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Capital & Coast District Health Board

Annual Report 2018–2019

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 District Health Board
Ūpuko Ki Te Uru Hauora

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Cover photo: Children from Holy Cross School in Wellington prepare meals using vegetables they've grown as part of the Garden to Table project.

COMMS: 0892-1910

CHAIR AND CHIEF EXECUTIVE'S FOREWORD

We are very pleased to present the *Capital & Coast District Health Board Annual Report 2018–2019*. This report outlines what we have achieved, our progress against our performance measures and how our health funding has been managed.

As a district health board we are focused on providing safe, quality health services and we 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.

As a Board we have refreshed our commitment to living sustainably within our means. We are deliberate in our investment choices to ensure we deliver better care and outcomes for our communities. Knowing that the services we deliver are achieving equitable outcomes, a high-performing health system and financial sustainability are top priorities.

The appointment of a joint Chief Executive for Capital & Coast and Hutt Valley DHBs will assist the boards to drive a joint strategic vision resulting in improved services and health outcomes for both populations. Capital & Coast District Health Board (CCDHB) and Hutt Valley DHB have already entered into a collaborative sub-regional clinical planning process and joint hospital network planning work programme that will inform our long-term investment plan.

We continue to foster and expand strategic partnerships that include our Māori Partnership Board and community and primary health care partners. This year we have been focused on implementing our Health System Plan that outlines CCDHB's strategy to improve the performance of our health care system and encourage better health and wellbeing.

The Health Care Home initiative is also a priority for CCDHB, underpinned by the development of our sector and community health networks. The emphasis in year three of this programme is on equity and ensuring models of service delivery are effective for all of our communities. Thirty-four providers are now Health Care Home practices, putting the needs of patients and their families at the heart of health care delivery by ensuring people can access services close to home and stay well in the community. The third tranche of 14 practices coming on board adds another 90,000 patients to the 150,000 patients already covered, and increases coverage to 80% of the region's population.

CCDHB is investing to sustainably achieve equity, with a focus on those where inequitable outcomes have the greatest negative impact. The development of the CCDHB pro-equity strategy puts in place the building blocks for the DHB to advance as a pro-equity organisation. We have also developed a new Māori health strategy, *Taurite Ora: CCDHB Māori Health Strategy and Action Plan 2019–2030*. This strategy will guide activity to achieve equitable Māori health outcomes by 2025 with a broader goal of pae ora (healthy futures) by 2030.

We are committed to fostering safe working environments that allow our staff to focus on patient care as their number one priority. We are concentrating on human resources, infrastructure and leadership to improve working conditions and patient safety. A quality framework that will ensure safety, quality and equity are closely monitored is currently being developed and will be implemented in the next financial year.

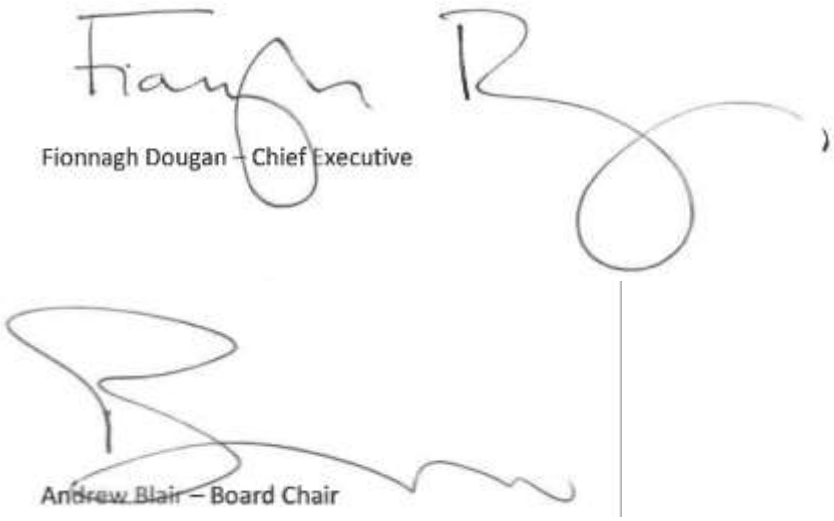
CCDHB has a comprehensive programme of work to improve mental health and wellbeing and ensure we effectively implement the recommendations of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. The 2019–2025 Mental Health and Addictions Strategy for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards was launched in May 2019 after a significant amount of planning, consultation and discussion with stakeholders across the three DHBs. This strategic plan sets the direction for mental health and addiction care in the sub-region to improve the experience and outcomes for our people, whānau and our communities.

This financial year also saw the opening of the Te Maara Forensic Intellectual Disability Service facility. Te Maara is an important rehabilitation centre where adult and youth clients living in different units across intellectual disability services can safely mix and participate in group activities together.

The construction of a new Children's Hospital is well under way thanks to a very generous donation from benefactor Mark Dunajtschik with the additional support of The Treasury and the Ministry of Health. Steel framing is going up and we expect the new building, which will bring our inpatient and outpatient child health services under one roof for the first time, to be open by mid-2021.

We continue to strengthen our commitment to the safety and development of our workforce including implementing Care Capacity Demand Management (CCDM). Continuing to build our clinical governance will further strengthen our focus on the quality and safety of the services we deliver. Leveraging the existing strengths in our organisation including our strong relationships within and across our communities, a committed and involved clinical workforce, and our equity focus will be key to deliver the ambitious targets we have set ourselves for the next three years.

We are also working closely with the Central Region DHBs (Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui) and, particularly Hutt Valley, to plan and coordinate our services across Wellington, Kenepuru and Hutt Valley Hospitals. Joint hospital network planning will ensure the effective use of our combined facilities and workforce. This work is also contributing to a bigger programme of work – a joint 2DHB long-term investment plan – to identify the investments needed to ensure we and Hutt Valley DHB have the assets needed in the future to manage growing demand and achieve our strategic objectives.



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: Keeping our communities healthy and well.

To deliver our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means using our resources in the most effective manner. We want to ensure that service delivery occurs in the most appropriate setting for our people and communities, and achieves equitable and improved health outcomes.

We recognise the role of many people in our success: our communities, families, workforce, provider partners, Ministry of Health and our social service partners. At the heart of this approach is enabling people and their whānau to take the lead in their own health and wellbeing.

As we implement our Health System Plan and long-term vision of how services will be delivered for our population, we are well positioned to successfully deliver against the New Zealand Health Strategy's objectives. We have a work programme that builds on existing successes and finds new ways of using existing resources wisely.

Overall, CCDHB's population is experiencing good health. Our residents are living longer and experiencing better health. However, inequities remain a significant challenge. Achieving equity is a priority for us. We know that we do not do as well for Māori, Pacific peoples, people with disabilities, those who have fewer resources available to them and those with enduring mental illness. We can see this in our measurement of health system performance, impacts and outcomes. We are committed to improving health outcomes and achieving equity for our communities. Our focus is on improving performance ensuring we make best use of our available resources and, ultimately, achieving equity for our populations.

We will continue to focus on:

- Taurite Ora: CCDHB's Māori Health Strategy and Action Plan 2019–2030
- Toe Timata Le Upega, the Pacific Action Plan 2017–2020
- the Sub-Regional Disability Strategy 2017–2022
- Living Life Well – A strategy for mental health and addiction 2019–2025.

Achieving equitable health outcomes for our communities requires a broader approach than the traditional boundaries of health. Partnership with local councils, government agencies, non-governmental organisations and community organisations is required to respond to the inequalities in our communities. We support these partnerships through local approaches with our communities in Kāpiti, Porirua and Wellington.

We also collaborate with our Māori Partnership Board, Sub-Regional Pacific Strategic Health Group and Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent.

Another strong feature of our priority work is improving our responsiveness to maternity care, and children and youth. Getting the best start is a great investment for achieving improved outcomes for

our communities and has an important role to play in creating a future where we have equitable health outcomes for all.

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

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

We operate with a long-term view that is supported by our 10-year long-term investment plan. We have a programme of work that builds on existing successes and that 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 don't have good health literacy and health behaviours
- intensify service delivery for those who are more vulnerable and have greater health needs to reduce inequalities and improve health gain
- implement models of care that promote early intervention closer to home and result in improved health outcomes
- organise technology and interdisciplinary teams in communities, people's homes, community health networks and our hospitals to ensure resources are used efficiently by reducing duplication and improving integration.

OUR VISION AND STRATEGIC DIRECTION

Capital & Coast District Health Board (CCDHB) is committed to meeting the Minister of Health's expectations and delivering our vision of: Keeping our community healthy and well.

To achieve our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means using our resources in the most effective manner to achieve equitable health outcomes and advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate setting for our people and communities.

We recognise the role of many in our success: our communities, our families, workforce, provider partners, Ministry of Health and social service partners. At the heart of this approach is enabling people and their whānau to take the lead in their own health and wellbeing.

Our Health System Plan 2030

Our Health System Plan 2030 outlines our vision and strategy to transform the health system to support people to have better health and wellbeing throughout their lives and ensure equity for our populations.

The Health System Plan enables us to respond to the growing demand for and increasing complexity of health care with a system design that will improve outcomes and equity for the people of CCDHB and the communities we serve. The Health System Plan is supported by this whakatauki:

Ma tini, ma mano, ka rapa, te whai
By joining together we will succeed

A health system focused on people and places

Collaboration between Wellington Free Ambulance and Kapiti GPs means local residents may be able to access urgent and after hours care closer to home. (L-R paramedics James Currie and Vanessa Simpson outside Waikanae Health with Dr Herman van Kradenburg.

Improved access to after hours and urgent health care for **Kāpiti**

Some Kāpiti residents requiring emergency ambulance care and a possible trip to Wellington Hospital now have a treatment option closer to home. Thanks to a joint partnership between local general practice teams, the Kāpiti Health Advisory Group, Wellington Free Ambulance and the CCDHB, some patients will receive treatment from their GP or medical centre.

Now, following clinical assessment, paramedic staff can work with the patient's GP or urgent care centre to establish if treatment can be provided at a local medical centre without a trip to hospital.

The changes have been welcomed by local GPs and patients. It is an excellent collaboration between Wellington Free Ambulance, Tū Ora Compass Health PHO and CCDHB. Key to getting this off the ground was working with the Kāpiti Health Advisory Group (KHAG) and the Mayor of Kapiti to identify the community's priority needs.

The focus was on supporting the community and implementing a system that takes care of GPs and their staff, ambulance paramedics and the patient to make the process of receiving health care as seamless as possible.

Every year, more than 6,200 Kāpiti residents travel to Wellington Hospital's emergency department seeking treatment outside normal consulting hours. More than half the people who attend the emergency department travel by ambulance, but fewer than 50% actually end up being admitted to hospital. This places a huge strain on available resources – both the hospital and ambulance system – and on families and loved ones.

Kāpiti GPs have a lot of experience in urgent and emergency medicine which, until now, has been under-utilised by the CCDHB.

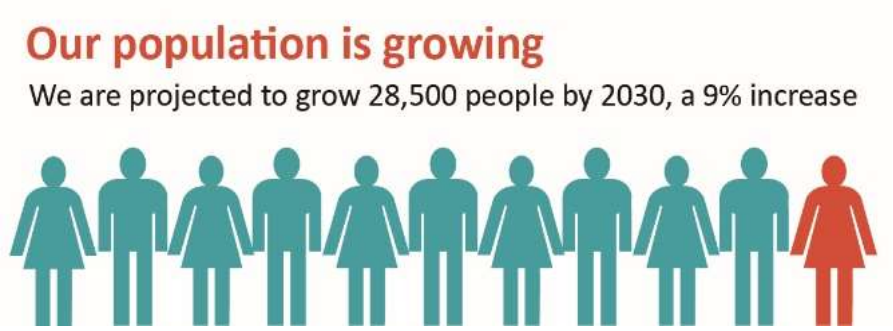
Collaboration between Wellington Free Ambulance and Kapiti GPs means local residents may be able to access urgent and after hours care closer to home. (L-R paramedics James Currie and Vanessa Simpson outside Waikanae Health with Dr Herman van Kradenburg.

ABOUT CAPITAL & COAST DHB

Capital & Coast DHB (CCDHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services to the residents living in the Kāpiti Coast District, Porirua City and Wellington City.

Who we are

The CCDHB region is diverse. Our communities reflect many cultures, ethnicities and abilities as well as geographic settings. In 2018, an estimated 318,000 people called the region home. This is projected to grow by 28,500 people by 2030; a 9% increase.



In 2018, 106,400 people under 25 years of age made up 33% of the region's population. Most people (58%) were aged 25-69 years (183,000). The remaining 9% were people over 70 years; 29,000 people.

In 2018, Wellington had a large proportion of people in the younger working age group of 20–44 years (90,500 people), while nearly one-quarter (23%) of the Porirua population were aged under 15 years (13,000 people). Just over one-quarter (26%) of the Kāpiti Coast population were aged over 65 years; 11,500 people.

The region is ethnically diverse. In 2018, 28,500 people identified as Māori (11% of the population), 21,000 identified as Pacific peoples (7%) and 35,500 identified as Asian (15%); 67 percent of the population identified as Non-Māori, Non-Pacific, Non-Asian (i.e. Other) category (228,000).

Porirua had a larger proportion of Māori (16% or 9,000 people) and Pacific peoples (21% or 12,000 people), while 89 percent of the Kāpiti Coast population identified as 'Other' ethnicities (70,800 people).

Our Māori and Pacific populations tend to be younger, with 29% of the region's Māori (10,600) and 27% of the region's Pacific people (6,000) aged under 15 years in 2018.

There are 72,200 people with a disability living in the CCDHB region. This is expected to increase to 84,500 by 2030; this partially reflects our ageing population.

A changing population

The CCDHB population is changing: the population is growing, ageing and becoming more diverse.

The majority of the population increase is predicted to be in our Māori and Asian communities. For Māori, we expect growth of 20% or 7,300 people. Our Asian population is predicted to grow by 43% or 20,300 people. Pacific peoples and 'Other' populations are expected to grow much more slowly and even decline in some younger age groups.

There will be significant growth in the number of older people in the region, as our large baby boomer generation shifts into older age brackets. The largest growth is expected be in the 70–79 and 80+ age groups; as our population is living to reach much older ages.

The health of our population

Compared to New Zealand as a whole, we are relatively 'healthy and wealthy'. We have a high life expectancy at 82 years, rates of premature deaths from conditions amenable to healthcare have declined by 45% between 2000 and 2015, and the majority of our population (62%) live in areas of low deprivation.

However, we also have groups who experience inequitable health outcomes; in particular, Māori, Pacific peoples, those experiencing disabilities and those who live in highly deprived areas, concentrated in Porirua.

What we do

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. These expectations are reflected in our vision:

Keeping our community healthy and well.

The objectives of DHBs are outlined within the Health and Disability Act 2000. These objectives include:

- Improve, promote, and protect the health of communities;
- Reduce inequalities in health status;
- Integrate health services, especially primary and hospital services; and,
- Promote effective care or support of people needing personal health services or disability support.

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets.

Local services

CCDHB provides community and hospital services throughout the region. CCDHB has a range of contract with community providers, such as primary health organisations, pharmacies, laboratory, and community NGOs.

CCDHB operates two hospitals: Wellington Regional Hospital in Newtown and Kenepuru Community Hospital in Porirua. We also operate the Kapiti Health Centre in Paraparaumu, and Rātonga-Rua-O-Porirua, a large mental health campus based in Porirua.

We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services. CCDHB also provides sub-regional, regional and tertiary services for other DHBs.

CCDHB employs around 5,700 staff and has an annual budget of $1.2 billion in 2019/20.

Sub-regional services

CCDHB provides services to the people of Hutt Valley DHB and Wairarapa DHB under 2DHB (CCDHB and Hutt Valley DHB) and 3DHB models.

CCDHB and Hutt Valley DHB serve populations that are geographically co-located. CCDHB provides more services to the Hutt Valley DHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at Hutt Valley DHB.

In 2018, an estimated 150,000 people lived in Hutt Valley DHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. Hutt Valley DHB's population is predicted to grow by 4% or 6,500 people by 2030.

A further 45,500 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 2,600 people (6%) by 2030.

Tertiary services

CCDHB is the complex care provider for the Central Region. The Central Region includes Hawke's Bay, MidCentral, Whanganui, Wairarapa, Hutt Valley and Capital & Coast DHBs.

In 2018, the Central Region population was 922,855 people. This represents 19% of the total New Zealand population and is projected to grow by 6 percent by 2030 to just under one million people (978,900).

Map of Central Region DHBs

CCDHB is also a provider of some tertiary services outside the Central Region (for example Taranaki DHB and Nelson Marlborough DHB) as well as some national services

2018-2019

a year at CCDHB

64,524
people presented to the emergency department at Wellington Regional Hospital

30,751
visits were made into people's homes by community allied health workers, such as physiotherapists or social workers

3,413
babies were born in our units

35,745
children had a free dental check

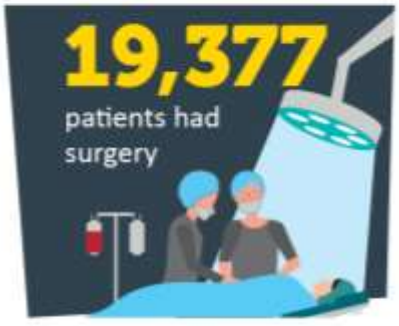
155,474
outpatient appointments

379,868
hours of home based support services

2.94million
laboratory tests were completed in the community and hospital

1,895
people are in aged residential on any given day

88,181
face to face client consultations with our specialist mental health services



2.7million
prescriptions were filled

671,074
meals made for patients

7,207
patients were seen by a district nurse at home

24,347
people were offered help to quit smoking

GOVERNANCE OF CAPITAL & COAST DHB

Role of the board

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

The board currently comprises 10 members who have overall responsibility for CCDHB's performance. Seven members are elected as part of the three-yearly local body elections and three are appointed by the Minister of Health.

Role of the chief executive

The board delegates to the chief executive 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 chief executive , assigning defined levels of authority to other specified levels of management within CCDHB's structure.

