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Capital & Coast District Health Board

Annual Report 2017-2018

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

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Capital & Coast DHB postal address:
Wellington Regional Hospital, Private Bag 7902, Wellington 6242

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

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

Cover photo: Speaking up for Support champions at the old hospital arches at Wellington Regional Hospital

COMMS: 0741-1809

CHAIR & CHIEF EXECUTIVE'S FOREWORD

We are pleased to present Capital & Coast District Health Board's (CCDHB) Annual Report for the financial year 1 July 2017 to 30 June 2018. This report outlines what we have achieved, our progress against our key performance measures, and details how the health funding we received has been managed.

Our Board is committed to providing the population of Wellington, Porirua and the Kapiti Coast with healthcare that is contemporary and responsive to our community's needs. As a DHB we are focused on the provision of safe, quality health services that strive to achieve equitable health outcomes for all. We provide a range of services across our community including outpatient clinics, maternity and mental health services and – at Wellington Regional Hospital – tertiary-level care.

We were delighted to return a financial result that, although remaining in deficit – is within our planned budget for 2017/18. We are proud of our achievements and continue to deliver efficient, high quality services while also reducing our deficit. We acknowledge the work of all our staff, especially our managers and leaders, for the work they continue to do to help us to live within our means.

This year included highlights such as the expansion of our Intensive Care Unit and the launch of the new Children's Hospital project in partnership with Wellington property developer and benefactor Mark Dunajtschik. This exciting project will see a new purpose-built facility in the region with 50 inpatient hospital beds as well as social and family areas, outpatient consultation rooms and an education and research centre.

Our partnerships with the wider health sector continue to strengthen, with our work with primary health care organisations (PHOs) recognised as a finalist for the Wellington Gold Awards. The Health Care Home (HCH) initiative is a team-based health care delivery model, led by primary health clinicians, providing comprehensive care to patients including extended hours and access to patient portals. Our Health Care Home programme is currently accessed by over 150,000 people across the Greater Wellington region and will be rolled out to a further 90,000 people in the upcoming year.

This is just one of the initiatives that demonstrates the positive relationship and range of services we are funding for our region through community-based and primary care services. This includes care for older people delivered by home-based support services and residential care, and increasing use of pharmacists to deliver services such as influenza prevention and smoking cessation.

We are also focused on service improvement across a range of areas supported by strategic planning, including the development of a new Māori Health Strategy. Our thanks to the Māori Partnership Board, for supporting this work and for its ongoing relationship with our Board and staff. We are also well supported by the Sub-Regional Pacific Strategic Advisory Group and Sub-Regional Disability Advisory Group, which are joint bodies with Hutt Valley and Wairarapa DHBs.

Our DHB partnerships – particularly with neighbouring Hutt Valley and Wairapapa DHBs – are going from strength-to-strength. This includes strategy and planning and, in some instances, combined directorates – such as our Mental Health, Addictions and Intellectual Disability Service (MHAIDS) and information technology services. We will continue to explore and deliver on the expectations on us for greater regional and sub-regional collaboration and co-operation with our neighbouring DHBs.

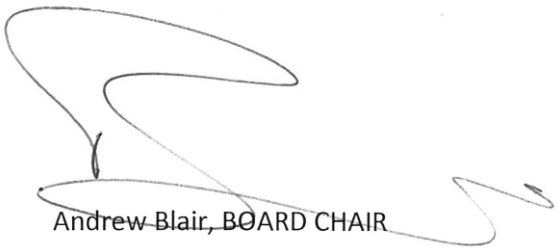
We are pleased to report excellent progress with the implementation of Care Capacity and Demand Management (CCDM) in the 2017/18 year. CCDM works to better match staff resources to patient need, so we can provide safe care for patients and a healthy workplace for our staff. A genuine partnership with the unions, CCDM's rapid uptake at CCDHB demonstrates the constructive working relationships we have with our union partners. We acknowledge and thank our union partners for the work they do to support their members and our organisation.

CCDHB is increasingly drawing on the understanding and experiences of staff, consumers and whānau working in partnerships to co-design or improve services together. An example of this is the Optimal Ward project operating in Wellington Regional Hospital's heart and lung unit. The project works with staff, patients, families and whānau to review how the ward operates and ensure the environment is fit to provide quality and timely care. By putting consumers at the heart of our services – and using their experiences to help design new models of care – we can provide safe, quality health services while also ensuring we're able to achieve more equitable outcomes.

Our renewed focus on health and safety has also led to good outcomes over the past financial year. This includes a seven percent reduction in the number of work-related injury claims, with our mental health service, MHAIDS having experienced the largest reduction – 33 percent. At the same time the number of injuries leading to lost time reduced by nine percent, and the number of days lost due to a work-related injury reduced by 57 percent. There was a 14 percent reduction in overall work-related injury management costs. The Board applauds the effort of all staff and management to achieve these significant improvements.

As part of our three-year supporting safety culture programme we launched Speaking Up For Safety in May, which is focused on staff and patient safety. By the end of this year, we want all of our staff to have completed a one-hour Speaking Up for Safety training session developed by the Cognitive Institute specifically for healthcare organisations. In June we launched our People Strategy, which was developed through engagement with our staff. The strategy aims to create a workplace where our staff are excited to come to work, with a focus on four key areas to achieve a better work environment – 'trust & partnership', 'strong foundations', 'promoting wellbeing' and 'learning from excellence'.

To our Board members and to each and every staff member, we extend our heartfelt thanks for their commitment to not only CCDHB but more importantly the health and wellbeing of the population we are here to serve.



Andrew Blair, BOARD CHAIR

Julie Patterson, INTERIM 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 "Keeping our Communities Healthy and Well". We are guided in this implementation of our longer term vision of how services will be delivered for our population, as articulated in the Health Systems Plan (HSP) 2030.

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. The following Ministerial Directions also apply:

- the 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000
- the requirement to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018, issued in May 2016 under s.107 of the Crown Entities Act
- the direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property and the former two apply to DHBs
- the direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

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 onset and development of avoidable illness
- Improve the health and wellbeing outcomes
- Support people to live better lives
- Support end of life with dignity

We must also:

- Create a sustainable and affordable healthcare system
- Deliver on government priorities
- Live within our means
- Ensure safety and quality of our services
- Be a good employer

We will achieve our obligations and deliver these outcomes as well as delivering services within available resources. We will also operate with a long-term view supported by the ten-year Long-Term Investment Plan. To do this we have a programme of work that builds on existing successes and finds 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 promote early intervention care closer to home and with improved health 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 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

The Capital and Coast HSP outlines CCDHB's strategy to improve the performance of the region's healthcare system. The vision statement for our health system, as outlined in the HSP is:

Keeping our Communities Healthy and Well

In your Home	In your Community	In your Hospitals
Giving people better control of health services where and when they needs them	*Community Health Networks help people access the services they need*	*Providing specialist services to those who need them most*

Ma Tini, Ma Mano, Ka Rapa Te Whai
By Joining Together We Will Succeed

We will work with our communities to help reduce disparities in health status and reduce the incidence of long term conditions amongst our population while increasing the independence of the people in our district.

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

Our key strategic goals are:

- ensuring safe and quality services
- creating equitable and better health outcomes amongst our population
- building a sustainable health system.

We are building an investment approach across the major service user groups. This is to actively plan care from a localities' perspective to ensure we meet the needs of communities, that we deliver services in people's homes, community health networks and our hospitals and specialty mental health units.

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

Improving service resources, systems and results via:

- operational management
- facilities development
- organisational performance
- models of care
- service reviews, plans and credentialing.

Investment and outcomes planning for:

- urgent and planned health care for everyone
- mother, babies, children, youth and their families
- people with complex care needs including those with mental illness and addiction.

Reducing Inequities for:

- Māori
- Pasifika
- those who experience poverty
- those with disability
- those with mental illness and addiction.

Building our sustainable health care system through:

- models of care supporting community health networks and localities
- a greater Wellington hospital/service network
- regional care arrangements that strengthen complex tertiary services
- digital technology to expand services in the community
- technology to share information between all providers/professionals
- multidisciplinary teams and a sustainable workforce.

ABOUT CAPITAL & COAST DHB

CCDHB is the Government's funder and provider of health services to the 300,000 people living in Wellington, Porirua and Kāpiti. We are also the leading provider of a number of tertiary and specialist services, including neurosurgery, oncology, neonatal intensive care, and specialised mental health services. We deliver these services for the upper South and lower North Islands, a population of about 900,000 people.

CCDHB is the sixth largest DHB in New Zealand and has an annual budget of more than $1 billion to deliver on a wide range of service responsibilities:

- As providers of:
    - Health and Hospital Services (HHS)
    - Mental Health Addiction and Intellectual Disability Services (MHAIDS)
- As funders of health services for people who live in CCDHB we commission:
    - Population health services
    - Primary care, community laboratory, pharmacy and community radiology
    - Aged residential care and home support
    - NGO and community provision of personal and mental health services

We operate two hospitals: Wellington Regional Hospital in Newtown and Kenepuru Hospital in Porirua, as well as the Kāpiti Health Centre in Paraparaumu. We also operate Ratonga Rua, a large mental health campus based at Porirua.

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

We have a close relationship with the University of Otago's School of Medicine Wellington and the Victoria University of Wellington's Graduate School of Nursing, Midwifery and Health. We also 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 Wellington Regional Hospital. 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.

Te Tiriti - Partnership Statement

The Māori Partnership Board is an independent entity established by Te Atiawa, Te Atiawa ki Whakarongotai, and Ngāti Toa Rangatiria. Capital & Coast District Health Board and the Māori Partnership Board support each other to achieve equity and health improvement for Māori living in the Capital & Coast district.

Capital and Coast District Health Board acknowledges that the Māori Partnership Board is an important mechanism in realising its legislative requirements to enable Māori to participate in decision-making processes and its responsibility to address health inequalities for Māori.

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 currently consists of 10 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 three are appointed by the Minister of Health.

Role of the chief executive

The Board delegates to the CE, 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 CE, 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 2017 – June 2018

Board member	**Board** (10 meetings)	**3DHB CPHAC-DSAC** July-December 2017 (3 meetings)	**3DHB DSAC** January-June 2018 (2 meetings)	**CCDHB CPHAC** January-June 2018 (4 meetings)	**FRAC** (10 meetings)
Andrew Blair	10	2	0	2	10
Fran Wilde	10	3	2	4	7
Kathryn Adams	10	-	-	1	10
Roger Blakeley	10	-	-	4	10
Eileen Brown	10	1	2	4	-
‘Ana Coffey	8	2	1	4	-
Sue Driver	10	1	2	3	-
Sue Kedgley	10	2	1	4	-
Kim Ngārimu	9	-	-	-	10
Darrin Sykes	10	-	-	-	10
Roger Jarrold*	5	-	-	-	6
Tino Pereira[+]	-	-	-	2	-
Bob Francis[++]	-	3	2	-	-
Tristram Ingham[+++]	-	1	2	3	-

Note:

- not a member
* resigned February 2018
[+] Board representative, Sub-Regional Pacific Strategic Health Advisory Group (SRPSHAG)
[++] Board representative, Sub-Regional Disability Advisory Group (SRDAG)
[+++] Board representatives, Māori Partnership Board (MPB)

Key:

CPHAC – Community & Public Health Advisory Committee

DSAC – Disability Services Advisory Committee

FRAC – Finance, Risk, Audit Committee

OUR PEOPLE

Our Staff Engagement Survey, completed in April 2017, provided the impetus for us to develop a strategic approach to optimising our workforce, culminating in the creation of a People Strategy (May 2018). In addition to this strategic work, two areas of specific focus in the 2017-2018 period have been a healthy workplace and inspirational leaders.

Development of the People Strategy

The first step in development of the people strategy began following results of the 2017 staff engagement survey, where data was analysed to identify eight key themes/areas of focus.

The second stage of the strategy development consisted of co-design workshops, which were held in October/November 2017 on all DHB sites. Over 200 staff members in 20 workshops explored each theme in small groups. A set of open questions e.g. “what is important for you….”, “do you have any ideas for how we create a culture of high performance?”, “how can we make working here smart and simple?” “What does a healthy workplace look like for you?” served as discussion prompts. Coding of these was shared with all staff members in December 2017 and was then utilised in step three.

In step three, the frameworks were augmented by discussions with eight expert panels which were designed to bring together strategic thinkers, subject matter experts, pragmatists (the people who would be charged with delivering future actions to develop from the strategy) and lived experts

(people who are seen as exemplars of best practice in the organisation). Each panel considered one of the eight themes. Four key principles emerged from across the whole process (see below).

Local solutions to local issues

Parallel to the organisation wide process, local level action planning was initiated from September 2017. All teams received brief reports of the engagement survey results and support to discuss and identify local opportunities to build engagement within local teams and services.

Key principles of the people strategy

Healthy Workplace

The survey data also identified the need to focus on supporting a safe and healthy workplace. The staff engagement survey indicated that many staff do not feel safe and supported at work. We know that staff who feel safe and engaged have increased productivity, decreased sick and stress leave and higher retention. Likewise, high levels of safety not only deliver better health outcomes and patient experience, they minimise the operational impact of complaints and of extended care needs. In late 2017, CCDHB embarked on a three year programme to Support Safety Culture. It will impact on staff and patient safety.

The key principles of Speaking Up and Always Checking are being used to bring together a programme across the organisation (see conceptual framework of the broader programme below).

First off the rank was Speaking Up For Safety which saw 17 staff members trained in February 2018 to present this framework from May 2017 onward. Managers also attended a programme orientation

workshop, which provided them with rationale for developing a safety culture, introduced the concepts behind speaking up and highlighted their responsibilities throughout the programme.

The following conceptual framework outlines our approach to build a strong safety culture. The framework creates a comprehensive and joined up approach to supporting safety culture, with the Cognitive Institute contributing to parts of the wider programme. This enables us to bring together a range of activity areas (such as leadership development, communication, high performance, wellness and resilience, learning from excellence and accountability) into a cohesive framework to support safety culture.

