventable disease notifications[5]

In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications has returned to previous levels in 2014. In Capital & Coast DHB, the number of vaccine-preventable disease notifications decreased from 127 cases in 2014 to 111 in 2015. In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will continue to decrease.



Source: Institute of Environmental Science and Research

[5] Includes the following notifiable diseases: Haemophilus influenzae type B, Hepatitis B, Invasive pneumoccocal disease, Measles, Mumps, Pertussis, and Rubella.

Impact measure: An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012, for sales to minors (in the sub-region)

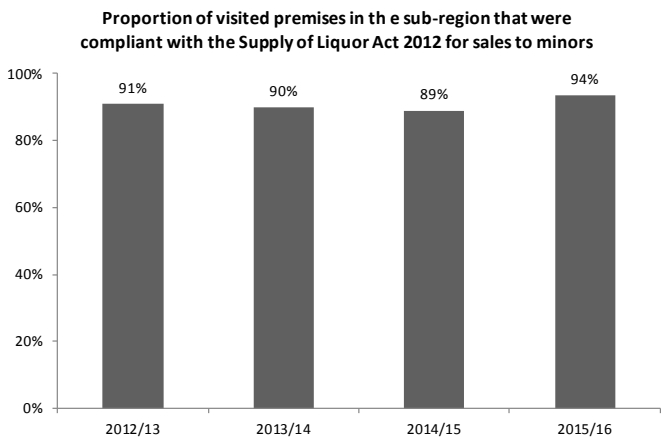
Alcohol is a significant contributor to disease and injury for New Zealanders. Alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime.

In 2007 alcohol consumption was attributed to 5.4% of all deaths for those under 80 years old. In 2004 alcohol accounted for 28,403 years of life lost (disability-adjusted life years – DALYs) representing 6.5% of all DALYs for those under 80 years[6]. Young people, Maori, Pacific peoples and those living in areas of higher socioeconomic deprivation are at greater risk of experiencing harms from alcohol.

Harm reduction strategies include changing both physical and social environments. Effective interventions include regulating the availability of alcohol through minimum legal age of purchase, hours and days of sale restrictions and restriction on the density of outlets.

Controlled purchase operations (CPOs) have been an effective compliance tool over the last ten years, with the national incidence of premises selling to minors declining during this time. Regional Public Health works with Police, volunteers aged 15-17 and the District Licensing Committee to carry out CPOs.

In 2015/16, 94% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors.



Source: Regional Public Health

[6] Ministry of Health (2013). Health loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016. Wellington: Ministry of Health.

POPULATION HEALTH OUTCOME: IMPROVED MANAGEMENT OF LIFESTYLE FACTORS THAT AFFECT HEALTH

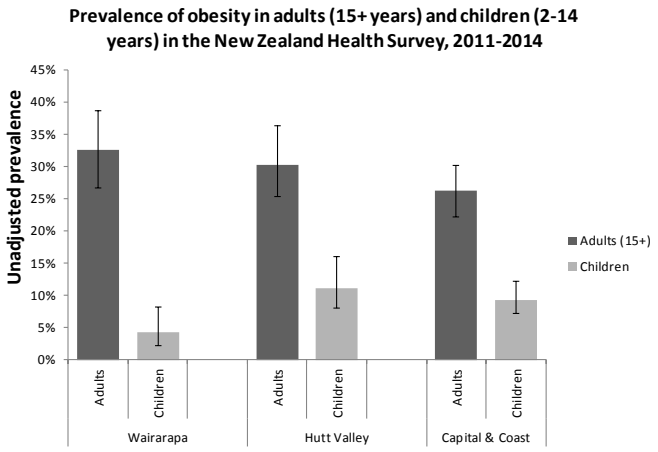
Lifestyle factors have a significant impact on overall health and well-being and are key contributors to cancer, obesity, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New Zealand using 'disability-adjusted life years' (DALYs) that include both burden from early death and from lives led with disability. There are four key lifestyle factors that drive health loss: smoking (9.1% of health loss), obesity (7.9%), physical inactivity (4.2%) and poor diet (3.3%). Reducing the incidence of these negative lifestyle factors will improve the health of our population.

Impact measures: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of overweight and obesity in developed countries has increased so quickly that is has been described as an epidemic[7].

The most recent NZ Health Survey shows that there is no significant difference in obesity rates across the sub-region. Adults have a much higher obesity rate than children in all three.

By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.



Source: New Zealand Health Survey, 2011-14. Error bars represent 95% confidence interval.

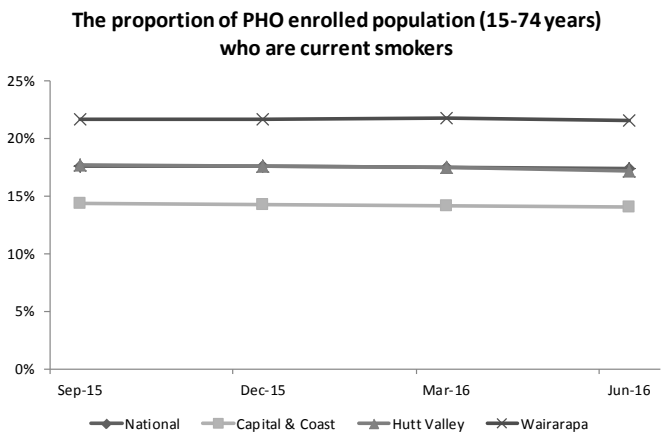
[7] Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health.

Impact measure: A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smoke free by 2025. Our DHB is working towards this goal by providing smoking advice and cessation support to patients when they visit their general practice or visit the hospital.

In Capital & Coast DHB, 14% of the PHO enrolled population are recorded as a 'current smoker'.

By continuing to provide smoking cessation advice and support, we expect that the percentage of people who smoke will decrease.



Source: Ministry of Health

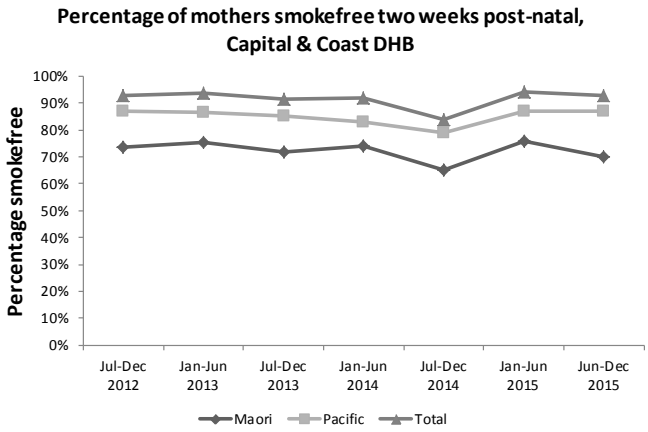
Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions, and tooth decay if they are exposed to cigarette smoke.

Mothers are given smoking cessation advice in hospital, and lead maternity carers provide information about the risks associated with smoking and referrals to smoking cessation providers. By continuing to provide cessation advice and support, we expect that the percentage of mothers who are smokefree two weeks post-natal will increase.

In Capital & Coast DHB, Māori and Pacific mothers were less likely to be smokefree compared to the total population.

Data for January to June 2016 was not available at time of publication.



Source: WCTO Quality Indicators, Ministry of Health via Trendly

OUTCOME 4: CHILDREN HAVE A HEALTHY START IN LIFE

A child's circumstances and health can have a lasting effect on their life. Poor health as a child predicts self-rated health and the development of chronic conditions as an adult[8]. For this reason, it important that the DHB provides children and their whānau with high-quality, equitable, and accessible services.

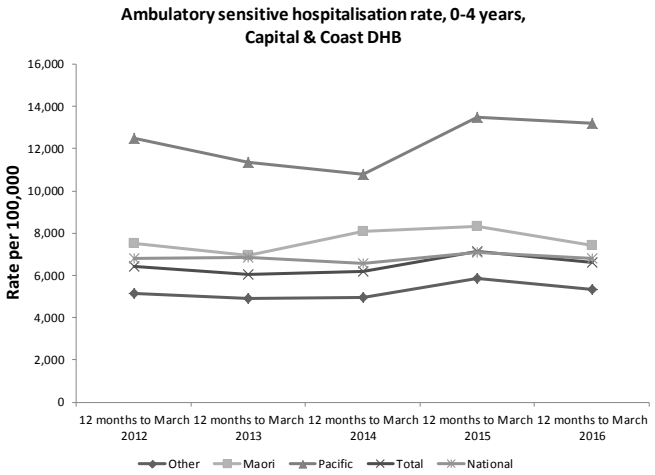
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, and gastroenteritis.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

In Capital & Coast DHB, ASH rates amongst Māori and Pacific children (0-4 years) are 1.3 and 2.5times higher, respectively, compared to Other ethnicities.

Note that the methodology for this measure was revised by the Ministry of Health in 2015/16. This figure uses the revised methodology.



Source: Ministry of Health

[8] Haas, H. A. (2007). The long-term effects of poor childhood health: An assessment and application of retrospective reports. *Demography, 44*(1), 113-135.

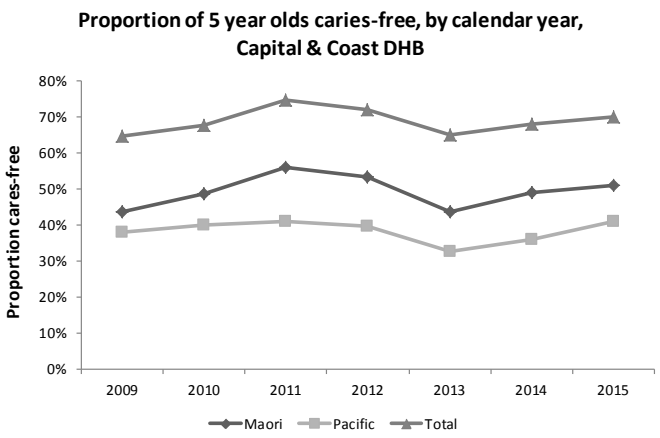
Impact measure: An increase in the proportion of children caries-free at 5 years

Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination, through which children with poor oral health are referred to community oral health services.

By ensuring that every child has access to and is receiving oral health services, we expect that the proportion of five year olds with no caries will increase.

In Capital & Coast DHB, the proportion of 5 year olds who are caries-free has increased. The proportion of Māori and Pacific children who are caries-free improved in 2014 and 2015.



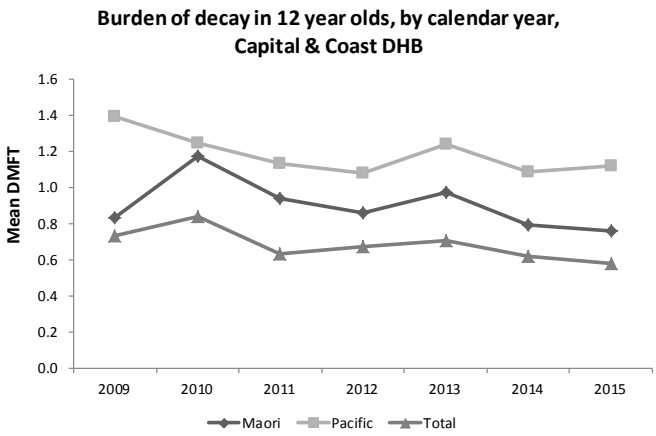
Source: Ministry of Health, Bee Healthy Dental Service

Impact measure: A decrease in the burden of tooth decay at Year 8

The burden of tooth decay is measured by the mean number of decayed, missing or filled teeth (DMFT) in twelve year old children. Māori and Pacific children have a higher burden of decay than other ethnicities.

By ensuring that every child has access to and is receiving oral health services, we expect that the burden of decay in twelve year olds will decrease.

In Capital & Coast DHB, the mean DMFT amongst 12 year olds continues to decrease. Mean DMFT amongst Māori children continues to decline, however in 2015 there was a slight increase in mean DMFT amongst Pacific children.



Source: Bee Healthy Dental Service

OUTCOME 5: LONG-TERM CONDITIONS ARE WELL-MANAGED

The New Zealand Burden of Disease Study[9] suggest that over the next decade people will be living longer with more long-term conditions and consequent disability. In response, our health system needs to increasingly focus on the prevention and on-going management of long-term conditions.

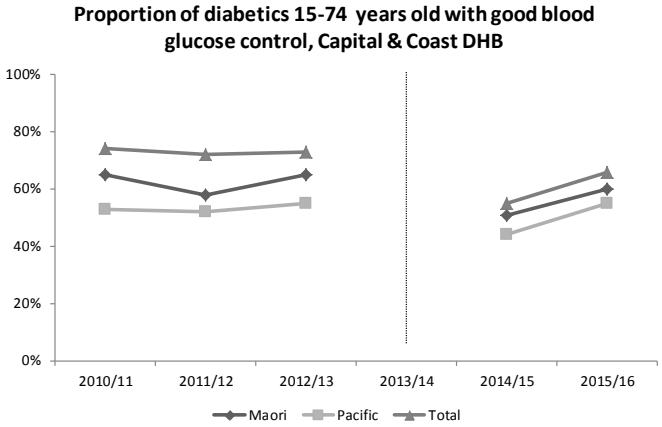
Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

Diabetes is a long-term condition that is caused by the body not being able to control its blood sugar levels properly. Diabetes is associated with kidney failure, eyesight problems, foot ulcers, and cardiovascular disease. However, with good diet and exercise, diabetes can be controlled and the risks associated with diabetes minimised. A lower level of HbA1c in the blood indicates that a person's diabetes is being well-managed.

General Practices in our sub-region are required to have a 'Practice Population Plan' that outlines the services and support that they will provide to diabetics. By improving the quality of care and empowering people with diabetes to look after their health, we expect to see an increase in the proportion of diabetics with good blood glucose control.

In Capital & Coast DHB, the proportion of peoples with diabetes with satisfactory blood glucose control increased and increased amongst Māori and Pacific.

Results from 2010/11 through to 2012/13 are as a proportion of diabetics who had an HbA1c tests. The methodology was revised in 2013/14 to be a proportion if all enrolled diabetics. Due to a delay in developing the new methodology, 2013/14 results are unavailable.



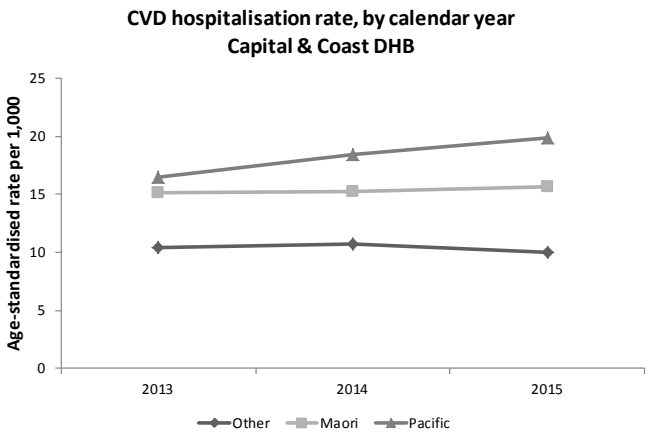
[9] Ministry of Health

Impact measure: A decrease in the hospitalisation rate for cardiovascular disease

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management.