Governance philosophy

Over the past few years, the Wairarapa, Hutt Valley and Capital & Coast DHBs boards have taken a whole-of-health-system approach, including integrating clinical and support services where this provides benefits across the health system. Each board provides 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 provide:

- preventative health and empowered self-care
- relevant services close to home
- 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 AND COMMITTEE MEETING ATTENDANCE

Key:
DSAC – Disability Services Advisory Committee
FRAC – Finance, Risk, Audit Committee
HSC – Health Systems Committee
- Not a member

Attendance from 1 July 2018 to 30 June 2019

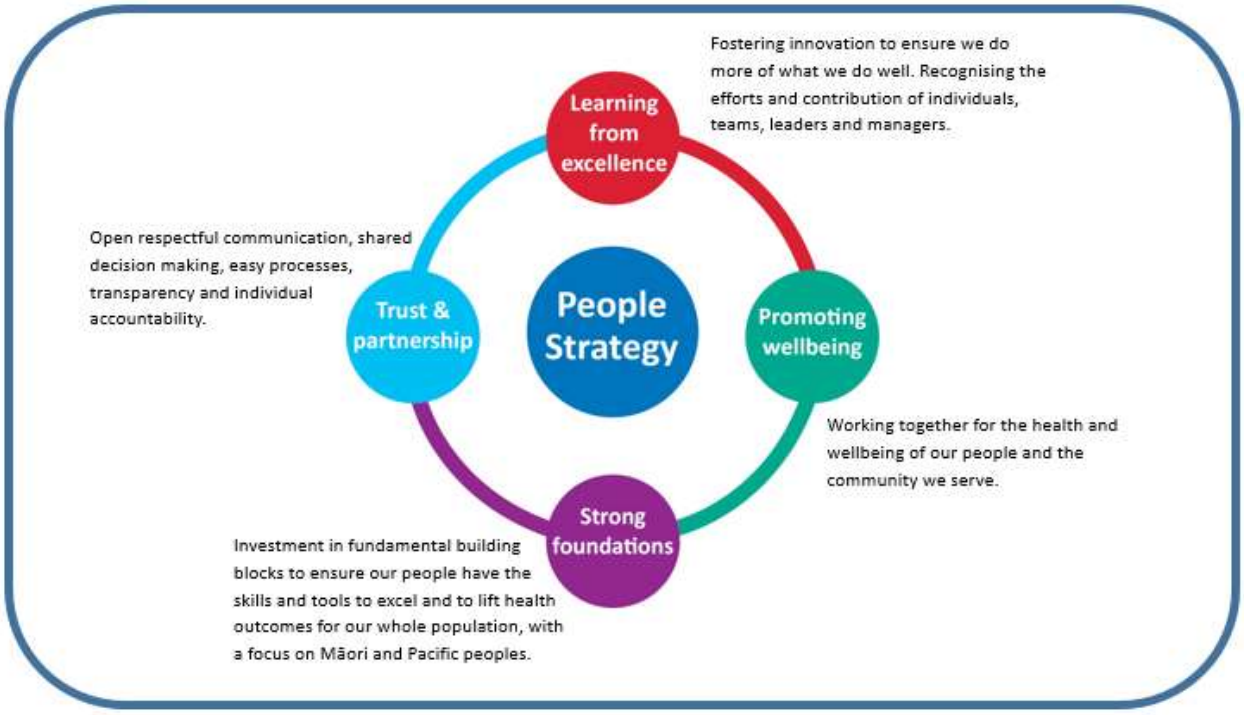
Board member	Board (11 meetings)	3DHB DSAC (4 meetings)	FRAC (10 meetings)	HSC (9 meetings)
Andrew Blair	10	0	8	2
Dame Fran Wilde	9	4	9	8
Dr Kathryn Adams	10	-	9	-
Dr Roger Blakeley	9	3	8	9
Eileen Brown	11	4	2	9
Sue Driver	10	4	-	9
Sue Kedgely	11	3	-	9
Kim Ngarimu	9	-	9	-
‘Ana Coffey	7	1	-	8
Darrin Sykes	7	-	7	-
Tiro Pereira	-	0/3 (left between Feb+May)	-	7
Tristram Ingham	-	3	-	8
Bob Francis	-	4 (to May)	-	0
Sue Emirali (replaced Bob Francis)	-	0/0 (replaced Bob Francis after May)	-	2/5
Pati Umaga (substitute for Tino Pereira)	-	1/1 (started between Feb and May)	-	-
Teresa Wall (substitute for Tristram Ingham)	-	-	-	1
Margaret Southwick (substitute for Tino Pereira)	-	-	-	1

Notes:
31 January board workshop was not a formal meeting and attendance was not registered.
HSC meetings in July and December were cancelled.
25 July FRAC meeting was cancelled.


Speaking Up™
for Safety
Speaking up
for Safety
ask me about it now
Speaking up
for Safety
Speaking up
for Safety

OUR PEOPLE

Our people programme has been guided by the principles identified in our People Strategy.



The focus has continued on our three-year Supporting Safety Culture programme. It was initiated in October 2017 and formally launched to all staff in May 2018. The framework for the Supporting Safety Culture programme is designed to create a cohesive approach to safety that brings together a range of activities for patients and staff.

We launched Team Speaking up for Safety at our one-year anniversary of the Supporting Safety Culture programme to help and enable staff to speak up for safety. It includes a resource for managers to lead for safety, incorporate Speaking up for Safety into team routines and meeting agendas and how to create learning moments for their teams. New managers attend a session on Speaking up for Safety as part of their induction, which focuses on listening and responding respectfully when staff speak up.

A research and evaluation framework was developed to support the programme's work and included a safety attitudes questionnaire in August 2018. The survey will be repeated in 2020 to measure progress.

August 2018 saw the launch of the Speaking up for Support programme that focuses on appreciation of our people and learning from excellence. We have formed a reference group of more than 40 staff with expertise in aspects of wellbeing to identify areas of importance, and a wellbeing framework for the organisation is being developed.

The very successful Frontline Leadership programme continued this year with 45 leaders attending the programme. The participants are often in their first year of leadership and have the opportunity to learn with leaders across medical, nursing and allied health professions, and with corporate leaders. This year we also continued with two Emerging Leaders programmes where people interested in taking a leadership role explored leadership, supported by their managers.

Leading to influence service improvement

Dr Robert Winkler, consultant paediatrician and allergist, was one of 22 participants in the most recent Frontline Leadership programme. The programme includes the opportunity to develop a service improvement project with workshops on leading change, service improvement and challenging conversations.

Robert applied this to a critical area of daily hospital activity – the ward round. His approach considered opportunities to improve the efficacy and efficiency of ward rounds in his area and, ultimately, improve patient safety. Key to his success was taking the time to understand the problem from all perspectives, including his patients, and acknowledging the many, often competing, motivations and interests of different team members.

Specific achievements included increased clarity of roles within the ward round, having the right resources in the right place at the right time, and educating trainee interns and house officers in the aim of the ward round to understand the patient's needs and make a plan. Significantly, a shift to a multidisciplinary approach through successfully engaging with the nurses on the ward increased efficiency by having decisions actioned immediately. An offshoot project has also improved drug safety. Changes to length of stay and staff satisfaction are also being measured.

The Frontline Leadership programme gave Robert the tools to consider the best approach to influence and facilitate the changes needed. Understanding and managing different perspectives and motivators in the team and how to engage the team in a shared vision have been key to his success.

Frontline Leadership graduates from August 2019

During the year we developed a leadership development framework. It shows how individual development opportunities fit together and guide future development plans.

Identifying our talent, understanding our talent pool and succession opportunities are key to strong organisational leadership and performance. We have embarked on a pilot talent mapping exercise, mapping our tier 3 managers using the State Services Commission Leadership Success Profile, and capturing the results to identify development needs. This has provided us with a picture of where our talent is, where our priority development needs are and has clarified our succession risks.

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). This year saw a historically high-level of collective bargaining activity.

The main focus for the first half of the year was on the continuing negotiation and subsequent settlement and implementation of the New Zealand Nurses Organisation (NZNO) Nursing and Midwifery MECA, which involved nationwide industrial action.

The rest of the year saw the Public Service Association (PSA) Administration MECA, E tū Security Orderlies MECA and Specialty Trainees of New Zealand (SToNZ) Resident Medical Officers (RMOs) MECAs also settled. SToNZ is a new union which covers resident medical officers in addition to the existing NZ Resident Doctors Association (NZRDA). The Midwifery Employee Representation & Advisory Service (MERAS) MECA was also settled that also involved nationwide industrial action. In addition, the negotiations for the NZRDA RMO MECA continued, also involving nationwide industrial action.

In accordance with the Government's employment relations expectations to focus on equity and work to narrow the gap between the highest and lowest earners at CCDHB, there was a strong focus on moving all employees to an hourly rate of not less than $20.55 per hour in line with the level of the 2018/19 Living Wage.

Support was also provided for the nationwide pay equity work for our administration and clerical workforce and preparations started for the pay equity process for our nursing workforce. We also continued work on updating our remuneration strategy for staff employed under individual employment agreements to more effectively achieve our recognition, recruitment, retention and budget objectives.

Fostering leadership

Leadership is required at all levels of the organisation. Not all leaders have formal leadership or managerial roles, yet through their actions and activities show great leadership. Their engagement in their team and the desire to improve the services they are part of can be the beginning of their formal leadership journey.

Lorena Domett's journey is a prime example of the path that people can take on the way to a formal leadership role. Lorena is an occupational therapist and works in the Kenepuru Community ORA (Older Adults, Rehabilitation and Allied Health) team. Lorena was quick to demonstrate leadership capabilities as a champion of service improvement, including team processes and occupational therapy-specific advancements. She is an active participant in special interest groups, has supervised other therapists and puts her hand up to be part of projects within the ORA Services.

Lorena also supervised students and became the coordinator for occupational therapy student placements in the general health teams. When the opportunity came up to step into a formal leadership role, acting professional leader for occupational therapy, Lorena was a prime applicant.

The Frontline Leadership programme has given Lorena the opportunity to develop and consolidate her skills and to put some frameworks and theories in place to allow her to move to the next level. It gave her the opportunity to meet other leaders and to consider the larger strategic picture at CCDHB.

Lorena Domett (centre) with student Phillipa Anderson and Laura Hayes, occupational therapist.

DEVELOPING OUR WORKFORCE

We continue to strengthen our commitment to the safety and development of our workforce including implementing the Care Capacity Demand Management (CCDM) programme. CCDM is about better matching staff resources to patient demand so we can improve patient care, make the best use of resources and provide a better work environment for our staff at the front line.

We are on track to implement CCDM by June 2021. The programme is meeting all reporting requirements set by the national Safe Staffing Healthy Workforce Unit CCDM governance group. The CCDM Council provides governance and oversight by enabling strong partnerships with our health unions. The partnership and whole-of-organisation commitment to CCDM has been a key factor in contributing to the good progress to date (see case study, p28).

It is essential that our People Strategy relates to the New Zealand Health Strategy, in particular actions to build one team, and also the Health System Plan to enable organisational success and health system sustainability. People Force 2025, developed by the national Workforce Strategy Group, continues to be relevant and guides investment in workforce development.

The past year has seen major service disruption to hospital services due to industrial action. The nationwide strike by NZNO nurses and Resident Medical Officers (RMOs), in particular, had a big impact on our clinical services and elective operating times.

The ability to recognise pay equity for nursing and midwifery in the public sector by December 2019, on top of the new negotiated pay rates is significant and will help secure a homegrown nursing workforce in New Zealand.

The RMO settlement will allow us to work with the NZ Resident Doctors' Association constructively to ensure local services are configured to promote better quality patient care and strengthen training for RMOs.

Overall, we have a positive relationship with our union partners and this was demonstrated by the goodwill that was maintained during an unsettled period caused by ongoing MECA negotiations and associated industrial action.

We continue to build our understanding of our workforce and will be developing our ability to integrate workforce intelligence and use forecasting tools.

We have maintained our focus on building capability through our commitment to workforce initiatives and high-quality training for undergraduates and postgraduates.

More than 100 graduates were employed in the Nurse Entry to Practice (NETP) programme last year, providing graduate registered nurses support and professional development during their first year of practice. There were also 36 graduates employed in the New Entry to Specialist Practice (NESP) programme for nurses wanting to develop specialist skills in mental health and addictions.

Undergraduate placements from tertiary education providers includes:

- 279 midwives
- 1,297 nurses
- 61 paramedics.

There were 734 placements to the Dedicated Education Unit (DEU) in nursing. The DEU is a student-centred model where clinical learning experiences are supported by clinical health professionals. It is a partnership between CCDHB, Massey University and Whitireia New Zealand and has been successfully implemented across 13 clinical areas over the last three years.

Dedicated Education Unit a first for Mental Health, Addictions and Intellectual Disability Service

The latest clinical areas to join the DEU at Wellington Regional Hospital are ward 7 south and Te Whare o Matairangi: the first area in Mental Health, Addictions and Intellectual Disability Service (MHAIDS).

Nursing student Jordan Bogisch has been working at Te Whare O Matairangi and says the placement has helped her become more familiar with clinical environments and to develop relationships with staff and clients.

“It has been really beneficial to see firsthand how the nurses work and to take on my own client load, as well as having staff quiz me on my pharmacology knowledge and ask about what I have observed. The support I’ve received has given me the confidence to work with clients and to share what I have observed,” Jordan says.

MHAIDS DEU staff

Mitch Wood has also been in the DEU at Te Whare O Matairang, and says staff have been particularly helpful with the move to a new clinical environment and the procedures and policies that go with it.

Nurse educator Kathy Trezise says the DEU fosters interaction and sharing knowledge among students and clinical staff, as well as having the practical benefit of reducing the workload on teams and providing professional development opportunities for nurses taking on leadership and education roles.

“The clinical staff have worked very hard to make this a success and the students are enjoying the additional support and learning opportunities the DEU provides,” she says.

Ward 7 south nursing student Abigail Hicklin agrees. “The nursing staff on the ward are so eager to have me learn and give me great constructive feedback on my practice. It has helped me to become more confident in my basic nursing skills allowing myself to then be open to learning more specialised nursing care.”

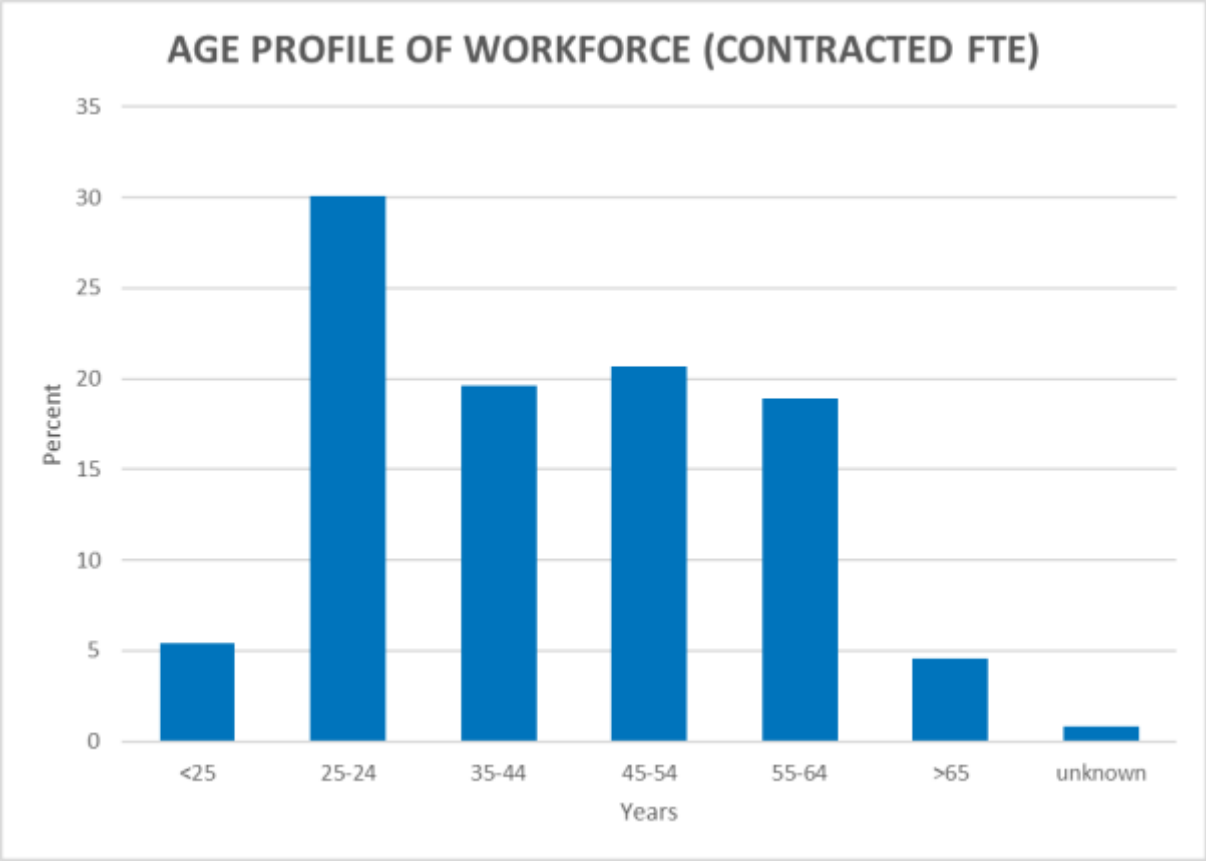
Workforce profile

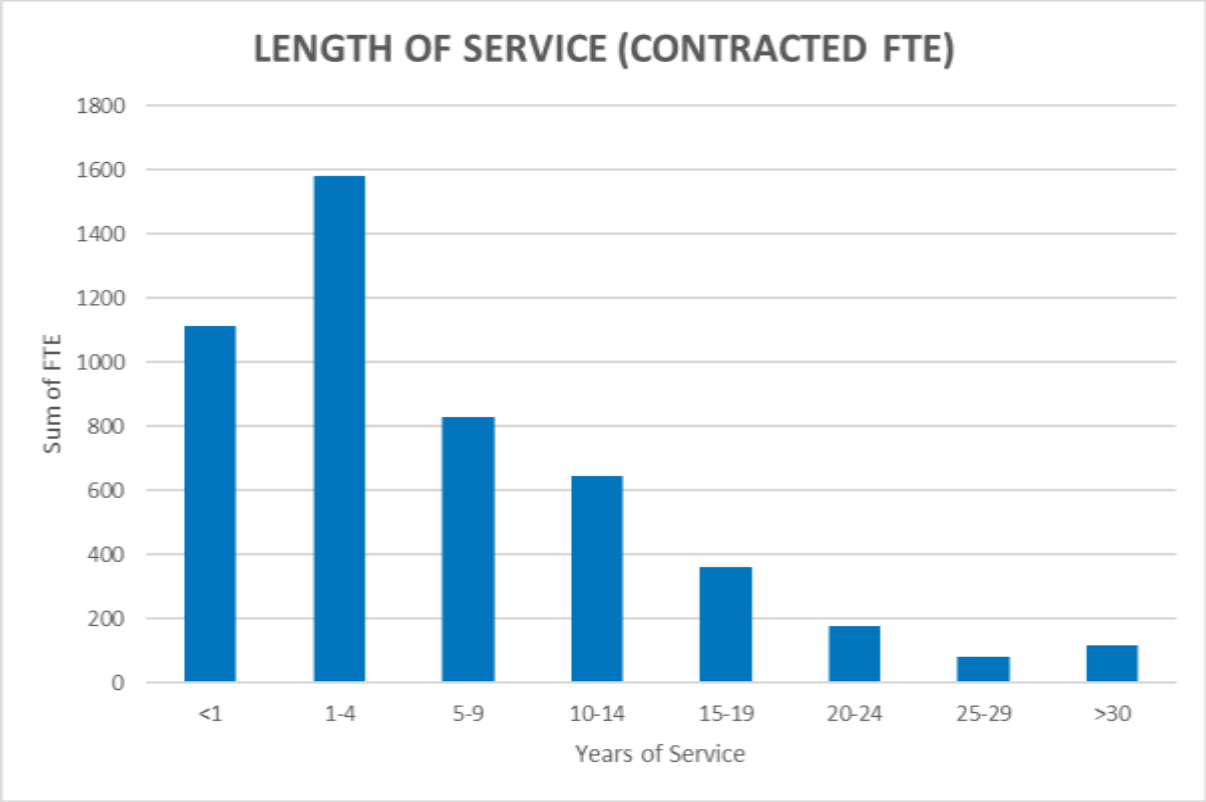
Full Time Equivalent (FTE) staff numbers

