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Capital & Coast District Health Board

Annual Report 2016-2017

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

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Cover photo: Raumati couple Tony and Brenda Smith with staff from Wellington Regional Hospital. The Smiths donated a 'Stedy-Eddy' - a tool to help patients stand and be more mobile - to the hospital's cancer ward after Tony's treatment for leukemia.

COMMS: 00469-1708

CHAIR AND CHIEF EXECUTIVE'S FOREWORD

We are pleased to present Capital & Coast District Health Board's (CCDHB) Annual Report for the financial year from 1 July 2016 to 30 June 2017. 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 new board was appointed in December to govern Capital & Coast DHB for the next three years. The board is committed to providing the best quality healthcare possible and continuing to improve health outcomes for our population.

We have continued to deliver more efficient, high quality services, and to develop new ways of working. Ongoing greater efficiency and innovation is required to meet our ageing population and growing demand for our services and reduce our deficit.

Great progress had been made in previous years to bring the deficit down. Unfortunately we weren't able to maintain that progress this year. There are a range of factors that caused this including increased demand for hospital and community services, and increased personnel costs.

While we have had financial challenges, we have continued to invest in health services and new equipment. This has including replacing our existing CT scanner and purchasing an additional one, introducing free Wifi in our hospitals, and creating a new waiting area for children in Wellington Regional Hospital's emergency department.

One of our most exciting investments is a collaborative project with our local primary health organisations and general practices. The Health Care Home project is about enhancing the range of services available in the community and making it easier to access health care. Over 100,000 people are now benefiting from this new way of working together.

Looking ahead and planning for our communities future health needs has been a big focus during the year. Our new Pacific action plan – Toe timata le upega – aims to help Pacific peoples lead healthier and more independent lives. The Sub Regional Disability Strategy 2017-2022, covering the Wairarapa, Hutt Valley and Capital & Coast DHB regions, was officially launched in June. This strategy gives a clear direction for health sector leaders to work alongside disability communities in addressing inequities and ensuring better health outcomes.

Feedback from patients and their families underlies many of the changes we make to our services. Staff and clients at Mental Health, Addictions and Intellectual Disabilities 3DHB (MHAIDs) forensic mental health are working together to strengthen services. The Nga Tapuwae (footsteps) co-design project looks at ways to improve care from when someone arrives until when they are discharged.

Prevention is a key part of our approach to improving the health and wellbeing of our community. Our new family violence intervention programme means our screening rate is now among the highest in the country. Project Energize continues to make progress to combat childhood obesity. This project teaches kids how to be healthy and gives schools practical support to implement health and fitness

programmes. A tele-stroke initiative was introduced to give stroke patients faster treatment and reduce the risk of permanent disability.

Growing our workforce is another area in which we have continued to make progress. We have been working with Massey University and Whitireia New Zealand to set up dedicated education units in our hospitals. These units provide a more supportive learning environment for graduate nurses.

During the year we hosted the inaugural 'Building Leaders' Māori and Pacific nurses forum. More than 200 Māori and Pasifika nurses came together to discuss how strengthening their workforce can help improve the health outcomes and wellbeing of Māori and Pasifika communities.

We also carried out a staff engagement survey to understand how we make our DHB the best place to work. The results allow us to move forward with confidence, with insight into the areas of strength and the areas of focus for improvement.

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 Hospital Foundation and the time given by our hospital volunteers.

Andrew Blair, BOARD CHAIR

Debbie Chin, CHIEF EXECUTIVE

INTRODUCTION

This Annual Report articulates Capital & Coast District Health Board's (CCDHB) progress towards meeting the intentions and priorities as outlined in the New Zealand Health Strategy and our Board's vision of "Better health and independence for people, families and communities".

In addition, CCDHB is guided by core legislative and governmental strategy including, the New Zealand Public Health and Disability Act 2000, the Treaty of Waitangi, and strategies that accompany the New Zealand Health Strategy; He Kowowai Oranga – the Māori Health Strategy, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018, Healthy Ageing, Living with Diabetes, Rising to the Challenge – Mental Health and Addiction Service Development Plan, Enabling Good Lives Disability Strategy and the Primary Health Care Strategy.

To achieve our responsibilities to the Minister, the region and our communities, we use our resources wisely and strategically to:

- promote health and wellbeing
- prevent the onset and development of avoidable illness
- strengthen the wellbeing and health outcomes of people who are experiencing illness
- enable people to achieve their life outcomes
- support the end of life with dignity.

To achieve our obligations, deliver improved health outcomes and deliver effective health services we build on our existing successes and continue to find new ways to:

- work with communities to improve health and wellbeing, with a focus on preventing or delaying the onset of avoidable illness or disability
- simplify service delivery for those people who have good health literacy and health behaviours
- intensify service delivery for those who are more vulnerable and have greater health need to reduce inequalities and improve health gain
- implement models of care that can intervene earlier, closer to home and with improved outcomes
- organise technology and interdisciplinary teams in communities, peoples' homes, community health networks and our hospitals to ensure efficient use of resources by reducing duplication and improving integration.

We have begun implementation of our longer term vision of how services will be delivered for our population, as articulated in the Health Systems Plan 2030 and supported by work that focuses on building sustainable health systems and healthy communities.

We are now well positioned to deliver against the themes of the New Zealand Health Strategy; to be people powered, provide services closer to home, operating as one team, using smart systems, as well as ensuring we deliver value and high performance for our population.

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

CCDHB receives funding to improve, promote and protect the health of around 300,000 people in:

- Wellington City
- Porirua
- and parts of the Kapiti Coast.

We are also the leading provider of a number of specialist services, including neurosurgery, oncology, neonatal intensive care, and specialised mental health services, for the upper South and lower North Islands, a population of about 900,000 people.

CCDHB has the equivalent of around 4,300 full time staff, making us a major employer in the Wellington Region.

Our DHB is the sixth largest in New Zealand and has an annual budget of more than $1 billion, which we use to deliver health services directly and to contract external providers, such as general practices, rest homes and pharmacists, to provide care.

CCDHB has two distinct roles:

- Hospital and Health Services (HHS) provides secondary services via the hospital and community outreach programmes.
- The Strategy, Innovation and Performance team's role is to assess the health needs of the people of the district and commission the most appropriate services to meet those needs.

We operate two hospitals – Wellington Regional Hospital in Newtown and Kenepuru Hospital in Porirua – as well as the Kapiti Health Centre at Paraparaumu. We also operate Te Korowai-Whāriki, a large mental health campus based at Porirua.

We provide a range of community-based services including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services.

We have a close relationship with the University of Otago School of Medicine, Wellington, adjacent to Wellington Regional Hospital. Also co-located with Wellington Regional Hospital is the Victoria University of Wellington Graduate School of Nursing, Midwifery and Health. We maintain close links with polytechnics and other tertiary institutions for student training.

CCDHB supports research that is subject to assessment and scrutiny by an independent ethics committee. We work with the Medical Research Institute of New Zealand, which is based at our Wellington location. We also have a 14-bed Clinical Trials Unit, where patients and volunteers can participate in medical research programmes run according to robust trial protocols.

GOVERNANCE OF CAPITAL & COAST DHB

Role of the Board

The Board of CCDHB 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.

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 Boards of Wairarapa, Hutt Valley and Capital & Coast DHBs 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 & COMMITTEE MEETING ATTENDANCE

Attendance from July 2016 – December 2016

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

Note:

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

Attendance from January 2017 – June 2017:

Board member	**Board** (6 meetings)	**CPHAC** (2 meetings)	**DSAC** (2 meetings)	**HAC** (0 meetings)	**FRAC** (6 meetings)
Andrew Blair (Chair)	6				6
Fran Wilde (Deputy Chair	6	2	2		6
Roger Jarrold	5				5
Darrin Sykes	6				6
‘Ana Coffey	5				
Sue Kedgley	5	2	2		
Sue Driver	5	1	1		
Kim Ngarimu	5				6
Roger Blakeley	6				6
Eileen Brown	6	2	2		
Kathryn Adams	6				6

Note:
- New Board was appointed with effect 5 December 2016
- Crown Monitor was not reappointed
- HAC committee did not meet – part of full Board proceedings
- There is no Board representative on the MPB or SRPSHAG – there is however an open invitation for both Board chair and deputy chair to attend meetings

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.

Leadership is also a key focus of our current and future work programme to deliver a people strategy developed with the findings of our engagement survey and engagement with staff and unions.

We undertook an engagement survey this year. This has given us information that specifically targets all the good employer elements and action planning is under way to support those. In addition the DHB is developing a people strategy to support engagement. This will also meet good employer obligations.

We are looking to support even better healthcare services through a focus on our place of work. This includes looking to build as safe and supportive a workplace as possible.

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.

Each is discussed below:

Leadership, accountability, and culture

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 and leaders are accountable for supporting and building a positive work environment.

The DHB currently has an HR Plan centred around building a positive workplace that has a key focus on leadership, accountability and culture.

To support capability in this area, last year we tendered for leadership development for our senior leadership teams. This year the programmes are running and have had good feedback. We have also run two front line leadership programmes internally. There is also a course for all managers called "What Leaders Need to Know" that is built from the leadership ethos and is run quarterly.

We ran an organisation wide engagement survey which is the precursor to the people strategy that will be developed by the end of the year and replace the current plan.

Leaders in the organisation are developing action plans through all levels of the organisation to support culture.

We have developed and are about to implement on line learning packages for staff and managers for the Code of Conduct and creating a healthy workplace. We have also developed manager face to face training for manager to complement the online learning and provide development on building a healthy workplace free from bullying, harassment, victimisation and unacceptable behaviour. In addition have trained more contact people for staff in relation to bullying and harassment prevention this year. We have other policies including the EEO Policy are being reviewed this year.

Recruitment, selection, and induction

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.

The recruitment and selection policy and guidelines are currently being reviewed with a view to ensuring affirmative approaches to ensuring the DHB is recruiting in a way that is aligned with the population it services.

There are structured inductions for staff. Some of this is approached generically and some by profession.

Employee development, promotion, and exit

Learning and development opportunities are offered to all staff, and personal performance and development plans are done annually. Exit interviews are also offered to all staff.

The organisation has bedded in a learning and management system that encourages and supports learning plan and allows good reporting on learning opportunities .

Flexibility and work design

We have a number of initiatives looking at this including looking at services provided to patients and clients are designed appropriately.

We also major projects using various methodology specifically looking at supporting nursing, midwifery and allied health staff with regard to flexibility and work design.

Remuneration, recognition, and conditions

Approximately 84% 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.

Harassment and bullying prevention

This is a key area of focus for the DHB. Our engagement survey specifically asked staff about it and as noted above we have a healthy workplaces programme of work specifically focused on it. We have developed and are about to implement on line learning packages for staff and managers for the Code of Conduct and creating a healthy workplace. We have also developed manager face to face training for manager to complement the online learning and provide development on building a healthy workplace free from bullying, harassment, victimisation and unacceptable behaviour. In addition have trained more contact people for staff in relation to bullying and harassment prevention this year. We are working with an expert organisation from Australia who have had excellent results in other countries around introducing a programme that addresses bullying and harassment specifically in a health care context. This will be an extensive programme.

Safe and healthy environment

Several forums are in place comprising of employees from across the DHB. These include active directorate health and safety committees, as well as a DHB Health and Safety Steering Committee, and sub committees for Workplace Violence and Security and Moving and Handling.

These forums meet to consider workplace practices and have active work programmes.

The DHB has reviewed a large number of health and safety policies over the year.

The DHB has a number of avenues to allow staff to raise concerns including reportable event processes, the Protected Disclosure Act 2000 and the Board's related policy, which protects the right of employees to raise matters of public concern in a safe and appropriate manner, its own occupational health and safety area where staff can get support and can make anonymous reports. It also has a further external service that staff can report to anonymously.

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.