- *The Speaking Up for Safety Programme®, the Safety C.O.D.E.™ and Speaking Up for Safety™, are the property of Cognitive Institute and are used under license.*
- *For more information please contact It's about our place [CCDHB] RES-ItsAboutOurPlace@ccdhb.org.nz*

Inspirational leaders

Our leadership strategy sets out to:-

- be clear about what we value in leaders
- support our leaders with skills and expertise providing the wider context of health systems
- provide growth through mentorship and coaching, and
- through talent management processes, grow our own next generation of leaders

Our strategic approach includes development programmes, coaching, secondments, project work, individualised development plans, alumni and learning sets. Our development programmes have grown from the Frontline Leadership Programme to include an Emerging Leaders workshop and a Senior Leadership Programme. Planning is underway for how best to support operational and clinical leaders with further leadership development initiatives and opportunities.

As we formulate the way forward we are taking into account the national context: what we need from our leaders in the state sector. In 2018 the Leadership Success Profile, a talent management framework which is used by the core public sector and is being implemented by District Health Boards, and forms the basis of determining our leadership development needs. The profile consists of five

domains: Strategic Leadership, System Leadership, Talent Management, Delivery Management and Leadership Character.

This is being coupled with the organisational context: what we need from our leaders at CCDHB, and allows us to acquire a more detailed understanding of our organisation's leadership development needs.

We have learnt more about our leaders, when it comes to learning they are curious, are connected, and continuously improving. They want to develop more confidence in coaching gaining practical tools and strategies for coaching and find effective feedback particularly important. This supports our future initiatives of building a community of learners and leaders as coaches.

We have commenced on the journey of introducing talent management into CCDHB. We have a plan for talent mapping our Tier 3 managers using the Sate Service Leadership Success Profile. The talent mapping process allows us to understand where our talent is, how it is being developed and how best it is deployed across our DHB and the sector.

Our development initiatives have been mapped to the State Sector Leadership Success Profile and individual learning plans, learning sets and on-line learning continue to be blended into our leadership development initiatives.

Forty eight people have completed our Frontline Leadership programme that gives new leaders the opportunity to learn new leadership and service improvement skills, gain 360 degree feedback, have networking opportunities and creates a community of learning where leaders learn amongst their peers and gain confidence in leading in a health context.

A first cohort have completed the Emerging Leaders programme. Designed for our future leaders as an early step in their leadership development journey the programme also provides an overview of leading in a healthcare context.

The Manage Well programme continues with "What Managers Need to Know" providing new managers with an overview of what is expected of managers in CCDHB and the Manage well series continuing to be aligned with organisational priorities such as creating a safe and supportive workplace.

Remuneration, recognition and conditions

With a highly unionised workforce, remuneration, recognition and other terms and conditions of employment are primarily set out in Multi-Employer Collective Agreements (MECA), with others specified in Single Employer Collective Agreements (SECA) or Individual Employment Agreements (IEA).

In addition to settlement of the senior medical officers MECA, the focus of MECA negotiations has largely been on the NZNO nurses and midwives MECA. This required significant input into the national MECA negotiations and, towards the end of the year, a significant focus on contingency planning in response to industrial action.

Throughout the year we maintained a focus on fairness and equity for all staff, including those on IEAs.

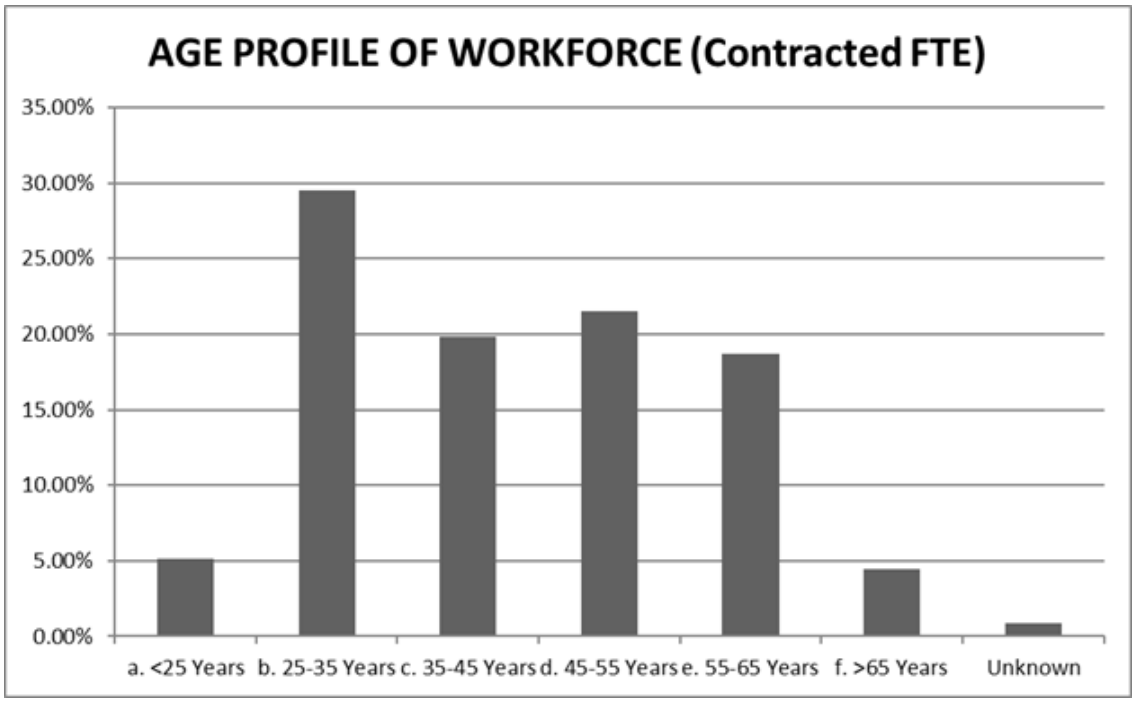
Workforce profile

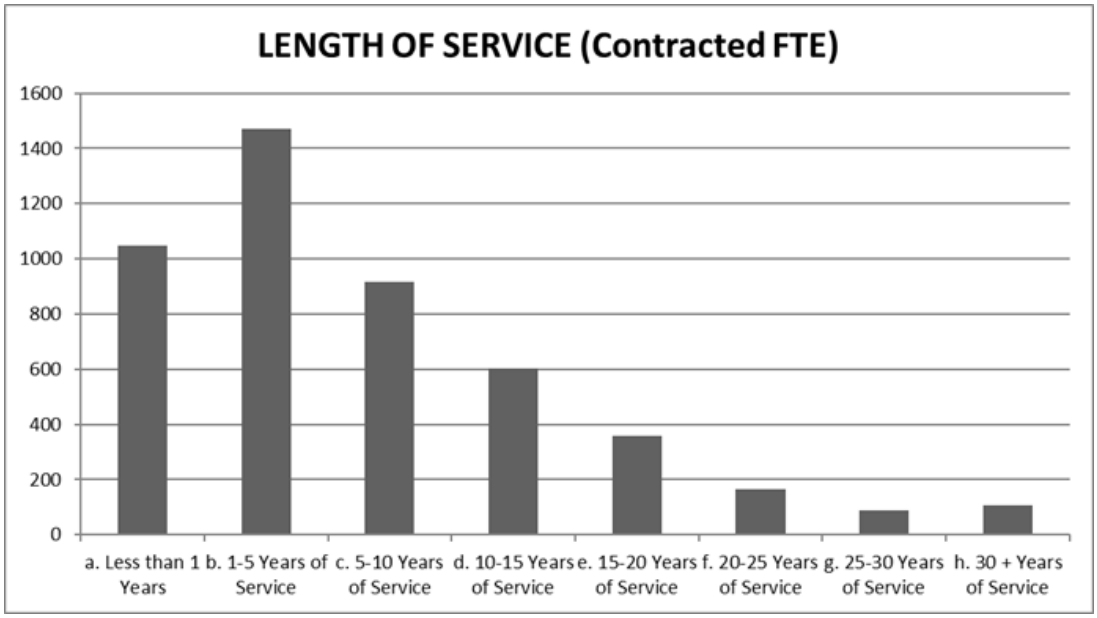
Full Time Equivalent (FTE) staff numbers

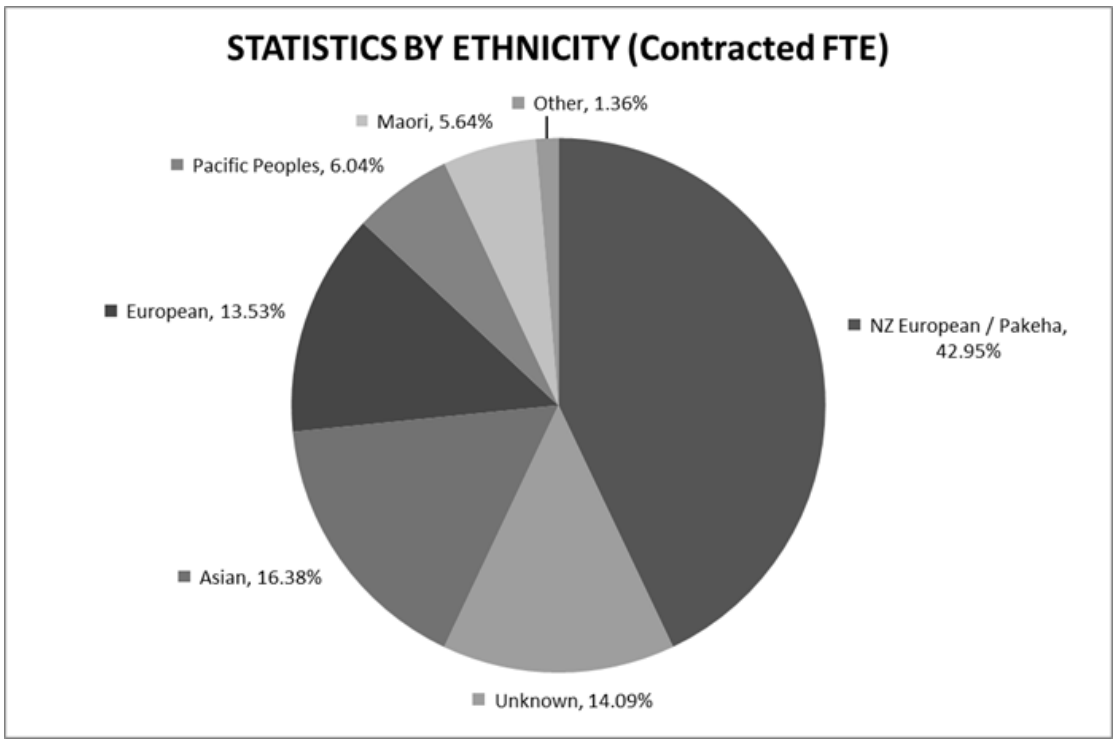
Profession	2018	2017	2016	2015	2014	2013	2012	2011
Medical	900	848	832	800	781	702	590	551
Nursing	2131	2043	2004	1940	1892	1907	1799	1790
Allied Health	724	713	707	766	774	760	729	708
Other	1000	950	963	997	978	1011	961	960
Total	4755	4554	4506	4502	4426	4379	4079	4009

Statistics by Gender

Gender	2018	2017	2016	2015	2014	2013	2012	2011
Female	72%	72%	73%	72%	72%	72%	73%	72%
Male	28%	28%	27%	28%	28%	28%	27%	28%







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 2017-2018

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 June 2018.

Marker Definition		NZ Goal	NZ Average	Q1 July to Sept 2017	Q2 Oct to Dec 2017	Q3 Jan to March 2018	Q4 April to June 2018
Falls: % if patients aged >75 (Māori and Pacific Islanders >55) that are given a falls risk assessment		90%	92%	91%	93%	89%	85%
Falls: % of patients assessed as being at risk who have an individualised care plan which addresses their falls risk		90%	95%	92%	95%	95%	94%
Safe Surgery: % of audits where all components of checklist were reviewed	**Sign In**	100%	n/a	100%	-	98%	98%
	Time Out			100%	-	99%	100%
	Sign Out			100%	-	100%	100%
Safe Surgery: % of audits with engagement scores of 5 or higher	**Sign In**	95%	n/a	94%	-	80%	80%
	Time Out			99%	-	90%	89%
	Sign Out			98%	-	95%	88%
Hand Hygiene: % of opportunities for hand hygiene for health professionals		80%	84%	84%	**	82%	80%

Surgical Site Infections - Timing: % of hip and knee arthroplasty primary procedures were given an antibiotic at the right time	**100%**	**98%**	**100%**	**99%**	**100%**	**100%**
Surgical Site Infections - Dosing: % of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose	**95%**	**97%**	**98%**	**99%**	**99%**	**100%**
Cardiac Surgery - Timing: 100% of audited patients were an antibiotic is given 0-60 minutes before knife to skin	**100%**	**97%**	**100**	**100%**	**+**	**+**
Cardiac Surgery - Dosing: 95% of audited patients given correct antibiotic dose	**95%**	**97%**	**99%**	**100%**	**+**	**+**
Cardiac Surgery – Skin prep: 100% of audited patients given appropriate skin antisepsis in surgery	**100%**	**100%**	**99%**	**100%**	**+**	**+**
Patient Deterioration % of audited patients that triggered an escalation of care and received the appropriate response to that escalation	**n/a**	**65%**	*****	*****	**98%**	**84%**
Patient Deterioration Number of patients where Early Warning Score was calculated correctly for the most recent set of vitals	**n/a**	**93%**	*****	*****	**96%**	**91%**
Patient Deterioration Number of eligible wards using early warning score	**n/a**	**n/a**	*****	*****	**79%**	**86%**

- Fewer than 50 observations

***** Deteriorating patients is a new safety marker which did not start until January 2018, there are currently no goals or NZ average on the HQSC site.

****** reported 3 times a year, therefore no data point is shown for Q4

+ reported 6 months after the other QSMs

n/a not applicable

Serious and sentinel adverse events

At CCDHB improving the quality and safety of care we provide to our patients and whanau 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 causing avoidable harm to our patients.

In the year from 1 July 2017 to 30 June 2018, we had 26 serious healthcare adverse events and 19 serious behavioural adverse events for MHAIDS (CCDHB only). The healthcare events occurred in our hospitals which meant that patients suffered serious harm or death as a result of system or process failures. Of the 26 healthcare events, 14 were related to patient falls, 11 were related to clinical processes such as assessment, diagnosis and treatment, and one was due to a medical device.