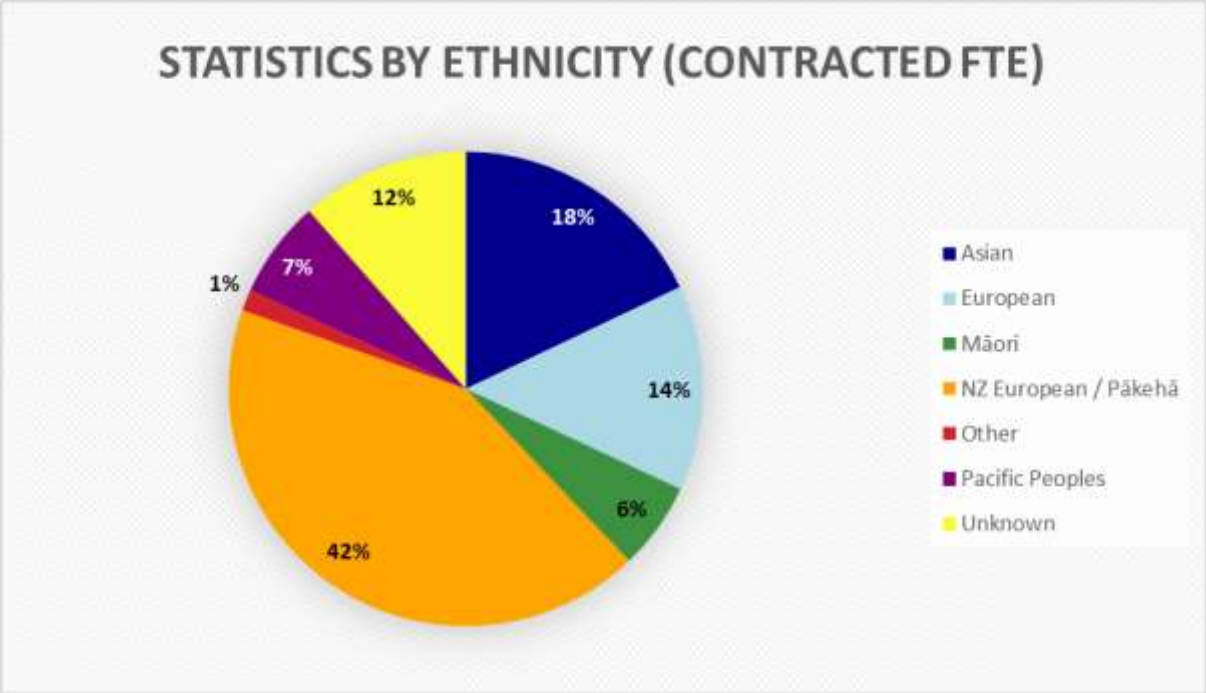
Profession	2019	2018	2017	2016	2015	2014	2013	2012
Medical	911	900	848	832	800	781	702	590
Nursing	2,254	2,131	2,043	2,004	1,940	1,892	1,907	1,799
Allied Health	727	724	713	707	766	774	760	726
Other	1,020	1,000	950	963	997	978	1,011	961
Total	4,912	4,755	4,554	4,506	4,502	4,426	4,379	4,079

Statistics by gender (%)

Gender	2019	2018	2017	2016	2015	2014	2013	2012
Female	72	72	72	73	72	72	72	73
Male	28	28	28	27	28	28	28	27







Notes:
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.


SOUTH SIDE
Student Rosters
TRONG, WINTER IS

QUALITY IMPROVEMENT AND PATIENT SAFETY

We are committed to improving the quality and safety of care provided to patients and the wellbeing of staff.

We recognise the importance of responsive leadership and a workplace culture that both supports staff and places patients and whānau at the centre of all decision-making.

In 2018 an external review was conducted to provide advice to the DHB board to improve the systems and processes that support patient and staff safety. An executive director of Quality Improvement & Patient Safety (QIPS) was recruited in December 2018. This role sits within the Executive Leadership Team and reports to the chief cxecutive. The executive director is responsible for leading the patient safety strategy and ensuring the recommendations of the review are implemented.

The clinical governance framework has been redesigned to meet a standard set by the Health Quality & Safety Commission (HQSC) and from the advice of the 2018 review.

The systems of clinical governance have been redeveloped, including the clinical governance board (CGB) and board subcommittees. The CGB has met five times and worked with the HQSC to ensure all board members understand their roles and accountabilities. Building our clinical governance will further strengthen our focus on the quality and safety of our services.

To support the processes of clinical governance, the QIPS team has been restructured to provide a clearer focus on consumer engagement, quality improvement, patient safety and clinical leadership.

The QIPS directorate leads and supports quality improvement and patient safety work across the DHB using quantitative measures to support evidence-based decisions, as well as streamlining systems and data reporting mechanisms.

Diabetes patients reaping the benefits from changes in care

The inpatient diabetes management package was introduced to improve results and reduce harm for patients with diabetes. It included changes and improved guidance around prescribing, using and monitoring insulin, including when a patient is fasting for surgery or procedures.

Hypoglycaemia – where a patient's blood glucose level becomes too low – is a real and common risk for people with diabetes. However, the inpatient diabetes management package has seen hypoglycaemic events drop by 26 percent.

"Around a quarter of our hospital patients have diabetes – and a single hypoglycaemic event can have a huge impact on their health," says diabetes inpatient nurse and project lead Miranda Walker.

"One hypoglycaemic event can extend a patient's hospital stay by more than two days because it slows their recovery and makes them more susceptible to further illness. The end result is a sicker patient who will likely take longer to recover, and a more expensive hospital stay.

"By reducing the number of hypoglycaemic events by 26 percent, we're ensuring patients aren't having to stay in hospital longer than they initially need to, which has also saved the DHB around $250,000 in costs for increased hospital stays."

Goals of Care framework

A new Goals of Care framework has been rolled out to all our inpatient services. The framework supports clinicians in their decision-making when assessing treatment for patients admitted to hospital. The framework also helps clinicians facilitate appropriate levels of care that best meets the patient's needs and wishes from the outset. Goals of Care encourages discussion between the patient and clinician about the most appropriate medical treatment for an individual.

"It helps, for example, identify those who may wish to decline treatments that might otherwise be given by default. It also raises awareness of the importance of discussing with patients and their whānau what their real wishes are with regard to medical treatment," says medical consultant Mark Beehre, who was instrumental in getting the pilot for the framework off the ground.

"This approach identifies the overall goals of care, and any specific treatment escalation and limitations as part of that treatment. With documented goals of care, the clinical team and after hours emergency responders can make decisions about appropriate treatment options with more clarity, and in advance of a critical situation arising."

New model of wound care proving successful

A new way of caring for leg wounds is seeing venous leg ulcers being treated sooner and healing faster.

The new model includes early assessment and intervention, better educating patients and nurses about the need for this specialised wound care, and having a team of wound care specialist nurses working in advanced wound care in the Wellington, Kenepuru and Kāpiti Community Health Service.

"We are seeing Māori and Pasifika patients tending to experience leg ulcers at a much younger age than European patients, which needs further investigation. A specialist nurse-led clinic has been set up in Porirua East PHO so patients referred by GPs can access wound assessment and treatment closer to where they live," says wound care nurse specialist Natalie Scott.

Matthew Callahan, Natalie Scott and Kapiti district nurse Alice Bourke.

"Over the 12 to 14 months we've seen an improvement in leg ulcer healing rates in the community. We're seeing ulcers healing within an average 9 to 10 weeks from the time a patient is referred to the service, and the majority of patients are completely healed within 24 weeks – compared to 33 weeks in 2016. This is an excellent result for patients."

Implementing a safe staffing project

Care Capacity Demand Management (CCDM) is a national programme aimed at improving quality of patient care and the work environment for our nurses and midwives within the best use health resources. The programme is underpinned by a dataset of 23 metrics and a partnership governance model between the DHBs and nursing and midwifery unions (the CCDM council). Performance improvement activity is run in clinical areas like wards and is overseen by clinically led CCDM local data councils.

Governance and improvement activity is less effective if data is not easily available and we faced a challenge in bringing the 23 metrics, which existed in multiple systems, into one place.

We are currently rolling out Qlik Sense, a data visualisation tool. We used this to create a CCDM dashboard which encompasses more than 80 percent of the metrics: increasing transparency, visibility and easy access for the entire organisation.

The dashboard tells the story of the clinical areas across the three main aims of the CCDM programme: quality patient care, quality work environment and the best use of health resources. It helps to identify and drive opportunities for quality improvement to improve the work environment and patient outcomes.

It has also enabled the CCDM council to see the results over all the areas supported by CCDM and identify challenges and successes.

The implementation of the dashboard is being supported by ongoing data literacy and quality improvement training.

As a result of the implementation of the core data set through the CCDM dashboard and the work of the CCDM council and the local data councils, CCDHB is a leader in implementing the CCDM programme.

CCDHB's data team, who helped create the new data dashboard.

QUALITY AND SAFETY MARKERS

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, health care associated infections and safe surgery. Below are our performance results as at 30 June 2019.

Marker definition		New Zealand target	New Zealand average	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Falls: % if patients aged >75 (Māori and Pacific >55) that are given a falls risk assessment		90%	87%	86%	90%	83%	86%
Falls: % of patients assessed as being at risk who have an individualised care plan which addresses their falls risk		90%	93%	93%	88%	95%	94%
Safe surgery: % of audits where all components of checklist were reviewed	**Sign in**	100%	97%	100%	100%	100%	100%
	Time out		97%	100%	100%	100%	100%
	Sign out		98%	98%	100%	100%	100%
Safe surgery: % of audits with engagement scores of 5 or higher	**Sign in**	95%	97%	87%	87%	96%	92%
	Time out		97%	76%	96%	96%	96%
	Sign out		93%	88%	90%	86%	76%
Hand hygiene: % of opportunities for hand hygiene for health professionals		80%	85%	80%	**	82%	84%
Surgical site infections – Timing: % of hip and knee arthroplasty primary procedures were given an antibiotic at the right time		100%	98%	100%	100%	100%	**
Surgical site infections – Dosing: % of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose		95%	97%	100%	100%	100%	**
Cardiac surgery – Timing: 100% of audited patients were given an antibiotic 0–60 minutes before knife to skin		100%	97%	96%	96%	97%	+

Cardiac surgery – Dosing: 95% of audited patients were given the correct antibiotic dose	95%	97%	97%	98%	97%	+
Cardiac surgery – Skin prep: 100% of audited patients were given appropriate skin antisepsis in surgery	100%	98%	100%	100%	98%	+
Patient deterioration: % of audited patients that triggered an escalation of care and received the appropriate response to that escalation	N/A	75%	97%	99%	75%	87%
Patient deterioration: Number of patients where Early Warning Score was calculated correctly for the most recent set of vitals	N/A	95%	94%	84%	86%	84%
Patient deterioration: Number of eligible wards using early warning score	N/A	N/A	100%	100%	100%	100%
Pressure injury: % of audited patients with a pressure injury assessment	N/A	83%	*	*	96%	91%
Pressure injury: % of at-risk patients with an individualised care plan	N/A	84%	*	*	80%	83%
Opioids: % of audited patients with sedation levels documented	N/A	73%	*	100%	100%	100%
Opioids: % of audited patients with bowel activity recorded	N/A	70%	*	57%	86%	89%
Opioids: % of audited patients prescribed an opioid that have uncontrolled pain	N/A	14%	*	25%	7%	15%

Key:
***New quality safety markers did not start until January 2019, there are currently no goals or New Zealand average on the HQSC site.
**** Reported three times a year, therefore no data point is shown.
+ Data not available for Q2 April to June 2019.

Serious and sentinel adverse events

At CCDHB improving the quality and safety of care we provide to our patients and whānau is a key priority. Early detection and review of adverse events that are the result of a health care 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.

From 1 July 2018 to 30 June 2019, we had 37 serious health care adverse events and 18 serious behavioural adverse events for MHAIDS (CCDHB only). The health care events occurred in our

hospitals which meant that patients suffered serious harm or death as a result of system or process failures. Of the 37 health care events, 10 were related to patient falls, 25 were related to clinical processes such as assessment, diagnosis and treatment; one was due to a medication and one related to resources.

There has been a formal review for each of these adverse events to better understand what happened and why, and to establish improvements in our systems of care to prevent harm occurring again.

IMPROVING HEALTH OUTCOMES

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

Our health priorities include:

- promoting health and wellbeing
- achieving equitable health outcomes
- preventing the onset and development of avoidable illness
- strengthening the wellbeing and health outcomes of people who are experiencing illness
- supporting dignity at the end of life

By far, our greatest opportunity to deliver better care and outcomes for our communities lies in improving equitable outcomes for all of our populations, including for Māori and Pacific peoples. This is supported by the Ministry of Health. We are establishing strategic views of equity and ensuring that a medium- to long-term strategy to address equity is explicit in all our strategies, clinical service planning, service commissioning and investment decisions. That is, improving equitable health outcomes is embedded in our core business.

Development of Taurite Ora – the Māori Health Strategy

Together with the Māori Partnership Board, we have developed a Māori health strategy.

Taurite Ora: CCDHB's Māori Health Strategy and Action Plan 2019–2030 will guide us to achieve health equity and optimal health for Māori by 2030.

Taurite Ora is tailored to the identified health needs of Māori living in the region and describes the outcomes and impacts that will be measured against to achieve health equity for Māori. It outlines how we will work with our partners to improve Māori interactions with our services and address the poor experiences many Māori have told us about.

The strategy focuses on:

- equity as a value which underpins everything we do
- system change through workforce development
- funding prioritisation through commissioning of services.

The plan is expected to be launched in late 2019.

Health Care Home reaches 80 percent coverage target

Health Care Home, a collaboration between CCDHB, all three primary health organisations in the CCDHB region and local hospital service, has reached its target of 80% coverage of the CCDHB population in its third year.

As a model of care, Health Care Home puts the needs of patients and their families at the heart of health care delivery by ensuring people can access services close to home and stay well in the community. For patients this means they receive the right care in the right place by the right person. For practices, it means using technology to move some aspects of care out of the consulting room, making the best of existing clinical roles, creating new ones to make practices more efficient, and customising appropriate care and attention for their patients.

There are 35 Health Care Home practices, including the third tranche of 14 practices coming on board in April. That brings the total to 340,000 patients and increases coverage to 80% of the region's population.

For the past three years, CCDHB Community ORA and district nurse teams, alongside the Care Coordination Centre and Mary Potter Hospice teams, have established multidisciplinary meetings (MDTM) at Health Care Home general practices in Wellington, Kenepuru and Kāpiti to provide wraparound health care services for patients with complex health needs.

Health Care Home allows the health system to be more proactive for at-risk patients with complex health needs and means patients can build relationships with their health care team, with the focus being much more about prevention than treatment. Building on general practice knowledge and using community health services supports people to stay at home and active in their community for longer.

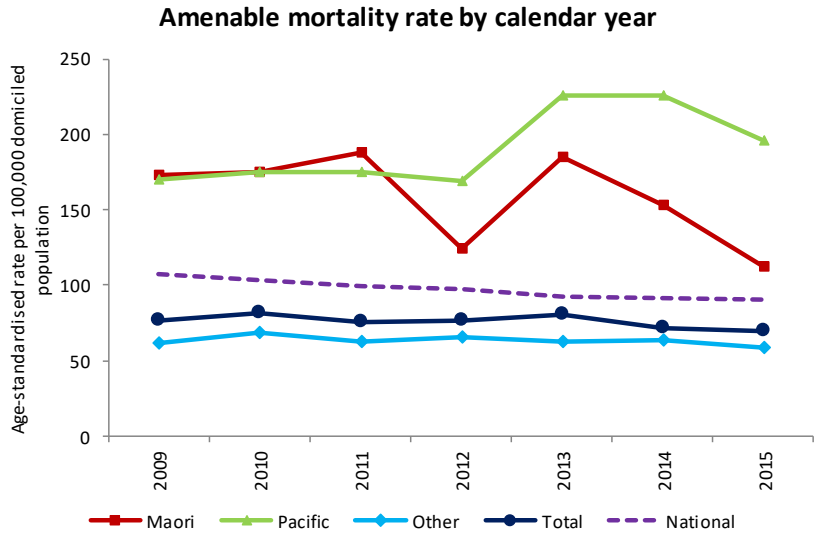
OUTCOME AND IMPACT MEASURES

Reduced ethnic disparities

There are recognised health disparities for some 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 premature death from conditions that are 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 2018/19, we committed to reducing amenable mortality rates for all ethnicities with a long-term aim to ensure rates of amenable mortality for Māori and Pacific populations reduce to at least the rates of other population groups. We have made progress towards achieving this milestone for all groups except Māori. Our amenable mortality rates remain below the national average.