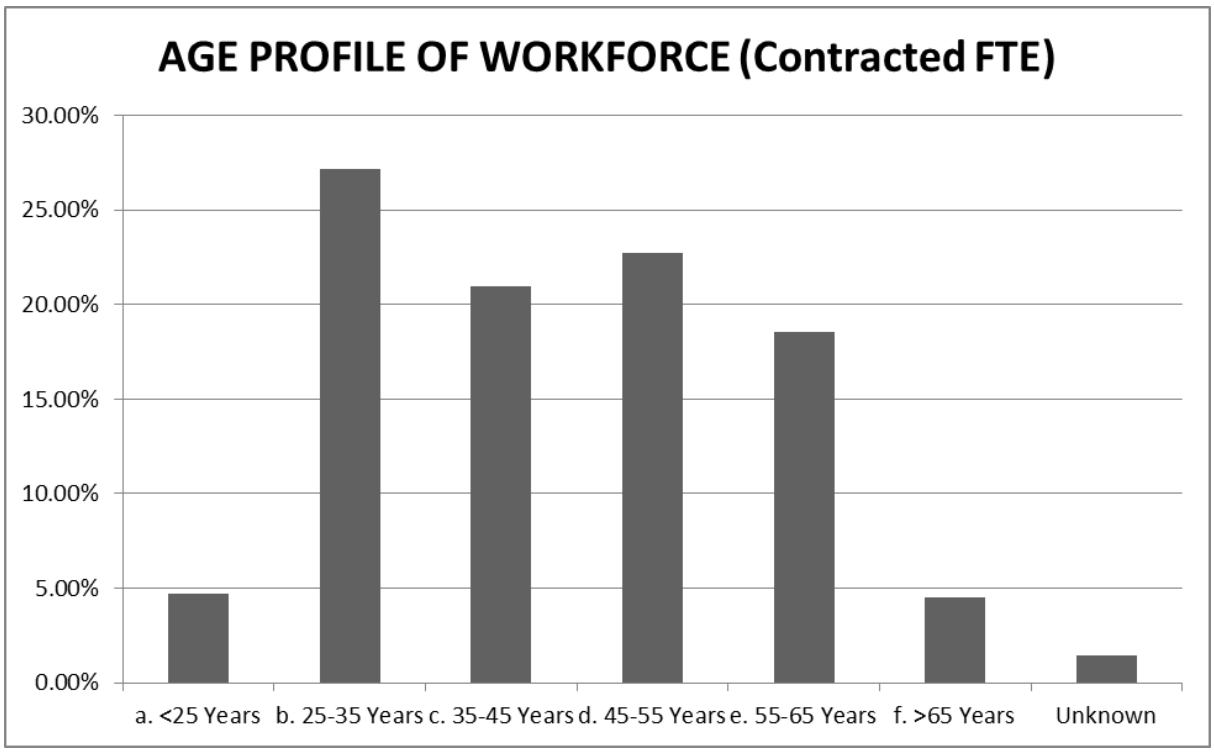
Workforce profile

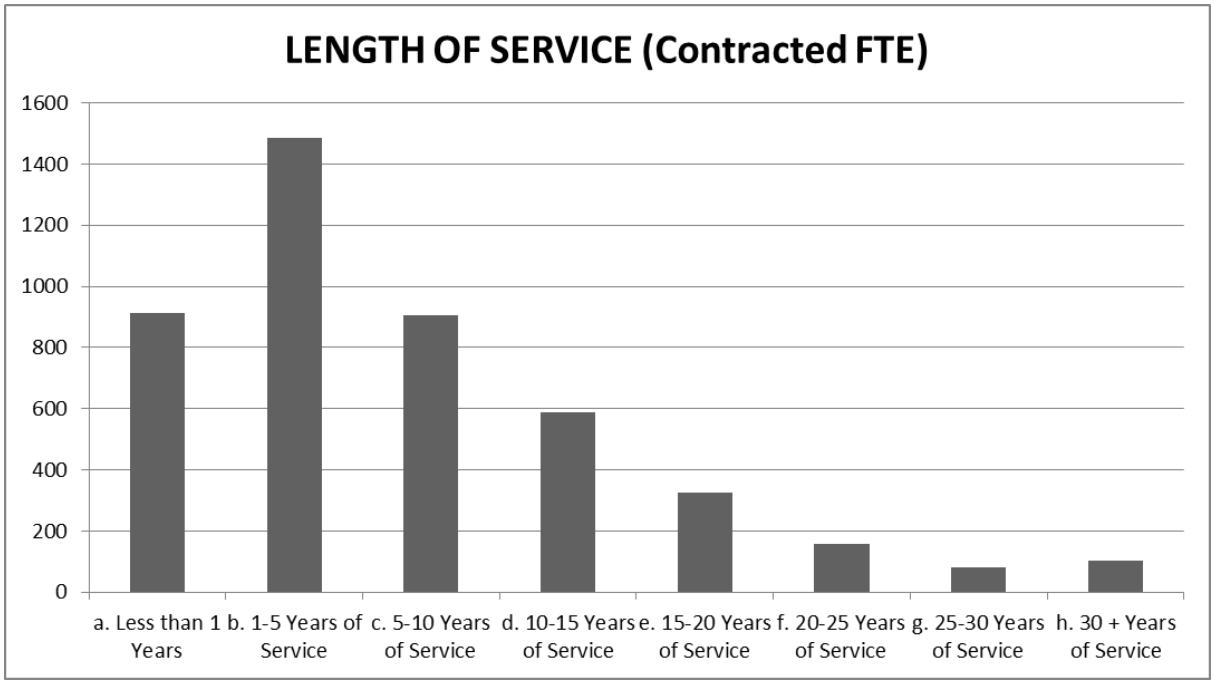
Full Time Equivalent (FTE) staff numbers

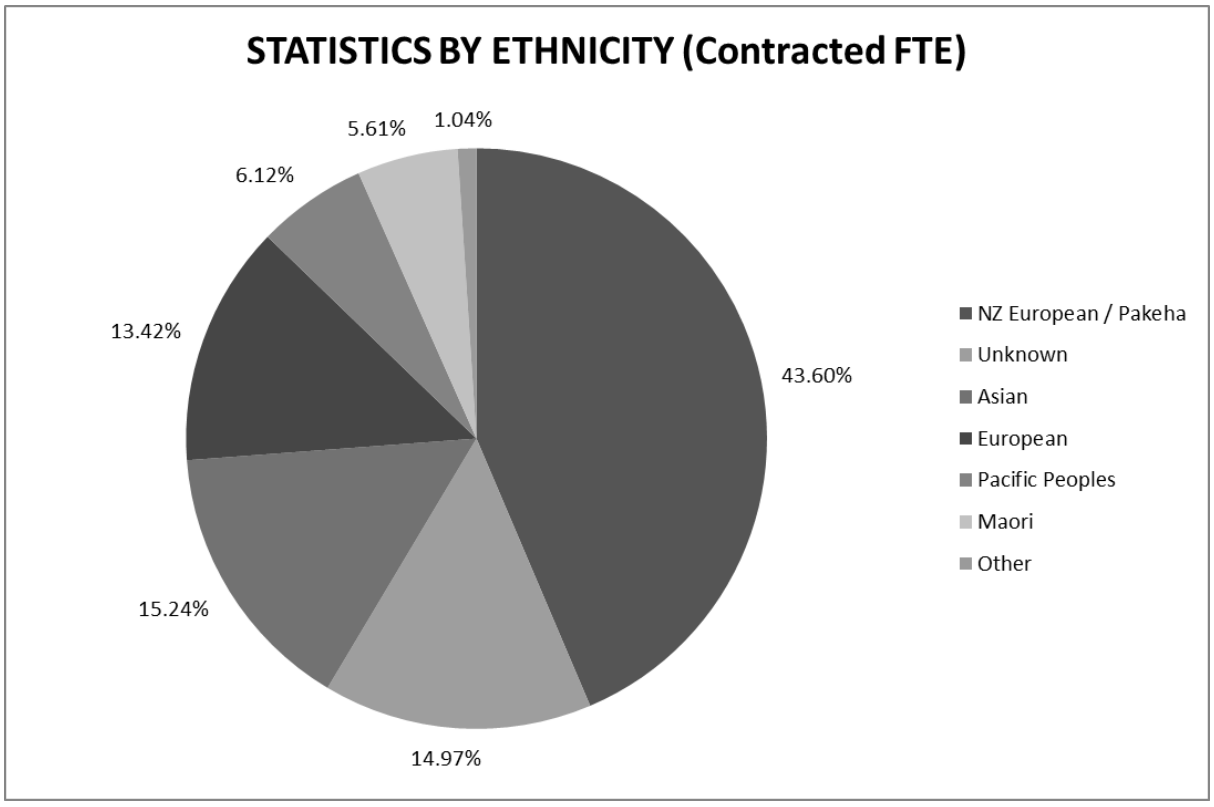
Profession	2017	2016	2015	2014	2013	2012	2011	2010
Medical	849	833	798	774	698	589	548	513
Nursing	2046	2004	1941	1895	1908	1801	1791	1801
Allied Health	712	705	763	771	759	728	707	682
Other	954	964	998	979	1010	959	959	966
Total	4561	4505	4500	4419	4374	4078	4006	3962

Statistics by Gender

Gender	2017	2016	2015	2014	2013	2012	2011	2010
Female	72%	73%	72%	72%	72%	73%	72%	73%
Male	28%	27%	28%	28%	28%	27%	28%	27%







Note these numbers are based on contracted FTE at the end of the financial year not capped at 1FTE. The numbers include those on LWOP/Parental leave, however excludes personnel not paid through the CCDHB payroll system.

QUALITY & SAFETY MARKERS 2016/2017

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through its quality improvement programmes. The quality and safety markers help evaluate the success of the programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred. The quality and safety markers concentrate on specific areas of harm: falls, healthcare associated infections and safe surgery. Below are our performance results as at 30 September 2017.

Marker Definition		NZ Goal	NZ Average	Q3 July to Sept 2016	Q4 Oct to Dec 2016	Q1 Jan to March 2017	Q2 April to June 2017
Falls: % if patients aged >75 (Māori and Pacific Islanders >55) that are given a falls risk assessment		90%	92%	91%	91%	99%	99%
Falls: % of patients assessed as being at risk who have an individualized care plan which addresses their falls risk		90%	95%	96%	93%	95%	95%
Safe Surgery: % of audits where all components of checklist were reviewed	**Sign In**	100%	-	*	91%	97%	99%
	Time Out			88%	93%	99%	99%
	Sign Out			*	93%	98%	100%
Safe Surgery: % of audits with engagement scores of 5 or higher	**Sign In**	95%	-	*	73%	91%	95%
	Time Out			69%	90%	94%	96%
	Sign Out			*	89%	97%	98%
Hand Hygiene: % of opportunities for hand hygiene for health professionals		80%	84%	82%	**	79%	76%

Surgical Site Infections - Timing: % of hip and knee arthroplasty primary procedures were given an antibiotic at the right time	**100%**	**98%**	**100%**	**100%**	**100%**	**100%**
Surgical Site Infections - Dosing: % of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose	**95%**	**97%**	**99%**	**98%**	**98%**	**99%**
Cardiac Surgery - Timing: % of cardiac surgery were given an antibiotic at the right time	**100%**	**97%**	**100%**	**100%**	**100%**	**+**
Cardiac Surgery – Dosing: % of cardiac surgery were given an antibiotic in the right dose	**95%**	**97%**	**100%**	**98%**	**99%**	**+**
Cardiac Surgery – Skin Preparation: % of cardiac surgery were given the appropriate skin preparation	**100%**	**100%**	**100%**	**100%**	**100%**	**+**

***** New Safe Surgery QSM as of 01/07/2016
****** reported 3 times a year, therefore no data point is shown for Q4
+ reported 6 months after the other QSMs

Serious and sentinel adverse events

At CCDHB improving quality, safety and experience of health care services is a key priority. The early detection and review of adverse events that are the result of a healthcare system or process failure is therefore essential. By learning from these reviews we can reduce the risk of similar adverse events re-occurring and improving the health and disability services we provide.

In the year from 1 July 2016 to 30 June 2017, we had 19 serious and sentinel adverse events where patients suffered serious harm or died as a result of a healthcare system or process failure while in our care. Of these, 12 were related to patient falls, five were related to clinical processes such as assessment, diagnosis, treatment, general care, one was a medication or IV fluids error and one was a patient accident such as burns or wounds.

IMPROVING HEALTH OUTCOMES

As the major commissioner 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 commission 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.

The key health priorities for CCDHB include:

- promoting health and wellbeing
- preventing the onset and development of avoidable illness
- strengthening the wellbeing and health outcomes of people who are experiencing illness
- enabling people to achieve their life outcomes
- supporting dignity at the end of life.

By far, the greatest opportunity for CC DHB to deliver better care and outcomes for our communities lies in improving equitable outcomes for all of our populations, including Māori. This opportunity is supported by the Ministry of Health and the expectation that DHBs focus on “equity of outcomes”.

To deliver against this opportunity, CCDHB is establishing strategic views of equity and ensuring that a medium-to-long term strategy to address equity is explicit in all of the DHB’s strategies, clinical service planning, service commissioning and investment decisions. That is, improving equitable health outcomes is embedded in our core business.

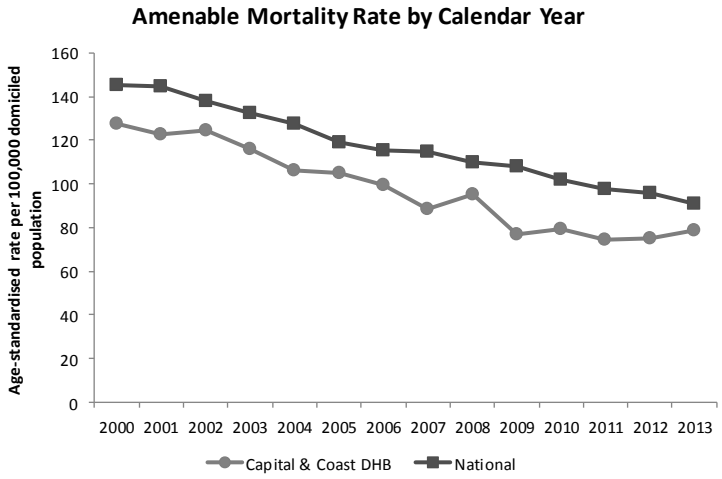
OUTCOMES AND IMPACTS

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.