In every instance a robust process has been untaken including a full clinical review to better understand and learn from the adverse event. Our sincerest apologies to patients and families who have been adversely affected. Patient safety is a key area of focus for our DHB and this year we have launched a new programme Speaking up for Safety, which has been rolled out to all staff as part of our three-year supporting safety culture programme.

IMPROVING HEALTH OUTCOMES

In the following section, we present 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 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 Capital & Coast DHB 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 Capital & Coast DHB to deliver better care and outcomes for our communities lies in improving equitable outcomes for all of our populations, including Māori and Pacific. This goal is supported by the Ministry of Health. To deliver on this, we are 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.

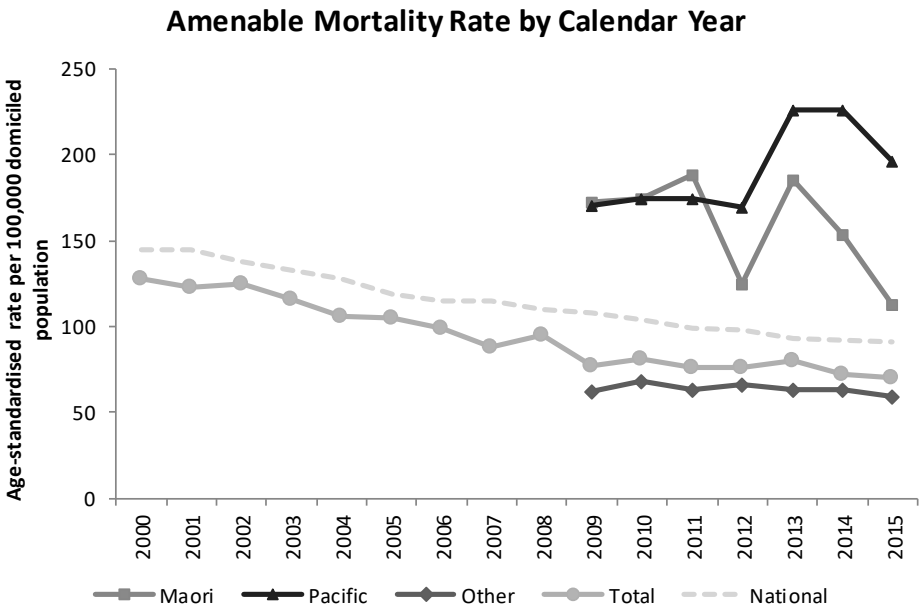
OUTCOMES AND IMPACTS

Reduced ethnic disparities

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.

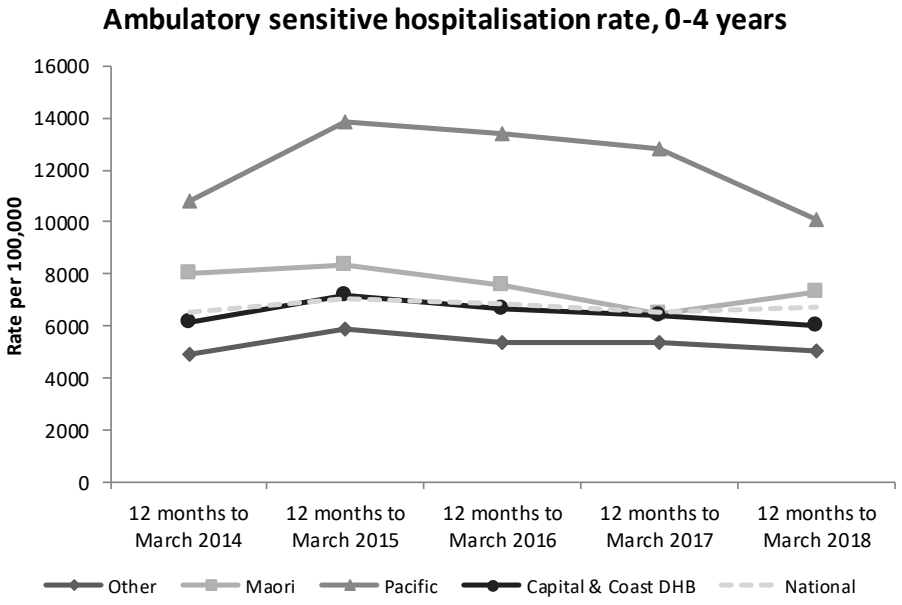
***Impact Measure*:** A reduction in amenable mortality ethnic disparity rates

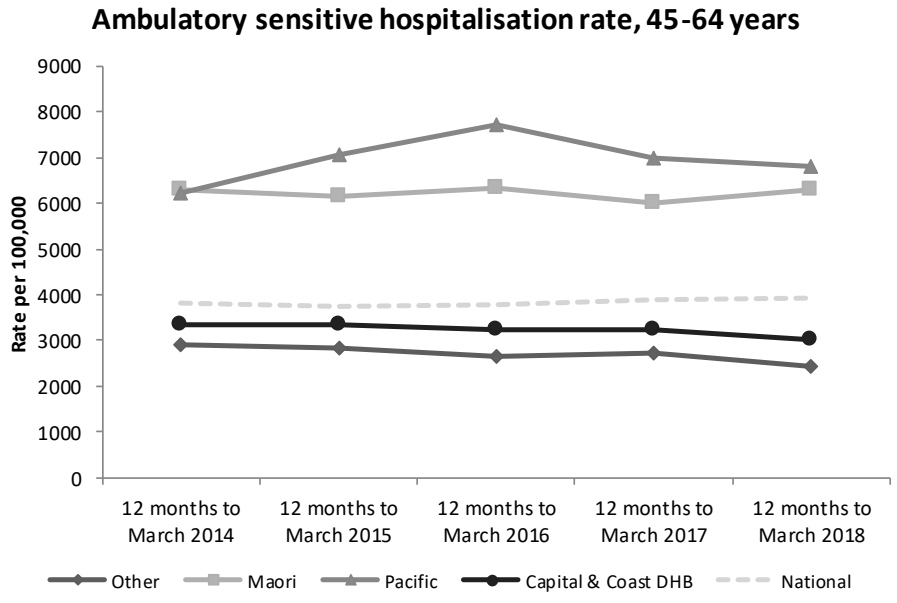
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care. Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them. In our System Level Measure Improvement Plan 2017/18, we set a milestone to reduce amenable mortality rates for Māori and Pacific, and half the equity gap by 2027. We have made progress towards achieving this milestone. Our amenable mortality rates remain below the national average. Data for amenable mortality rates is available up to 2015 only.



***Impact Measure*:** A reduction in Ambulatory Sensitive Hospitalisation ethnic disparity 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. Our ASH rates remain below the national average. However, the disparities for Māori and Pacific remain a priority for action.





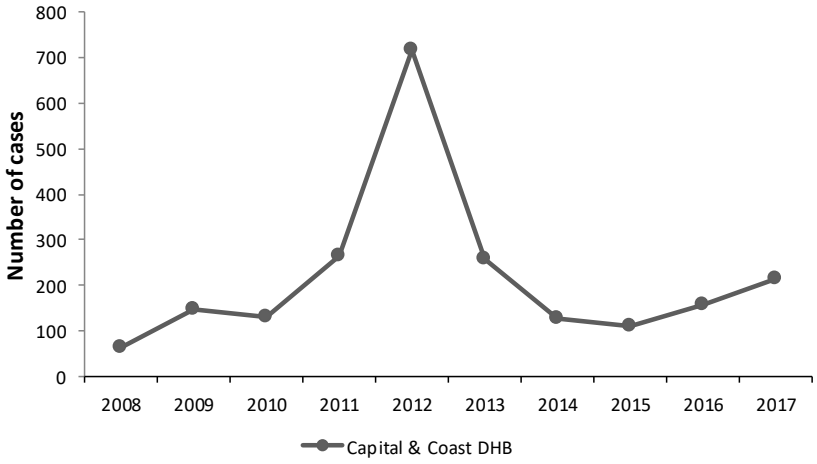
Environment and disease hazards are minimised

Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the Greater Wellington Region. To achieve this, Regional Public Health works with Police, councils, and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use.

***Impact Measure*:** A decrease in vaccine-preventable disease notifications

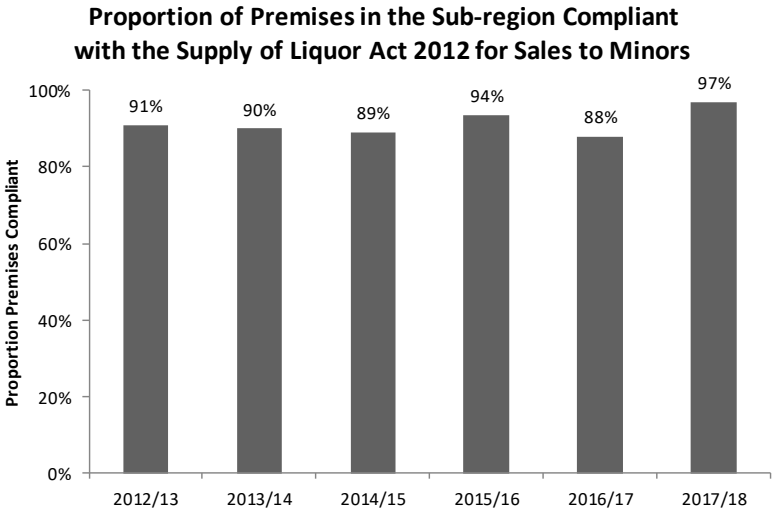
In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people. In 2012, Pertussis (whooping cough) outbreaks resulted in an increase in vaccine-preventable 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.

Number of Vaccine-preventable Disease Notifications in the Sub-region by Calendar Year



***Impact Measure*:** An increase in the percentage of premises visited that are compliant with the *Supply of Liquor Act 2012* for sales to minors

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 are an effective compliance tool and have contributed to a national decline in the incidence of premises selling to minors.

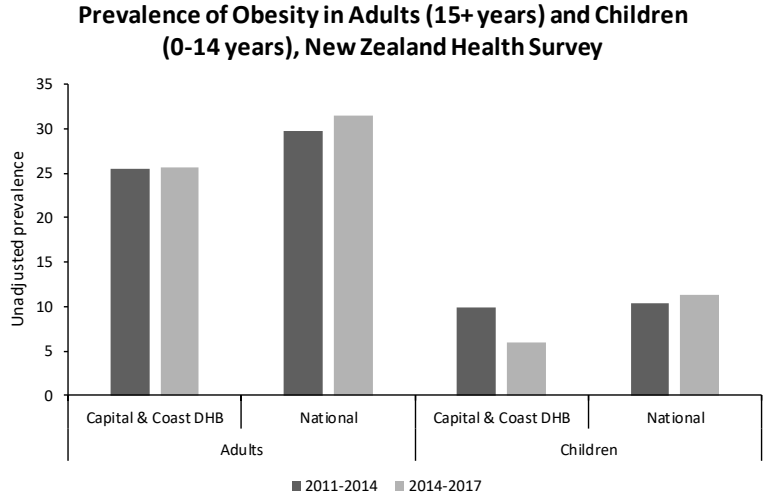


Lifestyle factors that affect health are well-managed

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.

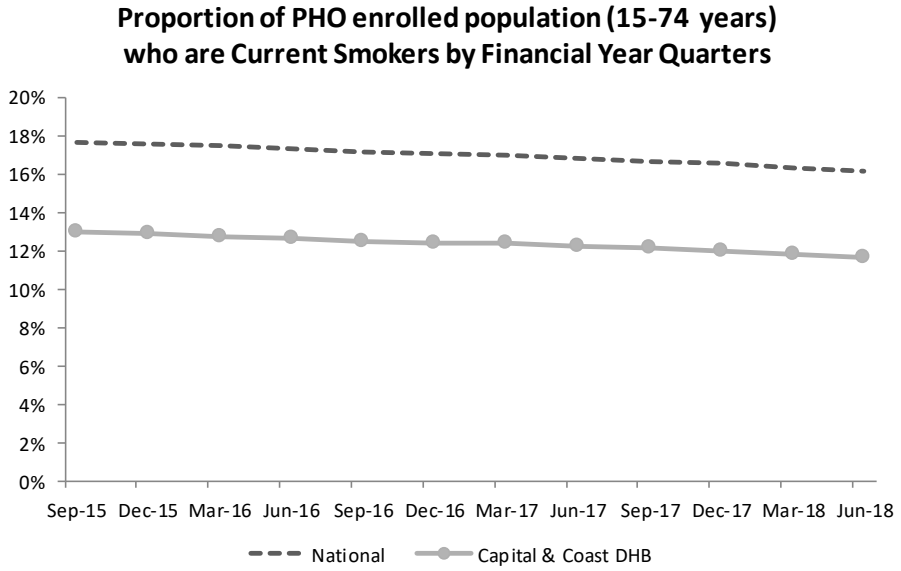
***Impact Measure*:** A decrease in the obesity prevalence in children and adults

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. The prevalence of obesity in our DHB is increasing at a slower rate than national for adults and has decreased for children.



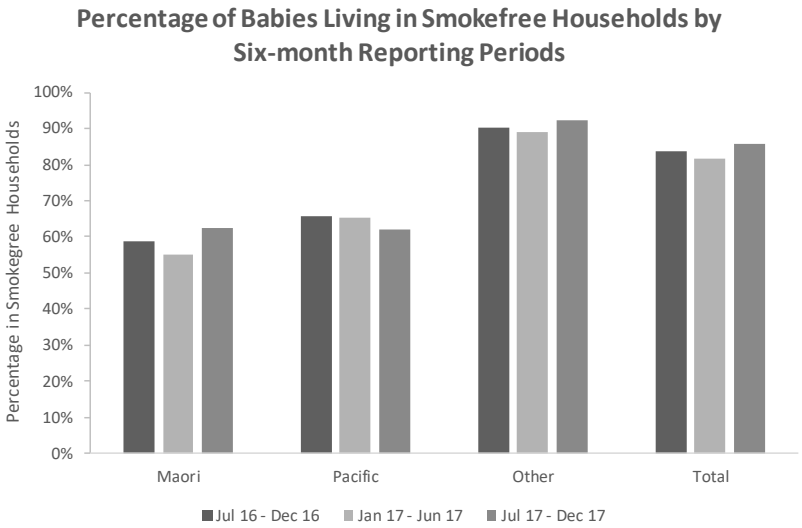
***Impact Measure*:** A decrease in the proportion of the Primary Health Organisation enrolled population that is recorded as a 'current smoker'

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smoke free by 2025. We are working towards this goal by providing smoking advice and cessation support to all patients enrolled in a general practice or when they visit the hospital. We recognise the significant ethnic disparities in smoking rates across our population and are committed to achieving equitable health outcomes for these populations.