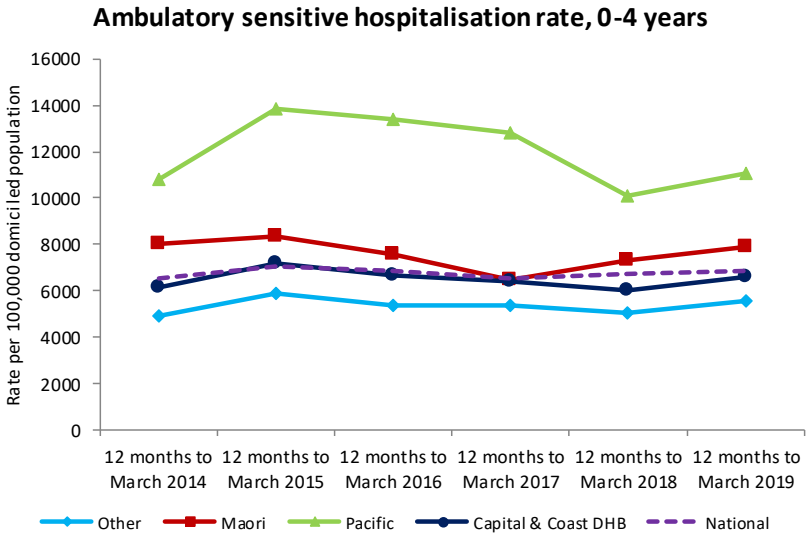
Note: Data is available up to 2015 only.
Source: Ministry of Health

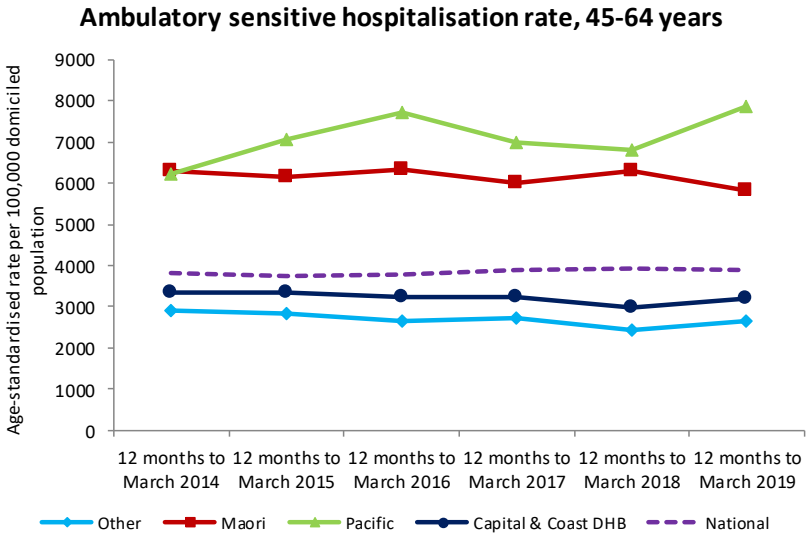
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation ethnic disparity rates

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary health 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 reflects 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.





Note: Data is available up to March 2019 only.
Source: Ministry of Health

Environment and disease hazards are minimised

Through effective public health disease surveillance, investigation and control, the impacts of communicable diseases can be minimised. Public health actions are also 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 the police, councils and community agencies to understand and address the issues behind the harmful consumption of alcohol and drug use.

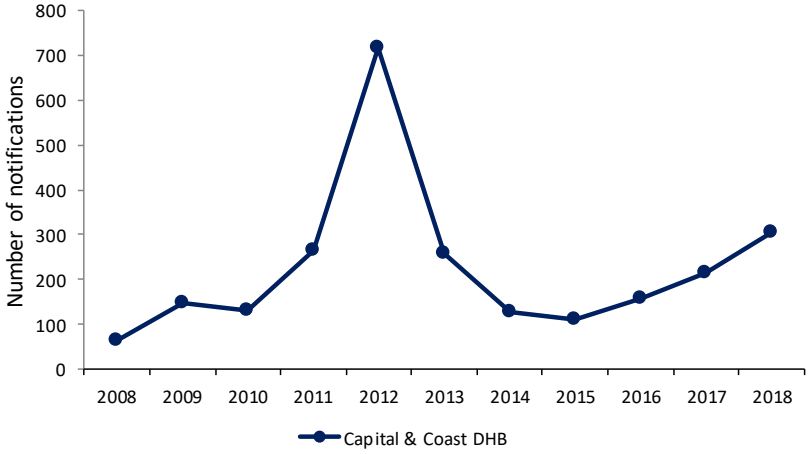
Impact measure: A decrease in vaccine-preventable disease notifications

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. In 2012, Pertussis (whooping cough) outbreaks resulted in an increase in vaccine-preventable disease notifications. This trend is also reflected nationally 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 by calendar year

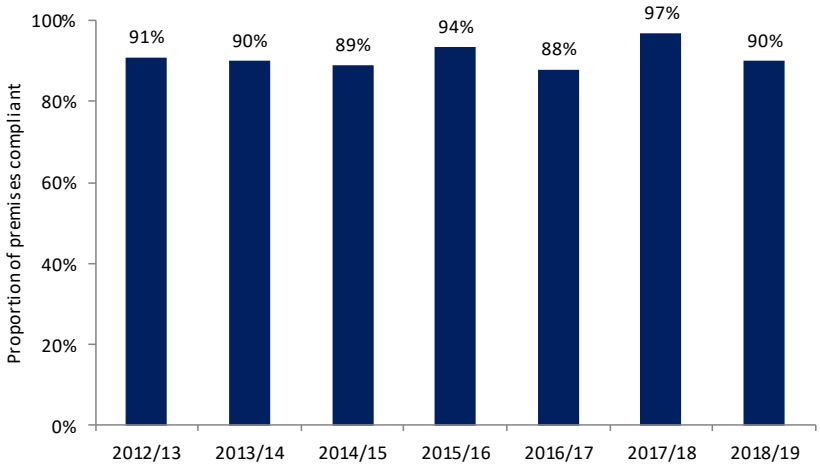


Source: ESR (Institute of Environmental Science and Research)

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, and crime. Harm reduction strategies include changing both physical and social environments. Effective interventions include regulating the legal age of purchase, restricting the hours and days of sale and restricting 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.

Proportion of premises in the sub-region compliant with the Supply of Liquor Act 2012 for sales to minors



Source: Regional Public Health

Lifestyle factors that affect health are well-managed

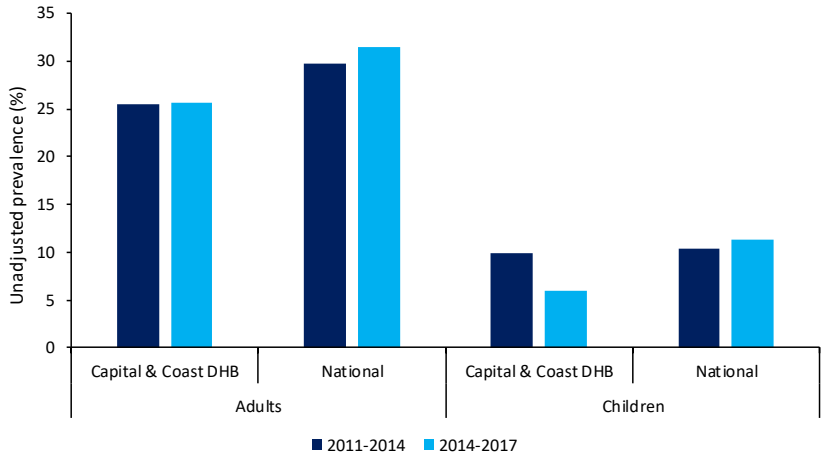
Lifestyle factors have a significant impact on overall health and wellbeing and contribute to cancer, obesity, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New Zealand using disability-adjusted life years (DALYs) that include both burden from early death and from lives led with disability. Four 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 rates for adults and has decreased for children.

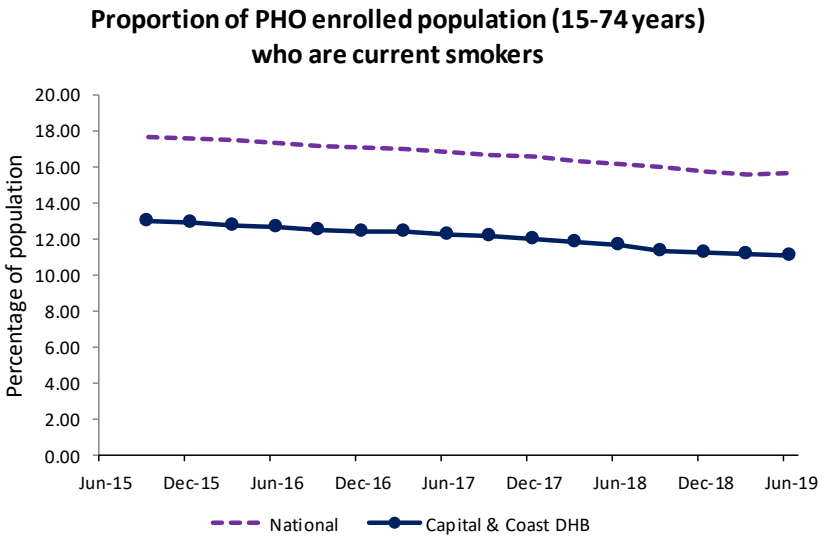
Prevalence of obesity in adults (15+ years) and children (0-14 years)



Note: The latest data from the New Zealand Health Survey is for 2017/18. The focus of the regional release is the most recent pooled data (2014–17), with data also available for 2011–14. Pooling data across years increases the sample size and produces more reliable estimates.
Source: New Zealand Health Survey, Ministry of Health

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. The Government has a goal that New Zealand will be smokefree 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.

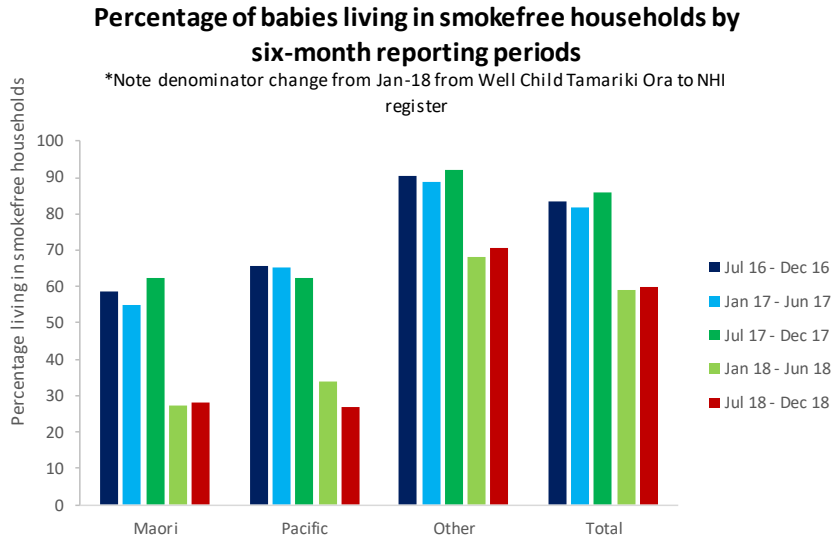


Source: Ministry of Health

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

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions and tooth decay. 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 smokefree households will increase. In our System Level Measure Improvement Plan 2018/19, we committed to improving the proportion of babies living in a smokefree household at six weeks postnatal. The Well Child / Tamariki Ora Quality Improvement Framework indicator 'the percentage of mothers smokefree at two weeks postnatal' stopped in 2016. The new indicator is 'the percentage of babies living in smokefree homes at six weeks postnatal', and is now part of our system level measure framework.



Source: Ministry of Health

Mothers matter campaign

We supported the mothers matter campaign designed to promote self-awareness of mental wellbeing. The posters prompted mothers and pregnant women to talk to someone if they were feeling anxious, stressed out, worried or not enjoying pregnancy or motherhood.

The campaign aimed to help women understand the basic expectations they should have for themselves and their wellbeing.

Posters, social media and take home cards were designed in English and te reo Māori, in collaboration with maternity, mental health, consumers and lead maternity carer (LMC) representatives. Developed through the Maternity Safety and Quality Programme, from Wellington, Hutt and Wairarapa DHBs, the campaign was distributed through maternity, neonatal intensive care units and emergency departments, GP and LMC practices, and through the CCDHB social media platform.

A massive challenge for our tiniest people

The Neonatal Intensive Care Unit (NICU) is one of the most dynamic research areas in medicine because of its constant state of discovery and improvement. A Neurological Foundation of New Zealand grant received in 2018 to investigate a new therapy that could potentially prevent disorders developing in children born prematurely is part of a large body of research going on in the unit which uses a holistic, joined up approach to scientific collaboration.

The neonatal research team is looking at how to best provide care for babies less than 500 g and 23 weeks' gestation right through to full-term babies with complex medical and surgical issues. Because it's such a dynamic field, there's a determination and desire to innovate across obstetric, neonatal and nursing care. Research is embedded in the fabric of what our clinicians do to give these most vulnerable patients we see across the health sector an opportunity to thrive.

Research comes from basic science, clinical medicine, research nurses, PhD and Masters students, as well as public health epidemiology looking at the big picture implications for New Zealand to develop new care pathways for extremely pre-term babies.

The more we understand the better able we are to develop new therapies, in particular, babies' brains and lungs. A child born at less than 28 weeks' gestation has incredibly immature lungs because they're not designed to breathe air. Once baby is born, it's critical to get their lungs strong enough to be able to breathe. As well, a pre-term baby's brain is immature as all the brain development that happens as a fetus now has to happen as a baby in an incubater. This is a massive challenge for a tiny baby and the team devoted to their survival.

Research in the unit focuses on quality of survival and saving these babies in the healthiest way possible so they aren't disadvantaged by their pre-term birth. The long-term impact for premature babies can be devastating and we want to see them thrive and grow into independent people.

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 chronic conditions as an adult. It is important we provide children and their whānau with high-quality and accessible services, including equitable access.

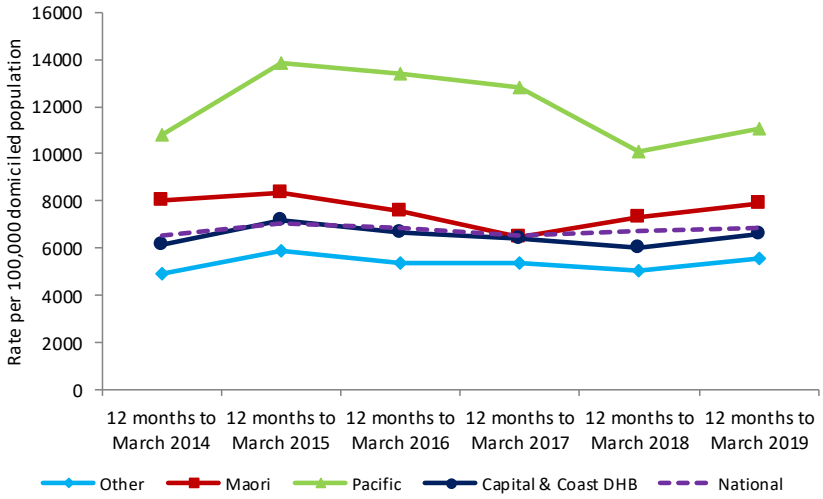
Impact Measure: A reduction in Ambulatory Sensitive Hospitalisation rates for 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary health 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 reflects better management and treatment across the whole health system. In our System Level Measure Improvement Plan 2018/19, we committed to reducing ASH rates for Māori and Pacific with a long-term aim to ensure ASH rates for Māori and Pacific populations reduce to at least the rates of other population groups.

A father holds his newborn tenderly at Wellington Regional Hospital

Ambulatory sensitive hospitalisation rate, 0-4 years



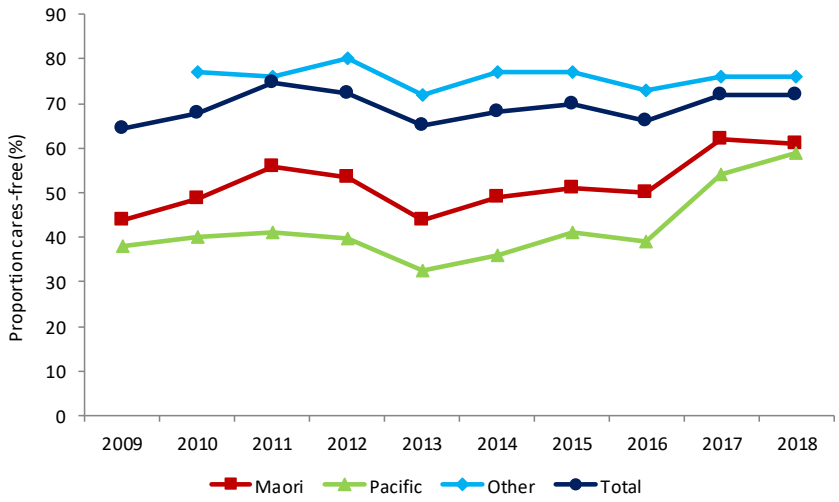
Source: Ministry of Health

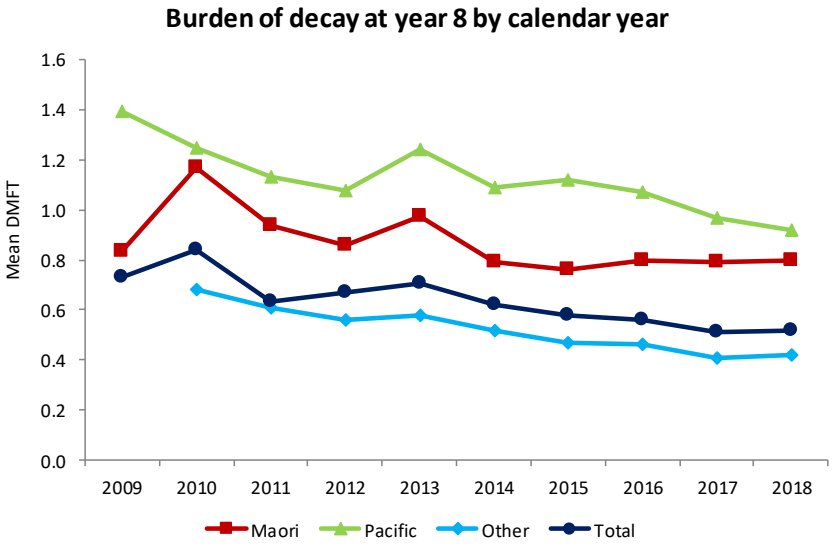
Impact measure: An increase in the proportion of children caries-free at 5 years & a decrease in the burden of tooth decay at Year 8

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 targeting those most in need, including Māori and Pacific children who have worse oral health than other ethnicities. We have 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 B4 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.