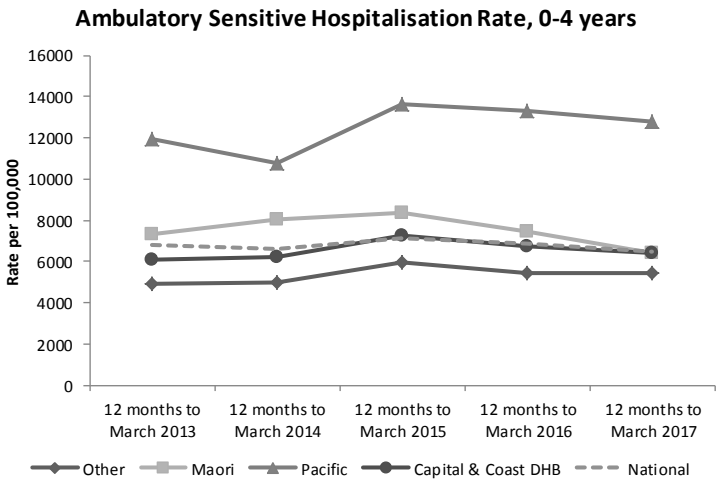
Impact Measure: Amenable Mortality

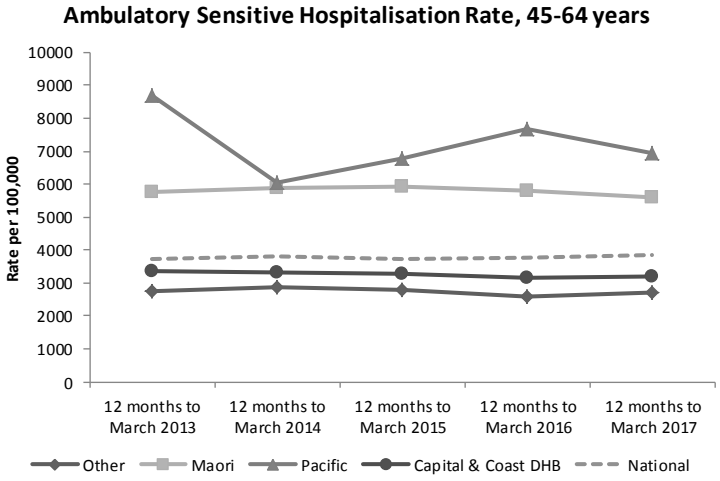
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care. Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them. In CCDHB's System Level Measure Plan 2016/17, we committed to maintaining rates below 80 per 100,000. Amenable mortality rates for CCDHB remain below the national average. The latest official data on amenable mortality is up to 2013.



Impact Measure: Ambulatory Sensitive Hospitalisation (ASH) rates

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 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 CCDHB, ASH rates remain below the national average. However, the significant disparities for Māori and Pacific remain a priority for action.



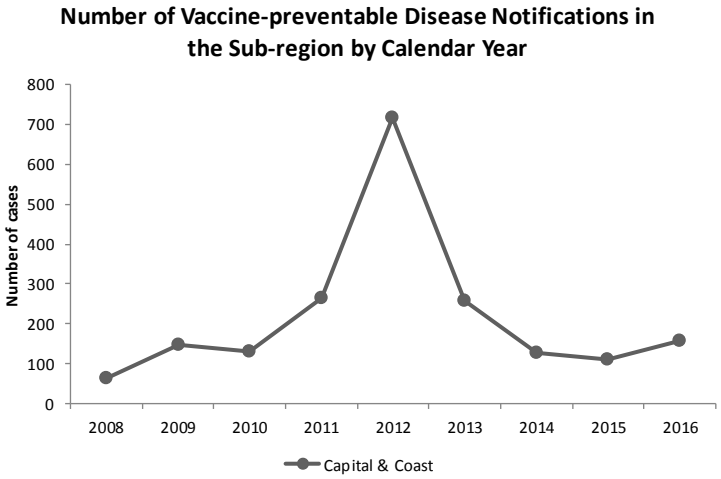


Improved Environmental and Disease Hazard Management

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.

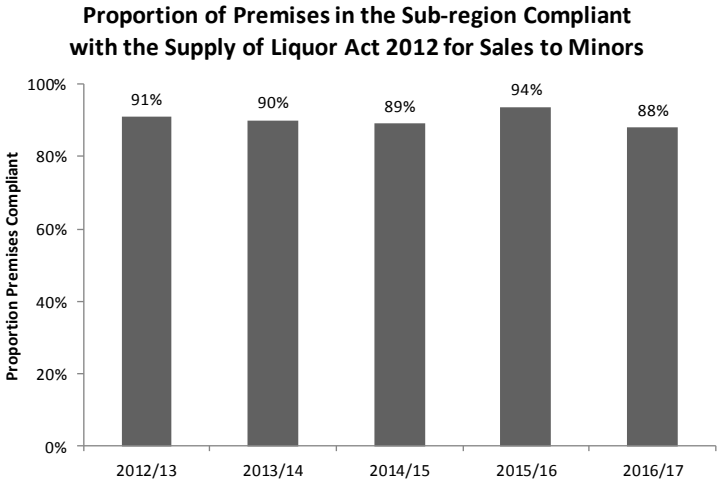
Impact Measure: Vaccine preventable disease notifications

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. In 2012, pertussis (whooping cough) outbreaks resulted in an increase in vaccine-preventable disease notifications. This trend is also reflected at a national level and across all DHBs. In the longer term, with increased immunisation, we anticipate that the number of vaccine preventable disease notifications will decrease.



Impact Measure: Compliance with Supply of Liquor Act 2012

In New Zealand, alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime. 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) are an effective compliance tool and have contributed to a national decline in the incidence of premises selling to minors. In 2016/17, changes in operating procedures and capacity resulted in fewer CPOs being conducted. CPOs were also targeted at higher risk premises which may contribute to the decrease in compliant premises.

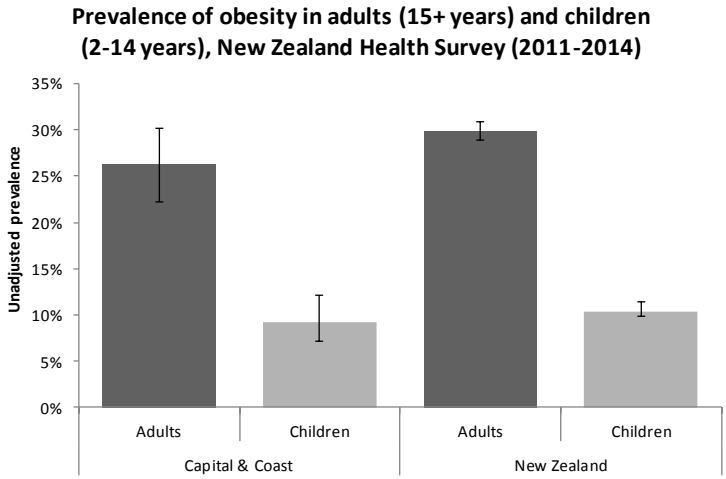


Improved Management of Lifestyle Factors that Affect Health

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. Four key lifestyle factors drive health loss: smoking, obesity, physical inactivity and poor diet. Reducing the incidence of these negative lifestyle factors will improve the health of our population.

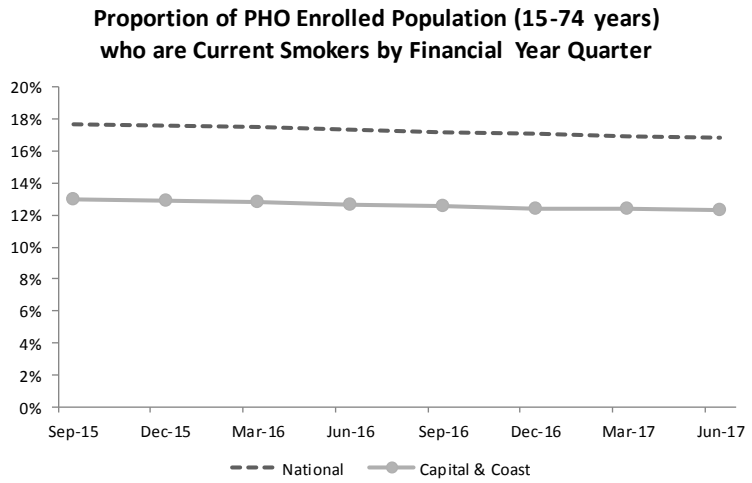
Impact Measure: Obesity Prevalence in adults and children

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. By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease. Updated data on obesity prevalence is planned for release in early 2018 and will establish trends in obesity prevalence.



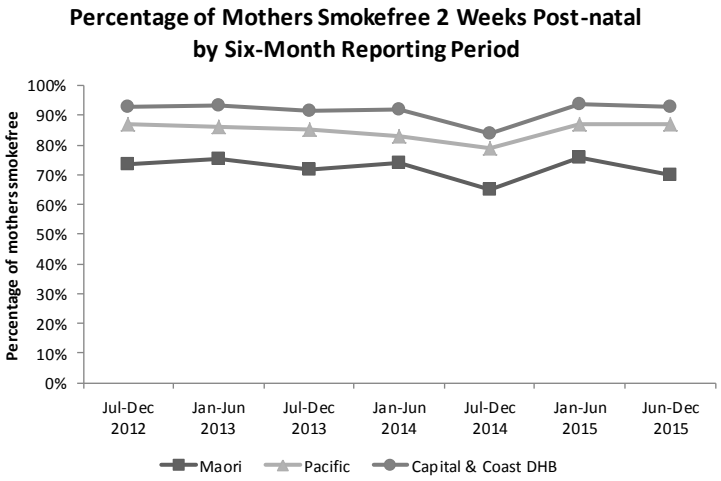
Impact Measure: Smoking Prevalence in adults

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 to all patients enrolled in a general practice or when they visit the hospital. CCDHB recognises the significant ethnic disparities in smoking rates across our population and are committed to achieving equitable health outcomes for these populations.



Impact Measure: Maternal Smoking Prevalence

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 smoke free two weeks post-natal will increase. In 2017/18, CCDHB is committed to improving the proportion of babies living in a smoke-free household at 6 weeks post-natal as part of the System Level Measure Improvement Plan.

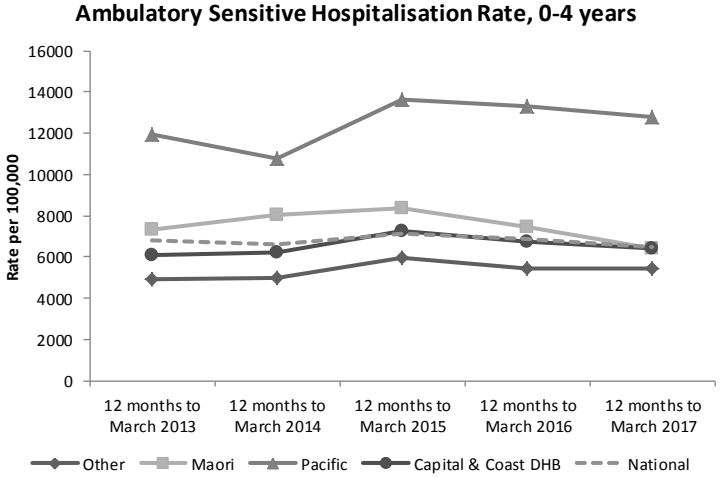


Children Have a Healthy Start in Life

The social determinants that affect the health of children can have a lasting effect on their life outcomes. Poor health as a child often predicts poor self-rated health and the development of chronic conditions as an adult. It is for these reasons that it is important the DHB provides children and their whānau with high-quality and accessible services, including equitable access.

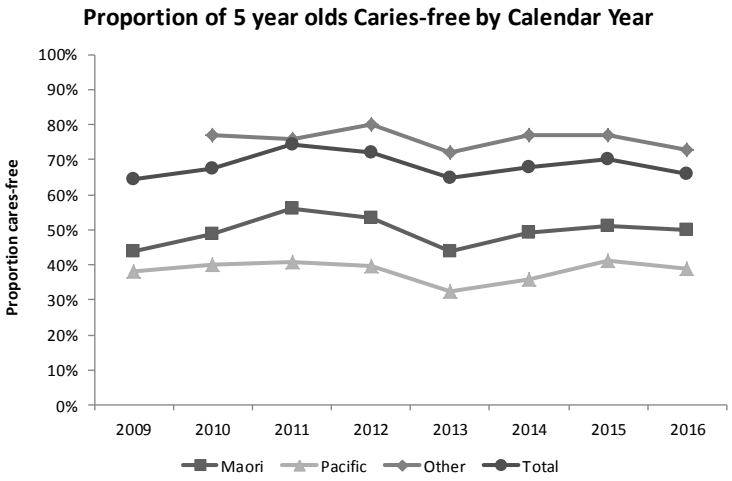
Impact Measure: Ambulatory Sensitive Hospitalisation (ASH) Rates

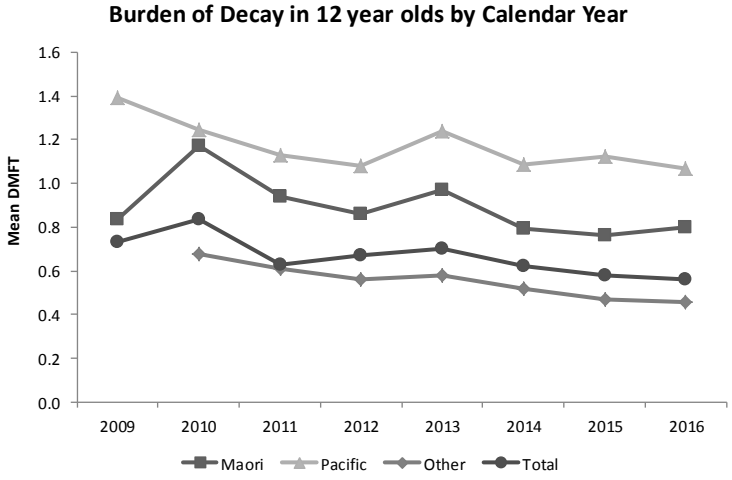
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, 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. As part of the System Level Measures Improvement Framework, CCDHB is committed to reducing the equity gap for Pacific children and make further improvements in reducing equity for Māori children.