One of the Health Targets is to provide CVD risk checks for the eligible population. By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

In Capital & Coast DHB, the CVD hospitalisation rate increased amongst Māori and Pacific and has declined amongst Other ethnicities.



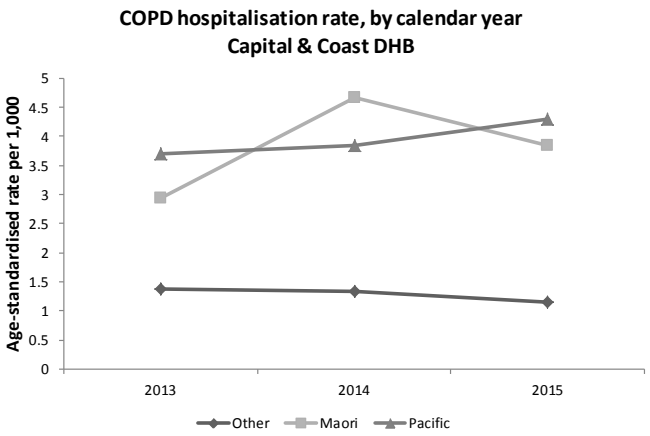
Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease.

Chronic obstructive pulmonary disease (COPD) is the result of damage to the lungs. COPD is most commonly associated with smoking, and although lung damage is permanent, quitting smoking can help to improve COPD symptoms and prevent further damage.

By providing cessation support for people who smoke, improving access to primary care, and helping people to take their medication regularly, we expect that the rate of COPD hospitalisations for our population will decrease.

In Capital & Coast DHB, the COPD hospitalisation rate for Maori and Pacific is higher compared to Other ethnicities. However, the Māori COPD hospitalisation rate decreased in 2015.



Source: National Minimum Dataset, ICD codes J40-J44, 15+ year olds

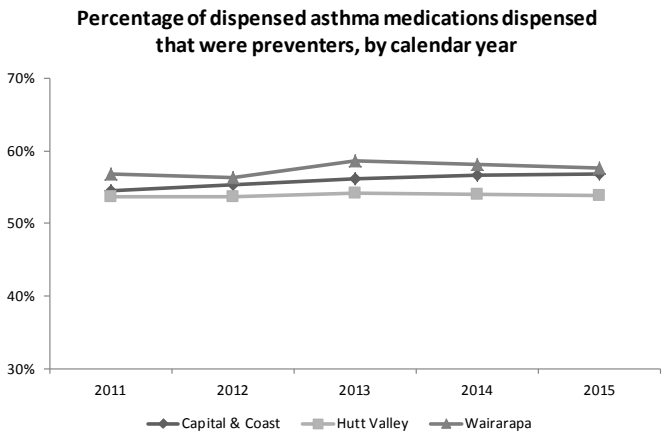
Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers.

Asthma occurs when a person's airways tighten and produce more mucous, making it difficult to breathe. It is often caused by pollen, cold air, or respiratory infections. People with on-going asthma generally use a preventer, which reduces the chance that their asthma will be triggered. They can also use a reliever, which they take to reduce their symptoms if they have trouble breathing.

If a person's asthma is well-managed, they should be using their preventer more frequently than their reliever.

A higher percentage of preventers dispensed indicates that asthma is being well-managed. By improving access to primary care, and supporting people to take their long term medications, we expect that people will use more preventers and less relievers.

In Capital & Coast DHB, the proportion of asthma medication dispensed which were preventers has increased to 57% over time.[10]



Source: Pharmaceutical Claims Data Mart

[10] Earlier figures published in the Annual Plan were based on an incorrect methodology supplied by HQSC. This figure presents revised calculations of the above impact measure.

OUTCOME 6: PEOPLE RECEIVE HIGH QUALITY HOSPITAL AND SPECIALIST HEALTH SERVICES WHEN THEY NEED THEM

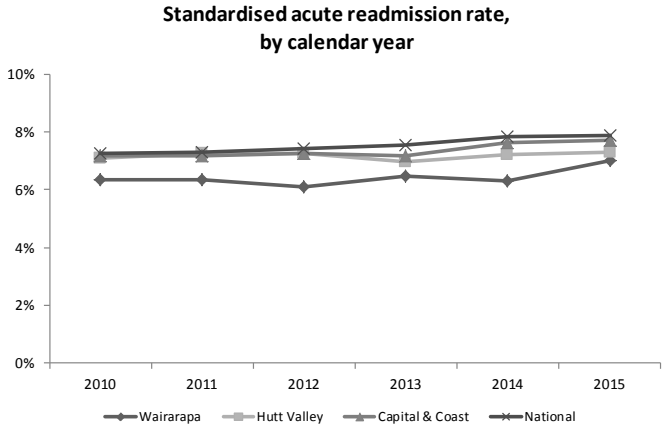
Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (i.e., removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e., major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services.

Impact measure: A reduction in the standardised[11] rate of acute readmissions to hospital within 28 days

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital.

The standardised acute readmission rate has remained at about 6.5% for Wairarapa and 7% for Hutt Valley and Capital & Coast over the last five years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased (see Section 3.3.3), which shows that the effectiveness and efficiency of treatment in hospital has improved.

Note that the methodology for this measure is being revised by Ministry of Health in 2015/16.



Source: Ministry of Health

[11] The standardised acute readmission rate accounts for casemix and population differences between DHBs, in order to improve the comparability of the measure across the sector. Refer to the Ministry of Health website (www.moh.govt.nz) for more information on how this measure is calculated.

Impact measure: Maintain or reduce the age-standardised[12] cancer mortality rate

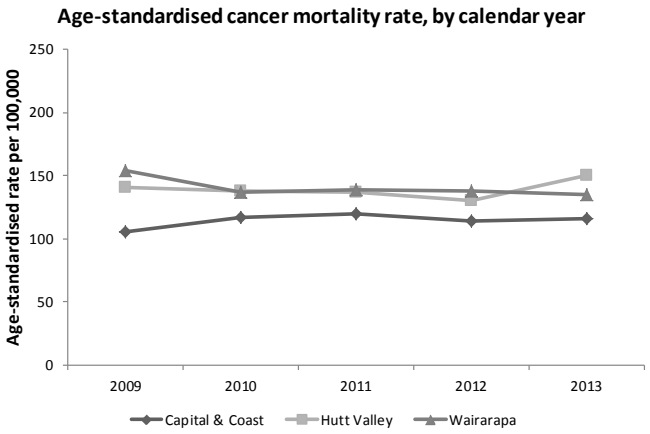
More people are developing cancer, mainly because the population is growing and getting older.

Many cancers can be cured if they're found and treated in time. It is estimated that in New Zealand, about one person in every three who gets cancer is cured.

By screening women for breast and cervical cancer, and providing timely cancer treatment, we expect that the cancer mortality rate will decrease.

In Capital & Coast DHB, the age-standardised cancer mortality rate was maintained during 2015.

The Ministry of Health's Mortality Collection data up to year end 2013 was released in June 2016.



Source: Ministry of Health Mortality dataset

[12] Age-standardisation accounts for differences in the age structure between populations and changes in the age structure over time. The age-standardised rate estimates what the rate would be if the age structures were the same. See also Section 3.2.2.

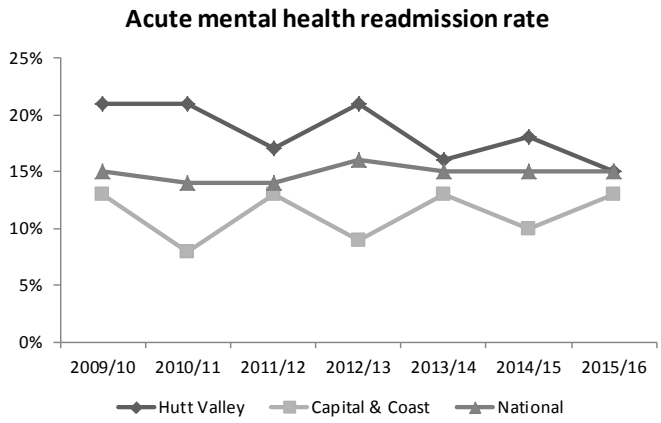
OUTCOME 7: PEOPLE RECEIVE HIGH QUALITY MENTAL HEALTH SERVICES WHEN THEY NEED THEM

Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act.

Impact measure: A reduction in the rate of acute readmissions to inpatient mental health services within 28 days

Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to support the person out of hospital. A decrease in the rate of acute mental health readmissions reflects good continuity of care across the health system.

In Capital & Coast DHB, the acute mental health readmission rate has increased from 2014/15. However, remained below the national rate.



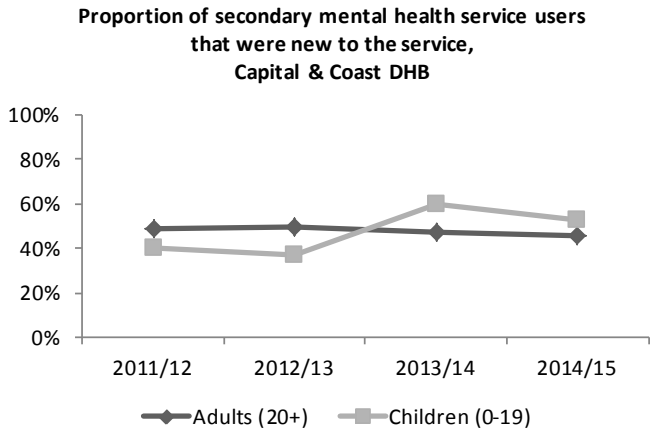
Source: Ministry of Health

Impact measure: An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years)

This measure indicates the responsiveness of secondary mental health services to people who require secondary mental health care for the first time.

By ensuring that existing users of secondary mental health services only receive these services for as long as they need them, we can increase our capacity and remove access barriers for new service users. As a result, we expect that the proportion of service users that are new will increase.

In Capital & Coast DHB, the proportion of children who are new users of secondary mental health has slightly decreased while the proportion of adults has remained comparatively stable.



Source: Ministry of Health

OUTCOME 8: RESPONSIVE HEALTH SERVICES FOR PEOPLE WITH DISABILITIES

Disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities. In 2013, an estimated 24% of people living in New Zealand were identified as disabled. National estimates by age and gender applied to the sub-region indicate a disabled population of approximately 109,000 people: 11,000 in Wairarapa (27%), 33,000 in Hutt Valley (24%) and 65,000 in CCDHB (23%). The DHB has a responsibility to provide responsive and appropriate health services to people with disabilities.

Impact measure: An increase in the proportion of patients and clinicians that found the Health Passport useful (as a percentage of patients and clinicians that responded to an evaluation survey and reported using the Health Passport) The Health Passport is a document that a person takes with them when they use medical services. The Health Passport contains information about the person that they would like hospital staff to know. For example, a Health Passport includes how a person would like to be communicated with, their medical conditions, what medications they are allergic to, and their religious/spiritual preferences. An increase in the proportion of people that find the Health Passport useful will indicate that the Health Passport is achieving its aims and improving the quality of care of patients when they are in hospital.	Measure to be developed

OUTCOME 9: IMPROVE THE HEALTH, WELL-BEING, AND INDEPENDENCE OF OUR REGION'S OLDER PEOPLE

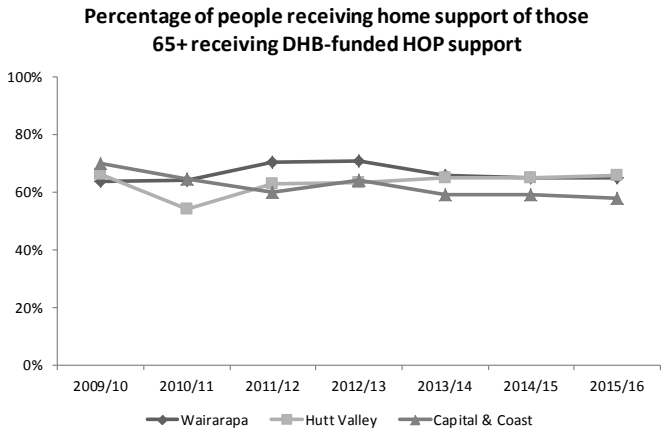
Our ageing population will increase pressure on the health system. National estimates suggest that the increase in health expectancy over the period 2006–2016 will be less than the corresponding increase in life expectancy. In other words, people will live longer, and they will live longer in good health, but they will also live longer in poor health, with multiple comorbidities, functional impairments and frailty. The DHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population.

Impact measure: Maintain or increase the proportion of patients receiving home based support services **(of those 65+ who receive DHB funded home based support or aged residential care services)**

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[13] found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy." This shows the importance of helping older people to maintain their independence.

By providing comprehensive and high-quality home-support services, we expect that there will be an increase in the proportion of people receiving home support rather than in residential care.

In Capital & Coast DHB, the proportion of patients receiving home based support services has been maintained.



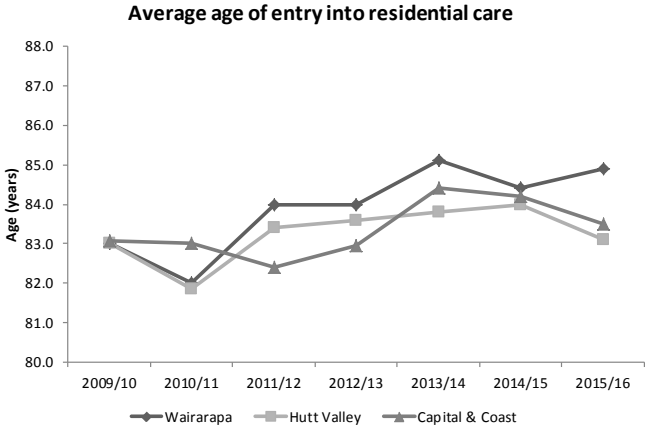
Source: Health of Older People regional benchmarking

[13] Hambleton, P., Keeling, S., & McKenzie, M. (2008). Quality of life is ... : The views of older recipients of low-level home support. *Social Policy Journal of New Zealand, 33*, 146-162.

Impact measure: Maintain or increase the average age of entry into residential care

An increase in the average age of entry into residential care would indicate that older people are remaining independent and staying at home for longer. By providing quality home support services to those who need them and high-quality and timely health services for older people to help them maintain their health, we expect that the average age of entry into residential care will increase.