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

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions, and tooth decay if they are exposed to cigarette smoke. Mothers are given smoking cessation advice in hospital, and lead maternity carers provide information about the risks associated with smoking and referrals to smoking cessation providers. By continuing to provide cessation advice and support, we expect that the percentage of babies living in smoke-free households will increase. In our System Level Measure Improvement Plan 2017/18, we committed to improving the proportion of babies living in a smoke-free household at 6 weeks postnatal. The Well Child Tamariki Ora Quality Improvement Framework indicator 'the percentage of mothers smoke-free at 2 weeks post-natal' ceased in 2016. The new indicator is 'the percentage of babies living in smoke-free homes at 6 weeks postnatal', which is now part of the System Level Measure framework.

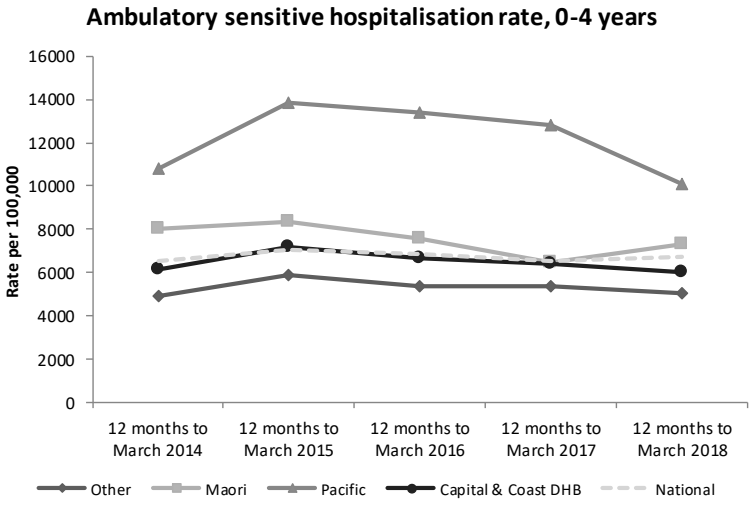


Children have a healthy start in life

A child's circumstances and health can have a lasting effect on their life. Poor health as a child often predicts 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.

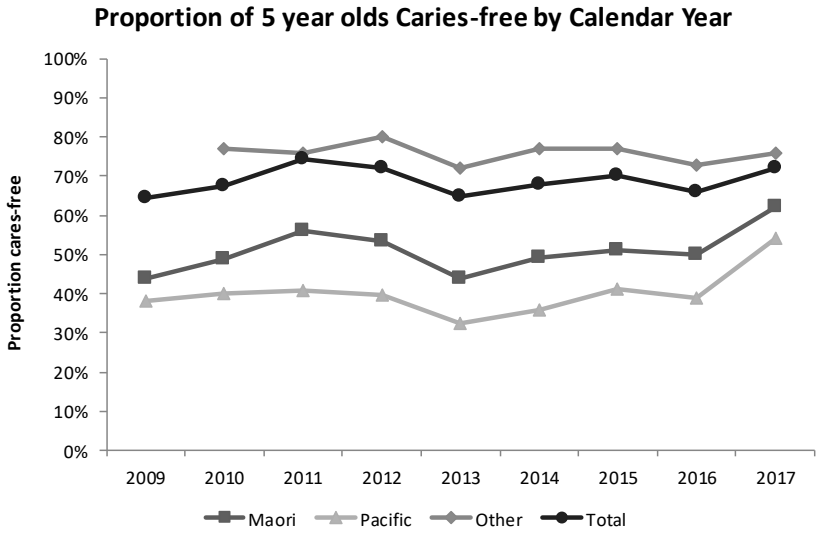
***Impact Measure*:** A reduction in Ambulatory Sensitive Hospitalisation rates for 0-4 year olds

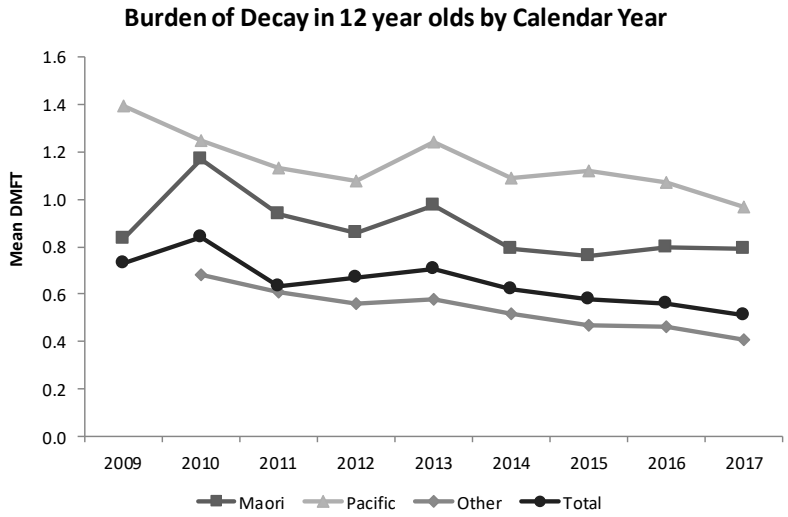
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, and gastroenteritis. ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system. In our System Level Measure Improvement Plan 2017/18, we set a milestone to reduce ASH rates for Pacific by 9% and maintain equitable rates for Māori. We achieved this milestone. We also committed to achieving equity for all population groups by 2021/22.



***Impact Measure*:** An increase in the proportion of children caries-free at 5 years & a decrase in the 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. We undertake 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.



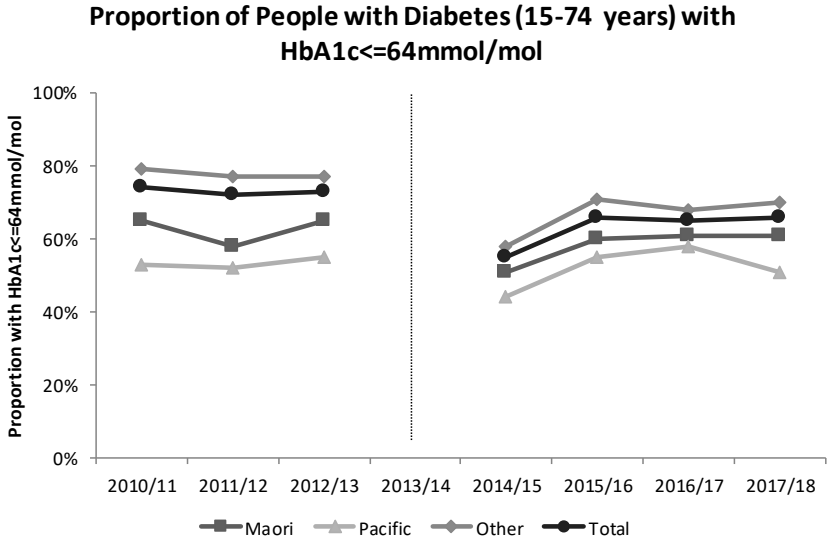


Long-term conditions are well managed

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.

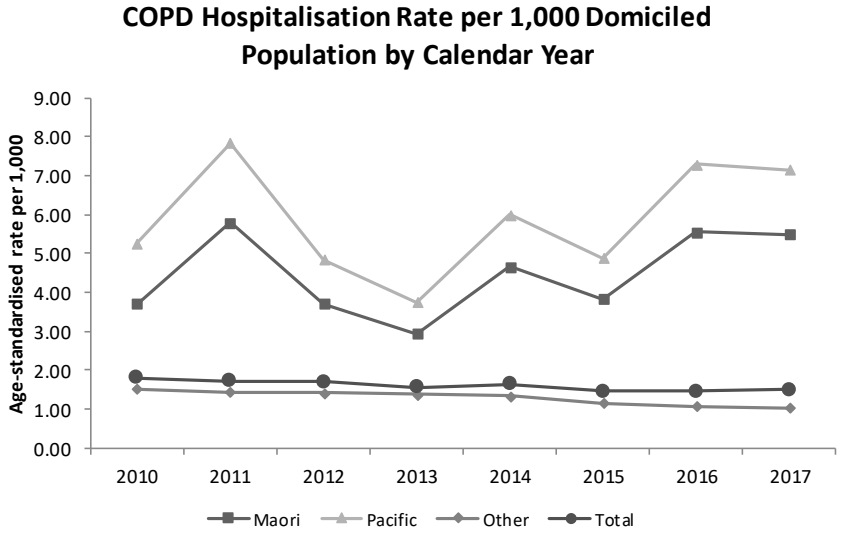
***Impact Measure*:** An increase in the proportion of people with diabetes with satisfactory blood glucose control

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. Note a revised methodology implemented from 2013/14, with results unavailable for 2013/14.



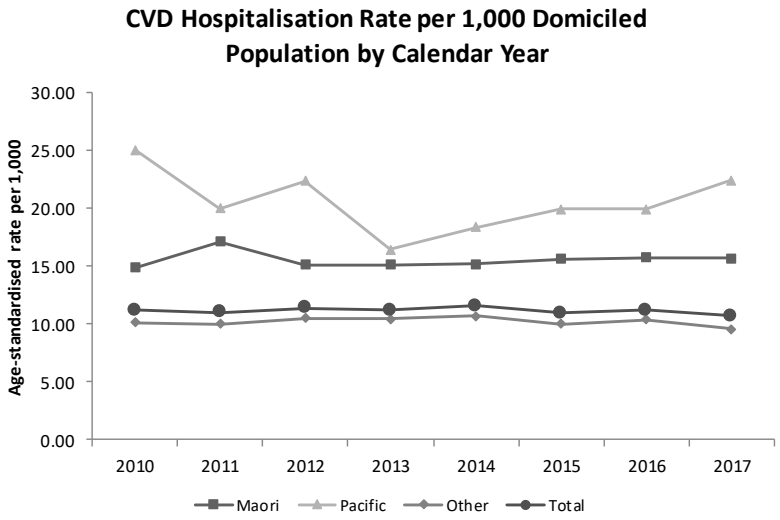
***Impact Measure*:** A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

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.



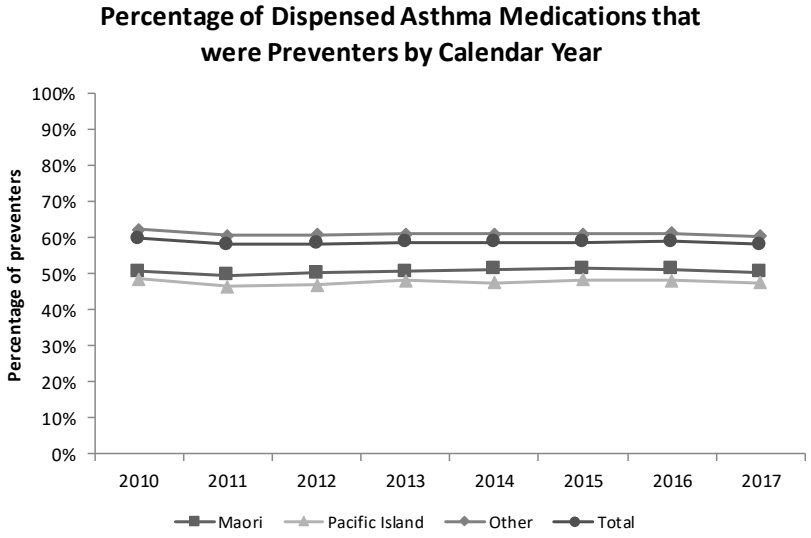
***Impact Measure*:** A decrease in the hospitalisation rate for cardiovascular disease

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management. By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population and improved equitable health outcomes.



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

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

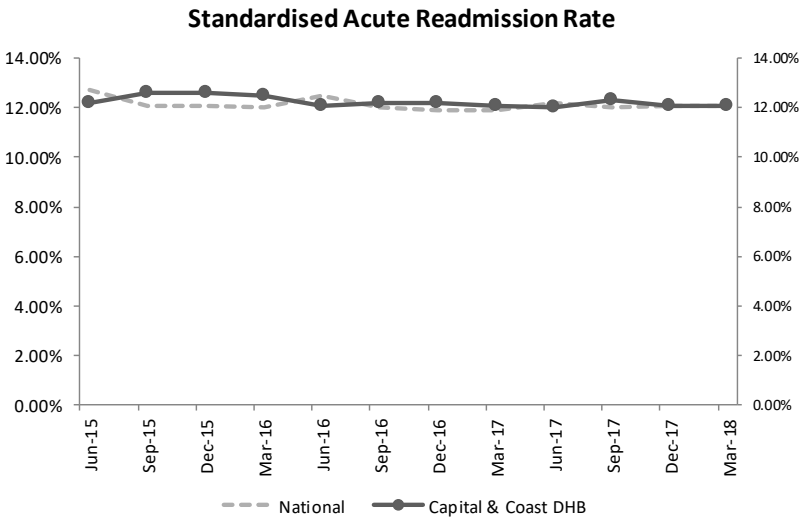


People receive high quality hospital and specialist health services when they need them

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

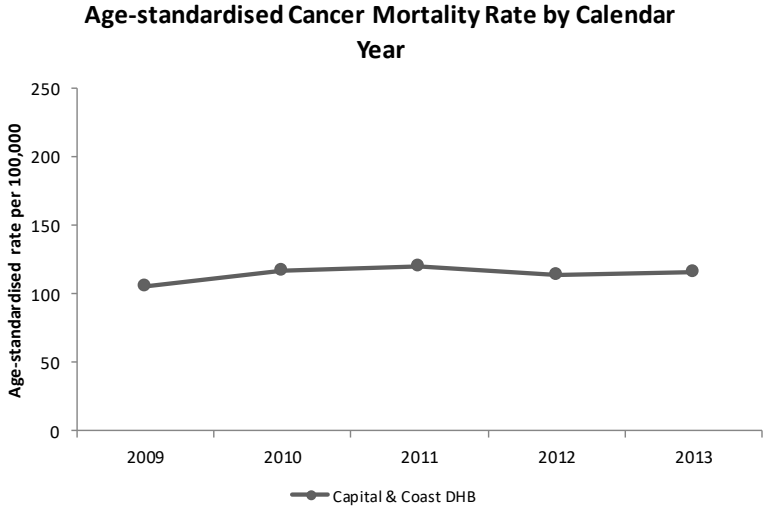
***Impact Measure*:** A reduction on the standardised rate of acute readmissions to hospital within 28 days

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital. We continue to drive improvements in the quality of care for people in our care. Our readmission rates are consistently on par with the national average and, in the long term, we expect that readmission rates will decrease.