Impact Measure: Caries free at 5 years/Burden of tooth decay at Year 8

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, including Māori and Pacific children who have worse oral health outcomes than other ethnicities. CCDHB is undertaking a number of activities to improve oral health outcomes for children, for example, the sub-regional enrolment system and the 'Lift the Lip' oral health examination as part of the Before School Check. By ensuring that every child has access to and is receiving oral health services, we expect that the oral health outcomes for children will improve.



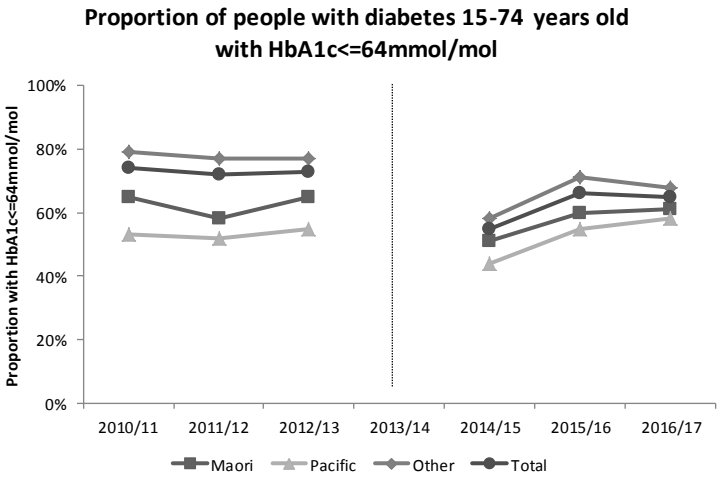


Long-term Conditions are Well Managed

The New Zealand Burden of Disease Study suggests 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

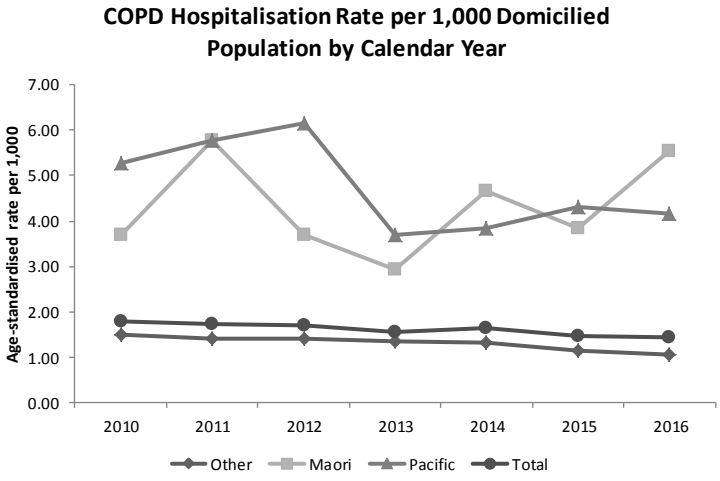
Impact Measure: Satisfactory blood glucose control (HbA1c ≤64 mmol/mol)

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 associated risks minimised. A lower level of HbA1c in the blood indicates that a person's diabetes is being well-managed. By improving the quality of care, empowering people with diabetes to look after their health and equity, we expect to see more people with diabetes having good blood glucose control and fewer high-risk people from developing diabetes and preventing diabetes-related complications. A revised methodology was implemented from 2013/14, with results unavailable for 2013/14.



Impact Measure: Hospitalisation rate for chronic obstructive pulmonary disease (COPD)

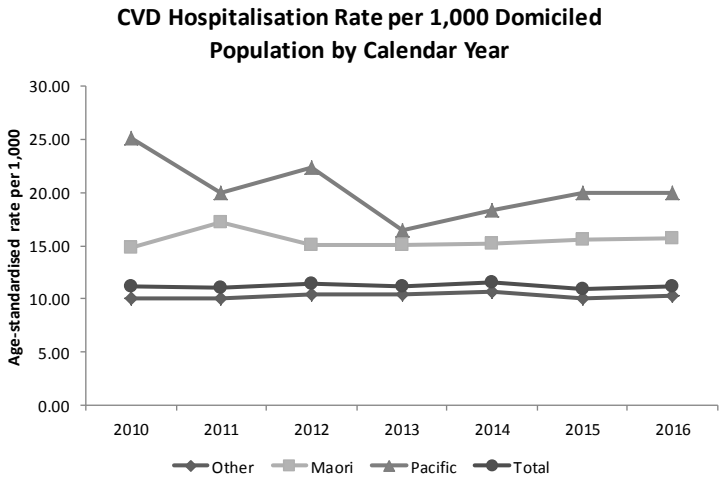
Chronic obstructive pulmonary disease (COPD) results from damage to the lungs. COPD is most commonly associated with smoking, and although lung damage is permanent, quitting smoking can help to improve COPD symptoms and prevent further damage. By providing cessation support for people who smoke and improving access to primary care, and supporting improved equity in these domains, as well as assisting people to take their medication regularly, we expect that the rate of COPD hospitalisations for our population will decrease and improved equitable health outcomes.



Impact Measure: Hospitalisation rate for cardiovascular disease (CVD)

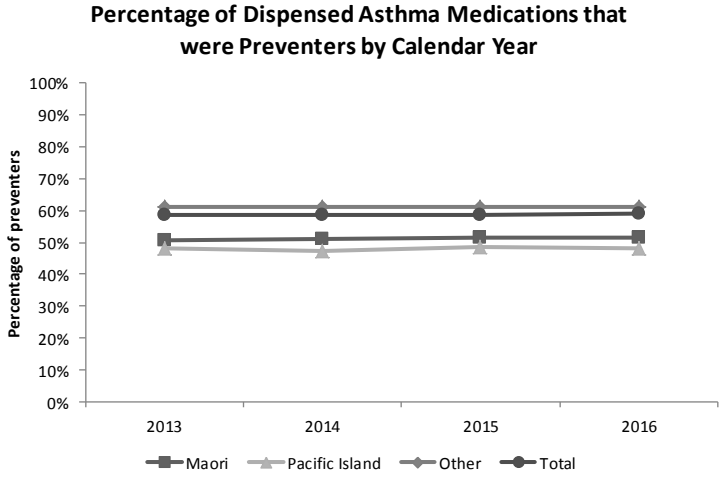
Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. CVD is the leading cause of death in the sub-region. Overall, around 70% of the burden of CVD 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. 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 CVD hospitalisation rate for our population and improved equitable health outcomes.



Impact Measure: 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 proportion of preventers dispensed than relievers suggests that asthma is 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.

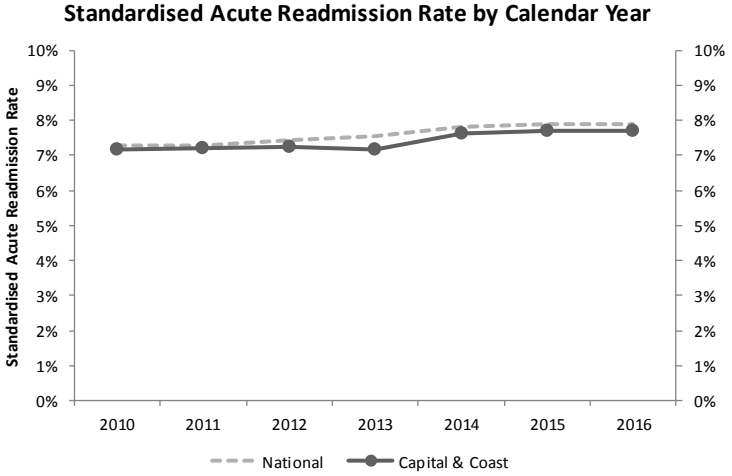


People receive high quality hospital and specialist health services when required

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.

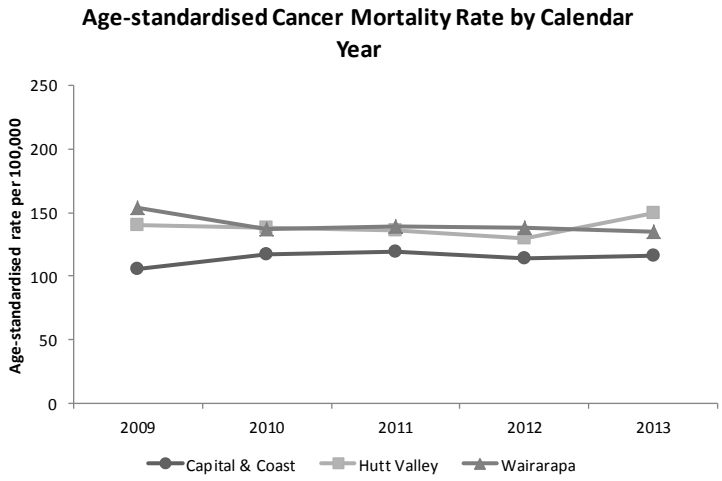
Impact Measure: Standardised acute readmission rate

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. CCDHB continues to drive improvements in the quality of care for people in our care. CCDHB's readmission rates are consistently below the national average and, in the long term, we expect that readmission rates will decrease.



Impact Measure: Age-standardised cancer mortality rate

In New Zealand, more people are developing cancer, mainly because the population is growing and getting older. If found and treated in time, many cancers can be cured. In New Zealand, it is estimated that one person in every three with cancer is cured. By screening for cancer and providing timely treatment, we expect that the cancer mortality rate will decrease. CCDHB is committed to improving screening rates for breast and cervical cancer, including improved outcomes for priority populations, and preparing for the local roll out of the National Bowel Screening Programme.

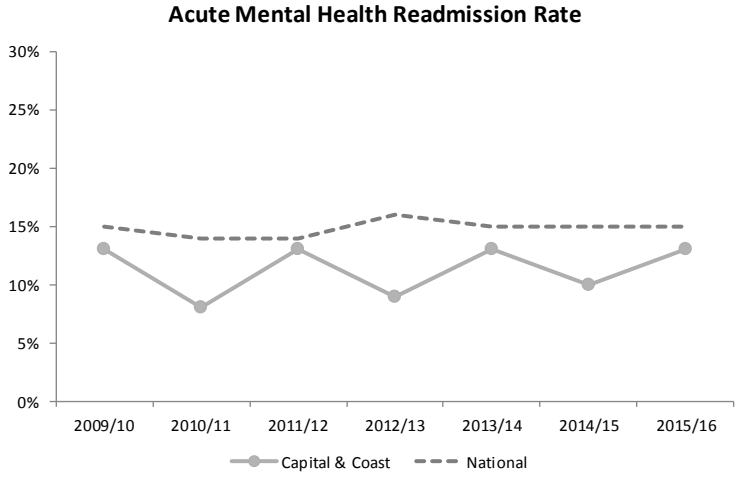


People receive high quality mental health services when required

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.

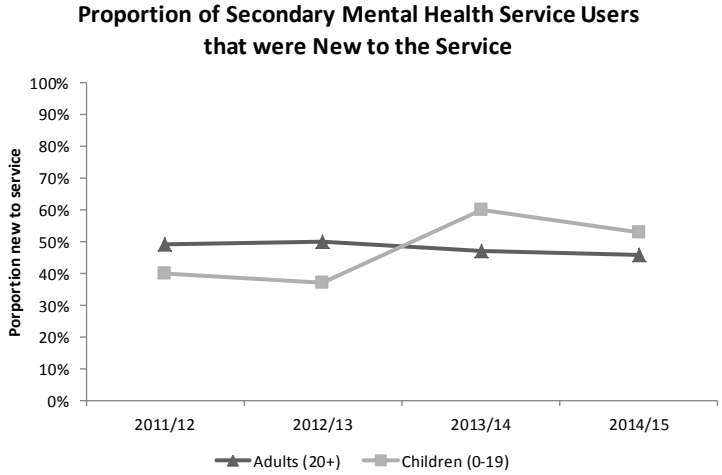
Impact Measure: Acute readmission rate to inpatient mental health services within 28 days

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. CCDHB's acute readmission rate to inpatient mental health services remains below the national average. Updated data is unavailable for national KPIs as the host is migrating to a new digital platform.



Impact Measure: New service users accessing secondary mental health services

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. Updated data is unavailable for national KPIs as the host is migrating to a new digital platform.



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 CCDHB population indicate a disabled population of approximately 65,000 (23%). The DHB has a responsibility to provide responsive and appropriate health services to people with disabilities.

Impact Measure: Proportion of patients and clinicians that found the Health Passport useful

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.