In Capital & Coast DHB, the average age of entry into residential care is 83.5 years.



Source: Health of Older People regional benchmarking

STATEMENT OF PERFORMANCE

3.2.1 Types of Measures

Identifying appropriate measures for each output class is difficult as it is important to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time. Because of this complexity, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness. In addition, some of our performance measures look at the health of the people who live in our district (DHB of domicile view), while other performance measures relate to the performance of the services we provide, regardless of where people live (DHB of service view). When possible and relevant, we have also broken our performance down by ethnicity.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T
DHB of Domicile	DoD
DHB of Service	DoS

Ethnicity	Abbreviation
Māori	M
Pacific	P
Total (all ethnicities)	T

We have identified new measures in 2015/16 with a † symbol. These measures were introduced in the 2015/16 Annual Plan and did not appear in the 2014/15 Annual Report. Our 2014/15 performance has therefore not been audited by Audit New Zealand.

3.2.2 Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly. But, by standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

3.2.3 Targets and Estimates

Some of our performance measures are demand-based, and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our 2015/16 performance as the target (indicated with 'Est.'), based on historical and population trends.

Appropriation reporting

In thousands of New Zealand dollars

	2016 Actual	2016 Budget	2015 Actual
Appropriation revenue*	690,915	690,915	678,807

Refer to the statement of service performance on page 42.

*The appropriation revenue received by CCDHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

OUTPUTS BY CLASS

3.3.1 Output class: Prevention Services

Description

'Preventative' health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

Context

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. It has been estimated that 70% of health funding is spent on long-term conditions. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The majority of chronic conditions are preventable or could be better managed. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing.

These prevention services also support people to address any risk factors that contribute to both acute events (e.g., alcohol-related injury) and the development of long-term conditions (e.g., obesity

or diabetes). High health need and at-risk population groups (low socio-economic, Māori, and Pacific) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Health promotion and public health services: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices. Health promotion and public health services enable people to increase control over their health and its determinants, and thereby improve their health. A range of strategies are used, such as those as described by the Ottawa Charter: public policy, reorienting the health system, developing supportive environments, community action, and supporting individual personal skills. While health has a significant role here, some outcomes such as obesity require a joined-up approach to address the determinants of health, such as income, housing, food security, employment, and quality working conditions; our DHB and RPH work with other sectors (e.g. housing, justice, education) to enable this.

Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care, allied health and public health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process[14]: Ask all patients whether they smoke and document their response; if the patient smokes, provide brief advice to quit smoking; and if patient agrees, provide Cessation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

Screening services: encourage uptake of services predominately funded and provided through the National Screening Unit that help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

[14] ABC for Smoking Cessation Quick Reference Card, PHARMAC

How we measure performance of our Prevention Services:

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Public health protection and regulatory services	The number of disease notifications investigated in the sub-region[15]	V	1,955	Est. 1,797	1,692	Not achieved
	The number of environmental health investigations in the sub-region	V	562	Est. 684	988	Achieved
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	354	Est. 277	142	Not achieved
Health promotion and preventive intervention services	Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	V	29	Est. 25	30	Achieved
	The percentage of infants fully or exclusively breastfed at 3 months[†16]	C		≥60%	M: 51.2%	Not achieved
					P: 41.2%	Not achieved
					T: 62.5%	Achieved
	Number of new referrals to Public Health Nurses in primary/intermediate schools[17]	V, DoS	2014: 1,258	Est. Total 1,197	1,120	Not achieved

[15] This measure and the following 'Health promotion and preventive intervention services' measures are part of RPH's statutory activity and cover the sub-region (Wairarapa, Hutt Valley, and Capital & Coast DHBs).
[16] This measure is based on all WCTO providers (not just Plunket).
[17] This target is an estimated volume, rather than an aspirational target.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The number of adult referrals to the Green Prescription programme in the sub-region†	V, DoS		Est. 3,904	3,734	Not achieved
Immunisations Services	**Integrated Performance & Incentive Framework (IPIF) Health Start:** The percentage of two year olds fully immunised	C	94%	≥95%	M: 95%	Achieved
					P: 94%	Not achieved
					T: 95%	Achieved
	Health Target: The percentage of eight month olds fully vaccinated	C	95%	≥95%	93%	Not achieved
	The percentage of Yr 7 children provided Boosterix vaccination in the schools in the DHB[18]	C, DoS	2014: 70%	2015: ≥70% 2016: ≥70%	72%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	2014: 61%	≥65%[19]	72%	Achieved
Smoking cessation services	**Health Target:** The percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months[20]	C	New Methodology	≥90%	83%	Not achieved

[18] Targets and performance are for the calendar year to align with school year.
[19] Target aligned to national target.
[20] From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	87%	≥95%	M: 92%	Not achieved
					P: 92%	Not achieved
					T: 92%	Not achieved
	Health Target: The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking[†]	C, DoS		≥90%	97%	Achieved
Screening services	The percentage of eligible children receiving a B4 School Check	C	High dep[21]: 87%	≥90%	High dep: 91%	Achieved
			T:85%		T: 90%	Achieved
	IPIF Health Adult: The percentage of eligible women (25-69 yrs) having cervical screening in the last 3 years	C	M: 63%	≥80%	M: 64%[22]	Not achieved
			P: 66%		P: 67%	Not achieved
			T: 80%		T: 80%	Achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 64%	≥70%	M: 64%[23]	Not achieved
			P: 64%		P:64%	Not achieved
			T:70%		T: 68%	Not achieved

[21] 'High dep' refers to children living in high deprivation areas: See Atkinson, J., Salmond, S., & Crampton, P. (2014). *NZDep2013 Index of Deprivation*, Wellington: Department of Public Health, University of Otago.

[22] Data from National Screening Unit. Note that coverage rates in 2013/14 are based on population projections derived from Census 2006, whilst rates in 2014/15 are based on population projections derived from Census 2013.

[23] Data from National Screening Unit. Note that coverage rates in 2013/14 are based on population projections derived from Census 2006, whilst rates in 2014/15 are based on population projections derived from Census 2013.

COMMENTARY

Public health protection and regulatory services

The target for the number of disease notifications investigated in the sub-region is an estimate based on the two previous year's disease notification/investigation data (across Wairarapa, Hutt Valley and Capital & Coast DHBs). For the 2015/2016 year, there was a decrease in the number of notified communicable diseases (1,692) based on the number of investigations in the previous year. The primary purpose of notification is to trigger an appropriate public health response to prevent further illness. The secondary purpose is for disease surveillance; to predict, observe and minimise the harm caused by an outbreak or epidemic/pandemic situation.

This year, fewer control purchase operations were conducted principally to reduce the financial cost of conducting control purchase operations outside of normal business hours.

Health promotion and preventive intervention services

In the sub-region, the Capital & Coast DHB Public Health Nurse (PHN) new referrals target was achieved. However, this target does not include the throat swabbing work the PHNs in Porirua undertake. Some of the throat swabbing work had been moved to community health workers (CHWs) and this reverted back to PHNs when the CHWs resigned and we knew the programme was ending on 30 June 2016. The PHNs in Porirua have also carried out the supply of antibiotics for GAS+ patients; this does not occur in Hutt Valley and Wairarapa DHBs.

The Community Breastfeeding Team is made up of the Community Lactation Coordinator (CLC) and the Pacific Breastfeeding Service. The team has been working to improve breastfeeding outcomes for priority groups by:

- Continuing a working relationship with Ora Toa (Takapuwahia) Tamariki Ora team at the Breastfeeding Centre
- Encouraging referrals from CMS Lactation Maori and Pacific
- Prioritising home visiting for priority groups

The Green Prescription referral target was increased by approximately 25% from the 2014/15 year and 96% of the new referral target was achieved. Increased promotion of the GRx programme is indicated. Within this sub-regional result, 91% (453/500) of the GRxPlus referral target for the year was achieved.

Smoking Cessation Support

PHO performance towards achieving the primary care Health Target reflects Compass Health PHO performing at an average of 82% throughout the year and Cosine maintaining an 89% result. Ora Toa and Well Health PHOs improved from low points to 89% and 88%, respectively. The introduction of the Health Care Homes project possibly incentivised the improvement.

Recent analysis related to the percentage of hospitalised smokers receiving advice and help to quit for the secondary has led to focusing on high patient turn over services, such as the emergency department and Short Stay Unit to improve performance.

Screening services

For the Before School Check target, both targets were achieved in the final quarter of the year.areas seen was exceeded resulting in the target being met early in June. Extra clinics, a great team effort and some new initiatives have allowed the targets to be achieved after a deficit earlier in the year.

There has been increased engagement with some PHOs leading to an MOU with Well Health in Porirua. This will hopefully lead to more vulnerable children being seen in the future.

Immunisation services

Due to the need to review the new model of care since its implementation (August 2015), coupled with a need to understand why immunisation rates had dropped, Capital & Coast DHB and Compass Health hosted a value stream mapping workshop on July 4th 2016. Service providers and stakeholders were invited to participate. The group mapped the current model of service delivery, enabling group discussion and learning between the various providers. Flowcharts and diagrams of the immunisation services (as provided by the Ministry) provided in Canterbury, Auckland and Northland were also discussed.

Through the mapping process, three main areas were identified as barriers for achieving the immunisation target. Three groups were subsequently formed and were tasked to define the problems and to provide a number of achievable actions. These actions are currently being implemented and the immunisation rate was back to 94% for Capital & Coast DHB in July.

Coverage for the 8 month immunisation target is the same as for last quarter, at 93% for the total population in the birth cohort and Pacific, and increased for Māori children from 87% to 91%.

3.3.2 Output Class: Early Detection & Management Services

Description

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations.

Context

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For our DHB, diabetes, COPD, asthma, and chronic respiratory conditions are significant long-term conditions that are prevalent in our population. Early detection and management services based in the community deliver earlier identification of risk, provide opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.

Oral health services: are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Primary care services	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	281,844	≥ 95%	93%	Not achieved
	The rate ratio of nurse and GP visits by high need patients versus non high need patients[24]	C, DoS	1.12	≥ 1.14	1.12	Not achieved
	The percentage of practices with a current Diabetes Practice Population Plan[†]	Q, DoS		100%	100%	Achieved
	Health Target: The percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	89%	≥ 90%	91%	Achieved

[24] The ratio (high need: non high need) of standardised GP and nurse utilisation rate. This measures equity of access, as those with high needs are likely to require more visits.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The number of new and localised Health Pathways in the sub-region†	Q		≥ 150	172	Achieved
	The average number of users (per month) of the Health Pathways website†	V		≥ 1,000	1,375	Achieved
Oral health services Immunisations Services	The percentage of children under 5 years enrolled in DHB-funded dental services[25]	C, DoD	2014: 59%	2015: ≥ 85% 2016: ≥ 85%	2015: 95%	Achieved
	The percentage of adolescents accessing DHB-funded dental services	C, DoD	2014: 74%	2015: ≥ 85% 2016: ≥ 85%	2015: 77%	Not achieved
Pharmacy services	The number of initial prescription items dispensed†	V, DoS		Est. 2,356,000	2,432,210	Achieved

[25] As oral health measures are reported on a calendar year the Ministry of Health requests targets be specified for each year.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item†	C, DoD		Est. 76%	78%	Achieved
	The number of people registered with a Long Term Conditions programme in a pharmacy†	V, DoS		Est. 6,600	6,092	Not achieved
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy†	V, DoS		Est. 200	224	Achieved

COMMENTARY

Primary care services

The DHB has identified the youth population as an area where non enrolment is an issue. Discussions about how best to get young people enrolled have been undertaken with the youth providers in the region.

During 2015/16, the DHB and the PHOs implemented the Health Care Home Initiative. This initiative aims to improve acute, proactive and preventative care. The Health Care Home initiative will build primary care sustainability and strengthen integration of community services and primary care. It is a key building block to more services being delivered closer to home, more proactive care, improved self-care, improved patient experience and allowing hospitals to better focus on providing episodic care to complex clients. The high level aims of the initiative are:

- Increased capacity in general practice teams
- Targeted additional support for people with greatest social, clinical or physical needs
- Proactively planned care over extended time frames – “a year of care”
- Reduced demand on hospital care for unplanned or low acuity care by ensuring more time and access is available in community settings to manage acute illness
- Maximised use of technology to deliver multidisciplinary and multi-sector support to patients
- Health and social care provision integrated around the individual patient and family/whānau needs
- Expanded core teams –including Primary Care Assistants, Nurse Practitioners, Clinical Pharmacists, Social Workers and Mobile Nurses.

All general practices in Capital & Coast DHB have implemented diabetes care improvement plans. These plans are developed and implemented by general practices to provide quality care and management for enrolled patients with diabetes. The plans have all been reviewed and approved during the year by the PHOs.

The DHB has exceeded the *More heart and diabetes checks* Health Target. The PHOs have continued to support general practices to achieve this target by providing feedback on performance and IT support to ensure that all eligible individuals are encouraged to get a CVD check when due.

To achieve the Health Pathways target, there have been more established pathway localisation and development processes, as well as a continued expanding network of engaged collaborators across primary and secondary care which have contributed to exceeding the target.

Based on achieving the average number of users (per month) of the Health Pathways website, and although not formally assessed, the assumption is that the information offered by Health Pathways meets the needs of primary care practitioners and that their use help clinicians be more effective during consultations and when making referrals.

Oral health services

The 5 year old enrolment target for dental services was reached by working in collaboration with PHOs to identify children not enrolled in the dental service and providing the ability for families to ‘opt out’ of the service. If no ‘opt out’ the preschool children are enrolled in the service.

Over 97% of year 8 students were transferred by the DHB to the dentists who hold the combined adolescent contract. There is no audit process in place to measure if individual dentists are doing all they can to examine the children referred to them.

The service’s Adolescent Coordinator is actively working with adolescents in the Porirua area to promote dental care and increase the number of adolescents accessing DHB funded dental services.

Pharmacy Services

The number of people registered with a Long Term Conditions programme in a Capital & Coast DHB pharmacy reflects a national trend. Improved access to primary and secondary care information

about patient conditions will enable pharmacies to more easily assess risk and select patient needing the higher level of care that this service would provide.

There has been a steady uptake in the number of people participating in the Community Pharmacy Anticoagulant Management (CPAM) service and some pharmacies are now at their maximum contracted volume. The DHB continues to encourage pharmacies to work with GPs to carefully select the patients who will benefit most from this higher cost service. Some pharmacies are at their maximum contracted volume. The DHB continues to encourage pharmacies to work with GPs to carefully select the patients who will benefit most from this higher cost service.