***Impact Measure*:** Maintain or reduce the 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. We are 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. Data for mortality rates is available up to 2013 only.

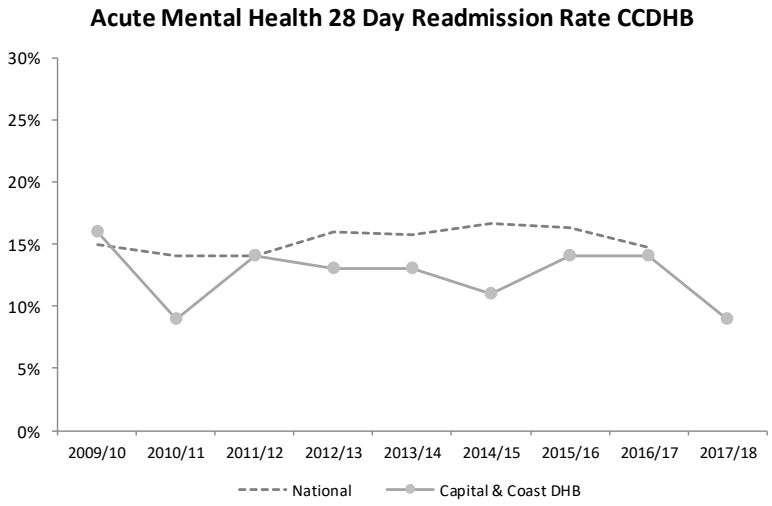


People receive high quality mental health services when they need them

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

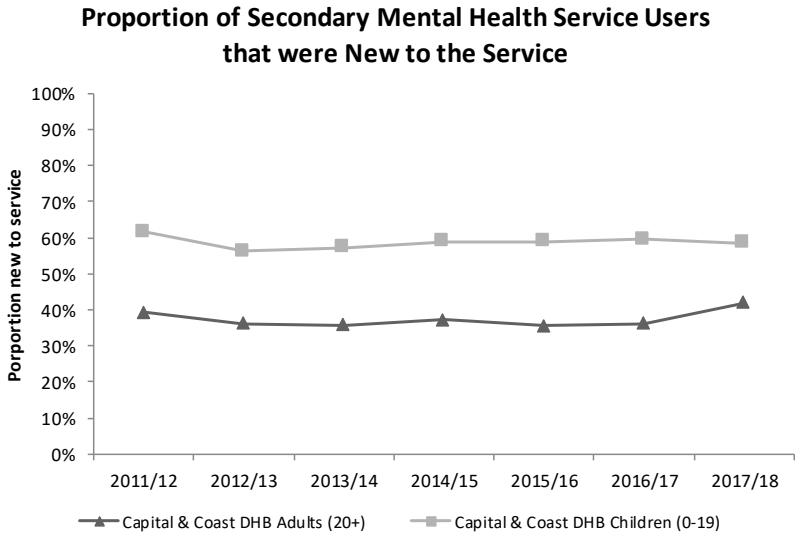
***Impact Measure*:** A reduction in the rate of acute readmission rate to inpatient mental health services within 28 days

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. Our acute readmission rate to inpatient mental health services remains below the national average.



***Impact Measure*:** An increase in the percentage of 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.



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 Capital & Coast DHB's 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*:** An increase in the 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.

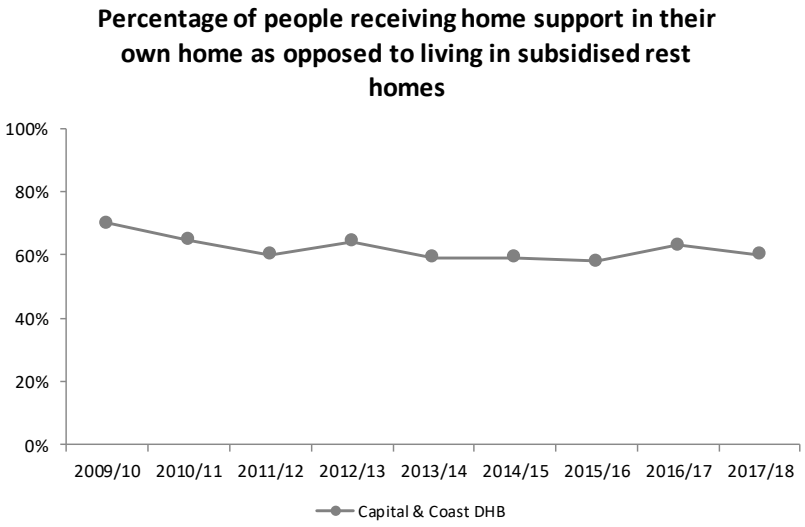
Note this measure is under-development with a review of the Health Passport.

Improve the health, well-being, and independence of our older people

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

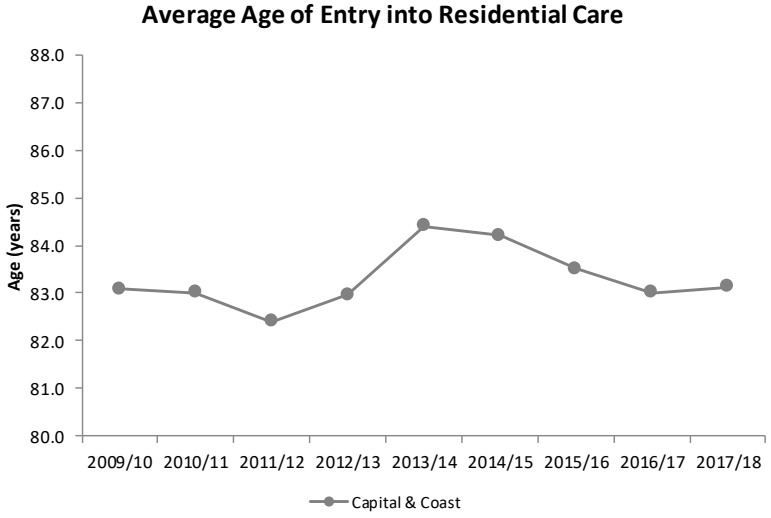
***Impact Measure*:** Maintain or increase the proportion of patients receiving home based support services, of those aged 65+ who receive DHB funded home-based support or aged residential care services

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. 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. 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*:** Maintain or increase the average age of entry into residential care

An increase in the average age of entry into residential care would indicate that older people are remaining independent and staying at home for longer. By providing quality home support services to those who need them and high-quality and timely health services for older people to help them maintain their health, we expect that the average age of entry into residential care will increase. While the average age of entry into residential care has decreased, 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) presented 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 outputs helps us to understand how we are progressing towards our impacts and outcomes set out in the Improving Outcomes section of this report. Each output class includes measures which help to evaluate the DHB'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 Capital & Coast DHB 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.

Appropriation reporting *in thousands of New Zealand dollars*

	2018 Actual	2018 Budget	2017 Actual
Appropriation revenue*	$735,631	$735,633	$702,655

*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 full year's performance as well as the fourth quarter's result, where relevant.

Health Targets		Target	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
	95% of patients admitted, discharged or transferred from emergency department (ED) within six hours.	95%	89%	92%	90%	90%
	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs).	10,852	2,813	5,583	8,259	11,341
	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer.	90%	89%	91%	91%	90%
	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%	94%	95%	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%	91%	91%	90%	90%
	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%	97%	96%	84%	92%
	95% of children identified as obese in the B4SC will be offered a referral to a health professional for assessment and lifestyle intervention.	95%	84%	98%	95%	95%

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 of 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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The number of disease notifications investigated (V)	Total	1126	986	1291	H
	Māori	88	66	109	H
	Pacific	49	57	92	H
The number of environmental health investigations (V)	Total	668	677	727	H
The number of premises visited for alcohol controlled purchase operations (V)	Total	12	107	70	H
The number of premises visited for tobacco controlled purchase operations*	Total	N/A	27	17	H

*New performance measure for 2017/18.

***Output Area*: Health Promotion and Preventative Intervention Services**

***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	2016/17 Result	2017/18 Target	2017/18 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	17	30	20	H

***Output Area*: Health Promotion and Preventative Intervention Services**

***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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of infants fully or exclusively breastfed at 3 months (C)	Total	62%	≥60%	63%	✓
	Māori	43%	≥60%	52%	⊘
	Pacific	49%	≥60%	44%	×
Number of new referrals to Public Health Nurses in primary/intermediate schools (V)	Total	1,126	1,222	1,887	H
	Māori	N/A	479	756	H
	Pacific	N/A	535	707	H
The number of adult referrals to the Green Prescription programme and the Green Prescription Plus programme (V) *	Total	3,315	1,200	2,777	✓
The number of pregnant women referred to the Maternal Green Prescription programme	Māori & Pacific	N/A	73	30	×
	Other	N/A	73	49	×
	Total	N/A	145	79	×
The number children (3 – 5 yrs) referred to the Pre-School Active Families programme	Māori & Pacific	N/A	104	65	×
	Other	N/A	44	42	⊘
	Total	N/A	148	103	×
The number of children (5 -18 yrs) referred to the Active Families programme (CCDHB component)	Total	N/A	120	284	✓
The number of primary schools enrolled in the Project Energize Programme**	Total	N/A	25	15	×

* Performance is for the 2017 calendar year in the sub-region (Wairarapa DHB, Hutt Valley DHB and Capital & Coast DHB)

**New performance measure for 2017/18.

***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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of two year olds fully immunised (C)	Total	94%	≥95%	96%	✓
	Māori	95%	≥95%	93%	⊘
	Pacific	98%	≥95%	98%	✓
The percentage of eight month olds fully vaccinated (C)	Total	93%	≥95%	93%	⊘
	Māori	86%	≥95%	86%	⊘
	Pacific	91%	≥95%	90%	⊘
The percentage of Year 7 children provided Boostrix vaccination in schools in the DHB (C)	Total	72%	≥70%	68%	⊘
	Māori	81%	≥70%	80%	✓
	Pacific	88%	≥70%	82%	✓
The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB (C)	Total	64%	≥75%	64%	⊘
	Māori	62%	≥75%	64%	⊘
	Pacific	79%	≥75%	75%	✓

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	2016/17 Result	2017/18 Target	2017/18 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	89%	≥90%	90%	✓
	Māori	88%	≥90%	89%	⊘
	Pacific	87%	≥90%	88%	⊘
The percentage of hospitalised smokers receiving advice and help to quit (C)	Total	91%	≥95%	86%	⊘
	Māori	91%	≥95%	87%	⊘
	Pacific	90%	≥95%	81%	✗

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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
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	100%	≥90%	92%	✓
	Māori	100%	≥90%	89%	⊘

***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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of eligible children receiving a B4 School Check (C)	High need	95%	≥90%	89%	⊘
	Total	90%	≥90%	90%	✓
The percentage of eligible women (25-69 years old) having cervical screening in the last 3 years (C)	Total	77%	≥80%	77%	⊘
	Māori	62%	≥80%	61%	✗
	Pacific	67%	≥80%	68%	✗
The percentage of eligible women (50-69 years old) having breast screening in the last 2 years (C)	Total	73%	≥70%	73%	✓
	Māori	68%	≥70%	67%	⊘
	Pacific	70%	≥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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of the DHB-domiciled population that is enrolled in a PHO (C)	Total	94%	≥94%	94%	⊘
The percentage of the eligible population assessed for CVD risk in the last five years (C)	Total	89%	≥90%	84%	⊘
	Māori	86%	≥90%	83%	⊘
	Pacific	87%	≥90%	85%	⊘
The number of new and localised Health Pathways in the sub-region (V)	Total	320	375	390	✓
The number of visits to the Health Pathways website in the last month of the financial year (V)	Total	7,913	2,000	2,192	✓

***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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of children under 5 years enrolled in DHB-funded dental services (C)	Total	97%	≥95%	94%	⊘
	Māori	70%	≥95%	67%	✗
	Pacific	86%	≥95%	80%	✗
The percentage of adolescents accessing DHB-funded dental services (C)	Total	78%	≥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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The number of initial prescription items dispensed (V)	Total	2,324,515	2,350,000	2,607,500	H
The percentage of the DHB-domiciled population that were dispensed at least one prescription item (C)	Total	80%	78%	78%	H
The number of people registered with a Long Term Conditions programme in a pharmacy (C)	Total	6,062	6,000	6,823	✓
The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy (V)	Total	171	220	225	✓

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 specialised 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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of patients admitted, discharged or transferred from Emergency Department within six hours (T)	Total	90%	≥95%	90%	⊘
The number of surgical elective discharges (V)	Total	10,785	10,852	11,341	✓
The standardised inpatient average length of stay (ALOS) in days, Acute (T)	Total	2.31	≤2.3	2.24	✓
The standardised inpatient average length of stay (ALOS) in days, Elective (T)	Total	1.57	≤1.47	1.55	⊘
The rate of inpatient falls causing harm, per 1,000 bed days (Q)	Total	0.5	≤1.0	0.5	✓
The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days (Q)	Total	0.8	≤0.8	0.2	✓
The rate of identified medication errors causing harm, per 1,000 bed days (Q)	Total	0.03	≤0.1	0.2	⊘
The weighted average score in the	Communication	8.3	≥8.4	8.5	✓

***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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
Patient Experience Survey by domain (Q)	Coordination	8.4	≥8.4	8.4	✓
	Partnership	8.8	≥8.6	8.7	✓
	Physical & Emotional Needs	8.5	≥8.5	8.7	✓
The percentage of "DNA" (did not attend) appointments for outpatient specialist appointments (Q)	Total	7.2%	≤6%	8.0%	⊘
	Māori	15.5%	≤15%	15.0%	✓
	Pacific	15.3%	≤16%	17.0%	⊘

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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy (T)*	Total	100%	100%	N/A	✓
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	81%	90%	90%	✓

*The Ministry of Health ceased reporting performance against this measure in 2017/18. Performance for this period is not available.