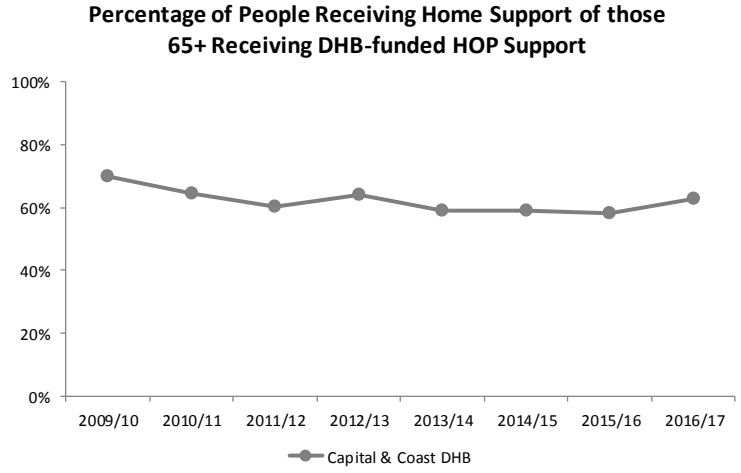
Note this measure is under-development with a review of the Health Passport.

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. CCDHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population.

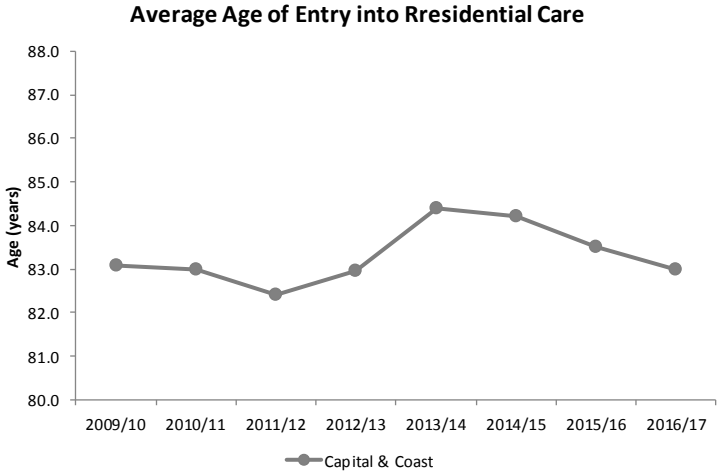
Impact Measure: Patients receiving home based support services

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. 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 CCDHB, we expect a greater proportion of our older people to receive DHB-funded support to remain independent and stay at home for longer.



Impact Measure: 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. While the average age of entry into residential care has decreased in CCDHB, older people are having shorter stays in residential care facilities indicating that they are supported to live in the community for longer.



STATEMENT OF PERFORMANCE

The Statement of Performance (SP) presents a snapshot of the services provided for our population and how these services are performing across the continuum of care provided. The SP is grouped into four output classes; Prevention services, Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support Services. Measuring our performance in these areas helps us to understand how we are affecting our impacts and outcomes set out in the Improving Outcomes section of this report. Each output class includes measures which help to evaluate CCDHB's performance over time, recognising the funding received, Government priorities, national decision-making and Board priorities. These measures include the Minister of Health's six Health Targets.

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Some of the measures reflect the performance of the broader health and disability services provided to CCDHB residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and improving health equity for Māori and Pacific. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population, as identified in the CCDHB Māori Health Plan 2016/17.

Appropriation reporting *in thousands of New Zealand dollars*

	2017 Actual	2017 Budget	2016 Actual
Appropriation revenue*	$702,655	$702,655	$690,915

*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.

Output class measures

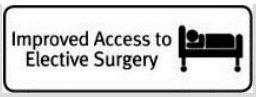
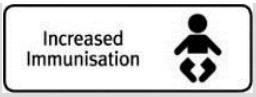
We have devised a criterion against which we measure our output performance and which has been applied to assess performance against each indicator in the Output Measures section. For performance measures that are demand driven, no assumptions about whether an increase or decrease is desirable have been made. A rating is has not been applied to demand driven indicators.

Criteria Description	Rating	Rating System
Achieved	At or above target	✓
Not achieved, but progress made	≤10% of target	⊘
Not achieved	≥10.1% of target	×
Demand-driven measure	No rating applied	H

Class	Class Description
Q	Quality
V	Volume
T	Timeliness
C	Coverage

National 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 and the impact they make can be measured to see how they are improving health for all New Zealanders. The results below show the results for the 2016/17 financial year.

Health Targets		Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
	95% of patients admitted, discharged or transferred from emergency department (ED) within six hours.	**95%**	**85%**	**88%**	**92%**	**90%**
	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs).	**10,713**	**2,659**	**5,225**	**7,867**	**10,785**
	85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer.	**85%**	**84%**	**82%**	**78%**	**81%**
	95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.	**95%**	**94%**	**95%**	**93%**	**93%**
	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.	**90%**	**85%**	**86%**	**86%**	**89%**
	90% of pregnant women who smoke registered with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	**90%**	**94%**	**98%**	**97%**	**100%**
	95% of children identified as obese in the B4SC will be offered a referral to a health professional for assessment and lifestyle intervention.	**95%**	**25%**	**47%**	**73%**	**79%**

Output Class – Prevention

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations by targeting changes to physical and social environments that engage, influence and support people to make healthier choices, thereby reducing inequalities in health status. Prevention services include health promotion to help prevent the development of disease; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services such as immunisation and screening services. A significant portion of the work undertaken by primary care is preventive in nature.

Output Area: Public Health Protection and Regulatory Services

***What we want to achieve*:** Protected healthy environments where environmental and disease hazards are minimised. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The number of disease notifications investigated (V)	Total	986	Est. ≥1,280	1126	H
	Māori	66	Est. ≥108	88	H
	Pacific	57	Est. ≥67	49	H
The number of environmental health investigations (V)	Total	988	Est. ≥208	668	H
The number of premises visited for alcohol controlled purchase operations (V)	Total	142	≥167	12	H

Output Area: Health Promotion and Preventative Intervention Service

***What we want to achieve*:** People are healthier and better supported to manage their own health. Children have a healthy start in life. Lifestyle factors that affect health are well-managed. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region (V)	Total	30	Est. ≥29	17	H
The percentage of infants fully or exclusively breastfed at 3 months (C)	Total	63%	≥60%	62%	✓
	Māori	51%	≥60%	43%	✗
	Pacific	41%	≥60%	49%	✗
Number of new referrals to Public Health Nurses in primary/intermediate schools (V)	Total	1,120	≥1,197	1,126	⊘
The number of adult referrals to the Green Prescription programme (V)	Total	3,734	≥2,409	3,315	✓

Output Area: Immunisation Services

***What we want to achieve*:** Fewer people experience vaccine preventable diseases. A high coverage rate. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of two year olds fully immunised (C)	Total	95%	≥95%	94%	⊘
	Māori	95%	≥95%	95%	✓
	Pacific	94%	≥95%	98%	✓
The percentage of eight month olds fully vaccinated (C)	Total	93%	≥95%	93%	⊘
	Māori	91%	≥95%	86%	⊘
	Pacific	93%	≥95%	91%	⊘
The percentage of Year 7 children provided Boostrix vaccination in schools in the DHB (C)	Total	72%	≥70%	72%	✓
	Māori		≥70%	81%	✓
	Pacific		≥70%	88%	✓
The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB (C)	Total	72%	≥70%	64%	⊘
	Māori		≥70%	62%	⊘
	Pacific		≥70%	79%	✓

Output Area: Smoking Cessation Services

***What we want to achieve*:** Fewer people take up smoking tobacco and quit attempts are made by more current smokers. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
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 (C)	Total	83%	≥90%	89%	⊘
	Māori	83%	≥90%	88%	⊘
	Pacific	80%	≥90%	87%	⊘
The percentage of hospitalised smokers receiving advice and help to quit (C)	Total	92%	≥95%	91%	⊘
	Māori	92%	≥95%	91%	⊘
	Pacific	92%	≥95%	90%	⊘
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)	Total	97%	≥90%	100%	✓
	Māori	100%	≥90%	100%	✓

Output Area: Screening Services

***What we want to achieve*:** More eligible people participate in screening programmes. Children entering school are ready to learn. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of eligible children receiving a B4 School Check (C)	High need	91%	≥90%	95%	✓
	Total	90%	≥90%	90%	✓
The percentage of eligible women (25-69 years old) having cervical screening in the last 3 years (C)	Total	80%	≥80%	77%	⊘
	Māori	64%	≥80%	62%	×
	Pacific	67%	≥80%	67%	×
The percentage of eligible women (50-69 years old) having breast screening in the last 2 years (C)	Total	68%	≥70%	73%	✓
	Māori	64%	≥70%	68%	⊘
	Pacific	64%	≥70%	70%	✓

Output Class – Early Detection and Management

Early detection and management services are:

- delivered by health and allied health professionals in various settings
- Include general practice, community and Māori health services, pharmacist services, and child and adolescent oral health and dental services.
- are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.
- On a continuum of care, are preventative and treatment services focused on individuals and smaller groups of individuals.

Output Area: Primary Care Services

***What we want to achieve*:** Accessible, affordable and connected primary care services. Long-term conditions are well-managed. Increased availability of urgent and acute primary health care services. Fewer people are admitted to hospital for avoidable conditions. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of the DHB-domiciled population that is enrolled in a PHO (C)	Total	93%	≥94%	94%	✓
The percentage of practices with a current Diabetes Practice Population Plan (C/Q)	Total	100%	100%	100%	✓
The percentage of the eligible population assessed for CVD risk in the last five years (C)	Total	91%	≥90%	89%	⊘
	Māori	87%	≥90%	86%	⊘
	Pacific	89%	≥90%	87%	⊘
The number of new and localised Health Pathways in the sub-region (V)	Total	172	≥250	320	✓
The number of visits to the Health Pathways website in the last month of the financial year (V)	Total	1,375	≥5,750	7,913	✓

Output Area: Oral Health Services

***What we want to achieve*:** Sustained level of utilisation of dental services by children and adolescents to improve oral health outcomes, including equitable outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of children under 5 years enrolled in DHB-funded dental services (C)	Total	95%	≥95%	97%	✓
	Māori	68%	≥95%	70%	✗
	Pacific	87%	≥95%	86%	⊘

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of adolescents accessing DHB-funded dental services (C)	Total	77%	≥85%	78%	⊘

Output Area: Pharmacy

***What we want to achieve*:** People are on the right medications to manage their conditions. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The number of initial prescription items dispensed (V)	Total	2,432,210	Est. ≥2,425,318	2,325,515	H
The percentage of the DHB-domiciled population that were dispensed at least one prescription item (C)	Total	78%	Est. ≥76%	80%	H
The number of people registered with a Long Term Conditions programme in a pharmacy (C)	Total	6,092	≥3.9%	4.0%	✓
The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy (V)	Total	224	≥220	171	×

Output Class – Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. On a continuum of care, these services are at the complex end of treatment services and focussed on individuals. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency department services including triage, diagnostic, therapeutic and disposition services.

Output Area: Medical and Surgical Services

***What we want to achieve*:** Reduced acute/unplanned hospital admissions. People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of patients admitted, discharged or transferred from Emergency Department within six hours (T)	Total	91%	≥95%	90%	⊘
The number of surgical elective discharges (V)	Total	10,864	≥10,713	10,785	✓
The standardised inpatient average length of stay (ALOS) in days, Acute (T)	Total	2.36	≤2.35	2.31	✓
The standardised inpatient average length of stay (ALOS) in days, Elective (T)	Total	1.58	≤1.55	1.57	⊘
The rate of inpatient falls causing harm, per 1,000 bed days (Q)	Total	1.3	≥1.2	0.5	✓
The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days (Q)	Total	0.8	≤0.4	0.8	⊘
The rate of identified medication errors causing harm, per 1,000 bed days (Q)	Total	0.1	≤1.0	0.03	✓
The weighted average score in the Patient Experience Survey by domain (Q)	Communication	8.4	≥8.4	8.3	⊘
	Coordination	8.7	≥8.4	8.4	✓
	Partnership	8.4	≥8.4	8.8	✓

	Physical & Emotional Needs	8.7	≥8.4	8.5	✓
The percentage of "DNA" (did not attend) appointments for outpatient specialist appointments (Q)	Total	5.0%	≤6%	7.2%	⊘
	Māori	15.2%	≤6%	15.5%	⊘
	Pacific	17.1%	≤6%	15.3%	⊘

Output Area: Cancer Services

***What we want to achieve*:** People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy (T)	Total	100%	100%	100%	✓
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 (T)	Total	83%	85%	81%	×

Output Area: Mental Health and Addictions Services

***What we want to achieve*:** People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The number of people accessing secondary mental health services (V)	Total	9,950	Est. 9,992	10,080	H
	Māori	2,039	Est. 2,118	2,046	H
	Pacific	707	Est. 728	718	H
The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks (T)	Total	61%	≥95%	87%	⊘
The percentage of patients 0-19 referred to non-urgent child & adolescent addictions	Total	91%	≥95%	77%	×

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
services that were seen within eight weeks (T)					
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)	Total	61%	≥75%	57%	✗
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)	Total	91%	≥90%	63%	✗

Output Class – Rehabilitation and Support

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services. On a continuum of care, these services will provide support for individuals.

Output Area: Disability Services

***What we want to achieve*:** Responsive health services for people with disabilities. Enhanced quality of life for people with disabilities. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
The number of sub-regional and CCDHB Disability Forums (V)	Total	CCDHB: 2 3DHB: 1	≥2	CCDHB: 2 3DHB: 2	✓
The number of sub-regional Disability Newsletters (V)	Total	8	≥2	12	✓
The total number of hospital staff that have completed the Disability Responsiveness eLearning Module (V/Q)	Total	547	≥500	718	✓
The total number of people with a Disability Alert (V/Q)	Total	5,530	≥6,220	8,526	✓

Output Area: Health of Older People Services

***What we want to achieve*:** Improve the health, well-being, and independence of our older people. Reduced acute/unplanned hospital admissions. Older people with complex health needs are supported to live in the community. Services provided are safe and effective. Equitable health outcomes.