3.3.3 Output Class: Intensive Assessment & Treatment Services

Description

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals in a hospital setting. Hospitals often provide these services because clinical expertise (across a range of areas) and specialist equipment need to be located in the same place. These services include inpatient, outpatient, emergency and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population. Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals, and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Context

Equitable and timely access to intensive assessment and treatment can significantly improve a person's quality of life, either through early intervention (i.e., removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e., major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

Medical and surgical services: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service; addressing increasing needs and matching commitments to capacity.

Cancer services: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

Mental health and addictions services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we measure performance of our Intensive Assessment & Treatment Services

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T, DoS	91%	≥ 95%	91%	Not achieved
	Health Target: The number of surgical elective discharges	V, DoD	8,969	≥ 10,439	10,864	Achieved
	The standardised[26] inpatient average length of stay (ALOS) in days, Acute[27]	T, DoS	3.49	≤ 2.41	2.36	Achieved
	The standardised inpatient average length of stay (ALOS) in days, Elective	T, DoS	3.12	≤ 1.59	1.58	Achieved

[26] Standardised to diagnosis-related group (DRG) and co-morbidity/complication codes. See the Ministry of Health website (www.moh.govt.nz) for more information about how this is calculated.

[27] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2015 (2015/16 baseline) and 12 months ending March 2016 (2015/16 performance).

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	1.10	< 1.2	1.3	Not achieved
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	71[28]	< 0.5	0.8	Not achieved
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	0.94	< 0.2	0.1	Achieved
	The weighted average score in the Patient Experience Survey[29†]	Q, DoS		> 8.0	Communication: 8.4 Partnership: 8.4 Co-ordination 8.7 Phys. & Emotional Needs: 8.7	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	5%	≤ 6.0%	5%	Achieved

[28] This measure was not reported as a rate per 1,000 in the previous annual report.

[29] In this measure, patients rate aspects of their hospital visit, with 10 being the best possible score. A person's age and gender affects how they respond in the Patient Experience Survey. The weighted score accounts for differences in the age and gender structure between DHBs to allow comparison.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments[†]	Q, DoS		≤ 6.0%	7.4%	Not achieved
Cancer services	The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	T, DoD	100%	100%	100%	Achieved
	Health Target: The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred[30]	T, DoD	81%	≥ 85%	83%	Not achieved
Mental health and addiction	The number of people accessing secondary	V	M: 2,118	Est. Total 9,940	M: 2,039	-
			P: 749		P: 707	-

[30] This is a new measure that replaced the 'Shorter Waits for Cancer Treatment' Health Target from 1 October 2014.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
services	mental health services		T: 9,995		T: 9,950	Achieved
	The percentage of people accessing secondary mental health services†	C		≥ 3.3%	3.28%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks[31]	T, DoS	86%	≥ 95%	61%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	55%	≥ 95%	91%	Not achieved

[31] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2015 (2015/16 baseline) and 12 months ending March 2016 (2015/16 performance).

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission	Q, DoS	54%	≥ 95%	61%	Not achieved
	The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge	Q, DoS	59%	≥ 95%	91%	Not achieved

COMMENTARY

Hospital services

Capital & Coast DHB did not achieve the shorter stays in emergency departments Health Target in 2015/16. This is despite a range of service improvements, reducing length of stay and reducing use of acute bed days. The target was consistently met for patients who were not admitted. The number of patients requiring admission increased, and high occupancy across the hospital (above 95%) had a significant impact on our acute flow. When occupancy is lower we can achieve patient flow out of ED. Increasing demand across all of our services continues to impact on capacity and therefore flow. Additional beds planned for 2016 will have an impact on overall capacity. Work continues to improve the models of care in acute and planned services to reduce overall occupancy and improve flow.

Over the past year, DNA rates for Māori and Pacific have increased. This has impacted on the DNA rate for follow ups. The DHB is working with primary care to target GP practices and families where DNA rates are high to address issues contributing to DNAs. The follow up practice and review of this is a priority for next year.

Work is on-going to achieve the target including:

- Regular meetings to discuss turnaround times for diagnostics bookings/requests and reports
- Meeting with specialist teams to review referral triaging times and processes
- Meeting with specialist teams to review cancer patient pathways and highlight delays
- Working with ICT to design IT solutions to flag FCT patients in triaging queues and facilitate prospective tracking of cancer patients
- Sending breach emails to all services quarterly for comment and suggestions
- Quarterly meetings with Hutt Valley and Wairarapa DHB staff to review breaches.

Hospital Quality

Since the establishment of the Falls Prevention Group and Programme, the Care Process Audits has driven improvement in falls risk and individualised care planning and ownership by areas with Programme overview and support. While we have missed the 2015/16 annual target (<1.2 and achieved 1.3) this is a significant reduction from 2014/15 performance of 1.10.

The Programme enables areas to address specific patient population challenges and improvement focus (e.g. Working with Mental Health and Health of Older People to target approaches). The co-design approach with patients/families in Health of Older People areas has also informed new approaches to working with confused patients, patients with dementia and delirium care needs. In-service sessions focus on areas for data and improvement opportunities. The next step is to introduce a revised Falls Incident Safety Huddle to promote a patient/family and multidisciplinary team review across all services.

In 2015/16, Capital & Coast DHB had 118 actual hospital acquired pressure injuries compared to 71 in 2014/15. One hundred of these were minor/minima and the rate of moderate pressure injuries has not increased since 2014/15. This data is collected from reportable events and we have encouraged better reporting of pressure injuries. Since the DHB's new reportable events system

introduced in April 2016, we are now able to track the grade of pressure injuries. The Pressure Injury Prevention Management (PIPM) Programme has evolved and gained momentum by developing resources and an improvement focus aligned through the PIPM Care Process Audits. These audits move from understanding harm to supporting practice development/improvement consistently. This is reinforced by real time learning addressing missed care at time of audits, follow-up with areas and shared learning across areas. Triangulation of reportable events, coding and ACC data ensures we have an understanding of the pressure injury harm and are driving an improved PIPM approach. We have recently started collecting regular prevalence data and since September 2015, PIPM Care Process audits are conducted monthly. ACC, Health Quality & Safety Commission and Ministry of Health attended the PI Creating Momentum Series hosted by Capital & Coast DHB. The DHB has also presented at three national pressure injury forums.

A six monthly care process medication audit has been introduced that looks at allergy, prescription, administration and discontinued medication status. Results are presented to the Medicines Committee and recommendations from audit results are actioned. There has been focussed improvement work on reducing preventable hypoglycaemic events, opioid related constipation harm, and the introduction of a specific warfarin chart. The DHB's antimicrobial stewardship programme improves antibiotic use through coordinated interventions. In 2016/17, we are focussed on improving the documentation of any change in medications on inpatients discharge summaries to reduce time taken to reconcile these medications by our elderly care facilities, and informing GPs of new medicines and any other medical interventions.

As of August 2014, the Health Quality & Safety Commission has facilitated a quarterly national adult patient experience survey (adult inpatient's over 15 years of age and excludes Mental Health & Te Mahoe). This is based on four domains: communication, partnership, coordination, and needs (physical and emotional). The DHB has exceeded the target of >8.0 in all four domains. We are also one of the few DHBs to be able to distribute this survey 100% via email. Our response rate (31%) exceeds the national average (29%). We have identified that the lowest scoring question in the national survey correlated with a similar question in the DHBs monthly survey regarding patients understanding of the side effects of discharge medications. In partnership with the Health Quality & Safety Commission, Capital & Coast DHB commenced an improvement project focussed on improving patients understanding of the side effects of their discharge medications.

Mental Health

Capital & Coast DHB met the target percentage of people accessing secondary mental health services. Increased access occurred for the 20-64 years and 65+ year population groups.

The DHB has not achieved the 95% target for non-urgent cases (children and adolescents) to be seen within 8 weeks. A number of factors contribute to this outcome.

- High demand for services with peaks in quarters 3 & 4 impacting on overall performance. Services were provided to 3.7% of target population.
- Workforce: Recruitment and retention to our Maori and Pasifika Services has been problematic and has led to long term vacancies impacting on service provision.
- 20-30% of Child and Adolescent Mental Health Service's (CAMHS) new intake received urgent appointments within one week of referral.

- Mitigations

Capital & Coast DHB has increased performance through:

- Provision of 5% more Choice appointments in 2015/16.
- Reviewed intake processes to Maori and Pasifika CAMHS to increase access for these population groups.
- Undertaken proactive recruitment including from overseas.
- A shift for some acute/urgent treatment for Children and Youth to generic Crisis Services from end of 2016.
- Actively working with primary care providers to support their treatment of young people with moderate MH presentations.

Capital & Coast DHB funds non-government organisations (NGOs) to deliver non-urgent child & adolescent addictions services. Data issues have been identified during 2015/16. Capital & Coast DHB is working with the Ministry of Health and NGOs to rectify data issues reported in 2015/16.

Due to the data lag in PRIMHD, it will take some time for any changes to take effect.

3.3.4 Output Class: Rehabilitation & Support Services

How we measure performance of our Rehabilitation & Support Services

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Disability services	The number of Disability Forums	V	4	CCDHB: 1 3DHB: 1	CCDHB: 2[32] 3DHB: 1	Achieved
	The number of sub-regional Disability Newsletters†	V		6	8[33]	Achieved
	The total number of hospital staff that have completed the Disability Responsiveness eLearning Module†	Q		550	547	Not achieved
	The total number of Disability Alert registrations†[34]	Q		5,190	5,530	Achieved
Health of older people services	The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	C, DoS	100%	100%	100%	Achieved

[32] Forums included Capital Support Forums

[33] The form of communication has changed and is equivalent to a newsletter

[34] It is estimated that 23% of the DHB's population has a disability. Disability Alerts help clinicians to identify and respond to the needs of the patients with disabilities. By increasing the number of Disability Alerts, we can improve the quality of care for our patients with disabilities. In addition, Disability Alerts allow us to track outcomes (e.g., length of stay) for patients with disabilities so that we can identify areas in which we need to focus or improve.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The total number of InterRAI assessments	V, DoS	3,163	Est. 6,043[35]	4,891[36]	Not achieved
	The number of people 65+ who are being supported to live at home	V, DoS	2,208[37]	Est. 2,232[38]	2,253	Achieved
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	C, DoS	59%[37]	≥ 59%	58%	Not achieved
	The number of subsidised aged residential care bed days[39]	V, DoS	564,146	Est. 560,627[40]	590,071	Achieved
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	94%	≥ 95%	97%	Achieved

[35] This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.
[36] Note that there have been changes in the recording and reporting of the number of InterRAI assessments. The methodology for 2014/15 gives an underestimate of performance compared to the methodology for the target.
[37] Snapshot as at last fortnight in June 2015

[38] This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.
[39] Subsidised bed days are any DHB-funded bed days including top-up clients and people paying less than the maximum client contribution.
[40] This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.

COMMENTARY

Health of older people services

The 100% target for the percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan continues to be achieved.

The total number of InterRAI assessments is a descriptive measure of volumes only and is not the focus for service improvement or improving health status. The DHB is satisfied that all people being referred for an interRAI assessments are receiving them and that these assessments are informing their care plans.

The 2015/16 result shows, the total assessments done in 2015/16 in the national interRAI data warehouse. These include RAI-HC & Contact assessments, created in each DHB's office including assessments transferred out of office. The result for 2015/16 is lower than the target because the method of measuring the number of assessments also included reviews and reassessments which are not recorded in the national data warehouse.

There are increased numbers of older people who are being supported to live at home. Although, more older people are being supported to live at home, they do not account for an increased percentage of all older people receiving DHB funded support. More have also been supported in residential care.

The percentage of residential care providers meeting three or more year certification standards is a strong reflection of quality in aged residential care as assessed against the Health and Disability Services Standards.

Disability services

Due to change in eLearning provider, there is no data available between 04/04/2015 – 1/09/2015, which has impacted the total number of hospital staff that have completed the Disability Responsiveness eLearning Module being reported.

STATEMENT OF RESPONSIBILITY

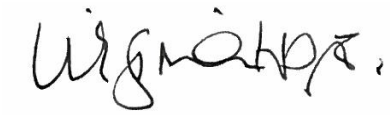
For the year ended 30 June 2016:

In terms of the Crown Entities Act 2004, the Board and Management of Capital & Coast District Health Board accepts responsibility for the preparation of the annual Financial Statements and the Statement of Performance and the judgements used in them.

The Board and Management of Capital & Coast District Health Board are responsible for any end-of-year performance information provided by Crown Service Enterprise under Section 19A of the Public Finance Act 1989.

The Board and Management of Capital & Coast District Health Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non financial reporting.

In the opinion of the Board and Management of Capital & Coast District Health Board, the annual Financial Statements and the Statement of Performance for the year ended 30 June 2016, fairly reflect the financial position and operations of Capital & Coast District Health Board.



Dr Virginia Hope MNZM - Board Chair
31 October 2016

Debbie Chin - Chief Executive
31 October 2016

Roger Jarrold - Finance, Risk and Audit Committee Chair
31 October 2016

Tony Hickmott - Chief Financial Officer
31 October 2016

INDEPENDENT AUDITOR'S REPORT

To the readers of Capital and Coast District Health Board's financial statements and performance information for the year ended 30 June 2016.

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

We have audited:

- the financial statements of the Health Board on pages 72-117,that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board on pages 16-66.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 72-117:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year

In respect of the 30 June 2015 comparative information only, some significant performance measures of the Health Board, (including some of the national health targets), relied on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2015 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2016 year, however, the limitation cannot be resolved for the 30 June 2015 year, which means that the Health Board's performance information reported in the statement of performance for the 30 June 2016 year, may not be directly comparable to the 30 June 2015 performance information.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on 16-66:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed 31 October 2016. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Standards;
- present fairly the Health Board's financial position, financial performance and cash flows; and
- present fairly the Health Board's performance.