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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The number of people accessing secondary mental health services (V)	Total	10,080	10,000	11,015	H
	Māori	2,046	2,120	2,450	H
	Pacific	718	730	740	H
The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks (T)	Total	87%	95%	89%	⊘
The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks (T)	Total	77%	95%	92%	⊘
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	57%	75%	62%	×
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	63%	90%	73%	×

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	2016/17 Result	2017/18 Target	2017/18 Result	Achievement
The number of sub-regional and CCDHB Disability Forums (V)	Total	CCDHB: 2 3DHB: 2	≥1	0	✗
The number of sub-regional Disability Newsletters (V)	Total	12	3	2	✗
The total number of hospital staff that have completed the Disability Responsiveness eLearning Module (V/Q)	Total	718	≥1,000	1,207	✓
The total number of people with a Disability Alert (V/Q)	Total	8,526	≥6,550	8,357	✓

***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	2016/17 Result	2017/18 Target	2017/18 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	63%	≥60%	62%	✓
The percentage of the population aged 75+ who are in Aged Residential Care (including private payers) (C)	Total	9.5%	≤11.8%	10%	✓
The percentage of residential care providers meeting three or more year certification standards (Q)	Total	100%	100%	97%	⊘
The percentage of residential care providers meeting four year certification standards	Total	N/A	45%	53%	✓

Statement of Performance Expectations Legislative Compliance

The DHB was required to complete its Statement of Performance Expectations for the 2018/19 year before 1 July 2018 under section 149C of the Crown Entities Act 2004. This requirement has not been met. The DHB published its signed Statement of Performance Expectations on 3rd July 2018, without the financial forecasts which have been approved by the Board and submitted to the Ministry at the time of issuing the 30th June 2018 financial statements.

ASSET PERFORMANCE MEASURES

Property Asset Performance Measures

Measure Portfolio: Property	Indicator	2017/18 Target	2017/18 Outcome
% of buildings with a condition rating equal to or better than 2	Condition	>=53%	53%
M2 of buildings that are not earthquake prone or risk	Condition	82%	82%
% occupancy rate of our buildings	Utilisation	94%	94%
M2 of buildings that meet current and foreseeable service delivery requirements (>10 years)	Functionality	38%	38%
M2 of buildings that meet current service delivery requirements but may fall short in the foreseeable future (5-10 years)	Functionality	43%	43%

I.C.T. Asset Performance Measures

Measure ICT Asset Portfolio	Indicator	2017/18 Target	2017/18 Outcome
% availability of critical systems.	Functionality	99.9%	99.9%

Clinical Engineering Asset Performance Measures

Measure Asset Portfolio: Clinical Equipment CE)	Indicator	2017/18 Target	2017/18 Outcome
% of CE assets that have passed indicated life expectancy	Functionality	37%	37%
% of CE assets with a physical condition rating equal to or better than 3 (Average)	Condition	98%	98%
Time MRI is in operation expressed as a % of available time	Utilisation	34.5%	34.5%

STATEMENT OF RESPONSIBILITY

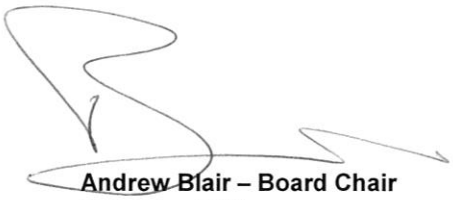
We are responsible for the preparation of Capital & Coast District Health Board's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the District Health Board under section 19A of the Public Finance Act 1989.

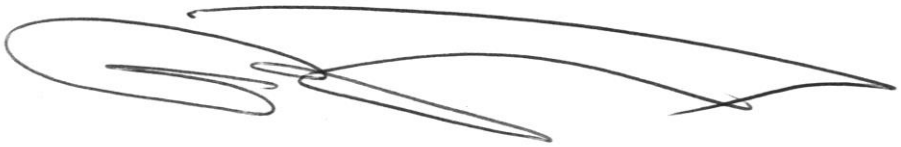
We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Capital & Coast District Health Board for the year ended 30 June 2018.

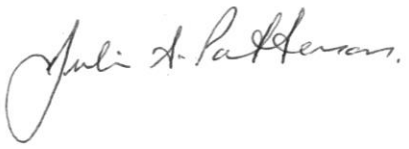
Signed on behalf of the Board:



Andrew Blair – Board Chair
31 October 2018



Darrin Sykes MNZM JP CMInstD – Finance, Risk and Audit Committee Chair
31 October 2018



Julie Patterson – Interim Chief Executive
31 October 2018

Michael McCarthy – Chief Financial Officer
31 October 2018

INDEPENDENT AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of
Capital and Coast District Health Board's financial statements and performance information for the year ended 30 June 2018

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

Opinion

We have audited:

- the financial statements of the DHB on pages 56 to 101, that comprise the statement of financial position and statement of contingent liabilities and assets as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the DHB on pages 22 to 48.

In our opinion:

- the financial statements of the DHB on pages 56 to 101:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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; and
- the performance information of the DHB on pages 22 to 48:
    - presents fairly, in all material respects, the DHB's performance for the year ended 30 June 2018, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

- what has been achieved with the appropriation; and

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

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2018. This is the date at which our opinion is expressed.

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

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The DHB has provided further disclosure about this matter in the statement of contingent liabilities and assets on page 61. Our opinion is not modified in respect of this matter.

Failure to complete the statement of performance expectations for the reporting period beginning 1 July 2018

We draw your attention to the disclosures made on page 48 about the failure to comply with section 149C of the Crown Entities Act 2004, which requires the DHB to complete its statement of performance expectations before the start of the financial year. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

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 opinion.

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

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

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the DHB for assessing the DHB'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 liquidate the DHB or there is no realistic alternative but to do so.

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the DHB's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the DHB's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the DHB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the DHB to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We 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 21, 49, and 50 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 DHB in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

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 2018

in thousands of New Zealand Dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Revenue	1	**1,091,480**	**1,076,515**	**1,039,207**
Total revenue		**1,091,480**	**1,076,515**	**1,039,207**
Expenditure				
Clinical supplies		115,189	109,926	110,375
Employee benefit costs	2	467,774	463,620	450,655
Infrastructure and non-clinical expenses		63,134	56,212	58,890
Other operating expenses	3	5,536	5,447	5,649
Outsourced services		36,385	31,936	32,233
Payments to other district health boards		96,424	95,943	92,735
Payments to non-health board providers		266,739	274,210	263,998
Capital charge	4	24,373	24,450	5,662
Finance costs	5	-	-	8,384
Depreciation and amortisation expense	6,7	34,161	35,771	35,394
Total expenditure		**1,109,715**	**1,097,515**	**1,063,975**
Surplus / (deficit)		**(18,235)**	**(21,000)**	**(24,768)**
Other comprehensive revenue and expense				
Revaluation of land and buildings		113,105	-	-
Total other comprehensive revenue and expense		**113,105**	**-**	**-**
Total comprehensive revenue and expense		**94,870**	**(21,000)**	**(24,768)**

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 2018

in thousands of New Zealand Dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Balance at 1 July		424,245	415,460	103,497
Total comprehensive revenue and expense for the year		94,870	(21,000)	(24,768)
Owner transactions				
Contribution from the crown		-	21,000	10,000
Conversion of loan to equity		-	-	339,000
Repayment of equity		(3,484)	(3,485)	(3,484)
Balance at 30 June	**19**	515,632	411,975	424,245

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 2018

in thousands of New Zealand Dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Assets				
Current assets				
Cash and cash equivalents	12	17,603	20,202	20,403
Trade and other receivables	11	52,151	51,823	49,597
Inventories	8	8,067	8,602	8,602
Trust and special funds	13	9,693	8,409	8,408
Total current assets		**87,514**	**89,037**	**87,010**
Non-current assets				
Property, plant and equipment	6	563,549	464,015	460,184
Intangible assets	7	27,761	20,643	28,034
Investments in joint ventures	9	-	-	-
Investments in associates	10	1,150	1,150	1,150
Total Non-Current Assets		**592,460**	**485,808**	**489,368**
Total Assets		**679,974**	**574,845**	**576,378**
Equity				
Crown Equity	19	766,952	795,825	770,435
Revaluation Reserve	19	136,711	23,606	23,606
Accumulated comprehensive revenue and expenses	19	(388,031)	(398,968)	(369,796)
Total equity		**515,632**	**420,463**	**424,245**
Liabilities				
Current Liabilities				
Trade and other payables	17	74,194	74,627	76,746
Borrowings	14	247	326	326
Employee entitlements	15	75,276	70,230	61,063
Provisions	16	739	2,424	593
Patient and restricted funds	18	50	-	81
Total current liabilities		**150,506**	**147,607**	**138,809**
Non-current liabilities				
Borrowings	14	55	302	302
Employee entitlements	15	13,078	5,868	12,646
Provisions	16	703	605	376
Total non-current liabilities		**13,836**	**6,775**	**13,324**
Total liabilities		**164,342**	**154,382**	**152,133**
Total equity and liabilities		**679,974**	**574,845**	**576,378**

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 2018

in thousands of New Zealand Dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		1,066,677	1,060,814	1,034,173
Other receipts		15,512	21,301	23,286
Cash paid to suppliers		(582,415)	(593,620)	(578,149)
Cash paid to employees		(453,548)	(448,835)	(441,005)
Cash generated from operations		**46,227**	**39,660**	**38,305**
Goods & services tax, other taxes (net) (a)		1,295	**(3,099)**	(3,152)
Capital charge paid		(24,373)	**(24,450)**	(5,662)
Net cash flows from operating activities		**23,149**	**12,111**	**29,491**
Cash flows from investing activities				
Interest received		1,557	1,436	1,697
Acquisition of property, plant and equipment		(21,121)	(26,400)	(12,728)
Acquisition of intangible assets		(1,291)	(3,600)	(4,496)
Appropriation from trust & special funds (b)		(1,284)	-	(1,274)
Net cash flows from investing activities		**(22,139)**	**(28,564)**	**(16,801)**
Cash flows from financing activities				
Contribution from the Crown		-	21,000	10,000
Repayment of borrowing		(326)	(325)	(326)
Repayment of equity		(3,484)	(3,484)	(3,484)
Interest Paid		-	(100)	(11,347)
Net cash flows from financing activities		**(3,810)**	**17,091**	**(5,157)**
Net increase/(decrease) in cash and cash equivalents		(2,800)	638	7,535
Cash and cash equivalents at beginning of year		20,403	20,403	12,868
Cash and cash equivalents at end of year	12	**17,603**	**21,041**	**20,403**

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

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

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

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

	2018 Actual	2017 Actual
Surplus/(deficit) for the year	(18,235)	(24,768)
Add back non-cash items:		
Depreciation & amortisation	34,161	35,394
Impairment on Intangibles	1,020	-
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	120	153
Interest revenue on financial assets	(1,963)	(1,579)
Donated assets	(481)	(1,859)
Add back items classified as financing activity:		
Interest expense on financial liabilities	-	8,384
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(2,555)	(3,057)
(Increase)/decrease in trust funds	(1,284)	(1,176)
(Increase)/decrease in inventories	535	(1,257)
Increase/(decrease) in trade and other payables	(3,287)	14,133
Increase/(decrease) in employee benefits	14,645	4,997
Increase/(decrease) in provisions	473	126
Net movement in working capital	8,527	13,766
Net cash inflow/(outflow) from operating activities	**23,149**	**29,491**

STATEMENT OF CONTINGENT LIABILITIES AND ASSETS

As at 30 June 2018

in thousands of New Zealand Dollars

	Note	2018 Actual	2017 Actual
Legal proceedings against the DHB		100	200
Other contractual matters		-	60
		100	260

The DHB has been notified of a potential claim as at 30 June 2018 (2017: 3) relating to an appeal following a win by the DHB in the High Court.

The private and public sectors have experienced widespread payroll issues relating to the compliance with the Holidays Act 2003. This is particularly for employees that are working on varying work patterns, complex entitlements, non-standard hours, allowances and overtime. 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 and there is a level of uncertainty with the application of the legislation an unquantified contingent liability has been disclosed.

The Wellington regional hospital domestic hot 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. Since the issues are currently being investigated an unquantified contingent liability has been disclosed. Legal proceedings have been commenced to recover the cost of replacing the hot 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.

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, 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 the DHB's accounting policies since the date of the last audited financial statements.

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 DHB 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.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial statements.

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 DHB 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 2018 were approved by the Board on 31 October 2018. The financial statements have been prepared for the period 1 July 2017 to 30 June 2018. Comparative figures and balances relate to the period 1 July 2016 to 30 June 2017. 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 2017/18 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 2 October 2018 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

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 and cash reserves 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 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

The DHB has no Finance Leases in this reporting period. 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.

In thousands of New Zealand dollars

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 associated depreciation rates are as follows:

Class of asset	Estimated life
• freehold buildings	1 to 60 years (1.6% to 100%)
• leasehold improvements	1 to 20 years (5% to 100%)
• plant and equipment	1 to 25 years (4% to 100%)
• furniture and fittings	1 to 40 years (2.5% to 100%)

The residual value of assets is reassessed annually. Leasehold improvements are depreciated over their lease term. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Research and development

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

Other intangibles

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
• Software	3 – 10 years (10% to 33%)
• Licences	3 – 10 years (10% to 33%)

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 entitlements

Short term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the year in which the employee renders the related service are measured based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, continuing medical education leave and expenses, and sick leave.

Long term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the year in which the employee renders the related service, such as sabbatical leave, long service leave, retirement

gratuities, sick leave, continuing medical education leave and expenses, have been calculated on an actuarial basis. The calculations are based on:

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

Presentation of employee entitlements

Sick leave, continuing medical education leave and expenses, annual leave, long service leave, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical leave and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

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.