Measure	Target Group	2015/16 Result	2016/17 Target	2016/17 Result	Achievement
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)	Total	100%	100%	100%	✓
The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home (C)	Total	58%	≥60%	63%	✓
The percentage of the population aged 75+ who are in Aged Residential Care (including private payers) (C)	Total	N/A	≤11.8%	9.5%	✓
The percentage of residential care providers meeting three or more year certification standards (Q)	Total	97%	≥95%	100%	✓

STATEMENT OF RESPONSIBILITY

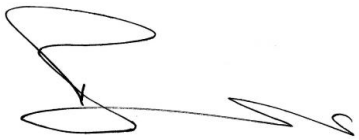
For the year ended 30 June 2017:

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 2017, fairly reflect the financial position and operations of Capital & Coast District Health Board.



Andrew Blair - Board Chair
25 October 2017

Debbie Chin - Chief Executive
25 October 2017

Roger Jarrold - Finance, Risk and Audit Committee Chair
25 October 2017

Michael McCarthy – Chief Financial Officer
25 October 2017

INDEPENDENT AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of Capital & Coast District Health Board's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of Capital & 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 his behalf.

Opinion

We have audited:

- the financial statements of the Health Board on pages 50 to 96, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 19 to 44

In our opinion:

- the financial statements of the Health Board on pages 50 to 96:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.
- the performance information on pages 19 to 44:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2017, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriation; and

- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 25 October 2017. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

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

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 3 to 18, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than in our capacity as auditor, 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 2017
in thousands of New Zealand Dollars

	Note	2017 Actual	Original 2017 Budget	Revised 2017 Budget	2016 Actual
Revenue	1	1,039,207	1,036,818	1,035,249	1,023,843
Total revenue		**1,039,207**	**1,036,818**	**1,035,249**	**1,023,843**
Expenditure					
Clinical supplies		110,375	105,800	112,379	108,319
Employee benefit costs	2	450,655	452,215	446,357	433,887
Infrastructure and non-clinical expenses		58,890	51,529	54,114	54,303
Other operating expenses	3	5,649	1,225	4,224	4,534
Outsourced services		32,233	28,411	33,578	37,545
Payments to other district health boards		92,735	91,229	91,229	81,507
Payments to non-health board providers		263,998	266,661	266,661	257,762
Capital charge	4	5,662	7,092	6,091	8,086
Finance costs	5	8,384	13,368	13,368	14,141
Depreciation and amortisation expense	6,7	35,394	35,248	35,248	35,677
Total expenditure		**1,063,975**	**1,052,778**	**1,063,249**	**1,035,761**
Surplus / (deficit)		**(24,768)**	**(15,960)**	**(28,000)**	**(11,918)**
Other comprehensive revenue and expense		-	-	-	-
Total comprehensive revenue and expense		**(24,768)**	**(15,960)**	**(28,000)**	**(11,918)**

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 2017
in thousands of New Zealand Dollars

	Note	2017 Actual	Original 2017 Budget	Revised 2017 Budget	2016 Actual
Balance at 1 July		103,497	96,265	96,265	113,299
Total comprehensive revenue and expense for the year		(24,768)	(15,960)	(28,000)	(11,918)
Owner transactions					
Contribution from the crown		10,000	21,960	21,960	5,600
Conversion of loan to equity		339,000	-	-	-
Repayment of equity		(3,484)	(3,485)	(3,485)	(3,484)
Balance at 30 June	19	**424,245**	**98,780**	**86,740**	**103,497**

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 2017

in thousands of New Zealand Dollars

	Note	2017 Actual	Original 2017 Budget	Revised 2017 Budget	2016 Actual
Assets					
Current assets					
Cash and cash equivalents	12	20,403	769	2,911	12,868
Trade and other receivables	11	49,597	51,300	51,300	46,540
Inventories	8	8,602	7,345	7,345	7,345
Trust and special funds	13	8,408	7,232	7,232	7,232
Total current assets		**87,010**	**66,646**	**68,788**	**73,985**
Non-current assets					
Property, plant and equipment	6	460,184	504,150	495,150	479,507
Intangible assets	7	28,034	17,343	17,343	27,035
Investments in joint ventures	9	-	-	-	-
Investments in associates	10	1,150	1,150	1,150	1,150
Total Non-Current Assets		**489,368**	**522,643**	**513,643**	**507,692**
Total Assets		**576,378**	**589,289**	**582,431**	**581,677**
Equity					
Crown Equity	19	770,435	451,364	449,404	424,919
Revaluation Reserve	19	23,606	23,606	23,606	23,606
Accumulated surplus / (deficit)	19	(369,796)	(368,785)	(380,825)	(345,028)
Total equity		**424,245**	106,185	**92,185**	**103,497**
Liabilities					
Current Liabilities					
Trade and other payables	17	76,746	74,878	82,020	71,660
Borrowings	14	326	34,326	34,326	62,326
Employee entitlements	15	67,842	59,931	59,931	59,783
Provisions	16	593	2,347	2,347	614
Patient and restricted funds	18	81	-	-	175
Total current liabilities		**145,588**	**171,482**	**178,624**	**194,558**
Non-current liabilities					
Borrowings	14	302	305,628	305,628	277,628
Employee entitlements	15	5,867	5,765	5,765	5,765
Provisions	16	376	229	229	229
Total non-current liabilities		6,545	311,622	**311,622**	**283,622**
Total liabilities		**152,133**	**483,104**	**490,246**	**478,180**
Total equity and liabilities		**576,378**	**589,289**	**582,431**	**581,677**

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 2017

in thousands of New Zealand Dollars

	Note	2017 Actual	Original 2017 Budget	Revised 2017 Budget	2016 Actual
Cash flows from operating activities					
Cash receipts from Ministry of Health and other Crown Entities		1,034,173	1,030,592	1,030,592	999,240
Other receipts		23,286	19,273	19,273	18,874
Cash paid to suppliers		(578,149)	(592,281)	(588,179)	(542,520)
Cash paid to employees		(441,005)	(434,737)	(434,737)	(435,099)
Cash generated from operations		**38,305**	**22,847**	**26,949**	**40,495**
Goods and services tax and other taxes (net) (a)		(3,152)	(2,165)	(2,165)	1,327
Capital charge paid		(5,662)	(8,528)	(8,528)	(8,086)
Net cash flows from operating activities	12	**29,491**	**12,154**	**16,256**	**33,736**
Cash flows from investing activities					
Interest received		1,697	725	725	2,043
Acquisition of property, plant and equipment		(12,728)	(21,000)	(21,000)	(21,426)
Acquisition of intangible assets		(4,496)	(9,000)	(9,000)	(7,402)
Investment in joint venture		-	-	-	(1,150)
Appropriation from trust and special funds (b)		(1,274)	-	-	406
Net cash flows from investing activities		**(16,801)**	**(29,275)**	**(29,275)**	**(27,529)**
Cash flows from financing activities					
Contribution from the Crown		10,000	21,960	20,000	5,600
Repayment of borrowing		(326)	-	-	(326)
Repayment of equity		(3,484)	(3,809)	(3,809)	(3,484)
Interest Paid		(11,347)	(13,129)	(13,129)	(14,230)
Net cash flows from financing activities		**(5,157)**	**5,022**	**3,062**	**(12,440)**
Net increase/(decrease) in cash and cash equivalents		7,535	(12,099)	(9,957)	(6,233)
Cash and cash equivalents at beginning of year		12,868	12,868	12,868	19,101
Cash and cash equivalents at end of year	12	**20,403**	**769**	**2,911**	**12,868**

(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.

As per note 14, the DHB's Crown loans have been converted to Crown equity as at 15th February 2017. The value of these loans was $339m. This conversation was completed through a non-cash transaction. Therefore, this transaction is not reflected in the statement of cash flows.

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 2017

in thousands of New Zealand Dollars

	Note	2017 Actual	2016 Actual
Legal proceedings against the DHB		200	200
Other contractual matters		60	910
		260	**1,110**

The DHB has been notified of 3 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2017 (2016: 12). The claims are employment related.

The private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. The government has 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 national review of DHBs' exposure to this matter is underway. A proactive approach to finding a long term pay process solution is also 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 failing due to corrosion in the copper pipes causing leaks throughout the building. The frequency of the leaks has fortunately slowed significantly this year, but the durability of the pipes has been compromised by the corrosion that has occurred, and the damage caused by the corrosion is not reversible. The current and projected performance of the copper pipes does not meet the standards expected under the building code. A concept plan to most efficiently replace the failing systems while minimising disruption to the hospital has been developed by external consulting engineers and a business case for funding for that project is being prepared. Legal proceedings have been commenced to recover the cost of replacing the hot and cold water pipes from the head contractor which constructed the building, the copper pipe manufacturer and the designer. Since the amount cannot be quantified, an unquantified contingent asset has been disclosed.

Statement of commitments

As at 30 June 2017

In thousands of New Zealand dollars

	Note	2017 Actual	2016 Actual
Buildings		3,376	6,668
Plant & equipment		6,023	4,576
Intangible assets		2,599	1,464
Capital Commitments		**11,998**	**12,708**

Non-cancellable operating lease commitments			
Not more than one year		3,548	2,841
One to two years		2,252	2,301
Two to five years		3,620	1,591
Over five years		90	28
		9,510	**6,761**

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

Notes to the financial statements

In thousands of New Zealand Dollars

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 and the New Zealand Public Health and Disability Act 2000, 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

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

Financial instruments

In January 2017, the External Reporting Board issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

The timing of CCDHB adopting PBE IFRS 9 will be guided by the Treasury's decision on when the

financial statements of Government will adopt PBE IFRS 9. CCDHB has not yet assessed the effects of the new standard.

Impairment of Revalued Assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes in revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards. Under the amendment, a revalued asset can be impaired without having to revalue the entire class of - asset to which the asset belongs. The timing of the Ministry adopting this amendment will be guided by the Treasury's decision on when the financial statements of Government will adopt the amendment.

Basis of preparation

The financial statements for the year ended 30 June 2017 were approved by the Board on 25 October 2017.

The financial statements have been prepared for the period 1 July 2016 to 30 June 2017. Comparative figures and balances relate to the period 1 July 2015 to 30 June 2016.

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, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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

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 2016/17 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 21 September 2017 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability. Capital injection of $10m 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 16.67% 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 18.25% 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 capitalised 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	5 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 or 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 2017, indirect costs accounted for 2.27% of the DHB's total costs (2016: 1.41%).

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.

Notes to the financial statements

In thousands of New Zealand Dollars

1 REVENUE

	2017 Actual	2016 Actual
Ministry of Health contract funding	784,132	772,988
Other government	14,453	12,916
Inter district flows (other DHBs)	215,712	212,158
Non government & crown agency sourced	21,472	19,847
Interest revenue	1,579	2,061
Revenue from donations	1,859	1,255
Reinstatement of property plant and equipment	-	2,618
	1,039,207	1,023,843

2 EMPLOYEE BENEFIT COSTS

	2017 Actual	2016 Actual
Direct staff costs (excluding increases in employee benefit provisions)	411,523	409,132
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	16,085	15,507
Contributions to defined contribution plans	13,285	12,806
Increase/(decrease) in employee benefit provisions	9,762	(3,558)
	450,655	433,887

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	2017 Actual	2016 Actual
Increase/(decrease) in provision of trade receivables (doubtful debts)	11	1,156	350
(Gain)/loss on disposal of property, plant and equipment		153	308
Audit fees for financial statements audit		217	210
Fees for other assurance services		139	141
Board member fees	22	355	375
Operating lease expense		2,717	2,765
Other operating expense		912	385
		5,649	4,534

Notes to the financial statements

In thousands of New Zealand Dollars

4 CAPITAL CHARGE

	2017 Actual	2016 Actual
The DHB pays capital charge on a six monthly basis to the Crown based on the greater of it's actual or budgeted closing equity balance. The capital charge rate was 7% from 1 July 2016 to 31 December 2016 and 6% from 1 January 2017 to 30 June 2017 (2016: 8 per cent)	5,662	8,086

5 FINANCE COSTS

	2017 Actual	2016 Actual
Interest on term borrowings	8,384	14,141

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 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)
Balance at 30 June 2016	25,705	478,210	1,191	89,325	27,492	621,923
Balance at 1 July 2016	25,705	478,210	1,191	89,325	27,492	621,923
Additions	-	10,398	-	6,369	399	17,166
Disposals	-	-	-	(736)	-	(736)
Balance at 30 June 2017	25,705	488,608	1,191	94,958	27,891	638,353
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
Balance at 30 June 2016	-	(68,747)	(367)	(59,476)	(22,530)	(151,120)
Balance at 1 July 2016	-	(68,747)	(367)	(59,476)	(22,530)	(151,120)
Depreciation charge for the year	-	(23,631)	(68)	(7,028)	(1,524)	(32,251)
Impairment losses	-	-	-	-	-	-
Disposals	-	-	-	567	-	567
Balance at 30 June 2017	-	(92,378)	(435)	(65,937)	(24,054)	(182,804)
Carrying amounts						
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
At 1 July 2016	25,705	409,463	824	29,849	4,962	470,803
At 30 June 2017	25,705	396,230	756	29,021	3,837	455,549