Proportion of 5 year olds caries-free by calendar year





Source: Bee Healthy - Regional Dental Service

Youthquake – We are the movement

Alistair Paiti, articulating his ideal workforce by explaining diversity is just as important as the services offered.

Forty-nine young people gathered in Porirua for a two-day co-design workshop around youth services. With the establishment of an integrated youth service for Porirua in the pipeline, involving young people in the design process was imperative from the outset.

We actively looked for a group of young people who could provide a wide range of perspectives. This included young people who are Māori, Pacific, LGBTQI, disabled, marginalised, migrant, refugee, those who are not in education or employment, those in alternative education and those who live in Porirua but are at school in Wellington.

Over the two days the young people actively engaged in design and system thinking activities that were devised to combine their experiences with innovation and service design.

The workshop culminated in a youth-led ‘walkthrough’ process where they presented their ideas and thinking to stakeholders, including government agencies.

Their messages were loud and clear and, as a result of the workshop, a youth panel of 12 young people has been established to maintain a strong link between the design and implementation phases.

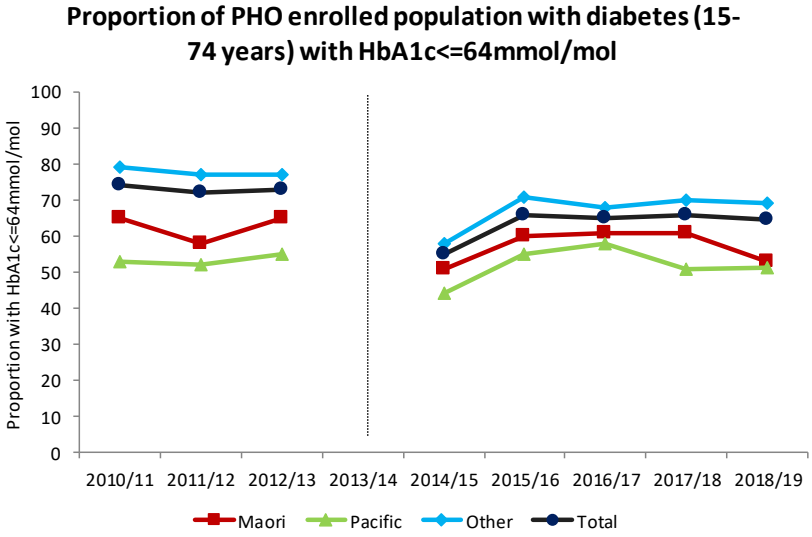
Long-term conditions are well-managed

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 increase its focus on the prevention and ongoing 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, we expect to see more people with diabetes having good blood glucose control and fewer people at high risk developing diabetes and preventing diabetes-related complications.

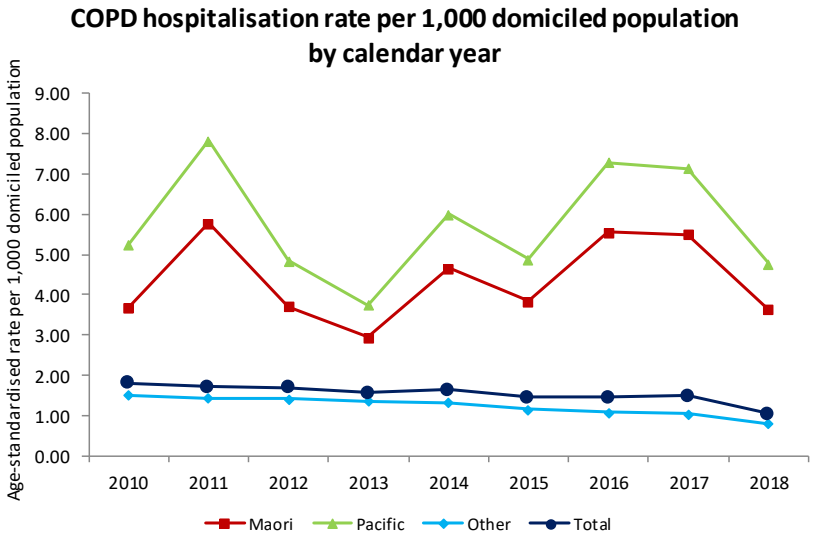


Note: A revised methodology implemented from 2013/14, with results unavailable for 2013/14.
Source: CCDHB via PHO partners

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

Chronic obstructive pulmonary disease (COPD) results from damage to the lungs. It 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 health care, and supporting improved equity in this area, as well as assisting people to take their medication regularly, we expect that the rate of COPD hospitalisations for our population will decrease and we will see improved equitable health outcomes.

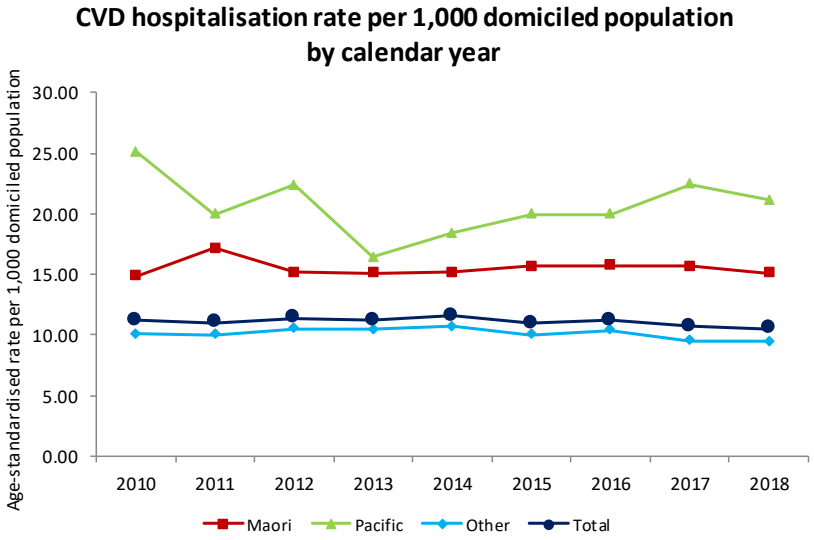


Source: Ministry of Health

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

Cardiovascular diseases (CVD) 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 see improved equitable health outcomes.



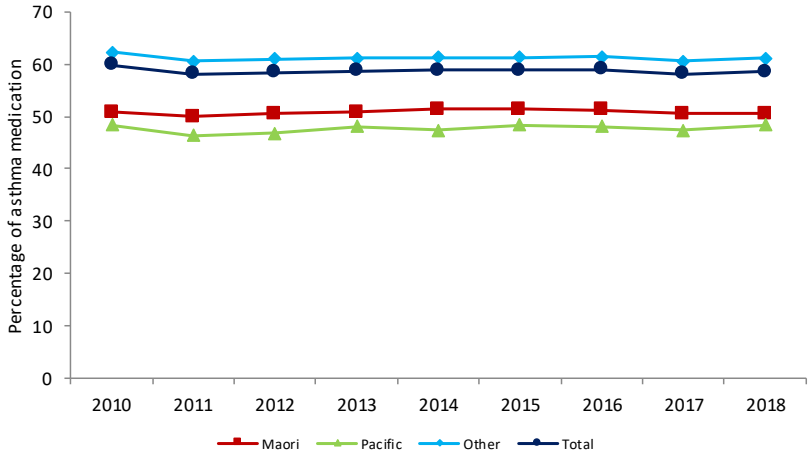
Source: National Minimum Dataset, Ministry of Health

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 ongoing 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 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 being well managed.

By improving access to primary health care, and supporting people to take their long-term medications, we expect that people will use more preventers and less relievers.

Percentage of dispensed asthma medications that were preventers by calendar year



Source: Pharmaceutical Collection, Ministry of Health

People receive high-quality hospital and specialist health services when required

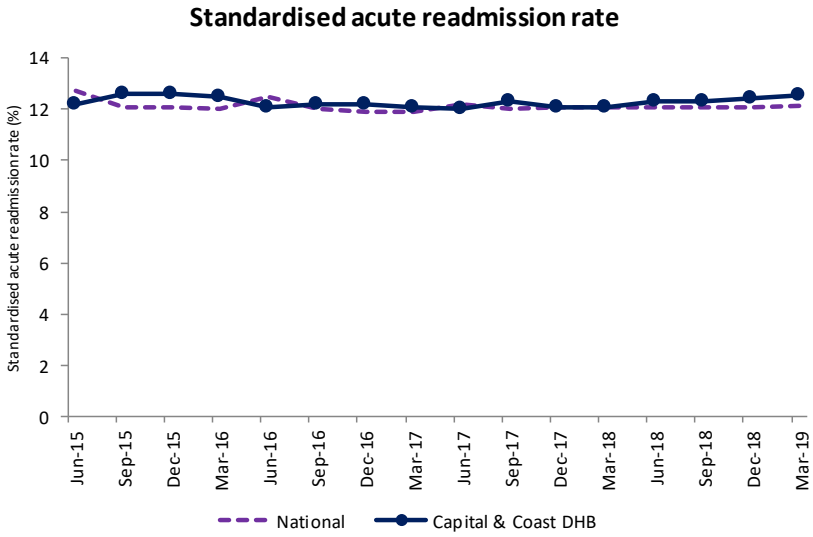
Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (eg, removing an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic and to reduce the risk of cancer and infection) or through corrective action (eg, 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 (ie, 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 improve the quality of care for people.

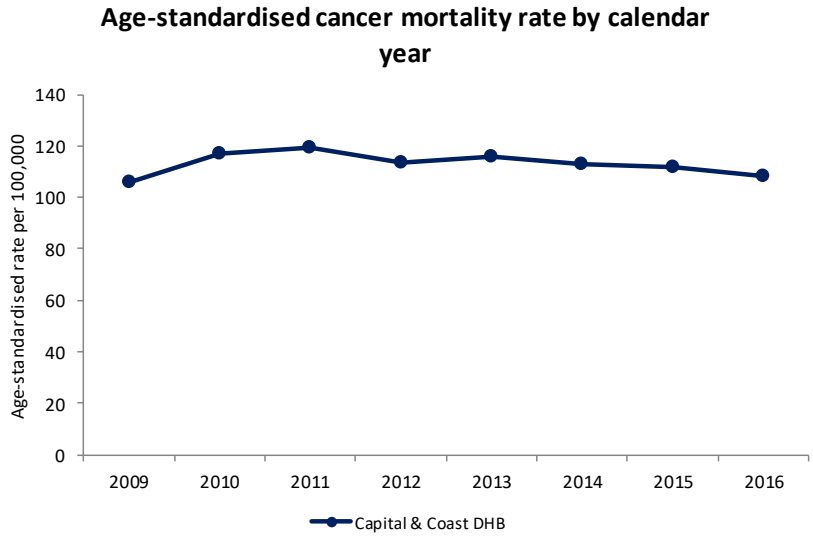
Our readmission rates are consistently on par with the national average and, in the long term, we expect that readmission rates will decrease.



Source: Ministry of Health

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

More people are developing cancer, mainly because the population is increasing 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 we are preparing for the local roll-out of the National Bowel Screening Programme.



Note: Data is available up to 2016 only.
Source: Mortality Collection, Ministry of Health

Noel Tiano

Dealing with death on your own terms

We have partnered with Māori, Pacific, Asian and other cultures to open the conversation with people in their communities about advance care planning in a familiar environment with people they know and trust.

Advance care planning recognises that dying has become highly medicalised over recent decades. The result is that people are being given futile or non-beneficial treatment that might trade quality of life with a prolonged life.

People are being encouraged to talk about their advance care plans with whānau or friends. Noel Tiano is one of those people who has embraced the advance care plan process. He has not only written his own advance care plan, but is a social worker at Mary Potter Hospice and trains volunteers to work with those who are dying. He believes his advance care plan gives him the freedom to deal with death on his own terms and the opportunity for his life's wishes to be honoured.

Noel's thoughts are echoed by many others who say advance care planning is about living life as they choose and thinking about what brings them joy, what matters to them, and how they want to spend the time they have left. It gives people an opportunity to document what makes life meaningful to them and how they would like to be treated and cared for at the end of their lives, particularly if they cannot speak for themselves

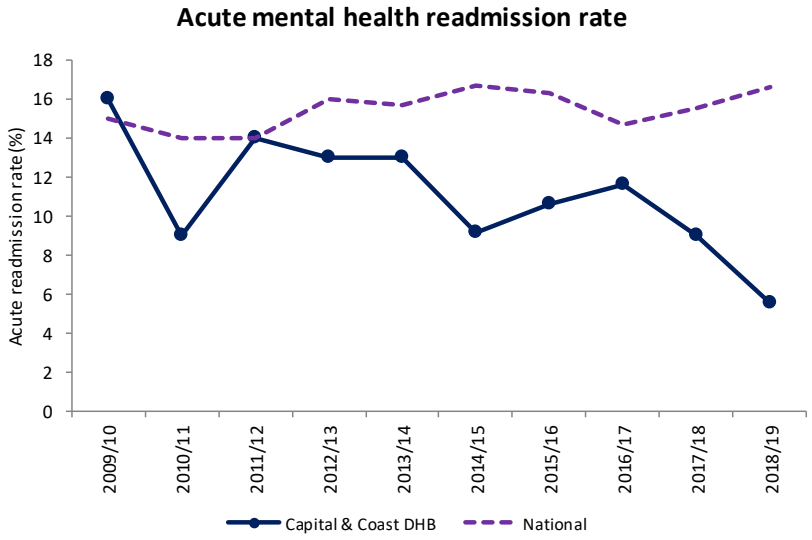
People receive high-quality mental health services when required

Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions. Services include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

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 people 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.

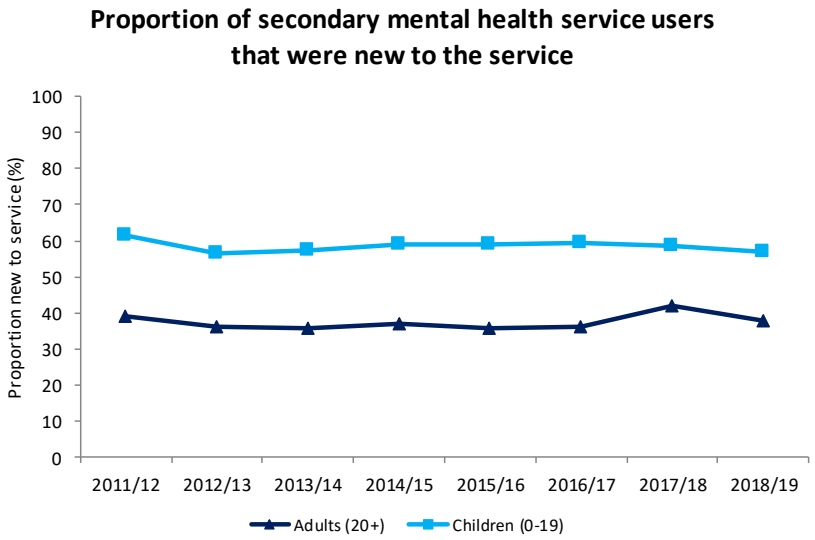


Source: Mental Health, Addictions and Intellectual Disability Service (MHAIDS)

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.



Source: PRIMHD, Ministry of Health

Living Life Well

A significant recent success story for us, Hutt Valley and Wairarapa DHBs has been board approval for and launch of a mental health and addiction strategy through to 2025, Living Life Well. The strategy sets the direction for mental health and addiction care in the sub-region (Capital & Coast, Hutt Valley and Wairarapa) to improve the experience and outcomes for our people, whānau and communities.

Many people have been involved in developing this strategy over a significant period of time. It is the result of collaborative efforts from many people, including consumers, clinicians, support workers, community agencies, government agencies, and DHB planning and funding units across the sub-region.

At present, mental health and addiction services largely provide specialist services for those with the highest need. This strategy supports covering the complete continuum of care: sustaining specialist mental health and addiction, recognising we can do a better job of providing earlier intervention when things start to go wrong, and focusing our attention on those with inequitable health outcomes. It aligns fully with the recommendations from *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.

One of the key threads in the strategy is to work with communities, collaborating more with other agencies and providing services to a wider group of people earlier on. The intention is to provide a greater range of support and services, including talking therapies and health promotion.

The good news is that we have the Living Life Well strategy; even better news will be the implementing activities needed to bring about transformative outcomes for our people, whānau and communities.

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; 23% of people in CCDHB (65,000) were identified as disabled in 2013. We have a esponsibility to provide responsive and appropriate health services to people with disabilities.

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

The Health Passport is a document that a person takes with them when they use medical services. It contains information about the person that they would like hospital staff to know. For example, it may include how a person would like to be communicated with, their medical conditions, what medications they are allergic to or their religious and spiritual preferences.

An increase in the number of people who find the Health Passport useful will indicate that it is achieving its aims and improving the quality of care of patients when they are in hospital.

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

Moving from ‘we know best’ to partnerships

A disability forum coordinated by CCDHB in June saw almost 100 people gather to discuss progress and review focus on the 3DHB’s Sub Regional Disability Strategy 2017–2022. Most of the attendees were disabled people and their whānau and their insights and experiences made a significant contribution to the ongoing implementation of the Disability Strategy. From both ‘inside the health system’ and ‘consumer of the health system’ perspectives, some enlightening views were presented to inform the focus of the Disability Strategy team.

The forum showed that a lack of accessible transport or money, or both, prevents many disabled people and their families from accessing health services. This means diasabled people and their families are becoming more isolated, which increases risks to their health. More staff who are mobile, who can visit people in their homes and local community and who can provide services outside of normal work hours, is in line with our Health System Plan’s intentions for moving services closer to where they are needed, in communities and homes.

Other barriers include stigma and stereotypes, the difficulty to access buildings, equipment and services, and as accessing information and communication. While there have been shifts over time, there is still a long way to go to ensure the health system is inclusive and accessible for the disability community.
Our team is led by Rachel Noble who, as a Deaf person, is focused on ensuring that we, as well as Hutt Valley and Wairarapa DHBs, embed a culture of meaningful and active participation for disabled people using all parts of the health system. This means a strong commitment to continue working on tools to promote an accessible and inclusive health care service and acknowledging the right to health is a fundamental right for all people.