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.

Income tax

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

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense. Commitments and contingencies are disclosed exclusive of GST. The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position. The net GST paid to, or received from the IRD, including the GST related to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Borrowing costs

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

Capital charge

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

Revenue

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

Crown funding

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

Goods sold and services rendered

Revenue from goods sold is recognised when the DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold. Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to the DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the DHB.

Revenue from other DHBs

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

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Rental revenue

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

Donated assets

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

Expenses

Operating lease payments

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

Finance lease payments

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

Cost of service (statement of performance)

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

Cost allocation

The DHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed and charged to output categories. Indirect costs are charged to output categories based on production cost drivers and related activity/usage information.

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.

NOTES TO THE FINANCIAL STATEMENTS

In thousands of New Zealand dollars

1 REVENUE

	2018 Actual	2017 Actual
Ministry of Health contract funding	825,450	784,132
Other government	16,861	14,453
Inter district flows (other DHBs)	224,705	215,712
Non-government & crown agency sourced	21,970	21,472
Reversal of impairment previously recognised	50	-
Interest revenue	1,963	1,579
Revenue from donations	481	1,859
	1,091,480	**1,039,207**

2 EMPLOYEE BENEFIT COSTS

	2018 Actual	2017 Actual
Direct staff costs (excluding increases in employee benefit provisions)	424,668	411,523
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	14,392	16,085
Contributions to defined contribution plans [1]	15,639	13,285
Increase/(decrease) in employee benefit provisions	13,075	9,762
	467,774	**450,655**

[1] 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	2018 Actual	2017 Actual
Increase/(decrease) in provision of trade receivables (doubtful debts)	**11**	568	1,156
(Gain)/loss on disposal of property, plant and equipment		41	153
Audit fees for financial statements audit		224	217
Fees for other assurance services		144	139
Board and Committee member fees	**22**	345	355
Operating lease expense		2,742	2,717
Other operating expense		1,472	912
Total other operating expenses		**5,536**	**5,649**

In thousands of New Zealand dollars

4 CAPITAL CHARGE

	2018 Actual	2017 Actual
The DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance. The capital charge rate for the period ended 30 June 2018 was 6 per cent (2017: 6 per cent)	24,373	5,662

5 FINANCE COSTS

	2018 Actual	2017 Actual
Interest on term borrowings	-	8,384

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 2016	25,705	478,210	1,191	89,325	27,492	621,923
Additions	-	10,398	-	6,369	399	17,166
Disposals	-	-	-	(736)	-	(736)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2017	25,705	488,608	1,191	94,958	27,891	638,353
Balance at 1 July 2017	25,705	488,608	1,191	94,958	27,891	638,353
Additions	-	3,053	-	5,185	551	8,789
Disposals	-	-	-	(799)	-	(799)
Impairment losses	-	-	-	-	-	-
Revaluations	15,460	(18,253)	-	-	-	(2,793)
Transfer to fixed assets	-	-	-	60	-	60
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	(18)	-	18	-	-
Balance at 30 June 2018	41,165	473,390	1,191	99,422	28,442	643,610
Depreciation and impairment losses						
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
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2017	-	(92,378)	(435)	(65,937)	(24,054)	(182,804)

In thousands of New Zealand dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	Freehold land	Freehold buildings	Leasehold improvements	Plant & equipment	Furniture & fittings	Total
Depreciation and impairment losses						
Balance at 1 July 2017	-	(92,378)	(435)	(65,937)	(24,054)	(182,804)
Depreciation charge for the year	-	(23,536)	(68)	(6,760)	(1,239)	(31,603)
Impairment losses	-	-	-	-	-	-
Disposals	-	-	-	660	-	660
Revaluations	-	115,949	-	-	-	115,949
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2018	-	35	(503)	(72,037)	(25,293)	(97,798)
Carrying amounts						
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
At 1 July 2017	25,705	396,230	756	29,021	3,837	455,549
At 30 June 2018	41,165	473,425	688	27,385	3,149	545,812

	Freehold land	Freehold buildings	Leasehold improvements	Plant & equipment	Furniture & fittings	Total
Work in progress						
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
Balance at 1 July 2017	-	2,216	-	1,935	484	4,635
Additions	-	16,449	-	3,281	2,964	22,694
Transfer from WIP	-	(3,973)	-	(5,066)	(551)	(9,590)
Balance at 30 June 2018	-	14,692	-	150	2,897	17,739

In thousands of New Zealand dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	2018 Actual	2017 Actual
Capital commitments		
Buildings	6,078	3,376
Plant & equipment	-	6,023
Intangible assets	1,234	2,599
Capital Commitments	7,312	11,998

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

Revaluation

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

The revaluation of land and buildings was carried out at 30 June 2018 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 $41.2m.

The total fair value of buildings valued by the valuer amounted to $473.4m.

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
2018	Revaluation gain	50
	Revaluation loss carried forward	**0**

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.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2018 was $0 (2017: $0m).

Restrictions

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

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

In thousands of New Zealand dollars

7 INTANGIBLE ASSETS

	Software	NOS shared services rights	Licenses	Total
Cost				
Balance at 1 July 2016	24,579	6,467	2,886	33,932
Additions	2,997	-	-	2,997
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2017	27,576	6,467	2,886	36,929
Balance at 1 July 2017	27,576	6,467	2,886	36,929
Additions	1,412	538	156	2,106
Disposals	(295)	-	-	(295)
Transfer to fixed assets	(26)	-	-	(26)
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2018	28,667	7,005	3,042	38,714
Amortisation and impairment losses				
Balance at 1 July 2016	(14,115)	-	(2,474)	(16,589)
Amortisation charge for the year	(2,924)	-	(219)	(3,143)
Impairment losses	-	-	-	-
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2017	(17,039)	-	(2,693)	(19,732)
Balance at 1 July 2017	(17,039)	-	(2,693)	(19,732)
Amortisation charge for the year	(2,433)	-	(124)	(2,557)
Impairment losses	-	(1,020)	-	(1,020)
Disposals	2	-	-	2
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2018	(19,469)	(1,020)	(2,817)	(23,307)
Carrying amounts				
At 1 July 2016	10,464	6,467	412	17,343
At 30 June 2017	10,537	6,467	193	17,197
At 1 July 2017	10,537	6,467	193	17,197
At 30 June 2018	9,198	5,985	225	15,407

In thousands of New Zealand dollars

7 INTANGIBLE ASSETS (CONTINUED)

	Software	Licenses	CRTAS	Total
Work in progress				
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
Balance at 1 July 2017	978	-	9,859	10,837
Additions	1,115	176	1,767	3,058
Transfer from WIP	(1,386)	(156)	-	(1,542)
Balance at 30 June 2018	707	20	11,626	12,353

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

New Zealand Health Partnerships

Health Benefits Limited (HBL) was established in July 2010 to undertake a range of shared services for DHBs. This includes 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 2018, the DHB has accrued $5.99m as its share of the project. This funding represents an intangible asset and gives the DHB the right to access shared services. The investment has been tested for impairment during the year by the DHB management and an impairment of $1.02m made.

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 2018, CCDHB had contributed $11.626m towards capital expenditure which has been recognised as work in progress in respect of intangible assets. The investment has been tested for impairment during the year by the DHB management. However at this stage on the information available no impairment is required at this point.

In thousands of New Zealand dollars

8 INVENTORIES

	2018 Actual	2017 Actual
Pharmaceuticals	2,414	2,456
Surgical & medical supplies	5,360	5,953
Other supplies	293	193
	8,067	**8,602**

The amount of inventories recognised as an expense during the year ended 30 June 2018 was $58m (2017: $57m). All inventories are distributed to operating areas in the normal course of business. The write-down of inventories held for distribution amounted to $nil (2017: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

9 INVESTMENTS IN JOINT VENTURES

	2018 Actual	2017 Actual
Carrying amount of investments in joint ventures		
Uncalled ordinary share capital	11,626	9,859
	11,626	**9,859**

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%)	2018 Actual	2017 Actual
Revenue	6,365	5,770
Expense	6,075	5,576
Non-current assets	163	183
Current assets	2,962	2,163
Non-current liabilities	119	119
Current liabilities	2,227	1,739
Contingent liabilities	-	-
Commitment	1,212	1,383

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

In thousands of New Zealand dollars

10 INVESTMENTS IN ASSOCIATES

	2018 Actual	2017 Actual
Carrying amount of investments in associates		
Investment in Allied Laundry Services Ltd. (ALSL)	1,150	1,150
	1,150	1,150

ALSL has a total ordinary share capital of 6,600,000 of which the DHB's share is 1,150,000. The shares have been fully paid. HVDHB shares are paid to $850k, with the remainder to be paid by 31st December 2018.

Summary of the DHB's interest in Allied Laundry Services Ltd. (18.25%)	2018 Actual	2017 Actual
Revenue	1,845	1,905
Expense	1,738	1,803
Non-current assets	1,548	1,701
Current assets	196	214
Non-current liabilities	73	116
Current liabilities	468	631
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

	2018 Actual	2017 Actual
Trade receivables from non-related parties	4,021	2,723
Ministry of Health receivables	19,585	18,428
Other DHB receivables	8,477	11,397
	32,083	32,548
Accrued revenue	16,993	11,417
Prepayments	3,075	5,632
Total receivables	52,152	49,597
Total receivables comprises:		
Receivable from the sale of goods and services (exchange transactions)	32,567	31,169
Receivable from Ministry funding (non-exchange transactions)	19,585	18,428

Trade receivables are shown net of a provision for doubtful debts amounting to $1.5m (2017: $1.4m)

The carrying value of receivables approximates their fair value.

As at 30 June 2018, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2018			2017		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	27,138	-	27,138	29,547	-	29,547
Past due 1-30 days	1,137	-	1,137	651	-	651
Past due 31-60 days	736	-	736	501	-	501
Past due 61-90 days	1,258	-	1,258	168	-	168
Past due > 91 days	3,319	1,504	1,815	3,076	1,395	1,681
Total	33,587	1,504	32,083	33,943	1,395	32,548

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:	2018 Actual	2017 Actual
Balance at 1 July 2017	1,395	597
Additional provisions made during the year	568	1,156
Receivables written-off during period	(459)	(358)
Balance at 30 June 2018	1,504	1,395

In thousands of New Zealand dollars

12 CASH AND EQUIVALENTS

	2018 Actual	2017 Actual
Petty cash	13	13
Bank accounts	8	91
NZHP call deposits	17,582	20,299
Cash and Cash equivalents	17,603	20,403

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 $55.8m. (2017:$54.9m). The highest overdrawn bank balance during financial year 2017/18 was $nil. (2017: $nil).

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.

	2018 Actual	2017 Actual
Non patient funds		
Balance at 1 July 2017	8,350	7,077
Monies received	3,350	3,536
Interest received	257	223
Payments made	(2,313)	(2,486)
Balance at 30 June 2018	9,644	8,350

In thousands of New Zealand dollars

Patient funds		
Balance at 1 July 2017	58	155
Monies received	145	183
Interest received	-	1
Payments made	(155)	(281)
Balance at 30 June 2018	49	58
Total trust and special funds	9,693	8,408

14 INTEREST BEARING LOANS AND BORROWINGS

	2018 Actual	2017 Actual
Current		
Unsecured EECA loans	247	326
	247	326
Non-current		
Unsecured EECA loans	55	302
	55	302

Unsecured loans

Interest rate summary	2018 Actual	2017 Actual
Energy Efficiency and Conservation Authority (EECA)	0%	0%

Loan repayable as follows:	2018 Actual	2017 Actual
Within one year	247	326
One to two years	55	247
Two to five years	-	55
Later than five years	-	-
Loan repayable as follows:	302	628

Term loan facility limits	2018 Actual	2017 Actual
Energy Efficiency and Conservation Authority (EECA)	302	628
	302	628

In thousands of New Zealand dollars

15 EMPLOYEE ENTITLEMENTS

	2018 Actual	2017 Actual
Current liabilities		
Liability for long service leave	2,900	2,600
Liability for sabbatical leave	340	310
Liability for retirement gratuities	830	770
Liability for annual leave	42,578	41,920
Liability for sick leave	318	187
Liability for continuing medical education leave and expenses	2,817	2,617
Salary and wages accrual	25,493	12,659
	75,276	61,063
Non-current liabilities		
Liability for long service leave	3,846	4,130
Liability for sabbatical leave	454	451
Liability for retirement gratuities	1,343	1,286
Liability for sick leave	1,800	1,545
Liability for continuing medical education leave and expenses	5,635	5,234
	13,078	12,646

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; this includes accruals for 2018 MECA settlements.

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%, (2017: 2.5%) and a discount rate ranging from 1.77% to 3.70% (2017: 1.87% to 3.61%) 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 $0.3m 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 $0.3m higher/lower.

In thousands of New Zealand dollars

16 PROVISION

	2018 Actual	2017 Actual
Current provisions		
ACC Partnership Programme	739	593
Non current provisions		
ACC Partnership Programme	703	376
	1,442	969
ACC Partnership Programme		
Undiscounted amount of claims at balance date	953	737
Discount	26	19
Central estimate of present value of future payments	1,299	873
Risk margin	143	96

The movement in provisions is represented by:

	ACC Partnership Programme
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

2018	
Balance at 1 July 2017	969
Additional provisions during the year for the risks borne in current period	591
Additional provisions relating to a reassessment of risks in a previous period	1048
Subtotal	2,608
Amounts used during the year	(1,166)
Total liability	1,442
(Decrease) / increase in provision	473

ACC Partnership Programme

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

insurance risk from the employee (policyholder) by agreeing to compensate the employee if a work-related injury (the insured event) adversely affects the employee.

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

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

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

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

An external independent actuarial valuer, Mr M Lardies, Bsc.FIA of Aon New Zealand Ltd, has calculated the DHB's liability. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report. Average inflation has been assumed as 1.77% for the year ended 30 June 2018. A discount rate of 2.43% has been used for the year ended 30 June 2018. The value of the liability is not material for the DHB's financial statements, therefore any changes in assumptions will not have a material impact on the financial statements.