	Freehold land	Freehold buildings	Leasehold improvements	Plant & equipment	Furniture & fittings	Total
Work in progress						
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
Balance at 1 July 2016	-	4,546	208	3,390	560	8,704
Additions	-	7,833	-	3,335	261	11,429
Transfer from WIP	-	(10,163)	(208)	(4,790)	(337)	(15,498)
Balance at 30 June 2017	-	2,216	0	1,935	484	4,635

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 as 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 2017 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 2017 was $16.8m (2016: $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 Māori 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	Licenses	Total
Cost				
Balance at 1 July 2015	20,339	6,467	2,847	29,653
Additions	4,394	-	57	4,451
Disposals	(154)	-	(18)	(172)
Balance at 30 June 2016	24,579	6,467	2,886	33,932
Balance at 1 July 2016	24,579	6,467	2,886	33,932
Additions	2,997	-	-	2,997
Disposals	-	-	-	-
Balance at 30 June 2017	27,576	6,467	2,886	36,929
Amortisation and impairment losses				
Balance at 1 July 2015	(11,910)	-	(2,164)	(14,074)
Amortisation charge for the year	(2,337)	-	(327)	(2,664)
Disposals	132	-	17	149
Balance at 30 June 2016	(14,115)	-	(2,474)	(16,589)
Balance at 1 July 2016	(14,115)	-	(2,474)	(16,589)
Amortisation charge for the year	(2,924)	-	(219)	(3,143)
Disposals	-	-	-	-
Balance at 30 June 2017	(17,039)	-	(2,693)	(19,732)
Carrying amounts				
At 1 July 2015	8 ,429	6,467	683	15,579
At 30 June 2016	10,464	6,467	412	17,343
At 1 July 2016	10,464	6,467	412	17,343
At 30 June 2017	10,537	6,467	193	17,197

	Software	Licenses	RHIP	Total
Work in progress				
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
Balance at 1 July 2016	1,331	-	8,361	9,692
Additions	2,644	-	1,498	4,142
Transfer from WIP	(2,997)	-	-	(2,997)
Balance at 30 June 2017	978	-	9,859	10,837

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

In thousands of New Zealand Dollars

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 2017, 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 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 2017, CCDHB had contributed $9.859m towards capital expenditure which has been recognised as work in progress in respect of intangible assets. The investment has been tested for impairment by the DHB management. However at this stage on the information available no impairment is required at this point.

8 INVENTORIES

	2017 Actual	2016 Actual
Pharmaceuticals	2,456	1,890
Surgical & medical supplies	5,953	5,285
Other supplies	193	170
	8,602	7,345

The amount of inventories recognised as an expense during the year ended 30 June 2017 was $57m (2016: $54.1m). All inventories are distributed to operating areas in the normal course of business. The write-down of inventories held for distribution amounted to $nil (2016: $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.

In thousands of New Zealand Dollars

9 INVESTMENTS IN JOINT VENTURES

Carrying amount of investments in joint ventures	2017 Actual	2016 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%)	2017 Actual	2016 Actual
Revenue	5,770	6,129
Expense	5,576	6,087
Non-current assets	183	109
Current assets	2,163	2,087
Non-current liabilities	119	119
Current liabilities	1,739	1,782
Contingent liabilities	-	-
Commitment	1,383	1,288

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

10 INVESTMENTS IN ASSOCIATES

Carrying amount of investments in associates	2017 Actual	2016 Actual
Investment in Allied Laundry Services Ltd. (ALSL)	1,150	1,150
	1,150	1,150

ALSL has a total ordinary share capital of 6,300,000 of which the DHB's share is 1,150,000. The shares have been fully paid. HVDHB shares are paid to $550k, with the remainder to be paid over the next two years.

Summary of the DHB's interest in Allied Laundry Services Ltd. (18.25%)	2017 Actual	2016 Actual
Revenue	1,905	1,767
Expense	1,803	1,700
Non-current assets	1,701	1,757
Current assets	214	223
Non-current liabilities	116	168
Current liabilities	631	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

	2017 Actual	2016 Actual
Trade receivables from non-related parties	2,723	5,763
Ministry of Health receivables	18,428	13,901
Receivables from other DHBs	11,397	10,314
	32,548	29,978
Accrued revenue	11,417	12,545
Prepayments	5,632	4,017
Total receivables	49,597	46,540
Total receivables comprises:		
Receivable from the sale of goods and services (exchange transactions)	31,169	32,639
Receivable from Ministry funding (non-exchange transactions)	18,428	13,901

Trade receivables are shown net of a provision for doubtful debts amounting to $1.4m (2016: $0.6m)
The carrying value of receivables approximates their fair value.
As at 30 June 2017, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2017			2016		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	29,547	-	29,547	25,933	-	25,933
Past due 1-30 days	651	-	651	1,022	-	1,022
Past due 31-60 days	501	-	501	1,051	-	1,051
Past due 61-90 days	168	-	168	284	-	284
Past due > 91 days	3,076	1,395	1,681	2,285	597	1,688
Total	33,943	1,395	32,548	30,575	597	29,978

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:

	2017 Actual	2016 Actual
Balance at 1 July 2016	597	605
Additional provisions made during the year	1,156	350
Receivables written-off during period	(358)	(358)
Balance at 30 June 2017	1,395	597

In thousands of New Zealand Dollars

12 CASH AND EQUIVALIENTS

	2017 Actual	2016 Actual
fcPetty cash	13	13
Bank accounts	91	80
NZHP call deposits	20,299	12,775
Cash and Cash equivalents	20,403	12,868

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. (2016:$54.9m). The highest overdrawn bank balance during financial year 2016/17 was $nil. (2016: $nil).

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

	2017 Actual	2016 Actual
Surplus/(deficit) for the year	(24,768)	(11,918)
Add back non-cash items:		
Depreciation & amortisation	35,394	35,677
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	153	308
Interest revenue on financial assets	(1,579)	(2,061)
Donated assets	(1,859)	(1,044)
Add back items classified as financing activity:		
Interest expense on financial liabilities	8,384	14,141
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(3,057)	(682)
(Increase)/decrease in trust funds	(1,176)	387
(Increase)/decrease in inventories	(1,257)	127
Increase/(decrease) in trade and other payables	14,133	4,348
Increase/(decrease) in employee benefits	4,997	(3,117)
Increase/(decrease) in provisions	126	188
Net movement in working capital	13,766	1,251
Net cash inflow/(outflow) from operating activities	29,491	33,736

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

	2017 Actual	2016 Actual
Non patient funds		
Balance at 1 July 2016	7,077	7,481
Monies received	3,536	2,597
Interest received	223	253
Payments made	(2,486)	(3,254)
Balance at 30 June 2017	8,350	7,077
Patient funds		
Balance at 1 July 2016	155	138
Monies received	183	221
Interest received	1	1
Payments made	(281)	(205)
Balance at 30 June 2017	58	155
Total trust and special funds	8,408	7,232

14 INTEREST BEARING LOANS AND BORROWINGS

	2017 Actual	2016 Actual
Current		
Secured Debt Management Office	-	62,000
Unsecured EECA loans	326	326
	326	62,326
Non-current		
Secured Debt Management Office	-	277,000
Unsecured EECA loans	302	628
	302	277,628

Conversion of existing Crown loans to Crown equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections. The termination of the loan agreement and

In thousands of New Zealand Dollars

the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

The details of terms and conditions were as follows:

Interest rate summary	**2017 Actual**	**2016 Actual**
Debt Management Office	2.21% - 6.37%	2.21% - 6.37%
New Zealand Health Partnership	2.24% – 3.52%	3.36% - 4.35%
Energy Efficiency & Conservation Authority (EECA)	0%	0%

Loan repayable as follows:	**2017 Actual**	**2016 Actual**
Within one year	326	62,326
One to two years	247	62,326
Two to five years	55	173,302
Later than five years	-	42,000
Loan repayable as follows:	628	339,954

Term loan facility limits	**2017 Actual**	**2016 Actual**
Debt Management Office	-	339,000
Energy Efficiency and Conservation Authority (EECA)	628	954
	628	339,954

15 EMPLOYEE ENTITLEMENTS

	2017 Actual	**2016 Actual**
Current liabilities		
Liability for long service leave	2,600	2,430
Liability for sabbatical leave	310	310
Liability for retirement gratuities	770	720
Liability for annual leave	41,920	37,417
Liability for sick leave	1,732	1,066
Liability for continuing medical education leave and expenses	7,851	7,984
Salary and wages accrual	12,659	9,856
	67,842	59,783
Non-current liabilities		
Liability for long service leave	4,130	3,922
Liability for sabbatical leave	451	410
Liability for retirement gratuities	1,286	1,433
Liability for continuing medical education leave and expenses	-	-
	5,867	5,765

In thousands of New Zealand Dollars

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 2.5%, (2016: 2.0%) and a discount rate ranging from 1.87% to 3.61% (2016: 2.14% to 3.30%) 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.

16 PROVISION

	2017 Actual	2016 Actual
Current provisions		
ACC Partnership Programme	593	614
Non current provisions		
ACC Partnership Programme	376	229
ACC Partnership Programme		
Undiscounted amount of claims at balance date	737	747
Discount	19	12
Central estimate of present value of future payments	873	759
Risk margin	96	84
	969	843

The movement in provisions is represented by:

	ACC Partnership Programme
2016	
Balance at 1 July 2015	655
Additional provisions during the year for the risks borne in current period	507

In thousands of New Zealand Dollars

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

2017	
Balance at 1 July 2016	843
Additional provisions during the year for the risks borne in current period	516
Additional provisions relating to a reassessment of risks in a previous period	382
Subtotal	1741
Amounts used during the year	772
Total liability	969
(Decrease) / increase in provision	126

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.

In thousands of New Zealand Dollars

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 1.74% for the year ended 30 June 2017. A discount rate of 2.88% has been used for the year ended 30 June 2017. 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.

17 TRADE AND OTHER PAYABLES

	2017 Actual	2016 Actual
Payables under exchange transactions		
Trade payables	7,729	8,068
Revenue in advance / Deferred Revenue	-	493
Other non-trade payables and accrued expenses	52,131	45,696
Total payables under exchange transactions	59,860	54,257
Payables under non-exchange transactions		
Revenue in advance	2,635	-
GST and other taxes payables	14,251	17,403
Total payables under non-exchange transactions	16,886	17,403
Total Payables	76,746	71,660

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

	2017 Actual	2016 Actual
Patient funds		
Balance at 1 July 2016	155	139
Monies received	184	220
Interest received	-	1
Payments made	(280)	(205)
Balance at 30 June 2017	59	155

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 2017 are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as at 30 June 2017, both as an asset and a liability.

	2017 Actual	2016 Actual
Holiday homes funds		
Balance at 1 July 2016	80	72
Monies received	20	20

In thousands of New Zealand Dollars

Interest received	2	2
Payments made	(14)	(14)
Balance at 30 June 2017	88	80
Hutt Valley DHB Portion ¼ of holiday homes total	22	20
Total patient and restricted funds	81	175

19 EQUITY

	2017 Actual	2016 Actual
Contributed capital		
Balance at 1 July	424,919	422,803
Capital contribution	10,000	5,600
Conversion of loans to equity	339,000	-
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	770,435	424,919
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	(345,028)	(333,110)
Surplus / (deficit) for the year	(24,768)	(11,918)
Balance at 30 June	(369,796)	(345,028)
Total equity	424,245	103,497

The DHB's capital is its equity, which comprises Crown equity, accumulated surpluses / (deficits), revaluation reserves and trust funds. Equity is represented by net assets. The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which imposes 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 purposes while remaining a going concern.

20 OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2017 Actual	2016 Actual
Less than one year	3,548	2,841
Between one and five years	5,872	3,892
More than five years	90	28
	9,510	6,761

During the year ended 30 June 2017, $2.7m was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2016: $2.8m)

In thousands of New Zealand Dollars

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:

	2017 Actual	2016 Actual
Less than one year	259	312
Between one and five years	965	1,092
More than five years	1,044	1,044
	2,268	2,448

During the year ended 30 June 2017, $2.3m was recognised as rental revenue in the statement of comprehensive revenue and expense (2016: $2.5m)

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.
- 34 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 52.84% in 2017 (2016: 50.06%). 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 $0.51m in 2017. (2016: $0.46m).

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 2017, it is estimated that a general increase of one percentage point in interest rates would not affect the DHB's surplus (2017: $0m, 2016: $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 $0.00003m for the year ended 30 June 2017 (2016: $0.0002m).

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.