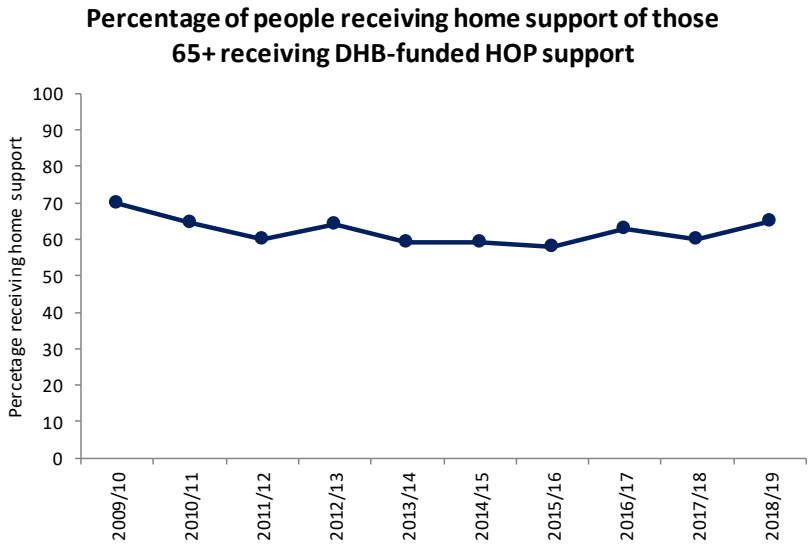
Rachel Noble, General Manager 3DHB Disability.

Improve the health, wellbeing, and independence of our region's older people

Our ageing population will increase pressure on the health system. National estimates suggest that the increase in health expectancy between 2006 and 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. We have 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 want to stay 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.

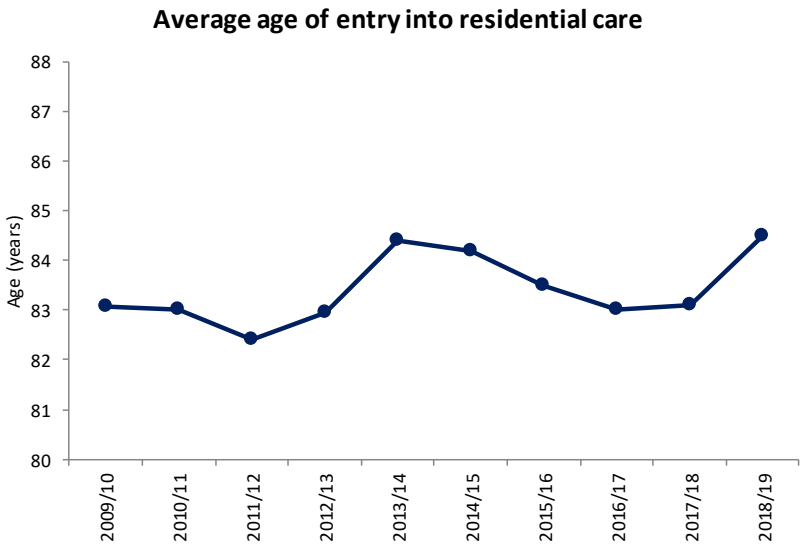


Source: Health Information Network, Ministry of Health; Needs Assessment and Service Coordination

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.

The average age of entry into residential care has increased, indicating that older people are overall healthier and are being supported to live in the community for longer.



Source: Needs Assessment and Service Coordination

STATEMENT OF PERFORMANCE

The Statement of Performance Expectations (SPE) presents a snapshot of the services provided for our population and how these services perform. The SPE 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 our performance over time, recognising the funding received, government priorities, national decision-making and board priorities. These measures include the 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 peoples. Therefore, a range of measures are used to monitor progress in improving the health and wellbeing of our Māori and Pacific populations. Equity is a priority and the targets set for Māori and Pacific reflect a pathway to achieving equity, or are universal and apply to all population groups. In some cases, data is not available by ethnicity. We are in the process of developing a programme of work to monitor and report our performance by ethnicity, and understand our performance for our Māori and Pacific populations.

Output class measures

We have devised criteria 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	
Partially achieved	Within 10% of target	
Not achieved	≥10.1% of target	
Demand-driven measure	No rating applied	
Data not available by ethnicity	No rating applied	
New target in 2018/19 or no data available in 2017/18	-	
Data not available	Data not available	N/A

Class	Class description
Q	Quality
V	Volume
T	Timeliness
C	Coverage
Est.	Estimate

Appropriation Reporting

Appropriation reporting in thousands of New Zealand dollars

	2019 Actual	2019 Budget	2018 Actual
Appropriation revenue*	$778,514	$778,514	$735,631

***The appropriation revenue received by CCDHB equals the Government's actual expenses incurred in relation to the appropriation, which is required disclosure from the Public Finance Act 1989.

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 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 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
	95% of patients admitted, discharged or transferred from emergency department (ED) within six hours	≥95%	86%	87%	84%	81%
	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)[1]	11,205	2,972	5,778	8,408	11,207
	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%	88%	90%	89%
	95% of eight-month-olds will have their primary course of immunisation (six-week, three-month and five-month immunisation events) on time	≥95%	93%	94%	93%	93%
	90% of PHO-enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	≥90%	89%	88%	87%	87%
	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%	75%	100%	86%	96%
	95% of children identified as obese in the B4SC will be offered a referral to a health professional for assessment and lifestyle intervention	95%	96%	95%	94%	95%

[1] Performance is cumulative across the financial year.

Output class – Prevention

Preventative services are publicly funded services that protect and promote health in the whole population or in identified populations by targeting changes to physical and social environments that engage, influence and support people to make healthier choices, thereby reducing inequalities. Preventative services include:

- health promotion to help prevent disease
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- population health protection services such as immunisation and screening services.

A significant portion primary health 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**	**2017/18 result**	**2018/19 target**	**2018/19 result**	**Achieve-ment**
The number of disease notifications investigated	Total	1,291	Est. 1,126	1,279	●
	Māori	109	Est. 88	100	●
	Pacific	92	Est. 49	81	●
The number of environmental health investigations[2]	Total	727	Est. 688	583	●
The number of premises visited for alcohol-controlled purchase operations	Total	70	Est. 12	31	●
The number of premises visited for tobacco-controlled purchase operations	Total	17	Est. 27	44	●

***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**	**2017/18 result**	**2018/19 target**	**2018/19 result**	**Achieve-ment**
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Total	20	Est. 17	29	●
The percentage of infants fully or	Total	63%	≥60%	64%	●

[2] The number of environmental investigations in the Wairarapa, Hutt Valley and Capital & Coast DHB sub-region

Measure	Target group	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
exclusively breastfed at three months[3]	Māori	52%		48%	
	Pacific	44%		43%	
Number of new referrals to public health nurses in primary and intermediate schools	Total	1,887	Est. 1,126	961	
	Māori	756	Est. 475	385	
	Pacific	707	Est. 411	365	
The number of adult referrals to the Green Prescription programme (CCDHB component)	Total	New Measure	≥600	671	
	Māori & Pacific	New Measure	≥360	255	
The number of adult referrals to the Green Prescription Plus programme (CCDHB component)	Total	New Measure	≥600	446	
	Māori & Pacific	New Measure	≥360	143	
The number of children (5–18 years) referred to the Active Families programme (CCDHB component)	Total	284	≥120	111	
	Māori & Pacific	★	≥72	69	
The number of pregnant women referred to the Maternal Green Prescription programme (CCDHB component)	Total	79	≥66	60	
	Māori & Pacific	★	≥70%	53%	
The number children (3– 5 years) referred to the Preschool Active Families programme (CCDHB component)	Total	103	≥111	92	
	Māori & Pacific	★	≥70%	58%	
The number of primary schools enrolled in the Project Energize Programme	Total	15	≥25	30	

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	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
The percentage of two-year-olds fully immunised	Total	96%	≥95%	92%	
	Māori	93%		89%	
	Pacific	98%		92%	
The percentage of eight-month-olds fully vaccinated	Total	93%	≥95%	93%	
	Māori	86%		87%	
	Pacific	90%		90%	

[3] The 2018/19 result is for the period July to December 2018. Due to data quality issues, the Ministry of Health is unable to provide data for January to June 2019.

Measure	Target group	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
The percentage of Year 7 children provided Boostrix vaccination in schools	Total	68%	≥70%	69%	●
	Māori	80%		73%	●
	Pacific	82%		81%	●
The percentage of Year 8 girls vaccinated against HPV (final dose) in schools	Total	64%	≥75%	70%	●
	Māori	64%		58%	●
	Pacific	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	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
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	Total	90%	≥90%	87%	●
	Māori	89%		84%	●
	Pacific	88%		83%	●
The percentage of hospitalised smokers receiving advice and help to quit[4]	Total	86%	≥95%	87%	●
	Māori	87%		88%	●
	Pacific	81%		87%	●
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[5]	Total	92%	≥90%	97%	●
	Māori	89%		100%	●
	Pacific	★		N/A	○

***Output area*: Screening services**

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

Measure	Target group	2017/18 result	2018/19 target	2018/19 result	Achieve ment
The percentage of eligible children receiving a B4 School Check	High need	89%	≥90%	100%	●
	Total	90%		95%	●
	Māori	★		76%	●
	Pacific	★		85%	●
The percentage of eligible women (25–	Total	77%	≥80%	76%	●

[4] The 2018/19 result is for Q4 2018/19. Full financial year performance is 87% (Total), 86% (Māori), 89% (Pacific).
[5] The 2018/19 result is for Q4 2018/19. Full financial year performance is 89% (Total), and 93% (Māori).

Measure	Target group	2017/18 result	2018/19 target	2018/19 result	Achievement
69-year-olds) having cervical screening in the last three years	Māori	61%		63%	
	Pacific	68%		66%	
The percentage of eligible women (50–69-year-olds) having breast screening in the last two years	Total	73%	≥70%	72%	
	Māori	67%		67%	
	Pacific	70%		68%	

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 health care services**
***What we want to achieve*:** Accessible, affordable and connected primary health 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	2017/18 result	2018/19 target	2018/19 result	Achievement
The percentage of the DHB-domiciled population that is enrolled in a PHO	Total	94%	≥94%	92%	
	Māori	★	90%	80%	
	Pacific	★	100%	96%	
The percentage of the eligible population assessed for CVD risk in the last five years	Total	84%	≥90%	78%	
	Māori	83%		78%	
	Pacific	85%		80%	
The number of people enrolled in the CCDHB Health Care Home model of care[6]	Total	New Measure	Est. 200,000	211,916	
	Māori	New Measure		25,711	
	Pacific	New Measure		16,746	
The number of cases discussed between Health Care Homes and the integrated hospital services in multidisciplinary team meetings	Total	New Measure	550	551	

[6] This measure is a volume target for total. A target was not set for Māori or Pacific. CCDHB set a coverage target of 80% for Health Care Homes. We have achieved this across all ethnic groups.

***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[7]	**Target group**	**2017 result**	**2018 target**	**2018 result**	**Achievement**
The percentage of children under five years enrolled in DHB-funded dental services	Total	94%	≥95%	90%	●
	Māori	67%		68%	●
	Pacific	80%		76%	●
The percentage of adolescents accessing DHB-funded dental services	Total	78%	≥85%	79%	●
	Māori	★		N/A	○
	Pacific	★		N/A	○

Output area: **Pharmacy**					
***What we want to achieve*:** People are on the right medications to manage their conditions. Equitable health outcomes.					
Measure	**Target group**	**2017/18 result**	**2018/19 target**	**2018/19 result**	**Achievement**
The number of initial prescription items dispensed	Total	2,607,500	Est. 2,655,870	2,638,260	●
	Māori	★		253,100	●
	Pacific	★		188,345	●
The percentage of the DHB-domiciled population that were dispensed at least one prescription item	Total	78%	Est. 78%	78%	●
	Māori	★		72%	●
	Pacific	★		81%	●
The number of people registered with a long-term conditions programme in a pharmacy	Total	6,823	Est. 6,370	6,571	●
	Māori	★		N/A	○
	Pacific	★		N/A	○
The number of people participating in a community pharmacy anticoagulant management service in a pharmacy	Total	225	Est. 172	208	●
	Māori	★		N/A	○
	Pacific	★		N/A	○

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

[7] Performance for for oral health service measures are for calendar years.

continuum of care, these services are at the complex end of treatment services and are focused 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	2017/18 result	2018/19 target	2018/19 result	Achievement
The percentage of patients admitted, discharged or transferred from emergency department within six hours[8]	Total	90%	≥95%	80%	●
	Māori	★		82%	●
	Pacific	★		81%	●
The number of surgical elective discharges	Total	11,341	11,205	11,207	●
	Māori	★		N/A	○
	Pacific	★		N/A	○
The standardised inpatient average length of stay (ALOS) in days, acute	Total	2.24	≤2.31	2.28	●
	Māori	★	N/A	N/A	○
	Pacific	★	N/A	N/A	○
The standardised inpatient average length of stay (ALOS) in days, elective	Total	1.55	≤1.57	1.53	●
	Māori	★	N/A	N/A	○
	Pacific	★	N/A	N/A	○
Number in-hospital cardiopulmonary arrests in adult inpatient wards	Total	New Measure	≤35	31	●
	Māori	New Measure	≤5	N/A	○
	Pacific	New Measure	≤5	N/A	○
The rate of identified opioid medication errors causing harm, per 1,000 bed days[9]	Total	New Measure	≤5	0.4	●
	Māori	New Measure	≤1	N/A	○
	Pacific	New Measure	≤1	N/A	○
The rate of hospital acquired pressure	Total	0.2	≤0.3	0.3	●

[8] The 2018/19 result is for Q4 2018/19. Full financial year performance is 84% (Total), 83% (Māori), 84% (Pacific).

[9] Data is for total medication errors causing harm.

injuries, per 1,000 bed days	Māori	★	≤0.1	N/A	○
	Pacific	★	≤0.1	N/A	○
The rate of inpatient falls causing harm, per 1,000 bed days from five identified inpatient areas (MAPU, ORA, 5 South, 5 North, 6 East)[10]	Total	New Measure	≤0.2	0.1	●
	Māori	New Measure	≤0.1	N/A	○
	Pacific	New Measure	≤0.1	N/A	○
The weighted average score in the Inpatient Experience Survey by domain[11]	Communication	8.5	8.4	8.5	●
	Coordination	8.4	8.4	8.3	●
	Partnership	8.7	8.6	8.6	●
	Physical and emotional needs	8.7	8.5	8.6	●
The percentage of DNA (did not attend) appointments for outpatient specialist appointments	Total	8.0%	≤7.0%	7.5%	●
	Māori	15.0%	≤15.3%	16.3%	●
	Pacific	17.0%	≤17.0%	17.7%	●

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	2017/18 result	2018/19 target	2018/19 result	Achievement
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[12]	Total	90%	≥90%	89%	●
	Māori	★		N/A	○
	Pacific	★		N/A	○

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	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
The number of people accessing secondary mental health services	Total	11,015	≥10,683	11,202	●
	Māori	2,450	≥2,287	2,500	●
	Pacific	740	≥729	777	●

[10] Data is for total inpatient falls causing harm.

[11] The 2018/19 result is for Q4 2018/19. Full financial year performance is 8.4 (Communication), 8.3 (Coordination), 8.5 (Partnership), 8.6 (Physical and emotional needs).

[12] The 2018/19 result is for Q4 2018/19. Full financial year performance is 89%.

Measure	Target group	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
The percentage of patients 0–19 years referred to non-urgent child and adolescent mental health services that were seen within eight weeks	Total	89%	≥95%	88%	●
	Māori	★		N/A	○
	Pacific	★		N/A	○
The percentage of patients 0–19 years referred to non-urgent child and adolescent addictions services that were seen within eight weeks	Total	92%	≥95%	93%	●
	Māori	★		N/A	○
	Pacific	★		N/A	○
The percentage of people admitted to an acute mental health inpatient service that were seen by the mental health community team in the seven days prior to the day of admission	Total	62%	≥75%	75%	●
	Māori	★		72%	●
	Pacific	★		67%	●
The percentage of people discharged from an acute mental health inpatient service that were seen by the mental health community team in the seven days following the day of discharge	Total	73%	≥90%	79%	●
	Māori	★		76%	●
	Pacific	★		77%	●

Output class – Rehabilitation and support

Rehabilitation and support services are delivered following a needs assessment process and coordination input by Needs Assessment and Service Coordination (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	2017/18 result	2018/19 target	2018/19 result	Achieve-ment
The number of sub-regional and CCDHB disability forums	Total	0	≥1	2	●
The number of sub-regional disability newsletters	Total	2	≥3	0	●
The total number of hospital staff that have completed the disability responsiveness eLearning module	Total	1,207	≥1,513	1,538	●
The total number of people with a disability alert	Total	8,357	≥9,000	8,881	●
The percentage of the disability alert population who are Māori or Pacific	Māori	New Measure	≥11.4%	10.7%	●
	Pacific	New Measure	≥7.0%	5.6%	●

***Output area*: Health of older people services**					
***What we want to achieve*:** Improve the health, wellbeing and independence of 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**	**2017/18 result**	**2018/19 target**	**2018/19 result**	**Achieve-ment**
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	Total	100%	100%	99%	●
	Māori	★		98%	●
	Pacific	★		97%	●
The percentage of people 65+ receiving DHB-funded Health of Older People (HOP) support who are being supported to live at home	Total	62%	≥63%	65%	●
	Māori	★		N/A	○
	Pacific	★		N/A	○
The percentage of the population aged 65+ who are in aged residential care (at all levels; subsidised and non-subsidised)	Total	New Measure	Est. 4.9%	5%	●
	Māori	New Measure		N/A	○
	Pacific	New Measure		N/A	○
The percentage of residential care providers meeting three or more year certification standards	Total	97%	100%	93%	●
The percentage of residential care providers meeting four-year certification standards	Total	53%	≥48%	64%	●

ASSET PERFORMANCE MEASURES

Property asset performance measures

Measure Portfolio: Property	Indicator	2018/19 Target	2018/19 Outcome
% of buildings with a condition rating equal to or better than 2	Condition	≥59%	59.4%
M2 of buildings that are not earthquake prone or risk*	Condition	≥83%	89.9%
% occupancy rate of our buildings	Utilisation	≥97%	97.8%
M2 of buildings that meet current and foreseeable service delivery requirements (>10 years - A) *	Functionality	≥45%	40.7%
M2 of buildings that meet current service delivery requirements but may fall short in the foreseeable future (5–10 years - B) *	Functionality	≤43%	45%
M2 of buildings that meet current service delivery requirements greater than 10 years and those that meet current service delivery requirement but may fall short in next 5–10 years*	Functionality	≤85%	86%

*Excludes buildings that are vacant and tagged for demolition.