In thousands of New Zealand dollars

17 TRADE AND OTHER PAYABLES

	2018 Actual	2017 Actual
Payables under exchange transactions		
Trade payables	5,326	7,729
Revenue in advance / Deferred Revenue	-	-
Other non-trade payables and accrued expenses	53,320	52,131
Total payables under exchange transactions	58,646	59,860
Payables under non-exchange transactions		
Revenue in advance	2	2,635
GST and other taxes payables	15,546	14,251
Total payables under non-exchange transactions	15,548	16,886
Total Payables	74,194	76,746

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

	2018 Actual	2017 Actual
Patient funds		
Balance at 1 July 2017	59	155
Monies received	144	184
Interest received	-	-
Payments made	(156)	(280)
Balance at 30 June 2018	48	59

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 2018 are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as at 30 June 2018, both as an asset and a liability.

	2018 Actual	2017 Actual
Holiday homes funds		
Balance at 1 July 2017	88	80
Monies received	21	20
Interest received	1	2
Payments made[1]	(101)	(14)
Balance at 30 June 2018	8	88
Hutt Valley DHB Portion ¼ of holiday homes total	2	22
Total patient and restricted funds	50	81

[1] FBT $84k, GST $8k and operating expenses $9k

In thousands of New Zealand dollars

19 EQUITY

	2018 Actual	2017 Actual
Contributed capital		
Balance at 1 July	770,435	424,919
Capital contribution	-	10,000
Conversion of loans to equity	-	339,000
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	766,951	770,435
Property revaluation reserves		
Balance at 1 July	23,606	23,606
Revaluations	113,105	-
Balance at 30 June	136,711	23,606
Accumulated surplus / (deficit)		
Balance at 1 July	(369,796)	(345,028)
Surplus / (deficit) for the year	(18,235)	(24,768)
Balance at 30 June	(388,031)	(369,796)
Total equity	515,631	424,245

Capital Management

The DHB's capital is its equity, which is comprised of equity contribution, accumulated funds and other reserves. Equity is represented by net assets. The DHB is subject to financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives. The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

20 OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2018 Actual	2017 Actual
Less than one year	3,318	3,548
Between one and five years	7,000	5,872
More than five years	255	90
	10,573	9,510

During the year ended 30 June 2018, $2.7m was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2017: $2.7m)

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:

	2018 Actual	2017[1] Actual
Less than one year	4,057	4,209
Between one and five years	8,659	11,300
More than five years	1,300	1,332
	14,016	16,841

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.
- a mix of short and medium term leases to both clinical and commercial tenants.

[1] The 2017 figures published last year ($2,268m) were incorrectly stated. The 2017 figures shown here have been corrected in order to provide relevant comparison to 2018.

21 FINANCIAL INSTRUMENTS

Exposure to credit, interest rate and currency risks arise in the normal course of the DHB's operations.

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 61.04% in 2018 (2017: 52.84%). 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.

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 $0.73m in 2018. (2017: $0.51m).

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.

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.

	2018 Actual							2017 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 unsecured loan	0	302	137	110	55	-	-	0	628	163	163	247	55	-

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
2018						
Creditors and other payables	74,194	74,194	74,194	-	-	-
Secured loans	-	-	-	-	-	-
Unsecured loans	302	302	247	55	-	-
Patient and restricted funds	50	50	50	-	-	-
Total	74,546	74,546	74,491	55	-	-
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	-

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
2018						
Cash and cash equivalents	17,603	17,603	17,603	-	-	-
Debtors and other receivables	52,151	52,151	52,151	-	-	-
Trust and special funds - bank	796	796	796	-	-	-
Trust and special funds - term deposit	8,300	8,395	8,395	-	-	-
Trust and special funds – debtors	573	573	573	-	-	-
Total	79,423	79,518	79,518	-	-	-
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	-	-	-

In thousands of New Zealand dollars

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	-	-	-

Maximum exposure to credit risk

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

	2018 Actual	2017 Actual
Cash and cash equivalents	17,603	20,403
Debtors and other receivables	52,151	49,596
Trust and special funds – bank	796	4,327
Trust and special funds – term deposit	8,300	3,800
Trust and special funds – debtors	573	280
	79,423	**78,406**

	2018 Actual	2017 Actual
Counterparties with credit ratings		
Cash at bank and term deposits	26,699	28,530
AA- (Standard & Poor's)	26,699	28,530

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 NZ Dollars. The currencies giving rise to this risk are primarily US Dollars and AU 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 2018 was $nil (2017: $nil), comprising assets of $nil (2017: $nil) and liabilities of $nil (2017: $nil) that were recognised in fair value derivatives.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of comprehensive revenue and expense. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of "Net loss on derivative classified as fair value through statement of comprehensive

In thousands of New Zealand dollars

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 2018 was $nil (2017: $nil) recognised in fair value derivatives.

Fair values

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

	Note	Carrying amount 2018 Actual	Fair value 2018 Actual	Carrying amount 2017 Actual	Fair value 2017 Actual
Trade and other receivables	11	52,151	52,151	49,596	49,596
Cash and cash equivalents	12	17,603	17,603	20,403	20,403
Secured loans	14	-	-	-	-
Unsecured loans	14	(302)	(302)	(628)	(628)
Trade and other payables	17	(74,194)	(74,194)	(76,746)	(76,746)
		(4,742)	(4,742)	(7,375)	(7,375)
Unrecognised (losses)/gains		-	-	-	-

Estimation of fair value analysis

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

Derivatives

Forward exchange contracts are either marked to market using listed market prices or by discounting the contractual forward price and deducting the current spot rate. Where discounted cash flow techniques are used, estimated future cash flows are based on management's best estimates and the discount rate is a market related rate for a similar instrument at the balance sheet date. Where other pricing models are used, inputs are based on market related data at the balance sheet date.

Interest bearing loans and borrowings

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

Finance lease liabilities

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

Trade and other receivables and payables

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

In thousands of New Zealand dollars

22 RELATED PARTIES TRANSACTIONS

CCDHB is a wholly owned entity of the Crown.

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

Remuneration

Key management personnel remuneration is as follows:

	2018 Actual	2017 Actual
Board Members		
Remuneration	$345	$355
Full-time equivalent members	1.19	1.14
Leadership Team		
Remuneration	$4,750	$3,583
Full-time equivalent members	18	15.67
Total key management personnel remuneration	**$5,095**	**$3,938**
Total members and full time equivalent personnel	**19.19**	**16.81**

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

In thousands of New Zealand dollars

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 2018		**2018**	**2017**	**2018**	**2017**
Mr Andrew Blair, Chair	Appointed	61	35	3	1
Dame Fran Wilde, Deputy Chair	Elected	32	18	5	2
Ms Kathryn Adams	Elected	25	15	3	1
Mr Roger Blakeley	Elected	25	15	3	1
Ms Eileen Brown	Elected	25	15	1	1
Ms ‘Ana Coffey	Elected	25	15	2	-
Mrs Sue Driver	Elected	25	15	1	-
Ms Sue Kedgley	Elected	25	25	1	1
Ms Kim Ngarimu	Appointed	25	15	2	1
Mr Darrin Sykes	Appointed	25	25	3	3
Board member who left during the year					
Mr Roger Jarrold	Appointed	25	25	3	3
Board members who left during 2016/17					
Dr Virginia Hope, MNZM		-	22	-	1
Mr Derek Milne		-	13	-	1
Dr Judith Aitken		-	11	-	2
Mr David Choat		-	11	-	0.5
Mr Peter Douglas		-	11	-	1
Ms Helene Ritchie		-	11	-	-
Mr Chris Laidlaw		-	11	-	-
Mr Nick Leggett		-	11	-	2
Crown monitor					
Dr Margaret Wilsher		-	15	-	-
		318	334	27	21

Committee members (other than Board members and employees)	CPHAC/DSAC fees ($)		HSC fees ($)	
	2018	**2017**	**2018**	**2017**
Dr Tristram Ingham	1	1	0.4	-
Mr Bob Francis	0.4	0.4	-	-
Mr Fa’amatuainu Tino Pereira	-	0.4	0.2	-
	1	2	1	-

In thousands of New Zealand dollars

23 EMPLOYEE REMUNERATION

The number of employees or former employees who received remuneration and other benefits of $100,000 or more per annum during 2017/18 within specified $10,000 bands were as follows:

Salary band	Number of Employees 2018	Number of Employees 2017	Salary band	Number of Employees 2018	Number of Employees 2017
100 – 110	167	175	*330 – 340*	11	4
110 – 120	115	99	*340 – 350*	8	8
120 – 130	90	78	*350 – 360*	4	6
130 – 140	54	68	*360 – 370*	4	11
140 – 150	48	35	*370 – 380*	3	1
150 – 160	37	32	*380 – 390*	3	2
160 – 170	38	25	*390 – 400*	1	2
170 – 180	22	27	*400 – 410*	4	4
180 – 190	22	16	*410 – 420*	2	4
190 – 200	18	27	*420 – 430*	2	1
200 – 210	23	15	*430 – 440*	2	1
210 – 220	12	21	*440 – 450*	2	1
220 – 230	17	15	*450 – 460*	2	3
230 – 240	18	15	*460 – 470*	2	-
240 – 250	25	19	*480 - 490*	-	1
250 – 260	13	16	*500 – 510*	1	-
260 – 270	17	12	*510 – 520*	1	1
270 – 280	8	5	*520 – 530*	-	2
280 – 290	16	17	*530 – 540*	1	-
290 – 300	11	6	*550 – 560*	1	-
300 – 310	13	12	*560 – 570*	2	-
310 – 320	10	6	*610 – 620*	1	1
320 – 330	5	11		856	805

Of the 856 employees shown above, 527 are or were medical or dental employees and 329 were neither medical nor dental employees. This represents an increase of 51 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 1,173 compared with the actual total number of 856.

24 TERMINATION PAYMENTS

During the year ended 30 June 2018, 19 (2017: 22) employees received compensation and other benefits in relation to cessation totalling $0.3m (2017: $0.4m).

No Board members (2017: nil) received compensation or other benefits in relation to cessation (2017: $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.

Statement of comprehensive revenue and expense

The DHB recorded a deficit of $18.2m compared with a budgeted deficit of $21m.

Revenue was greater than budget in most categories, including the Funder Arm new contracts, IDF, other DHB and other government revenues. A $3.87m accrual was also made for operational support for the new children's hospital. This was slightly offset by reduced revenue for the electives.

Expenditure was over budget for the following reasons:

- Clinical supplies costs were higher than budget due to increased activity in hospital volumes including IDF patients
- Employee benefit costs were higher than budget due to unplanned increases in bed days and watches, provision for Nursing MECA and unmet savings targets
- Infrastructure & Non Clinical expenses were over budget due to $3.87m of expenses related to the Children's Hospital matched to additional revenue, and other project related costs
- Outsourced Services were over budget due to medical vacancies filled with Locums to meet targets and maintain theatre throughput
- Payments to non-health board providers were lower than budget, due to lower costs for demand driven services, pharmaceutical rebates, and pay equity costs lower than planned.

Statement of changes in Equity

There was an addition of $94.9m to equity, due to a land and buildings revaluation gain of $113.1m, less deficit of $18.2m.

Statement of financial position

There was an increase in Property, Plant and Equipment due to the gain from revaluation of land and buildings. Investment in intangibles remained on trend compared to 2017.

Trade and other Payables were higher than budget due to timing of supplier payments. The total employee entitlements were higher than budget due to actuarial valuations.

Statement of cash flows

The net cash flow from operating activities was higher than budget due to increased cash receipts from Ministry of Health and other Crown Entities.

The net cash flow from investment activities was less than budget due to lower than expected capital spend.

The net cash flow from financing activities was less than budget due to non- receipt of budgeted $21m deficit support from the Crown.

26 EVENTS AFTER BALANCE DATE

There were no significant events after the balance date.

27 SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual	2018 Actual	2017 Actual	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Revenue										
Crown	10,619	10,947	214,113	209,741	733,864	694,507	109,386	104,980	1,067,981	1,020,175
Other	-	-	-	-	23,499	19,032	-	-	23,499	19,032
Total revenue	10,619	10,947	214,113	209,741	757,363	713,539	109,386	104,980	1,091,480	1,039,207
Expenditure										
Personnel	96	113	1,821	2,138	464,882	447,260	975	1,144	467,774	450,655
Depreciation	-	-	-	-	34,161	35,288	-	-	34,161	35,288
Capital charge	-	-	-	-	24,373	5,662	-	-	24,373	5,662
Provider payments	9,102	9,624	197,215	193,508	57,020	57,738	99,826	95,863	363,163	356,733
Other	628	632	14,253	13,435	197,128	193,875	8,235	7,695	220,244	215,637
Total expenditure	**9,827**	**10,369**	**213,289**	**209,081**	**777,564**	**739,823**	**109,035**	**104,702**	1,109,715	1,063,975
Net surplus/(deficit)	**792**	**578**	**823**	**660**	**(20,201)**	**(26,284)**	**351**	**278**	(18,235)	(24,768)

Actual revenue and expenditure has been mapped to output classes in accordance with guidance on classifications from the Ministry of Health. Expenditure paid from the funder arm is matched to a purchase unit code and mapped to the relevant output class. This is done at a detailed transactional level and accounts for the majority of DHB's revenue and expenditure. The DHB's remaining activity is within the provider arm, and is assumed to come under the intensive assessment and treatment output class.

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2018 Actual	2018 Budget	2017 Actual	2018 Actual	2018 Budget	2017 Actual	2018 Actual	2018 Budget	2017 Actual	2018 Actual	2018 Budget	2017 Actual
Opening balance	(402,517)	(402,517)	(374,107)	(16,084)	(16,084)	(17,070)	41,008	41,008	38,352	(377,593)	(377,593)	(352,825)
Surplus/(deficit)	(28,562)	(21,000)	(28,410)	1,319	-	986	9,008	-	2,656	(18,235)	(21,000)	(24,768)
Closing balance	**(431,079)**	**(423,517)**	**(402,517)**	**(14,765)**	**(16,084)**	**(16,084)**	**50,016**	**41,008**	**41,008**	**(395,828)**	**(398,593)**	**(377,593)**