	2017 Actual							2016 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	-	-	-	-	-	-
NZD fixed rate loan*	3.43	-	-	-	-	-	-	3.43	-	-	-	-	-	-
NZD fixed rate loan*	3.65	-	-	-	-	-	-	3.65	9,000	9,000	-	-	-	-
NZD fixed rate loan*	4.04	-	-	-	-	-	-	4.04	34,000	-	-	-	34,000	-
NZD fixed rate loan*	4.15	-	-	-	-	-	-	4.15	6,000	-	-	-	6,000	-
NZD fixed rate loan*	3.72	-	-	-	-	-	-	3.72	25,000		25,000			-
NZD fixed rate loan*	3.61	-	-	-	-	-	-	3.61	8,000	-	-	-	-	8,000
NZD fixed rate loan*	3.51	-	-	-	-	-	-	3.51	34,000	-	-	-	34,000	-
NZD fixed rate loan*	3.38	-	-	-	-	-	-	3.38	28,000	-	-	-	28,000	-
NZD fixed rate loan*	6.37	-	-	-	-	-	-	6.37	62,000	-	-	62,000	-	-
NZD fixed rate loan*	2.21	-	-	-	-	-	-	2.21	28,000	28,000	-	-	-	-
NZD fixed rate loan*	3.06	-	-	-	-	-	-	3.06	6,000	-	-	-	-	6,000
NZD fixed rate loan*	3.57	-	-	-	-	-	-	3.57	28,000	-	-	-	-	28,000
NZD fixed rate loan*	3.34	-	-	-	-	-	-	3.34	36,000	-	-	-	36,000	-
NZD fixed rate loan*	3.37	-	-	-	-	-	-	3.37	35,000	-	-	-	35,000	-
NZD unsecured loan	0	628	163	163	247	55	-	0	954	163	163	326	302	-
		628	163	163	247	55	-		339,954	37,163	25,163	62,326	173,302	42,000

* 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.

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2017						
Creditors and other payables	76,746	76,746	76,746	-	-	-
Secured loans	-	-	-	-	-	-
Unsecured loans	628	628	326	247	55	-
Patient and restricted funds	81	81	81		-	-
Total	77,455	77,455	77,153	247	55	-
2016						
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

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
2017						
Cash and cash equivalents	20,403	20,403	20,403	-	-	-
Debtors and other receivables	49,596	49,596	49,596	-	-	-
Trust and special funds - bank	4,327	4,327	4,327	-	-	-
Trust and special funds – term deposit	3,800	3,826	3,826	-	-	-
Trust and special funds – debtors	280	280	280	-	-	-
Total	78,406	78,432	78,432	-	-	-
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 -	74	74	74	-	-	-

In thousands of New Zealand Dollars

bank						
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	-	-	-

21 FINANCIAL INSTRUMENTS continued

Maximum exposure to credit risk

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

	2017 Actual	2016 Actual
Cash and cash equivalents	20,403	12,868
Debtors and other receivables	49,596	46,540
Trust and special funds – bank	4,327	74
Trust and special funds – term deposit	3,800	6,700
Trust and special funds – debtors	280	303
	78,406	66,485

	2017 Actual	2016 Actual
Counterparties with credit ratings		
Cash at bank and term deposits	28,530	20,100
AA- (Standard & Poor)	28,530	20,100

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 2017 was $nil (2016: $nil), comprising assets of $nil (2016: $nil) and liabilities of $nil (2016: $nil) that were recognised in fair value derivatives.

In thousands of New Zealand Dollars

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 2017 was $nil (2016: $nil) recognised in fair value derivatives

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 2017 Actual	Fair value 2017 Actual	Carrying amount 2016 Actual	Fair value 2016 Actual
Trade and other receivables	11	49,596	49,596	46,540	46,540
Cash and cash equivalents	12	20,403	20,403	12,868	12,868
Secured loans	14	-	-	(339,000)	(356,048)
Unsecured loans	14	(628)	(628)	(954)	(954)
Trade and other payables	17	(76,746)	(76,746)	(71,660)	(71,660)
		(7,375)	(7,375)	(352,206)	(369,254)
Unrecognised (losses)/gains			-		(17,048)

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.

In thousands of New Zealand Dollars

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 2017 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2017 Actual %	2016 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	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

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:

	2017 Actual	2016 Actual
Board Members		
Remuneration	$355	$375
Full-time equivalent members	1.14	1.27
Leadership Team		
Remuneration	$3,583	$3,343
Full-time equivalent members	18	14
Total key management personnel remuneration	**$3,938**	**$3,718**
Total members and full time equivalent personnel	**19.14**	**15.27**

In thousands of New Zealand Dollars

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.

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 fees ($)		Committee fees ($)	
Current board members as at 30 June 2017		**2017**	**2016**	**2017**	**2016**
Mr Andrew Blair, Chair	Appointed	35	-	1	-
Ms Fran Wilde, Deputy Chair	Elected	18	-	2	-
Ms Kathryn Adams	Elected	15	-	1	-
Mr Roger Blakely	Elected	15	-	1	-
Ms Eileen Brown	Elected	15	-	1	-
Ms ‘Ana Coffey	Elected	15	-	-	-
Ms Sue Driver	Elected	15	-	-	-
Mr Roger Jarrold	Appointed	25	26	3	2
Ms Sue Kedgley	Elected	25	26	1	2
Ms Kim Ngarimu	Appointed	15	-	1	-
Mr Darrin Sykes	Appointed	25	26	3	2
Board members who left during the year					
Dr Virginia Hope, MNZM		22	53	1	3
Mr Derek Milne		13	32	1	2
Dr Judith Aitken		11	26	2	3
Mr David Choat		11	26	0	2
Mr Peter Douglas		11	26	1	1
Ms Helene Ritchie		11	26	-	1
Mr Chris Laidlaw		11	26	-	1
Mr Nick Leggett		11	26	2	2
Crown monitor					
Dr Margaret Wilsher		15	35	-	-
		334	354	21	21

Committee members	CPHAC fees ($)		DSAC fees ($)		HAC fees ($)	
(other than Board members and employees)	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**
Fa'amatuainu Pereira	-	1	-	1	-	-
Lisa Bridson	-	-	-	-	-	-
Yvette Grace	-	-	-	-	-	-
Prue Lamason	-	-	-	-	-	-
Jane Hopkirk	-	-	-	-	-	-
Alan Shirley	-	-	-	-	-	-

In thousands of New Zealand Dollars

Committee members (continued) (other than Board members and employees)	CPHAC fees ($) 2017	CPHAC fees ($) 2016	DSAC fees ($) 2017	DSAC fees ($) 2016	HAC fees ($) 2017	HAC fees ($) 2016
Kim Smith	-	-	-	-	-	-
John Terris	-	-	-	-	-	-
Bob Francis	0	-	0	-	-	-
Tino Pereria	0	-	0	-	-	-
Bryan Betty	-	-	-	-	-	3
Leo Buchanan	-	-	-	-	0	2
Dr Tristram Ingham	1	-	1	-	-	2
Margaret Faulkner	0	-	0	-	-	1
	1	1	1	1	0	8

23 EMPLOYEE REMUNERATION

The number of employees or former employees who received remuneration and other benefits of $100,000 or more per annum during 2016/17 within specified $10,000 bands were as follows:

Salary band	Number of Employees 2017	Number of Employees 2016
100 – 110	175	162
110 – 120	99	100
120 – 130	78	65
130 – 140	68	52
140 – 150	35	40
150 – 160	32	28
160 – 170	25	19
170 – 180	27	16
180 – 190	16	16
190 – 200	27	28
200 – 210	15	16
210 – 220	21	19
220 – 230	15	20
230 – 240	15	5
240 – 250	19	22
250 – 260	16	12
260 – 270	12	13
270 – 280	5	9
280 – 290	17	9
290 – 300	6	14
300 – 310	12	8
310 – 320	6	7
320 – 330	11	9
330 – 340	4	5
340 – 350	8	6
350 – 360	6	4
360 – 370	11	9
370 – 380	1	5
380 – 390	2	4
390 – 400	2	-
400 – 410	4	7
410 – 420	4	3
420 – 430	1	4
430 – 440	1	2
440 – 450	1	1
450 – 460	3	1
470 – 480	-	1
480 - 490	1	-
490 – 500	-	-
500 – 510	-	1
510 – 520	1	2
520 – 530	2	1
530 – 540	-	-
540 – 550	-	1
550 – 560	-	-
600 – 610	-	1
610 – 620	1	
	805	747

Of the 805 employees shown above, 496 are or were medical or dental employees and 309 were neither medical nor dental employees. This represents an increase of 58 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 1,097 compared with the actual total number of 805.

24 TERMINATION PAYMENTS

During the year ended 30 June 2017, 22 (2016: 32) employees received compensation and other benefits in relation to cessation totalling $0.4m (2016: $0.9m).

No Board members (2016: nil) received compensation or other benefits in relation to cessation (2016: $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. The 'original 2017 budget' column relates to the initial break-even budget agreed with the Ministry of Health and tabled in Parliament.

However, subsequent to the original submission, due to on-going negotiations with the Ministry of Health, the budget numbers were later revised to reflect a $28m deficit for financial year 2016/17. The 'revised 2017 budget' column reflects the latest budget numbers and has been disclosed for additional information.

Explanations of significant variances from the 'revised 2017 budget' in the Statement of Intent when compared to actual figures for the year ended 30 June 2017 are provided below.

Statement of comprehensive revenue and expense

The DHB recorded a deficit of $24.768m compared with the budgeted deficit of $28m.

Revenue for 2016/17 was greater than budget due to increased IDF and ACC revenue.

Expenditure was higher than budget for the following reasons:-

- Employee benefit costs were higher than budget due to increased acute activity in hospital volumes.
- Infrastructure and non clinical costs were above budget due to copper pipe costs and other initiatives;
- Increased operating expenses related to doubtful debts provision and other savings initiatives not progressed.

- Finance costs were less than budget due to conversion of Crown loans to equity in February 2017.
- Capital charge was less than budget due to reduction in the rate from 8% to 6%.

Statement of changes in Equity

- The variance in equity balance is mainly due to the conversion of Crown loans to equity.

Statement of financial position

- The cash balance is significantly higher than budget due to less than expected capital spend and other timing differences.
- Non current assets are less than budget due to less than expected capital spend.
- Trade and other payables were lower than budget due to the timing of supplier payments.
- Borrowings are significantly lower than budget mainly due to the conversion of Crown loans to equity.

Statement of cash flows

- The net cash flow from operating activities is significantly higher than budget due to timing differences in supplier payments and reduction in capital charge rate from 8% to 6%.
- The net cash flow from investment activities is less than budget due to less than expected capital spend.
- The net cash flow from financing activities is less than budget due to non receipt of deficit support of $10m.

26 EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

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	
	2017 Actual	2016 Actual	2017 Actual	2016 Actual	2017 Actual	2016 Actual	2017 Actual	2016 Actual	2017 Actual	2016 Actual
Revenue										
Crown	10,947	10,702	209,741	190,794	694,507	698,199	104,980	101,683	1,020,175	1,001,378
Other	-	-	-	-	19,032	19,847	-	-	19,032	19,847
Total revenue	**10,947**	**10,702**	**209,741**	**190,794**	**713,539**	**718,046**	**104,980**	**101,683**	**1,039,207**	**1,021,225**
Expenditure										
Personnel	113	152	2,138	2,877	447,260	429,319	1,144	1,539	450,655	433,887
Depreciation	-	-	-	-	35,288	33,138	-	-	35,288	33,138
Capital charge	-	-	-	-	5,662	8,086	-	-	5,662	8,086
Provider payments	9,624	9,301	193,508	175,641	57,738	60,375	95,863	93,952	356,733	339,269
Other	632	580	13,435	11,594	193,875	200,478	7,695	6,111	215,637	218,763
Total expenditure	**10,369**	**10,033**	**209,081**	**190,112**	**739,823**	**731,396**	**104,702**	**101,602**	**1,063,975**	**1,033,143**
Net surplus/(deficit)	**578**	**669**	**660**	**682**	**(26,284)**	**(13,350)**	**278**	**81**	**(24,768)**	**(11,918)**

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.

Notes to the financial statements

In thousands of New Zealand Dollars

Reconciliation to retained earnings (Original)

	Provider			Governance			Funder			Consolidated		
	2017 Actual	**2017 Budget**	**2016 Actual**	**2017 Actual**	**2017 Budget**	**2016 Actual**	**2017 Actual**	**2017 Budget**	**2016 Actual**	**2017 Actual**	**2017 Budget**	**2016 Actual**
Opening balance	(374,107)	(374,104)	(348,567)	(17,070)	(17,070)	(17,158)	38,352	38,352	24,818	(352,825)	(352,822)	(340,907)
Surplus/(deficit)	(28,410)	(15,307)	(25,540)	986	-	88	2,656	(653)	13,534	(24,768)	(15,960)	(11,918)
Closing balance	**(402,517)**	**(389,411)**	**(374,107)**	**(16,084)**	**(17,070)**	**(17,070)**	**41,008**	**37,699**	**38,352**	**(377,593)**	**(368,782)**	**(352,825)**

Reconciliation to retained earnings (Revised)

	Provider			Governance			Funder			Consolidated		
	2017 Actual	**2017 Budget**	**2016 Actual**	**2017 Actual**	**2017 Budget**	**2016 Actual**	**2017 Actual**	**2017 Budget**	**2016 Actual**	**2017 Actual**	**2017 Budget**	**2016 Actual**
Opening balance	(374,107)	(374,104)	(348,567)	(17,070)	(17,070)	(17,158)	38,352	38,352	24,818	(352,825)	(352,822)	(340,907)
Surplus/(deficit)	(28,410)	(27,347)	(25,540)	986	-	88	2,656	(653)	13,534	(24,768)	(28,000)	(11,918)
Closing balance	**(402,517)**	**(401,451)**	**(374,107)**	**(16,084)**	**(17,070)**	**(17,070)**	**41,008**	**37,699**	**38,352**	**(377,593)**	**(380,822)**	**(352,825)**