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2016

in thousands of New Zealand Dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Revenue	1	1,023,843	1,002,941	996,227
Total revenue		**1,023,843**	**1,002,941**	**996,227**
Expenditure				
Clinical supplies		108,319	98,073	112,656
Employee benefit costs	2	433,887	426,632	413,360
Infrastructure and non-clinical expenses		54,303	47,883	52,754
Other operating expenses	3	4,534	4,297	4,137
Outsourced services		37,545	32,352	29,060
Payments to other district health boards		81,507	71,348	67,682
Payments to non-health board providers		257,762	262,675	258,256
Capital charge	4	8,086	8,483	8,382
Finance costs	5	14,141	14,187	16,147
Depreciation and amortisation expense	6,7	35,677	35,570	37,775
Total expenditure		**1,035,761**	**1,001,501**	**1,000,209**
Surplus/(deficit)		**(11,918)**	**1,440**	**(3,982)**
Other comprehensive revenue and expense		-	-	-
Total comprehensive revenue and expense		**(11,918)**	**1,440**	**(3,982)**

The accompanying statement of accounting policies and notes form part of these financial statements.
Explanations of significant variances against budget are detailed in note 25.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2016

in thousands of New Zealand Dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Balance at 1 July		113,299	108,566	115,165
Total comprehensive revenue and expense for the year		(11,918)	1,440	(3,982)
Owner transactions				
Contribution from the Crown		5,600	5,600	5,600
Repayment of equity		(3,484)	(3,485)	(3,484)
Balance at 30 June	19	**103,497**	**112,121**	**113,299**

The accompanying statement of accounting policies and notes form part of these financial statements.
Explanations of significant variances against budget are detailed in note 25.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2016

in thousands of New Zealand Dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Assets				
Current assets				
Cash and cash equivalents	12	12,868	32,679	19,101
Trade and other receivables	11	46,540	45,470	45,858
Inventories	8	7,345	7,471	7,472
Trust and special funds	13	7,232	7,619	7,619
Total current assets		**73,985**	**93,239**	**80,050**
Non-current assets				
Property, plant and equipment	6	479,507	479,025	488,857
Intangible assets	7	27,035	20,441	22,302
Investments in joint ventures	9	-	-	-
Investments in associates	10	1,150	-	-
Total non-current assets		**507,692**	**499,466**	**511,159**
Total assets		**581,677**	**592,705**	**591,209**
Equity				
Crown equity	19	424,919	425,094	422,803
Revaluation reserve	19	23,606	23,606	23,606
Accumulated comprehensive revenue and expense	19	(345,028)	(331,690)	(333,110)
Total equity		**103,497**	**117,010**	**113,299**
Liabilities				
Current liabilities				
Trade and other payables	17	71,660	63,266	68,153
Borrowings	14	62,326	34,326	34,326
Employee entitlements	15	59,783	63,202	61,356
Provisions	16	614	2,418	363
Patient and restricted funds	18	175	-	157
Total current liabilities		**194,558**	**163,212**	**164,355**
Non-current liabilities				
Borrowings	14	277,628	305,954	305,954
Employee entitlements	15	5,765	6,236	7,309
Provisions	16	229	292	292
Total non-current liabilities		**283,622**	**312,482**	**313,555**
Total liabilities		**478,180**	**475,694**	**477,910**
Total equity and liabilities		**581,677**	**592,705**	**591,209**

The accompanying statement of accounting policies and notes form part of these financial statements.
Explanations of significant variances against budget are detailed in note 25.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2016

in thousands of New Zealand Dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		999,240	983,282	978,390
Other receipts		18,874	14,484	17,752
Cash paid to suppliers		(542,520)	(517,464)	(538,659)
Cash paid to employees		(435,099)	(425,237)	(411,340)
Cash generated from operations		**40,495**	**55,065**	**46,143**
Goods and services tax and other taxes (net) (a)		1,327	2,161	2,374
Capital charge paid		(8,086)	(8,381)	(12,579)
Net cash flows from operating activities	12	**33,736**	**48,845**	**35,938**
Cash flows from investing activities				
Interest received		2,043	1,860	2,167
Acquisition of property, plant and equipment		(21,426)	(13,000)	(9,644)
Acquisition of intangible assets		(7,402)	(12,000)	(6,309)
Investment in joint venture		(1,150)	-	-
Appropriation from trust and special funds (b)		406	-	(521)
Net cash flows from investing activities		**(27,529)**	**(23,140)**	**(14,307)**
Cash flows from financing activities				
Contribution from the Crown		5,600	5,600	5,600
Borrowings raised		-	-	-
Repayment of borrowings		(326)	-	(84)
Repayment of equity		(3,484)	(3,485)	(3,484)
Repayment of finance leases		-	-	9
Interest paid		(14,230)	(14,242)	(16,668)
Net cash flows from financing activities		**(12,440)**	**(12,127)**	**(14,627)**
Net increase/(decrease) in cash and cash equivalents		(6,233)	13,578	7,004
Cash and cash equivalents at beginning of year		19,101	19,101	12,097
Cash and cash equivalents at end of year	12	**12,868**	**32,679**	**19,101**

(a) The goods and services tax (net) component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The goods and services tax component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial reporting purposes.

(b) Appropriation from trust and special funds in investing activities reflects the net of trust and special fund revenue received and expenses paid during the year.

The accompanying statement of accounting policies and notes form part of these financial statements.
Explanations of significant variances against budget are detailed in note 25.

STATEMENT OF CONTINGENT LIABILITIES AND ASSETS

As at 30 June 2016

in thousands of New Zealand Dollars

	Note	2016 Actual	2015 Actual
Legal proceedings against the DHB		200	230
Other contractual matters		910	474
		1,110	**704**

The DHB has been notified of 12 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2016 (2015: 16). The claims are both patient and employment related. The DHB is contesting the claims, and whilst there is an element of uncertainty as to what the courts may award, the DHB believes that any damages awarded in relation to patient claims will be met by its insurers.

Recently the private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. The government has also announced a payroll inconsistency that has left thousands of state sector workers underpaid. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting & analytics, people and processes. Since the issues are currently being reviewed an unquantified contingent liability has been disclosed.

The Wellington Regional Hospital domestic hot and cold water systems are exhibiting signs of failure due to corrosion in the copper pipes, and this is causing leaks throughout the building. The issues are currently being investigated, and the total cost of repairing the pipes cannot be quantified at this time.

Legal proceedings have been commenced against the head contractor that constructed the building, the copper pipe manufacturer and the designer. The claim has not been quantified while the issues are being investigated, so we are unable to give any estimate of the maximum financial exposure or likely financial settlement at this stage.

STATEMENT OF COMMITMENTS

As at 30 June 2016

in thousands of New Zealand Dollars

	Note	2016 Actual	2015 Actual
Buildings		6,668	13,933
Leasehold improvements		-	306
Plant & equipment		4,576	1,302
Intangible assets		1,464	688
Capital commitments		**12,708**	**16,229**
Non-cancellable commitments – operating lease commitments			
Not more than one year		2,841	2,340
One to two years		2,301	1,728
Two to five years		1,591	1,771
Over five years		28	785
		6,761	**6,624**

The accompanying statement of accounting policies and notes form part of these financial statements.

Statement of Accounting Policies

Reporting entity
Capital & Coast District Health Board (DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. The DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, and the Crown Entities Act 2004.

The primary objective of the DHB is to provide goods or services for the community or social benefit rather than making a financial return. Accordingly, the DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

Statement of compliance
The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes a requirement of compliance with New Zealand Generally Accepted Accounting Practice (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

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

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted
In 2015, the External Reporting Board issued Disclosure Initiative (Amendments to PBE IPSAS 1), 2015 Omnibus Amendments to PBE Standards, and Amendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. The DHB will apply these amendments in preparing its 30 June 2017 financial statements. The DHB expects there will be no effect in applying these amendments.

Basis of preparation
The financial statements for the year ended 30 June 2016 were approved by the Board on 28 October 2016.

The financial statements have been prepared for the period 1 July 2015 to 30 June 2016. Comparative figures and balances relate to the period 1 July 2014 to 30 June 2015.

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand.

The financial statements are prepared on the historical cost basis except where modified by the revaluation of certain items of land, buildings and the measurement of equity instruments and derivative financial instruments at fair value.

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

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

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

Statement of Going Concern
The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2015/16 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort
The Board has received a letter of comfort, dated 26 September 2016 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Capital injection of $5.6m was received during the current financial year.

Operating and cash flow forecasts
The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements
The forecast for the next year prepared by the DHB shows that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

While the Board is confident in the ability of the DHB to continue as a going concern, if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether the DHB would be able to continue as a going concern based on current trading terms and legislative requirements.

If the DHB was unable to continue as a going concern, adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Joint ventures
Joint ventures are those entities over whose activities the DHB has joint control, established by contractual agreement.

The DHB has a 16.7% shareholding in a joint venture, Central Region Technical Advisory Services Limited (CRTAS) and participates in its commercial and financial policy decisions. CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region.

The results of the joint venture company have not been included in the financial statements as they are not considered significant.

Associates
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 DHB has a 19% interest in an associate entity, Allied Laundry Services Limited. The principal activity of the associate is the provision of laundry services. There are no significant restrictions on the ability of the associate to transfer funds to the DHB in the form of cash dividends.

The results of the associate company have not been included in the financial statements as they are not considered significant.

Foreign currency
Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Foreign exchange differences arising on translation are recognised in the statement of comprehensive revenue and

expense. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date.

Budget figures
The budget figures are those approved by the DHB in its District Annual Plan and included in the Statement of Intent tabled in Parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with PBE Standards and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by the DHB for the preparation of these financial statements.

Property, plant and equipment
Classes of property, plant and equipment
The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- leasehold improvements
- plant and equipment
- furniture and fittings
- work in progress

Owned assets
Except for land and buildings assets are stated at cost less accumulated depreciation and impairment losses.

Land and buildings are valued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive revenue and expense.

Addition to property, plant and equipment
Additions to property, plant and equipment are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Disposal of property, plant and equipment
Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive revenue and expense is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets
Finance Leases
Leases where the DHB assumes substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred, are classified as finance leases. At the commencement of the lease term, the DHB recognises finance leases as assets and liabilities in the statement of financial position at the lower of their fair value or the present value of the minimum lease payments. The amount recognised as an asset is depreciated over its useful life. If there is uncertainty as to whether the DHB will obtain ownership of the asset at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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

Subsequent costs
Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is

incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to the DHB. All other costs are recognised in the statement of comprehensive revenue and expense as an expense as incurred.

Depreciation
Depreciation is charged to the statement of comprehensive revenue and expense using the straight line method. Land is not depreciated.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life
• freehold buildings	1 to 60 years
• leasehold improvements	1 to 5 years
• plant and equipment	1 to 25 years
• furniture and fittings	1 to 15 years

The residual value of assets is reassessed annually.

Leasehold improvements are depreciated over their lease term.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets
Research and development
Expenditure on research activities, undertaken with the prospect of gaining new scientific or technical knowledge and understanding, is recognised in the statement of comprehensive revenue and expense as an expense as incurred. Other development expenditure is recognised in the statement of comprehensive revenue and expense as an expense as incurred.

Other intangibles
Other intangible assets that are acquired by the DHB are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure
Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation
Amortisation is charged to the statement of comprehensive revenue and expense on a straight-line basis over the estimated useful lives of intangible assets. Intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life
Software	3 years
Licences	5 years

Financial instruments

Non-derivative financial instruments
Non-derivative financial instruments comprise of trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value. A financial instrument is recognised if the DHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the DHB's contractual rights to the cash flows from the financial assets expire or the DHB transfers the financial asset to another party without retaining control or substantially all the risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, i.e. the dates that the DHB commits itself to

purchase or sell the asset. Financial liabilities are derecognised if the DHB's obligations specified in the contract expire or are discharged, or cancelled.

Trade and other receivables
Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

Inventories
Inventories are held for the DHB's own use, and are stated at the lower of cost and net realisable value. Cost is based on weighted average cost. Inventories held for distribution are stated at cost, adjusted where applicable for any loss of service potential.

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

Impairment
The carrying amounts of the DHB's assets other than inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated. If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive revenue and expense.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

Calculation of recoverable amount
The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit, value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on items of property, plant and equipment carried at fair value is reversed through the revaluation reserve. All other impairment losses are reversed through the statement of comprehensive revenue and expense.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest bearing borrowings
Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Employee benefits
Short term employee entitlements
Employee entitlements that the DHB expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date.

Defined contribution plans
Certain employees are members of defined contribution schemes and the DHB contributes to those schemes. A defined contribution scheme is a plan under which the employee and the DHB pay fixed contributions to a separate entity. The group has no legal or constructive obligation to pay further contributions in relation to employee service in the current and prior periods. Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive revenue and expense as incurred.

Defined benefit plan
The DHB belongs to some Defined Benefit Plan Contributors Schemes. The schemes are multi-employer defined benefit schemes for which the DHB has no liability to fund, apart from a set percentage of members remuneration. Any surplus/deficit of the schemes which may affect future contributions by individual employers is the liability of the government alone. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave, sick leave, medical education leave and retirement gratuities
The DHB's net obligation in respect of long service leave, sabbatical leave, medical education leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave
Annual leave are short term obligations and are calculated on an actual basis at the amount the DHB expects to pay. The DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions
A provision is recognised when the DHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring
A provision for restructuring is recognised when the DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Trade and other payables
Trade and other payables are initially recognised at fair value and subsequently stated at amortised cost using the effective interest rate.

Derivative financial instruments
The DHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Derivatives that do not qualify for hedge accounting are accounted for as trading instruments.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are stated at fair value. The gain or loss on re-measurement to fair value is recognised immediately in the statement of comprehensive revenue and expense. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount that the DHB would receive or pay to terminate the

swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Hedging: cash flow hedges
Where a derivative financial instrument is designated as a hedge of the variability in cash flows of a recognised asset or liability, or a highly probable forecast transaction, the effective part of any gain or loss on the derivative financial instrument is recognised directly in equity.

When the forecast transaction subsequently results in the recognition of a non-financial asset or non-financial liability, or the forecast transaction becomes a firm commitment, the associated cumulative gain or loss is removed from equity and included in the initial cost or other carrying amount of the non-financial asset or liability. If a hedge of a forecast transaction subsequently results in the recognition of a financial asset or a financial liability, the associated gains and losses that were recognised directly in equity are reclassified into the statement of comprehensive revenue and expense in the same period or periods during which the asset acquired or liability assumed affects the statement of comprehensive revenue and expense (i.e. when interest revenue or expense is recognised). For cash flow hedges, other than those covered by the preceding two policy statements, the associated cumulative gain or loss is removed from equity and recognised in the statement of comprehensive revenue and expense in the same period or periods during which the hedged forecast transaction affects the statement of comprehensive revenue and expense. The ineffective part of any gain or loss is recognised immediately in the statement of comprehensive revenue and expense.

When a hedging instrument expires or is sold, terminated or exercised, or the entity revokes designation of the hedge relationship but the hedged forecast transaction is still expected to occur, the cumulative gain or loss at that point remains in equity and is recognised in accordance with the above policy when the transaction occurs. If the hedged transaction is no longer expected to take place, the cumulative unrealised gain or loss recognised in equity is recognised immediately in the statement of comprehensive revenue and expense.