ICT asset performance measures

Measure ICT asset portfolio	Indicator	2018/19 Target	2018/19 Outcome
% availability of critical systems	Functionality	≥99.9%	99.9%
% of ICT hardware at a condition level of 'Acceptable' or better (a rating of 3 or lower)	Condition	≥80%	70%
% usage of storage data network (SAN)	Utilisation	≥75% peak	60%

Clinical engineering asset performance measures

Measure Asset portfolio: Clinical equipment (CE)	Indicator	2018/19 Target	2018/19 Outcome
% of CE assets that have passed indicated life expectancy	Functionality	≤37%	45.3%
% of CE assets with a physical condition rating equal to or better than 3 (average)	Condition	≥98%	99.4%
Time MRI is in operation expressed as a % of available time*	Utilisation	≥34.5%	30.6%

*Lower outcome impacted by addition MRI commissioned during the reporting year

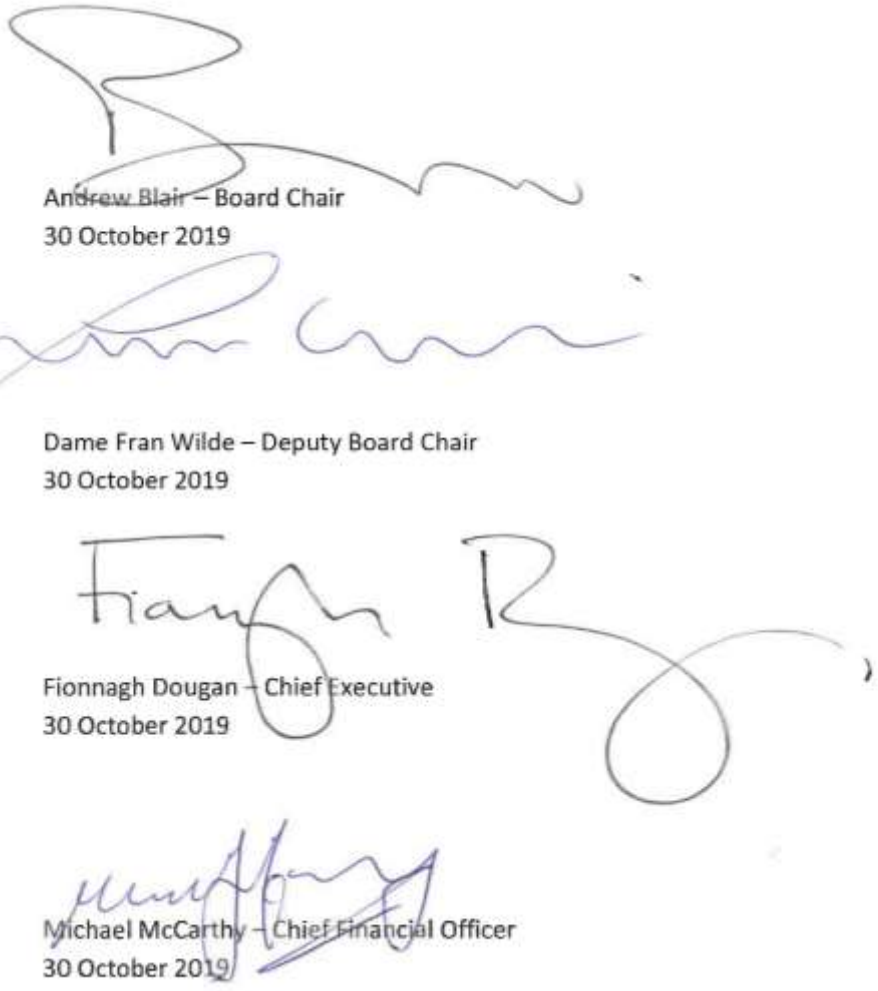
STATEMENT OF RESPONSIBILITY

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 2019.



Andrew Blair – Board Chair
30 October 2019

Dame Fran Wilde – Deputy Board Chair
30 October 2019

Fionnagh Dougan – Chief Executive
30 October 2019

Michael McCarthy – Chief Financial Officer
30 October 2019

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 2019

The Auditor-General is the auditor of Capital and Coast District Health Board (the Health Board). The Auditor-General has appointed me, Andrew Clark, 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 Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 77 to 119, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 34 to 38, 41 to 43, 45 to 48, 50, 51, 53 and 55 to 68.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the Basis for our qualified opinion section of our report:

- the financial statements of the Health Board on pages 77 to 119:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; 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 Health Board on pages 34 to 38, 41 to 43, 45 to 48, 50, 51, 53 and 55 to 68:
    - presents fairly, in all material respects, the Health Board 's performance for the year ended 30 June 2019, 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 appropriations; 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 30 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we draw outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 5 on page 92 and 93, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $67 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

We have fulfilled 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 qualified opinion.

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in the statement of accounting policies on page 84 that outline the financial difficulties being experienced by the Health Board and the expected reliance on borrowing facilities. The Health Board has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown acknowledges that equity support may be required and that the Crown will provide such support, where necessary to maintain viability. We consider these disclosures to be adequate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 119 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

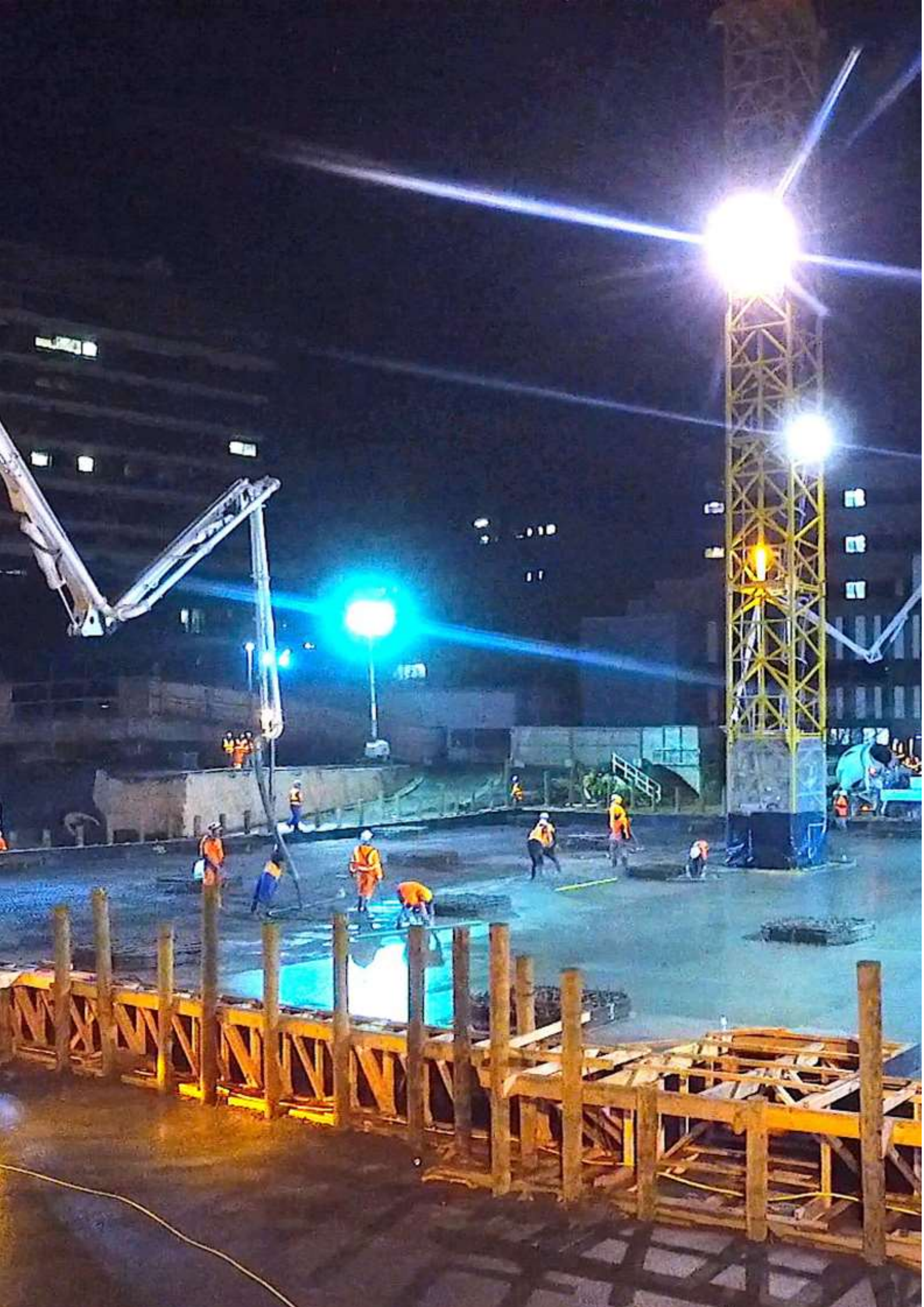
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge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

Independence

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

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

Andrew Clark
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 2019

in thousands of New Zealand Dollars

	Note	2019 Actual	2019 Budget	2018 Actual
Revenue	1	1,161,622	1,139,617	1,091,480
Total revenue		**1,161,622**	**1,139,617**	**1,091,480**
Expenditure				
Clinical supplies		121,834	115,935	115,189
Employee benefit costs	2	505,739	503,171	467,774
Infrastructure and non-clinical expenses		63,090	60,748	63,134
Other operating expenses	3	5,012	5,587	5,536
Outsourced services		35,793	31,328	36,385
Payments to other district health boards		98,083	94,599	96,424
Payments to non-health board providers		288,681	285,211	266,739
Capital charge	4	29,805	24,701	24,373
Depreciation and amortisation expense	6,7	36,419	34,200	34,161
Total expenditure excluding Holidays Act and NOS*		**1,184,456**	**1,155,481**	**1,109,715**
Surplus / (deficit) excluding Holidays Act and NOS*		**(22,834)**	**(15,864)**	**(18,235)**
Holidays Act Provision	2,5	67,161		
National Oracle System (NOS) impairment	7	6,379		
Surplus / (deficit) for the year		**(96,374)**	**(15,864)**	**(18,235)**
Other comprehensive revenue and expense				
Revaluation of land and buildings	19	-	-	113,105
Impairment losses on revalued assets	6	(5,350)	-	-
Total other comprehensive revenue and expense		**(5,350)**	**-**	**113,105**
Total comprehensive revenue and expense		**(101,724)**	**(15,864)**	**94,870**

*NOS = National Oracle System

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 2019

in thousands of New Zealand Dollars

	Note	2019 Actual	2019 Budget	2018 Actual
Balance at 1 July		515,632	514,828	424,245
Total comprehensive revenue and expense for the year		(101,724)	(15,864)	94,870
Owner transactions				
Contribution from the crown		14,100	16,000	-
Conversion of loan to equity		-	-	-
Repayment of equity		(3,484)	(3,484)	(3,484)
Balance at 30 June	**19**	**424,523**	**511,480**	**515,632**

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

For the year ended 30 June 2019

in thousands of New Zealand Dollars

	Note	2019 Actual	2019 Budget	2018 Actual
Assets				
Current assets				
Cash and cash equivalents	12	-	14,110	17,603
Trade and other receivables	11	56,063	53,265	52,151
Inventories	8	9,046	8,067	8,067
Trust and special funds	13	10,754	10,193	9,693
Total current assets		**75,863**	**85,635**	**87,514**
Non-current assets				
Property, plant and equipment	6	556,089	561,377	563,549
Intangible assets	7	26,583	31,146	27,761
Investments in joint ventures	9	-	-	-
Investments in associates	10	1,150	1,150	1,150
Total Non-Current Assets		**583,822**	**593,673**	**592,460**
Total Assets		**659,685**	**679,308**	**679,974**
Equity				
Crown Equity	19	777,568	786,463	766,952
Revaluation Reserve	19	131,361	136,711	136,711
Accumulated comprehensive revenue and expenses	19	(484,406)	(411,694)	(388,031)
Total equity		**424,523**	**511,480**	**515,632**
Liabilities				
Current Liabilities				
Bank overdraft	12	2,671	-	-
Trade and other payables	17	72,900	72,269	74,194
Borrowings	14	55	247	247
Employee entitlements	15	145,638	85,029	75,276
Provisions	16	628	3,981	739
Patient and restricted funds	18	72	-	50
Total current liabilities		**221,964**	**161,526**	**150,506**
Non-current liabilities				
Borrowings	14	-	55	55
Employee entitlements	15	12,646	5,642	13,078
Provisions	16	552	605	703
Total non-current liabilities		**13,198**	**6,302**	**13,836**
Total liabilities		**235,162**	**167,828**	**164,342**
Total equity and liabilities		**659,685**	**679,308**	**679,974**

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 2019

in thousands of New Zealand Dollars

	Note	2019 Actual	2019 Budget	2018 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		1,139,635	1,117,851	1,066,677
Other receipts		19,299	15,512	15,512
Cash paid to suppliers		(616,299)	(607,963)	(572,722)
Cash paid to employees		(501,958)	(481,233)	(453,548)
Cash generated from operations		**40,677**	**44,167**	**55,919**
Goods & services tax, other taxes (net) (a)		(2,244)	(1,535)	1,295
Capital charge paid		(29,805)	(24,373)	(24,373)
Net cash flows from operating activities		**8,628**	**18,259**	**32,841**
Cash flows from investing activities				
Interest received		1,204	1,557	1,557
Acquisition of property, plant and equipment		(35,271)	(27,000)	(21,121)
Acquisition of intangible assets		(4,142)	(8,000)	(1,291)
Investment in joint venture		-	-	-
Appropriation from trust & special funds (b)		-	-	(1,284)
Net cash flows from investing activities		**(38,209)**	**(33,443)**	**(22,139)**
Cash flows from financing activities				
Contribution from the Crown		14,100	16,000	-
Repayment of borrowing		(247)	(326)	(326)
Repayment of equity		(3,484)	(3,484)	(3,484)
Repayment of finance leases		-	-	-
Interest Paid		-	-	-
Net cash flows from financing activities		**10,369**	**12,190**	**(3,810)**
Net increase/(decrease) in cash and cash equivalents		(19,212)	(2,993)	6,892
Cash and cash equivalents at beginning of year		27,296	27,296	20,403
Cash and cash equivalents at end of year		**8,084**	**24,303**	**27,296**
Represented by				
Bank overdraft	12	**(2,671)**		
Trust and special funds	13	**10,754**		

(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 WITH NET CASH FLOWS FROM OPERATING ACTIVITIES

For the year ended 30 June 2019

in thousands of New Zealand Dollars

	2019 Actual	2018 Actual
Surplus/(deficit) for the year	(96,374)	(18,235)
Add back non-cash items:		
Depreciation & amortisation	36,419	34,161
Impairment on Intangibles	6,379	1,020
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	14	120
Interest revenue on financial assets	(1,263)	(1,963)
Donated assets	-	(481)
Add back items classified as financing activity:		
Interest expense on financial liabilities	-	-
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(3,912)	(2,555)
(Increase)/decrease in trust funds	-	(1,284)
(Increase)/decrease in inventories	(979)	535
Increase/(decrease) in trade and other payables	398	(3,287)
Increase/(decrease) in employee benefits	70,448	14,645
Increase/(decrease) in provisions	(2,502)	473
Net movement in working capital	63,453	8,527
Net cash inflow/(outflow) from operating activities	**8,628**	**23,149**

STATEMENT OF CONTINGENT LIABILITIES AND ASSETS

For the year ended 30 June 2019

in thousands of New Zealand Dollars

	Note	2019 Actual	2018 Actual
Legal proceedings against the DHB		100	100
Other contractual matters		-	-
		100	**100**

The DHB has been notified of a potential claim as at 30 June 2019 (2018: 1) relating to an appeal following a win by the DHB in the High Court.

The Wellington regional hospital domestic hot water systems are failing due to corrosion in the copper pipes causing leaks throughout the building. 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 is being 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, the installer and the designer. A full hearing is scheduled by the High Court for late 2020. Since the amount cannot be quantified, an unquantified contingent asset has been disclosed.

Statement of Accounting Policies

Reporting entity

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

The primary objective of the DHB is to provide goods or services for the community or social benefit rather than making a financial return. Accordingly, the DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes. The DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

Statement of compliance

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

Changes in accounting policies

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

Standards early adopted

Financial instruments

In line with the Financial Statements of the Government, the DHB has elected to early adopt PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 21.

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes 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. This amendment is effective for financial periods beginning on or after 1 January 2019, with early adoption permitted. The DHB has elected to early adopt this amendment.

Standards issued that are not yet effective and not early adopted

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

PBE IPSAS 34-38

PBE IPSAS 34-38 replace the existing standards for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019. The DHB will apply these new standards in preparing the 30 June 2020 financial statements. No effect is expected as a result of this change.

PBE IPSAS 41 Financial Instruments

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after1 January 2021. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

Basis of preparation

The financial statements for the year ended 30 June 2019 were approved by the Board on 30 October 2019. The financial statements have been prepared for the period 1 July 2018 to 30 June 2019. Comparative figures and balances relate to the period 1 July 2017 to 30 June 2018. 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 2018/19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of Comfort

The Board has received a letter of comfort, dated 21 October 2019 from the Ministers of Health and Finance which states that the Crown acknowledges that equity support may be required and that the Crown will provide such support where necessary to maintain viability.

Operating and cash flow forecasts

Taking the Letter of Comfort into consideration, the Board has considered forecast information relating to operational viability and is satisfied that there will be sufficient cash flows from income and overdraft facilities available to meet the operating 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, with the assumption the DHB's approved facilities will be available taking into account the needs of the rest of the health sector. 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 three 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

In thousands of New Zealand dollars

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

Leased assets

Finance Leases

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

Operating Lease

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to the DHB. All other costs are recognised in the statement of comprehensive revenue and expense as an expense as incurred.

Depreciation

Depreciation is charged to the statement of comprehensive revenue and expense using the straight line method. Land is not depreciated. Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life
• freehold buildings	1 to 60 years (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 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
Short-term receivables are recorded at the amount due, less an allowance for credit losses. The DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables. In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.
Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

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 DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return. Property, plant, and equipment are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value, less costs to sell, and value in use.
Value in use is the present value of an asset's remaining service potential. It is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.
If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable service amount. For revalued assets, the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.
For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss on a revalued asset is credited to other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the

impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

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**.**

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.

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.

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.

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

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

Estimating useful lives and residual values of 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.