Income tax
The DHB is a Crown entity under the New Zealand Public Health and Disability Act 2000 and is therefore exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Goods and services tax
All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

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

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

Borrowing costs
Borrowing costs are recognised as an expense in the period in which they are incurred, except to the extent that they are directly attributable to the acquisition or construction of a qualifying asset, in which case, they are capitalised as part of the cost of that asset.

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

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

Crown funding
The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year. The DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

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

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to the DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the DHB.

Revenue from other DHBs
Inter-district patient inflow revenue occurs when a patient treated within the DHB region is domiciled outside of the DHB region. The Ministry of Health credits the DHB with a monthly amount based on estimated patient treatment for non - DHB residents within Capital & Coast region. An annual wash-up occurs at year end to reflect the actual number of non - DHB patients treated at the DHB.

Interest revenue
Interest revenue is recognised using the effective interest rate method.

Rental revenue
Rental revenue from property is recognised in the statement of comprehensive revenue and expense on a straight-line basis over the term of the lease.

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

Expenses

Operating lease payments
Payments made under operating leases are recognised as an expense in the statement of comprehensive revenue and expense on a straight-line basis over the term of the lease.

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

Cost of service (statement of performance)
The cost of service statements, as reported in the statement of performance, report the revenue and expenses of services for the outputs of the DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation
The DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost allocation policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

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

Cost drivers for allocation of indirect costs
The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2016, indirect costs accounted for 1.41% of the DHB's total costs (2015: 1.46%).

Accounting estimates and judgements
Management has discussed with the Finance Risk & Audit Committee the development, selection and disclosure of the DHB's critical accounting policies and estimates and the application of these policies and estimates.

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

Property, plant and equipment
At each balance date the DHB reviews the useful lives and residual values of its property plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property plant and equipment requires the DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset, and expected disposal proceeds from the future sale of the asset.
An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of comprehensive revenue and expense, and carrying amount of the asset in the statement of financial position. The DHB minimises the risk of estimation uncertainty by:

- physical inspection of assets
- asset replacement programmes
- obtaining valuations

The DHB has not made significant changes to past assumptions concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 6.

Retirement, long service leave, sick leave and continuing education
Assessing the exposure to long term employee benefits involves making estimates of future length of service and interest rates. The risk is minimised by utilising the services of an actuary.

Critical accounting judgements in applying the DHB's accounting policies

Leases classification
Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards to the DHB.

Finance and operating leases
Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options on the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of equipment leases, and has determined a number of lease arrangements are finance leases.

in thousands of New Zealand Dollars

1 REVENUE

	2016 Actual	2015 Actual
Ministry of Health contract funding	772,988	754,035
Other government	12,916	20,332
Inter district flows (other DHBs)	212,158	201,501
Non government & crown agency sourced	19,847	17,551
Interest revenue	2,061	2,514
Revenue from donations	1,255	294
Reinstatement of property plant and equipment	2,618	-
	1,023,843	996,227

2 EMPLOYEE BENEFIT COSTS

	2016 Actual	2015 Actual
Direct staff costs (excluding increases in employee benefit provisions)	409,132	384,174
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	15,507	14,354
Contributions to defined contribution plans	12,806	12,070
Increase/(decrease) in employee benefit provisions	(3,558)	2,762
	433,887	413,360

Employer contributions to defined contribution plans include contributions to Kiwisaver, State Sector Retirement Savings Scheme and the Defined Benefit Plan Contributors Scheme.

3 OTHER OPERATING EXPENSES

	Note	2016 Actual	2015 Actual
Increase /(decrease) in provision of trade receivables (doubtful debts)	11	350	122
(Gain)/loss on disposal of property, plant and equipment		308	29
Audit fees for financial statements audit		210	207
Fees for other assurance services		141	6
Board member fees	22	375	370
Operating lease expense		2,765	2,744
Other operating expenses		385	659
		4,534	4,137

in thousands of New Zealand Dollars

4 CAPITAL CHARGE

	2016 Actual	2015 Actual
The DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance. The capital charge rate for the period ended 30 June 2016 was 8 per cent (2015: 8 per cent)	8,086	8,382

5 FINANCE COSTS

	2016 Actual	2015 Actual
Interest on term borrowings	14,141	16,147

in thousands of New Zealand Dollars

6 PROPERTY, PLANT AND EQUIPMENT

	Freehold land	Freehold buildings	Leasehold Improvements	Plant & Equipment	Furniture & Fittings	Total
Cost						
Balance at 1 July 2014	25,705	457,817	624	84,982	26,672	595,800
Additions	-	4,730	151	3,311	1,132	9,324
Disposals	-	-	(11)	(135)	(40)	(186)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2015	25,705	462,547	764	88,158	27,764	604,938
Balance at 1 July 2015	25,705	462,547	764	88,158	27,764	604,938
Additions	-	15,681	427	6,741	600	23,449
Disposals	-	(18)	-	(5,574)	(872)	(6,464)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2016	25,705	478,210	1,191	89,325	27,492	621,923
Depreciation and impairment losses						
Balance at 1 July 2014	-	(23,235)	(247)	(45,709)	(17,884)	(87,075)
Depreciation charge for the year	-	(22,635)	(65)	(9,470)	(3,001)	(35,171)
Impairment losses	-	-	-	-	-	-
Disposals	-	-	11	68	40	119
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2015	-	(45,870)	(301)	(55,111)	(20,845)	(122,127)

in thousands of New Zealand Dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	Freehold land	Freehold buildings	Leasehold Improvements	Plant & Equipment	Furniture & Fittings	Total
Depreciation and impairment losses						
Balance at 1 July 2015	-	(45,870)	(301)	(55,111)	(20,845)	(122,127)
Depreciation charge for the year	-	(22,880)	(66)	(8,012)	(2,055)	(33,013)
Impairment losses	-	-	-	-	-	-
Disposals	-	3	-	3,647	370	4,020
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2016	-	(68,747)	(367)	(59,476)	(22,530)	(151,120)
Carrying amounts						
At 1 July 2014	25,705	434,582	377	39,273	8,788	508,725
At 30 June 2015	25,705	416,677	463	33,047	6,919	482,811
At 1 July 2015	25,705	416,677	463	33,047	6,919	482,811
At 30 June 2016	25,705	409,463	824	29,849	4,962	470,803

	Freehold land	Freehold buildings	Leasehold Improvements	Plant & Equipment	Furniture & Fittings	Total
Work in progress						
Balance at 1 July 2014	-	3,982	202	385	808	5,377
Additions	-	5,789	132	3,337	-	9,258
Transfer from WIP	-	(4,733)	(141)	(3,073)	(642)	(8,589)
Balance at 30 June 2015	-	5,038	193	649	166	6,046
Balance at 1 July 2015	-	5,038	193	649	166	6,046
Additions	-	15,098	442	8,962	781	25,283
Transfer from WIP	-	(15,590)	(427)	(6,221)	(387)	(22,625)
Balance at 30 June 2016	-	4,546	208	3,390	560	8,704

in thousands of New Zealand Dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with PBE IPSAS 17, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings was carried out at 21 June 2013 by Milton Bevin, FPINZ, an independent registered valuer with Colliers International New Zealand Limited. The valuation conforms to international valuation standards. Land revaluation was determined by reference to its highest and best use. The revaluation of buildings was based on depreciated replacement cost methodology.

The total fair value of land valued by the valuer amounted to $25.7m.

The total fair value of buildings valued by the valuer amounted to $445.3m.

Buildings revaluation recognised in statement of comprehensive revenue and expense

Year	Particulars	Actual
2002	Revaluation loss	(65,939)
2004	Revaluation gain	11,898
2006	Revaluation gain	16,257
2011	Revaluation gain	17,433
2013	Revaluation gain	20,301
	Revaluation loss carried forward	**(50)**

The initial revaluation loss on buildings as at 30 June 2002 of $65.9m was recognised in the statement of comprehensive revenue and expense. PBE IPSAS 17 states that any subsequent revaluation increase in buildings shall be recognised in the statement of comprehensive revenue and expense to the extent that it reverses a revaluation decrease, of the same asset, previously recognised in the statement of comprehensive revenue and expense. As at 30 June 2016 net revaluation losses of $0.05m are carried forward to future years.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2016 was $16.8m (2015: $16.8m).

Restrictions

The DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981 and Maori Protection Mechanisms.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

in thousands of New Zealand Dollars

7 INTANGIBLE ASSETS

	Software	NOS Shared Services Rights	Licences	Total
Cost				
Balance at 1 July 2014	14,130	5,089	2,567	21,786
Additions	6,209	1,378	280	7,867
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2015	20,339	6,467	2,847	29,653
Balance at 1 July 2015	20,339	6,467	2,847	29,653
Additions	4,394	-	57	4,451
Disposals	(154)	-	(18)	(172)
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2016	24,579	6,467	2,886	33,932
Amortisation and impairment losses				
Balance at 1 July 2014	(9,749)	-	(1,721)	(11,470)
Amortisation charge for the year	(2,161)	-	(443)	(2,604)
Impairment losses	-	-	-	-
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2015	(11,910)	-	(2,164)	(14,074)
Balance at 1 July 2015	(11,910)	-	(2,164)	(14,074)
Amortisation charge for the year	(2,337)	-	(327)	(2,664)
Impairment losses	-	-	-	-
Disposals	132	-	17	149
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2016	(14,115)	-	(2,474)	(16,589)
Carrying amounts				
At 1 July 2014	4,381	5,089	846	10,316
At 30 June 2015	8,429	6,467	683	15,579
At 1 July 2015	8,429	6,467	683	15,579
At 30 June 2016	10,464	6,467	412	17,343

in thousands of New Zealand Dollars

7 INTANGIBLE ASSETS (CONTINUED)

	Software	Licences	CRTAS	Total
Work in progress				
Balance at 1 July 2014	4,357	280	-	4,637
Additions	3,713	-	4,862	8,575
Transfer from WIP	(6,209)	(280)	-	(6,489)
Balance at 30 June 2015	1,861	-	4,862	6,723
Balance at 1 July 2015	1,861	-	4,862	6,723
Additions	1,049	57	3,499	4,605
Transfer from WIP	(1,579)	(57)	-	(1,636)
Balance at 30 June 2016	1,331	-	8,361	9,692

There are no restrictions over the title of Capital & Coast District Health Board's intangible assets, nor are any intangible assets pledged as security for liabilities

New Zealand Health Partnerships
Health Benefits Limited (HBL) was established in July 2010 to undertake a National Oracle Solution (NOS) shared services project aimed at reducing costs in administrative support and procurement for the public health sector. The NOS project was funded by the 20 DHBs across the country who would be the beneficiaries of these savings.

In June 2015, HBL was wound down and its assets and liabilities were transferred to a new company - New Zealand Health Partnerships (NZHP). Each of the 20 DHBs have obtained a direct interest in NZHP based on their proportional contribution to the establishment of the NOS shared services.

As at 30 June 2016, the DHB has accrued $6.47m as its share of the project. This funding represents an intangible asset and gives the DHB the right to access shared services.

The investment has been tested for impairment during the year by the DHB management. However, at this stage, on the information available no impairment is required at this point.

Regional Health Informatics Programme (RHIP)
RHIP is a programme to move the Central Region District Health Boards from a current state of disparate, fragmented and, in some cases obsolescent, clinical and administrative information systems to a future state of shared, standardised and fully integrated information systems that will enhance clinical practice, drive administrative efficiencies, enable regionalisation of services and reduce current operational risks.

It was originally agreed that Central Region Technical Advisory Services Limited (CRTAS) would create the RHIP assets and provide services in relation to those assets to the DHBs. Each DHB would provide funding to CRTAS and in return for the funding relating to capital items the DHBs would be provided with Class B Redeemable Shares in CRTAS.

The agreement to provide the RHIP assets and services was amended on 1 December 2014 to transfer the ownership of RHIP assets to the DHBs jointly. As at 30 June 2016, CCDHB had contributed $8.361m towards capital expenditure which has been recognised as work in progress in respect of intangible assets.

The investment has been tested for impairment during the year by the DHB management. However at this stage on the information available no impairment is required at this point.

in thousands of New Zealand Dollars

8 INVENTORIES

	2016 Actual	2015 Actual
Pharmaceuticals	1,890	1,682
Surgical & medical supplies	5,285	5,631
Other supplies	170	159
	7,345	7,472

The amount of inventories recognised as an expense during the year ended 30 June 2016 was $54.1m (2015: $53.0m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2015: $nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

9 INVESTMENTS IN JOINT VENTURES

Carrying amount of investments in joint ventures

	2016 Actual	2015 Actual
Uncalled ordinary share capital	-	-
	-	-

Central Region Technical Advisory Services (CRTAS) has a total ordinary share capital of $600 of which the DHB share is $100. At balance date all ordinary share capital remains uncalled.

Summary of the DHB's interests in Central TAS joint venture (16.67%)

	2016 Actual	2015 Actual
Revenue	6,129	5,693
Expense	6,087	5,667
Non-current assets	109	67
Current assets	2,087	2,115
Non-current liabilities	119	-
Current liabilities	1,782	1,929
Contingent liabilities	-	-
Commitment	65	-

Owing to the minor nature of the joint venture, no results are recorded in the DHB's financial statements.

in thousands of New Zealand Dollars

10 INVESTMENTS IN ASSOCIATES

Carrying amount of investments in associates

	2016 Actual	2015 Actual
Investment in Allied Laundry Services Ltd. (ALSL)	1,150	-
	1,150	-

ALSL has a total ordinary share capital of 6,050,000 of which the DHB's share is 1,150,000. The shares have been fully paid. HVDHB shares are paid to $300k, with the remainder to be paid over the next three years.

Summary of the DHB's interest in Allied Laundry Services Ltd. (19%)

	2016 Actual	2015 Actual
Revenue	1,767	-
Expense	1,700	-
Non-current assets	1,757	-
Current assets	223	-
Non-current liabilities	168	-
Current liabilities	671	-
Contingent liabilities	-	-
Commitment	-	-

Owing to the minor nature of the associates, no results are recorded in the DHB's financial statements.

in thousands of New Zealand Dollars

11 TRADE AND OTHER RECEIVABLES

	2016 Actual	2015 Actual
Trade receivables from non-related parties	5,763	3,327
Ministry of Health receivables	13,901	14,718
Other DHB receivables	10,314	12,584
	29,978	30,629
Accrued revenue	12,545	10,997
Prepayments	4,017	4,232
Total receivables	46,540	45,858
Total receivables comprises:		
Receivable from the sale of goods and services (exchange transactions)	32,639	31,140
Receivable from Ministry funding (non-exchange transactions)	13,901	14,718

Trade receivables are shown net of a provision for doubtful debts amounting to $0.6m (2015: $0.6m)

The carrying value of receivables approximates their fair value.

As at 30 June 2016, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2016			2015		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	25,933	-	25,933	28,558	-	28,558
Past due 1-30 days	1,022	-	1,022	501	-	501
Past due 31-60 days	1,051	-	1,051	443	-	443
Past due 61-90 days	284	-	284	512	-	512
Past due > 91 days	2,285	597	1,688	1,220	605	615
Total	30,575	597	29,978	31,234	605	30,629

Each year trade receivables are reviewed as to collectability, and where a doubt is identified a provision is made. Factors considered are the age of the debt, domicile of the debtor, and the type of service provided. Large receivables are individually reviewed, whilst for small debts the historical pattern is used as a guide.

Movements in the provision for impairment of receivables are as follows:

	2016 Actual	2015 Actual
Balance at 1 July 2015	605	819
Additional provisions made during the year	350	122
Provisions reversed during the year	-	-
Receivables written-off during period	(358)	(336)
Balance at 30 June 2016	597	605

in thousands of New Zealand Dollars

12 CASH AND EQUIVALENTS

	2016 Actual	2015 Actual
Petty cash	13	13
Bank accounts	80	74
NZHP call deposits	12,775	19,014
Cash and Cash equivalents	12,868	19,101

Patient funds
The DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and interest earned is allocated to the individual patients. The funds are not included in the above balances.

Bank facility
Capital & Coast DHB is party to the "DHB Treasury Services Agreement" between New Zealand Health Partnership (NZHP) and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts daily and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at on-call interest rate received by NZHP plus an administrative margin. The maximum working capital facility limit for the DHB is $54.9m. (2015:$51.9m). The highest overdrawn bank balance during financial year 2015/16 was $nil. (2015: $6m).

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

	2016 Actual	2015 Actual
Surplus/(deficit) for the year	(11,918)	(3,982)
Add back non-cash items:		
Depreciation & amortisation	35,677	37,775
Reinstatement of property plant and equipment	(2,618)	-
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	308	(461)
Interest revenue on financial assets	(2,061)	(2,514)
Donated assets	(1,044)	-
Add back items classified as financing activity:		
Interest expense on financial liabilities	14,141	16,148
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(682)	(1,713)
(Increase)/decrease in trust funds	387	(505)
(Increase)/decrease in inventories	127	712
Increase/(decrease) in trade and other payables	4,348	(11,565)
Increase/(decrease) in employee benefits	(3,117)	2,019
Increase/(decrease) in provisions	188	24
Net movement in working capital	1,251	(11,028)
Net cash inflow/(outflow) from operating activities	33,736	35,938

in thousands of New Zealand Dollars

13 TRUST AND SPECIAL FUNDS

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived and are accounted for separately through the DHB's trust ledger. The revenue and expenditure in respect of these funds is included in the statement of comprehensive revenue and expense.

The DHB also administers funds on behalf of certain patients. Patient fund transactions are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as both an asset and a liability.

All trust and special funds are held in bank accounts that are separate from the DHB's normal banking facilities.

Non patient funds	2016 Actual	2015 Actual
Balance at 1 July 2015	7,481	6,961
Monies received	2,597	1,987
Interest received	253	300
Payments made	(3,254)	(1,767)
Balance at 30 June 2016	7,077	7,481
Patient funds		
Balance at 1 July 2015	138	155
Monies received	221	177
Interest received	1	2
Payments made	(205)	(196)
Balance at 30 June 2016	155	138
Total trust and special funds	7,232	7,619

in thousands of New Zealand Dollars

14 INTEREST BEARING LOANS AND BORROWINGS

	2016 Actual	2015 Actual
Current		
Secured Debt Management Office	62,000	34,000
Unsecured EECA loans	326	326
	62,326	34,326
Non-current		
Secured Debt Management Office	277,000	305,000
Unsecured EECA loans	628	954
	277,628	305,954

Secured loans
The DHB secured loans are from Debt Management Office. The details of terms and conditions are as follows:

Interest rate summary	2016 Actual	2015 Actual
Debt Management Office	2.21% - 6.37%	3.34% - 6.37%
New Zealand Health Partnership	3.36% - 4.35%	4.22% - 5.28%
Finance leases	6.50%	6.50%
Energy Efficiency and Conservation Authority (EECA)	0%	0%

Loan repayable as follows:	2016 Actual	2015 Actual
Within one year	62,326	34,326
One to two years	62,326	34,326
Two to five years	173,302	201,628
Later than five years	42,000	70,000
	339,954	340,280

in thousands of New Zealand Dollars

14 INTEREST BEARING LOANS AND BORROWINGS (CONTINUED)

Term loan facility limits	2016 Actual	2015 Actual
Debt Management Office	339,000	339,000
Energy Efficiency and Conservation Authority (EECA)	954	1,280
	339,954	340,280

Security and terms

The loan facility is provided by the Ministry of Health. $311m facility limit expires in December 2021. $28m facility limit expires in April 2022. Without the Ministry's prior written consent the DHB cannot perform the following actions:

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

The DHB is not required to meet any covenants. The NZ Government does not guarantee term loans.

The total borrowings with the Debt Management Office is $339m. Of this $28m is maturing in October 2016, $9m is maturing in November 2016 and $25m is maturing in April 2017.

in thousands of New Zealand Dollars

15 EMPLOYEE ENTITLEMENTS

	2016 Actual	2015 Actual
Current liabilities		
Liability for long service leave	2,430	1,702
Liability for sabbatical leave	310	268
Liability for retirement gratuities	720	1,030
Liability for annual leave	37,417	36,711
Liability for sick leave	1,066	1,096
Liability for continuing medical education leave and expenses	7,984	7,369
Salary and wages accrual	9,856	13,180
	59,783	61,356
Non-current liabilities		
Liability for long service leave	3,922	4,237
Liability for sabbatical leave	410	403
Liability for retirement gratuities	1,433	1,596
Liability for continuing medical education leave and expenses	-	1,073
	5,765	7,309

Defined benefit plans
The DHB has employees who are members of defined benefit plans. The funding liability of these plans is assumed by central government.

Other employee entitlement liabilities
Liability for salaries and wages accrued is recognised as at current actual salaries.

Liability for annual leave is calculated as the greater of average weekly earnings for the 12 months immediately before the end of the last pay period before the annual holiday is taken or the employee's ordinary weekly pay as at the beginning of the annual holiday.

Actuarial valuations have been obtained for the remaining liabilities. The actuarial valuations include a salary growth factor of 2.0%, (2015: 2.5%) and a discount rate ranging from 2.14% to 3.30% (2015: 2.97% to 4.29%) from 1-10+ years.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the retirement and long service leave liability would be an estimated $0.4m higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the retirement and long service leave liability would be an estimated $0.4m higher/lower.

in thousands of New Zealand Dollars

16 PROVISION

	2016 Actual	2015 Actual
Current provisions		
ACC Partnership Programme	614	363
Non current provisions		
ACC Partnership Programme	229	292

ACC Partnership Programme	2016 Actual	2015 Actual
Undiscounted amount of claims at balance date	747	577
Discount	12	13
Central estimate of present value of future payments	759	590
Risk margin	84	65
	843	655

The movement in provisions is represented by:

	ACC Partnership Programme
2015	
Balance at 1 July 2014	631
Additional provisions during the year for the risks borne in current period	439
Additional provisions relating to a reassessment of risks in a previous period	248
Subtotal	1,318
Amounts used during the year	663
Total liability	655
(Decrease) / increase in provision	24

	ACC Partnership Programme
2016	
Balance at 1 July 2015	655
Additional provisions during the year for the risks borne in current period	507
Additional provisions relating to a reassessment of risks in a previous period	472
Subtotal	1634
Amounts used during the year	791
Total liability	843
(Decrease) / increase in provision	188

16 PROVISION (CONTINUED)

ACC Partnership Programme

The ACC Partnership Program (APP) offers the DHB the option to accept injury management and financial responsibility for employees who suffer work-related illness or injury for a specified period. In return, the accredited employer's ACC premiums are reduced. Participation in the APP is an insurance contract between the employer and the employee, as the employer (insurer) accepts significant insurance risk from the employee (policyholder) by agreeing to compensate the employee if a work-related injury (the insured event) adversely affects the employee.

The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which the DHB has responsibility under the terms of the Partnership Programme.

The liability is measured at the present value of anticipated future payments to be made in respect of the employee injuries and claims up to the reporting date using actuarial techniques. Consideration is given to expected future wage and salary levels, and experience of employee claims and injuries. The liability for claims reported prior to balance date has been determined by assuming that the future experience for each current claim is consistent with historical claim information since the commencement of the programme.

The value of the liability includes a risk margin that represents the inherent uncertainty of the present value of the expected future payments. The DHB manages its exposure arising from the programme by promoting a safe and healthy working environment by:

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

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

An external independent actuarial valuer, Mr M Lardies, Bsc.FIA of Aon New Zealand Ltd, has calculated the DHB's liability. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

Average inflation has been assumed as 1.7% for the year ended 30 June 2016. A discount rate of 2.5% has been used for the year ended 30 June 2016.

The value of the liability is not material for the DHB's financial statements, therefore any changes in assumptions will not have a material impact on the financial statements.

in thousands of New Zealand Dollars

17 TRADE AND OTHER PAYABLES

	2016 Actual	2015 Actual
Payables under exchange transactions		
Trade payables	8,068	6,778
Revenue in advance / Deferred Revenue	493	358
Other non-trade payables and accrued expenses	45,696	44,431
Total payables under exchange transactions	54,257	51,567
Payables under non-exchange transactions		
Revenue in advance	-	2,416
GST and other taxes payables	17,403	14,170
Total payables under non-exchange transactions	17,403	16,586
Total Payables	71,660	68,153

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

18 PATIENT AND RESTRICTED FUNDS

Patient funds	2016 Actual	2015 Actual
Balance at 1 July 2015	139	155
Monies received	220	178
Interest received	1	2
Payments made	(205)	(196)
Balance at 30 June 2016	155	139

Patient funds are held in a separate bank account. Any interest earned is allocated to the individual patient balances. Patient fund transactions during the year ended 30 June 2016 are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as at 30 June 2016, both as an asset and a liability.

Holiday homes funds	2016 Actual	2015 Actual
Balance at 1 July 2015	72	75
Monies received	20	21
Interest received	2	2
Payments made	(14)	(26)
Balance at 30 June 2016	80	72
Hutt Valley DHB Portion ¼ of holiday homes total	20	18
Total patient and restricted funds	175	157

in thousands of New Zealand Dollars

19 EQUITY

	2016 Actual	2015 Actual
Contributed capital		
Balance at 1 July	422,803	420,687
Capital contribution	5,600	5,600
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	424,919	422,803
Property revaluation reserves		
Balance at 1 July	23,606	23,606
Balance at 30 June	23,606	23,606
Accumulated surplus / (deficit)		
Balance at 1 July	(333,110)	(329,128)
Surplus / (deficit) for the year	(11,918)	(3,982)
Balance at 30 June	(345,028)	(333,110)
Total equity	103,497	113,299

in thousands of New Zealand Dollars

20 OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2016 Actual	2015 Actual
Less than one year	2,841	2,340
Between one and five years	3,892	3,499
More than five years	28	785
	6,761	6,624

During the year ended 30 June 2016, $2.8m was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2015: $2.7m)

The DHB:

- leases a number of buildings, vehicles and items of medical equipment under operating leases.
- leases are on normal commercial terms and include restrictions on sub-leasing. For leased buildings some leases have ratchet clauses, and most have rights of renewal.
- leases include no contingent rentals.
- operating lease payments are recognised as an expense on a straight line basis over the term of the lease.
- leased properties are not subleased by the DHB.

Leases as lessor

The DHB leases out various surplus properties under operating leases. The future minimum lease payments under non-cancellable leases are as follows:

	2016 Actual	2015 Actual
Less than one year	312	259
Between one and five years	1,092	825
More than five years	1,044	1,044
	2,448	2,128

During the year ended 30 June 2016, $2.5m was recognised as rental revenue in the statement of comprehensive revenue and expense (2015: $2.3m)

The DHB has:

- a long term agreement with the University of Otago for the provision of medical consultancy services and facilities from which they operate these services.
- long term ground leases in operation where the lessee owns all the improvements.
- medium term leases (consulting rooms) in two separate health centres.
- 29 short term commercial leases, all subject to 6 month termination notice.

21 FINANCIAL INSTRUMENTS

Exposure to credit, interest rate and currency risks arise in the normal course of the DHB's operations. Derivative financial instruments are used to hedge exposure to fluctuations in foreign exchange rates and interest rates.

Credit risk
Financial instruments, which potentially subject the DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The DHB places its cash and short term deposits with high quality financial institutions and the DHB has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor, approximately 50.06% in 2016 (2015: 48.05%). It is assessed to be a low risk and high quality entity due to its nature as the government funded purchaser of health and disability support services.

At the balance sheet date there were no significant other concentrations of credit risk.

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

The DHB adopts a policy of having a spread of interest rate repricing dates on borrowings to limit the exposure to short term interest rate movements. The DHB will from time to time utilise hedge instruments when term borrowings are to be renewed. The DHB borrowings are all fixed term and fixed interest rate, except for the overdraft facility for working capital, which is on a floating rate basis and subject to an interest rate swap.

The only financial instrument that DHB measures at fair value in the statement of financial position is the interest rate swap. The fair value of the interest rate swap is determined using a valuation technique that uses observable market inputs (level 2).

Sensitivity analysis
If the Official Cash Rate had been 100 basis points higher, the working capital facility interest rate and the interest on surplus funds would be higher. The net impact on the DHB would have been favourable $0.46m in 2016. (2015: $0.50m).

In managing interest rate and currency risks the DHB aims to reduce the impact of short-term fluctuations on the DHB’s earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

At 30 June 2016, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB’s surplus by approximately $3.4m (2015: $3.4m). It is estimated that a general increase of one percentage point in the value of NZD against other foreign currencies to which the DHB had direct exposure would have decreased the DHB’s surplus before tax by approximately $0.00020m for the year ended 30 June 2016 (2015: $0.00086m).

in thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Effective interest rates and repricing analysis

In respect of interest-bearing financial liabilities, the following table indicates their effective interest rates at balance sheet date and the periods in which they reprice.

	2016 Actual							2015 Actual						
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs
Loans:														
NZD fixed rate loan*	5.16	-						5.16	28,000		28,000			
NZD fixed rate loan*	3.43	-						3.43	6,000	6,000				
NZD fixed rate loan*	3.65	9,000	9,000					3.65	9,000			9,000		
NZD fixed rate loan*	4.04	34,000				34,000		4.04	34,000				34,000	
NZD fixed rate loan*	4.15	6,000				6,000		4.15	6,000				6,000	
NZD fixed rate loan*	3.72	25,000		25,000				3.72	25,000			25,000		
NZD fixed rate loan*	3.61	8,000					8,000	3.61	8,000					8,000
NZD fixed rate loan*	3.51	34,000				34,000		3.51	34,000					34,000
NZD fixed rate loan*	3.38	28,000				28,000		3.38	28,000				28,000	
NZD fixed rate loan*	6.37	62,000			62,000			6.37	62,000				62,000	
NZD fixed rate loan*	2.21	28,000	28,000					6.30	-					
NZD fixed rate loan*	3.06	6,000					6,000	7.13	-					
NZD fixed rate loan*	3.57	28,000					28,000	3.57	28,000					28,000
NZD fixed rate loan*	3.34	36,000				36,000		3.34	36,000				36,000	
NZD fixed rate loan*	3.37	35,000				35,000		3.37	35,000				35,000	
NZD unsecured loan	0	954	163	163	326	302		0	1,280	163	163	326	628	
		339,954	37,163	25,163	62,326	173,302	42,000		340,280	6,163	28,163	34,326	201,628	70,000

* These liabilities bear interest at fixed rates.

in thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Contractual maturity analysis of financial liabilities

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

2016	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
Creditors and other payables	71,660	71,660	71,660	-	-	-
Secured loans	339,000	374,562	74,607	70,590	186,275	43,090
Unsecured loans	954	954	326	326	302	-
Patient and restricted funds	175	175	175	-	-	-
Total	411,789	447,351	146,768	70,916	186,577	43,090
2015						
Creditors and other payables	68,153	68,153	68,153	-	-	-
Secured loans	339,000	387,257	47,865	46,242	219,897	73,253
Unsecured loans	1,280	1,280	326	326	628	-
Patient and restricted funds	157	157	157	-	-	-
Total	408,590	456,847	116,501	46,568	220,525	73,253

Contractual maturity analysis of financial assets

The table below analyses the DHB's financial assets into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date.

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2016						
Cash and cash equivalents	12,868	12,868	12,868	-	-	-
Debtors and other receivables	46,540	46,540	46,540	-	-	-
Trust and special funds - bank	74	74	74	-	-	-
Trust and special funds – term deposit	6,700	6,803	6,803	-	-	-
Trust and special funds – debtors	303	303	303	-	-	-
Total	66,485	66,587	66,587	-	-	-
2015						
Cash and cash equivalents	19,101	19,101	19,101	-	-	-
Debtors and other receivables	45,858	45,858	45,858	-	-	-
Trust and special funds - bank	546	546	546	-	-	-
Trust and special funds – term deposit	6,900	7,000	7,000	-	-	-
Trust and special funds – debtors	60	60	60	-	-	-
Total	72,465	72,565	72,565	-	-	-

in thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Maximum exposure to credit risk

The DHB's maximum credit exposure for each class of financial instrument is as follows:

	2016 Actual	2015 Actual
Cash and cash equivalents	12,868	19,101
Debtors and other receivables	46,540	45,858
Trust and special funds – bank	74	546
Trust and special funds – term deposit	6,700	6,900
Trust and special funds – debtors	303	60
	66,485	72,465

	2016	2015
Counterparties with credit ratings		
Cash at bank and term deposits	20,100	26,547
AA- (Standard & Poor)	20,100	26,547

Debtors and other receivables mainly arise from the DHB's statutory functions, therefore there are no procedures in place to monitor or report the credit quality of debtors and other receivables to internal or external credit ratings.

Foreign currency risk

The DHB is exposed to foreign currency risk on purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily US Dollars and AUD Dollars.

The DHB hedges large transactions denominated in a foreign currency. The DHB uses forward exchange contracts to hedge its foreign currency risk. The DHB has no forward exchange contracts as at the balance sheet date.

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2016 was $nil (2015: $nil), comprising assets of $nil (2015: $nil) and liabilities of $nil (2015: $nil) that were recognised in fair value derivatives.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of comprehensive revenue and expense. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of "Net loss on derivative classified as fair value through statement of comprehensive revenue and expense. The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2016 was $nil (2015: $nil) recognised in fair value derivatives.

in thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Fair values

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

	Note	Carrying amount 2016 Actual	Fair value 2016 Actual	Carrying amount 2015 Actual	Fair value 2015 Actual
Trade and other receivables	11	46,540	46,540	45,858	45,858
Cash and cash equivalents	12	12,868	12,868	19,101	19,101
Secured loans	14	(339,000)	(356,048)	(339,000)	(350,414)
Unsecured loans	14	(954)	(954)	(1,280)	(1,280)
Trade and other payables	17	(71,660)	(71,660)	(68,153)	(68,153)
		(352,206)	(369,254)	(343,474)	(354,888)
Unrecognised (losses)/gains			(17,048)		(11,414)

Estimation of fair value analysis

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

Derivatives

Forward exchange contracts are either marked to market using listed market prices or by discounting the contractual forward price and deducting the current spot rate.

Where discounted cash flow techniques are used, estimated future cash flows are based on management's best estimates and the discount rate is a market related rate for a similar instrument at the balance sheet date. Where other pricing models are used, inputs are based on market related data at the balance sheet date.

Interest bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

Finance lease liabilities

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

Trade and other receivables and payables

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

Interest rates used for determining fair value

The entity uses the government bond rate as at 30 June 2016 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2016 Actual %	2015 Actual %
Derivatives	N/A	N/A
Loans and borrowings	2.21, 3.06, 3.34, 3.37, 3.38, 3.51, 3.57, 3.61, 3.65, 3.715, 4.04, 4.15, 6.37	3.34, 3.37, 3.38, 3.43, 3.51, 3.57, 3.61, 3.65, 3.715, 4.04, 4.15, 5.16, 6.37

in thousands of New Zealand Dollars

22 RELATED PARTIES TRANSACTIONS

CCDHB is a wholly owned entity of the Crown.

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

Remuneration
Key management personnel remuneration is as follows:

	2016 Actual	2015 Actual
Board Members		
Remuneration	$375	$370
Full-time equivalent members	1.27	1.27
Leadership Team		
Remuneration	$3,343	$3,100
Full-time equivalent members	14	17
Total key management personnel remuneration	**$3,718**	**$3,470**
Total members and full time equivalent personnel	**15.27**	**18.27**

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

in thousands of New Zealand Dollars

22 RELATED PARTIES TRANSACTIONS (CONTINUED)

The Board has taken insurance cover for Board members, Board Committee members, and employees for personal loss caused by wrongful acts in the course of their duties where indemnity is not available from the organisation. The Board has also taken insurance cover covering personal accident and travel risk for Board members, Board Committee members and employees where injury or loss occurs whilst on DHB business.

Board members		**Board Fees**		**Committee Fees**	
Current board members as at 30 June 2016		**2016**	**2015**	**2016**	**2015**
Dr Virginia Hope, MNZM, Chair	Elected	53	53	3	3
Mr Derek Milne, Deputy Chair	Appointed	32	32	2	3
Dr Judith Aitken	Elected	26	26	3	3
Mr David Choat	Elected	26	26	2	1
Mr Peter Douglas	Appointed	26	26	1	1
Ms Helene Ritchie	Elected	26	26	1	1
Mr Darrin Sykes	Appointed	26	26	2	2
Ms Sue Kedgley	Elected	26	26	2	1
Mr Chris Laidlaw	Elected	26	26	1	2
Mr Nick Leggett	Elected	26	26	2	-
Mr Roger Jarrold	Appointed	26	26	2	2
Crown monitor					
Dr Margaret Wilsher	Appointed	35	32	-	-
		354	351	21	19

Committee members (other than Board members and employees)	**2016**	**2015**
Community and Public Health Advisory Committee		
Fa'amatuainu Pereira	1	-
Disability Services Advisory Committee		
Fa'amatuainu Pereira	1	-
Hospital Advisory Committee		
Bryan Betty	3	-
Leo Buchanan	2	-
Tristram Ingham	2	-
Margaret Faulkner	1	-
	10	-

in thousands of New Zealand Dollars

23 EMPLOYEE REMUNERATION

The number of employees or former employees who received remuneration and other benefits of $100,000 or more per annum during 2015/16 within specified $10,000 bands were as follows:

	Number of Employees 2016	Number of Employees 2015
100 – 110	162	141
110 – 120	100	76
120 – 130	65	70
130 – 140	52	45
140 – 150	40	43
150 – 160	28	23
160 – 170	19	23
170 – 180	16	15
180 – 190	16	26
190 – 200	28	22
200 – 210	16	11
210 – 220	19	13
220 – 230	20	20
230 – 240	5	19
240 – 250	22	17
250 – 260	12	5
260 – 270	13	13
270 – 280	9	12
280 – 290	9	7
290 – 300	14	9
300 – 310	8	8
310 – 320	7	4
320 – 330	9	4
330 – 340	5	6
340 – 350	6	7
350 – 360	4	9
360 – 370	9	4
370 – 380	5	4
380 – 390	4	2
390 – 400	-	3
400 – 410	7	1
410 – 420	3	3
420 – 430	4	2
430 – 440	2	-
440 – 450	1	1
450 – 460	1	-
470 – 480	1	-
490 – 500	-	1
500 – 510	1	-
510 – 520	2	1
520 – 530	1	-
530 – 540	-	1
540 – 550	1	1
550 – 560	-	1
580 – 590	-	1
600 – 610	1	-

in thousands of New Zealand Dollars

	747	674

23 EMPLOYEE REMUNERATION (CONTINUED)

Of the 747 employees shown above, 471 are or were medical or dental employees and 276 were neither medical nor dental employees. This represents an increase of 73 staff in total over the previous year.
If the remuneration of part-time employees were grossed-up to an FTE basis, the total number of employees with FTE salaries of $100,000 or more would be 1,664 compared with the actual total number of 747.

24 TERMINATION PAYMENTS

During the year ended 30 June 2016, 32 (2015: 7) employees received compensation and other benefits in relation to cessation totalling $0.9m (2015: $0.2m).

No Board members (2015: nil) received compensation or other benefits in relation to cessation (2015: $nil).

25 EXPLANATIONS TO FINANCIAL VARIANCES FROM BUDGET

Section 154(3)(c) of the Crown Entities Act requires the Annual Financial Statements to include the forecast financial statements (Budget numbers) prepared at the start of the financial year for comparison with the actual financial statements. The Budget numbers are obtained from the Statement of Performance Expectation Budget approved by the DHB Board and tabled in Parliament.

Explanation of significant variances from the Budget in the Statement of Intent when compared to actual figures for the year ended 30 June 2016 are provided below.

Statement of comprehensive revenue and expense
The DHB recorded a deficit of $11.9M compared with the budgeted surplus of $1.4M.
Revenue for 15/16 was greater than budget due to increased MOH and IDF revenue due to an opening of a new psychiatric ward, additional under 13 year old revenue and increased activities in other services.
Expenditure was higher than budget for the reasons noted below:

- Personnel and clinical supply costs were above budget due to higher levels of activity as a result of a new mental health service opening, increased health of older people bed days and acute hospital demand.
- Increased outsourced cost due to vacancies and the need to outsource to meet health targets.
- Increased infrastructure costs mainly related to increased facility maintenance, legal costs and affiliation fees for regional initiatives.

Statement of changes in Equity

- The variance in equity balance is mainly due to the DHB not meeting its budgeted comprehensive revenue and expense for the year.

Statement of financial position

- The cash balance is significantly less than budget due to the increase in operational spend explained above.
- Trade and other payables were higher mainly due to the timing of supplier payments.

Statement of cash flows

- The net cash flow from operating activities is significantly less than budget due to the increase in operational spend explained above.
- The net cash flow from investment activities is higher than the budget. This is mainly due to the reclassification of $1.1 million RHIP project costs from operating costs to capital costs and approximately $1 million towards capital contribution to Wellington Southern Community Laboratories.
- The net cash flow from financing activities is in line with the budget.

26 CAPITAL MANAGEMENT

The DHB's capital is its equity, which is comprised of equity contribution, accumulated funds and other reserves. Equity is represented by net assets.

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

in thousands of New Zealand Dollars

27 SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2016 Actual	2015 Actual	2016 Actual	2015 Actual	2016 Actual	2015 Actual	2016 Actual	2015 Actual	2016 Actual	2015 Actual
Revenue										
Crown	10,702	7,399	190,794	184,070	698,199	677,940	101,683	97,428	1,001,378	966,837
Other	-	-	-	-	19,847	29,379	-	11	19,847	29,390
Total revenue	**10,702**	**7,399**	**190,794**	**184,070**	**718,046**	**707,319**	**101,683**	**97,439**	**1,021,225**	**996,227**
Expenditure										
Personnel	152	144	2,877	3,089	429,319	408,269	1,539	1,858	433,887	413,360
Depreciation	-	-	-	-	33,138	37,775	-	-	33,138	37,775
Capital charge	-	-	-	-	8,086	8,382	-	-	8,086	8,382
Provider payments	9,301	7,254	175,641	163,580	60,375	66,456	93,952	88,648	339,269	325,938
Other	580	1	11,594	17,401	200,478	190,431	6,111	6,921	218,763	214,754
Total expenditure	**10,033**	**7,399**	**190,112**	**184,070**	**731,396**	**711,313**	**101,602**	**97,427**	**1,033,143**	**1,000,209**
Net surplus/(deficit)	**669**	**0**	**682**	**0**	**(13,350)**	**(3,994)**	**81**	**12**	**(11,918)**	**(3,982)**

Actual revenue and expenditure has been mapped to output classes in accordance with guidance on classifications from the Ministry of Health. All expenditure paid from the funder arm is matched to a purchase unit code, and then mapped to the relevant output class. This is done at a detailed transactional level and accounts for the majority of the DHB's revenue and expenditure.

The DHB's remaining activity is within the provider arm, and as a result has been assumed to come under the intensive assessment and treatment output class.

in thousands of New Zealand Dollars

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2016 Actual	**2016 Budget**	**2015 Actual**	**2016 Actual**	**2016 Budget**	**2015 Actual**	**2016 Actual**	**2016 Budget**	**2015 Actual**	**2016 Actual**	**2016 Budget**	**2015 Actual**
Opening balance	(340,769)	(322,862)	(311,181)	(17,159)	(19,573)	(17,160)	24,818	(7,801)	(787)	(333,110)	(340,924)	(329,128)
Surplus/(deficit) for the year	(25,540)	(9,955)	(29,588)	88	(11)	1	13,534	11,406	25,605	(11,918)	1,440	(3,982)
Closing balance	**(366,309)**	**(332,817)**	**(340,769)**	**(17,071)**	**(19,584)**	**(17,159)**	**38,352**	**3,605**	**24,818**	**(345,028)**	**(339,484)**	**(333,110)**