In thousands of New Zealand dollars

Estimating the fair value of land and buildings

The most recent full valuation of land and buildings was performed by Milton Bevin, FPINZ, an independent registered valuer with Colliers International New Zealand Limited, as at 30 June 2018. 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. Specialised buildings are valued using depreciated replacement cost because no reliable market data is available for such buildings. Refer to note 6 for additional details.

Retirement, long service leave, sick leave and continuing education

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

Critical accounting judgements in applying the DHB's accounting policies

Leases classification

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

Finance and operating leases

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

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

1 REVENUE

	2019 Actual	2018 Actual
Ministry of Health contract funding	882,565	825,450
Other government	15,780	16,861
Inter district flows (other DHBs)	237,983	224,705
Non government & crown agency sourced	23,821	21,970
Reversal of impairment previously recognised	-	50
Interest revenue	1,263	1,963
Revenue from donations	210	481
	1,161,622	1,091,480

2 EMPLOYEE BENEFIT COSTS

	2019 Actual	2018 Actual
Direct staff costs (excluding increases in employee benefit provisions)	537,668	424,668
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	18,743	14,392
Contributions to defined contribution plans [1]	15,634	15,639
Increase/(decrease) in employee benefit provisions	854	13,075
	572,899[2]	467,774

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

In thousands of New Zealand dollars

[2] Includes Holidays Act Provision of $67,161k

3 OTHER OPERATING EXPENSES

	Note	2019 Actual	2018 Actual
Increase/(decrease) in provision of trade receivables (doubtful debts)	11	428	568
(Gain)/loss on disposal of property, plant and equipment		14	41
Audit fees for financial statements audit		236	224
Fees for other assurance services		136	144
Board member fees	22	323	345
Operating lease expense		2,572	2,742
Other operating expense		1,303	1,472
Total other operating expenses		5,012	5,536

4 CAPITAL CHARGE

	2019 Actual	2018 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 2019 was 6 per cent (2018: 6 per cent)	29,805	24,373

5 HOLIDAYS ACT PROVISION

	2019 Actual	2018 Actual
Holidays Act Provision	67,161	-

Holidays Act Provision

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU

will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, Capital & Coast District Health Board recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

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 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
Balance at 1 July 2018	41,165	473,390	1,191	99,422	28,442	643,610
Additions	-	3,741	-	15,408	3,871	23,020
Disposals	-	-	-	(474)	(91)	(565)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2019	41,165	477,131	1,191	114,356	32,222	666,065
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)

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 2018	-	35	(503)	(72,037)	(25,293)	(97,798)
Depreciation charge for the year	-	(24,801)	(65)	(6,230)	(2,628)	(33,724)
Impairment losses	-	(5,350)	-	-	-	(5,350)
Disposals	-	-	-	461	90	551
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2019	-	(30,116)	(568)	(77,806)	(27,831)	(136,321)
Carrying amounts						
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
At 1 July 2018	41,165	473,425	688	27,385	3,149	545,812
At 30 June 2019	41,165	447,015	623	36,550	4,391	529,744

	Freehold land	Freehold buildings	Leasehold improvements	Plant & equipment	Furniture & fittings	Total
Work in progress						
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
Balance at 1 July 2018	-	14,692	-	150	2,897	17,739
Additions	-	7,959	-	20,080	3,589	31,628
Transfer from WIP	-	(3,742)	-	(15,409)	(3,871)	(23,022)
Balance at 30 June 2019	-	18,909	-	4,821	2,615	26,345

In thousands of New Zealand dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	2019 Actual	2018 Actual
Capital commitments		
Buildings	828	6,078
Plant & equipment	-	-
Intangible assets	938	1,234
Capital Commitments	**1,766**	**7,312**

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.

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. Subsequent revaluation increases have since reduced the initial revaluation loss to nil.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2019 was $0 (2018: $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 Māori Protection Mechanisms.

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

In thousands of New Zealand dollars

7 INTANGIBLE ASSETS

	Software	NOS shared services rights	Licenses	Total
Cost				
Balance at 1 July 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
Balance at 1 July 2018	28,667	7,005	3,042	38,714
Additions	3,136	394	951	4,481
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2019	31,803	7,399	3,993	43,195
Amortisation and impairment losses				
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)
Balance at 1 July 2018	(19,469)	(1,020)	(2,817)	(23,307)
Amortisation charge for the year	(2,479)	-	(217)	(2,696)
Impairment losses	-	(6,379)	-	(6,379)
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2019	(21,948)	(7,399)	(3,034)	(32,382)
Carrying amounts				
At 1 July 2017	10,537	6,467	193	17,197
At 30 June 2018	9,198	5,985	225	15,407
At 1 July 2018	9,198	5,985	225	15,407
At 30 June 2019	9,855	-	959	10,813

In thousands of New Zealand dollars

7 INTANGIBLE ASSETS (CONTINUED)

	Software	Licenses	CRTAS	Total
Work in progress				
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
Balance at 1 July 2018	707	20	11,626	12,353
Additions	4,790	931	1,783	7,504
Transfer from WIP	(3,136)	(951)	-	(4,087)
Balance at 30 June 2019	2,361	-	13,409	15,770

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 included 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). Following advice from New Zealand Health Partnerships and PWC, CCDHB has written off its investment in the National Oracle Solution (NOS), as the DHB is not expected to derive further benefit from this investment.

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 2019, CCDHB had contributed $13.409m 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 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

	2019 Actual	2018 Actual
Pharmaceuticals	3,161	2,414
Surgical & medical supplies	5,546	5,360
Other supplies	339	293
	9,046	8,067

The amount of inventories recognised as an expense during the year ended 30 June 2019 was $125m (2018: $119m). All inventories are distributed to operating areas in the normal course of business. The write-down of inventories held for distribution amounted to $nil (2018: $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

	2019 Actual	2018 Actual
Carrying amount of investments in joint ventures		
Uncalled ordinary share capital	-	-
	-	-

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

Summary of the DHB's interests in Central TAS joint venture (16.67%)	2019 Actual	2018 Actual
Revenue	6,678	6,365
Expense	6,623	6,075
Non-current assets	313	163
Current assets	2,708	2,962
Non-current liabilities	119	119
Current liabilities	2,068	2,227
Equity	834	779
Contingent liabilities		-
Commitment	1,084	1,212

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

	2019 Actual	2018 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 6,900,000 of which the DHB's share is 1,150,000. The shares have been fully paid.

Summary of the DHB's interest in Allied Laundry Services Ltd. (16.67%)	2019 Actual	2018 Actual
Revenue	1,821	1,845
Expense	1,726	1,738
Non-current assets	1,428	1,548
Current assets	225	196
Non-current liabilities	28	73
Current liabilities	411	468
Equity	1,214	1,203
Contingent liabilities	-	-
Commitment	-	-

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

11 TRADE AND OTHER RECEIVABLES

	2019 Actual	2018 Actual
Trade receivables from non-related parties	6,966	4,021
Ministry of Health receivables	19,313	19,585
Other DHB receivables	9,547	8,477
	35,826	32,083
Accrued revenue	16,040	16,993
Prepayments	4,197	3,075
Total receivables	56,063	52,152
Total receivables comprises:		
Receivable from the sale of goods and services (exchange transactions)	36,750	32,567
Receivable from Ministry funding (non-exchange transactions)	19,313	19,585
	56,063	52,152

Trade receivables are shown net of a provision for doubtful debts amounting to $1.5m (2018: $1.5m)

The carrying value of receivables approximates their fair value.

In thousands of New Zealand dollars

As at 30 June 2019, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

Past due days	Amount	Estimates of losses	Impaired credit loss	Expected credit loss
Current	8,060	0.0%		
< 6 months	7,690	1.5%		113
6 months - 1 year	1,498	16.1%		241
1 - 2 years	2,152	27.6%		593
>2 years	723	79.7%		576
Identified bad debts	410	100.0%	410	
Total	20,533		410	1,523

Trade receivables are reported at their face value, less an allowance for expected losses. Expected losses are assessed on an individual basis for large receivables, whilst for small debts the historical pattern is used to assess expected losses on a collective basis.

Movements in the provision for impairment of receivables are as follows:	2019 Actual	2018 Actual
Balance at 1 July 2018	1,504	1,395
Additional provisions made during the year	428	568
Receivables written-off during period	(410)	(459)
Balance at 30 June 2019	1,522	1,504

12 BANK OVERDRAFT

	2019 Actual	2018 Actual
Petty cash	13	13
Bank accounts	(10)	8
NZHP call deposits	(2,674)	17,582
Bank overdraft	(2,671)	17,603

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

In thousands of New Zealand dollars

limit for the DHB is $61.4m. (2018:$55.8m). The highest overdrawn bank balance during financial year 2018/19 was $14.2m. (2018: $nil).

While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

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.

	2019 Actual	2018 Actual
Non patient funds		
Balance at 1 July 2018	9,644	8,350
Monies received	3,594	3,350
Interest received	320	257
Payments made	(2,871)	(2,313)
Balance at 30 June 2019	10,687	9,644
Patient funds		
Balance at 1 July 2018	49	58
Monies received	207	145
Interest received	-	-
Payments made	(188)	(155)
Balance at 30 June 2019	67	49
Total trust and special funds	10,754	9,693

14 INTEREST BEARING LOANS AND BORROWINGS

	2019 Actual	2018 Actual
Current		
Unsecured EECA loans	55	247
	55	247
Non-current		
Unsecured EECA loans	-	55
	-	55

In thousands of New Zealand dollars

Unsecured loans

Interest rate summary	2019 Actual	2018 Actual
Energy Efficiency and Conservation Authority (EECA)	0%	0%

Loan repayable as follows:	2019 Actual	2018 Actual
Within one year	55	247
One to two years	-	55
Two to five years	-	-
Later than five years	-	-
Loan repayable as follows:	55	302

Term loan facility limits	2019 Actual	2018 Actual
Energy Efficiency and Conservation Authority (EECA)	55	302
	55	302

15 EMPLOYEE ENTITLEMENTS

	2019 Actual	2018 Actual
Current liabilities		
Liability for long service leave	3,270	2,900
Liability for sabbatical leave	400	340
Liability for retirement gratuities	1,010	830
Liability for annual leave	46,664	42,578
Liability for sick leave	405	318
Liability for continuing medical education leave and expenses	2,337	2,817
Salary and wages accrual	91,553	25,493
	145,638	75,276
Non-current liabilities		
Liability for long service leave	4,616	3,846
Liability for sabbatical leave	510	454
Liability for retirement gratuities	1,227	1,343
Liability for sick leave	1,620	1,800
Liability for continuing medical education leave and expenses	4,673	5,635
	12,646	13,078

In thousands of New Zealand dollars

Defined benefit plans

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

Other employee entitlement liabilities

Liability for 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%, (2018: 2.5%) and a discount rate ranging from 1.35% to 2.42% (2018: 1.77% to 3.70%) from 1-10+ years.

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

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

16 PROVISION

	2019 Actual	2018 Actual
Current provisions		
ACC Partnership Programme	628	739
Non current provisions		
ACC Partnership Programme	552	703
	1,180	1,442
ACC Partnership Programme		
Undiscounted amount of claims at balance date	958	953
Discount	20	26
Central estimate of present value of future payments	1,057	1,299
Risk margin	123	143

The movement in provisions is represented by:

	ACC Partnership Programme
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	1,048
Subtotal	2,608
Amounts used during the year	(1,166)
Total liability	1,442
(Decrease) / increase in provision	473

In thousands of New Zealand dollars

2019	
Balance at 1 July 2018	1,442
Additional provisions during the year for the risks borne in current period	600
Additional provisions relating to a reassessment of risks in a previous period	73
Subtotal	2,115
Amounts used during the year	(935)
Total liability	1,180
(Decrease) / increase in provision	(262)

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 S Ferry, FNZSA 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 1.52% for the year ended 30 June 2019. A discount rate of 1.83% has been used for the year ended 30 June 2019. 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

	2019 Actual	2018 Actual
Payables under exchange transactions		
Trade payables	8,730	5,326
Revenue in advance / Deferred Revenue	-	-
Other non-trade payables and accrued expenses	47,723	53,320
Total payables under exchange transactions	56,453	58,646
Payables under non-exchange transactions		
Revenue in advance	177	2
GST and other taxes payables	16,270	15,546
Total payables under non-exchange transactions	16,447	15,548
Total Payables	72,900	74,194

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

	2019 Actual	2018 Actual
Patient funds		
Balance at 1 July 2018	48	59
Monies received	207	144
Interest received	-	-
Payments made	(188)	(156)
Balance at 30 June 2019	67	48

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 2019, both as an asset and a liability.

	2019 Actual	2018 Actual
Holiday homes funds		
Balance at 1 July 2018	8	88
Monies received	22	21
Interest received	-	1
Payments made	(10)	(101)
Balance at 30 June 2019	20	8
Hutt Valley DHB Portion ¼ of holiday homes total	5	2
Total patient and restricted funds	72	50

In thousands of New Zealand dollars

19 EQUITY

	2019 Actual	2018 Actual
Contributed capital		
Balance at 1 July	766,951	770,435
Capital contribution	14,100	-
Conversion of loans to equity		-
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	777,567	766,951
Property revaluation reserves		
Balance at 1 July	136,711	23,606
Revaluations	-	113,105
Impairment losses on revalued assets	(5,350)	-
Balance at 30 June	131,361	136,711
Accumulated surplus / (deficit)		
Balance at 1 July	(388,031)	(369,796)
Surplus / (deficit) for the year	(96,374)	(18,235)
Balance at 30 June	(484,405)	(388,031)
Total equity	424,523	515,631

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:

	2019 Actual	2018 Actual
Less than one year	3,257	3,318
Between one and five years	6,766	7,000
More than five years	221	255
	10,244	10,573

During the year ended 30 June 2019, $2.6m was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2018: $2.7m)

The DHB:

In thousands of New Zealand dollars

- 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:

	2019 Actual	2018 Actual
Less than one year	4,030	4,057
Between one and five years	7,717	8,659
More than five years	2,053	1,300
	13,800	14,016

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.

21 FINANCIAL INSTRUMENTS

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

Adoption of PBE IFRS 9 Financial Instruments

In accordance with the transitional provisions of PBE IFRS 9, the DHB has elected not to restate the information for previous years to comply with PBE IFRS 9.Under PBE IFRS 9, impairment of short-term receivables is determined by applying an expected credit loss model. The DHB's impairment of receivables in previous years was consistent with this model. Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

On the date of initial application of PBE IFRS 9, being 1 July 2018, the classification of financial instruments under PBE IPSAS 29 and PBE IFRS 9 is as follows:

	Measurement category		Carrying amount		
	Original PBE IPSAS 29 category	New PBE IFRS 9 category	Closing balance 30 June 2018 (PBE IPSAS 29)	Adoption of PBE IFRS 9 adjustment	Opening balance 1 July 2018 (PBE IFRS 9)
Cash at bank and on hand	Loans and Receivables	Amortised cost	17,603	-	17,603
Receivables	Loans and Receivables	Amortised cost	32,083	-	32,083
Term Deposits	Loans and Receivables	Amortised cost	8,300	-	8,300
Total financial assets			57,986	-	57,986

The measurement categories and carrying amounts for financial liabilities have not changed between the closing 30 June 2018 and opening 1 July 2018 dates as a result of the transition to PBE IFRS 9.

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 53.91% in 2019 (2018: 61.04%). 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 $0.47m in 2019. (2018: $0.73m).

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.

	2019 Actual							2018 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	55	55	-	-	-	-	0	302	137	110	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
2019						
Creditors and other payables	72,900	72,900	72,900	-	-	-
Secured loans	-	-	-	-	-	-
Unsecured loans	55	55	-	-	-	-
Patient and restricted funds	73	73	73	-	-	-
Total	73,028	73,028	72,973	-	-	-
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	-	-

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
2019						
Cash and cash equivalents	(2,671)	(2,671)	(2,671)	-	-	-
Debtors and other receivables	56,063	56,063	56,063	-	-	-
Trust and special funds - bank	582	582	582	-	-	-
Trust and special funds – term deposit	9,600	9,832	9,832	-	-	-
Trust and special funds – debtors	452	452	452	-	-	-
Total	64,027	64,259	64,259	-	-	-
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	-	-	-

In thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Maximum exposure to credit risk

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

	2019 Actual	2018 Actual
Cash and cash equivalents	-	17,603
Debtors and other receivables	56,063	52,151
Trust and special funds – bank	582	796
Trust and special funds – term deposit	9,600	8,300
Trust and special funds – debtors	452	573
	66,697	79,423

	2019 Actual	2018 Actual
Counterparties with credit ratings		
Cash at bank and term deposits	10,182	26,699
AA- (Standard & Poor's)	10,182	26,699

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

Foreign currency risk

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

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

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2019 was $nil (2018: $nil), comprising assets of $nil (2018: $nil) and liabilities of $nil (2018: $nil) that were recognised in fair value derivatives.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of comprehensive revenue and expense. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of "Net loss on derivative classified as fair value through statement of comprehensive revenue and expense". The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2019 was $nil (2018: $nil) recognised in fair value derivatives.

In thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (continued)

Fair values

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

	Note	Carrying amount 2019 Actual	Fair value 2019 Actual	Carrying amount 2018 Actual	Fair value 2018 Actual
Trade and other receivables	11	56,063	56,063	52,151	52,151
Cash and cash equivalents	12	-	-	17,603	17,603
Secured loans	14	-	-	-	-
Unsecured loans	14	(55)	(55)	(302)	(302)
Trade and other payables	17	(72,900)	(72,900)	(74,194)	(74,194)
		(16,892)	(16,892)	(4,742)	(4,742)
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:

	2019 Actual	2018 Actual
Board Members		
Remuneration	$323	$345
Full-time equivalent members	1.3	1.19
Leadership Team		
Remuneration	$4,404	$4,750
Full-time equivalent members	17	18
Total key management personnel remuneration	$4,727	**$5,095**
Total members and full time equivalent personnel	18.3	**19.19**

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

In thousands of New Zealand Dollars

22 RELATED PARTIES TRANSACTIONS (CONTINUED)

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

Current board members as at 30 June 2019		Board fees ($) 2019	Board fees ($) 2018	Committee fees ($) 2019	Committee fees ($) 2018
Mr Andrew Blair, Chair	Appointed	61.0	61.0	2.3	2.7
Dame Fran Wilde, Deputy Chair	Elected	31.9	31.9	4.6	4.7
Dr Kathryn Adams	Elected	25.5	25.5	2.0	2.5
Dr Roger Blakeley	Elected	25.5	25.5	4.0	2.5
Ms Eileen Brown	Elected	25.5	25.5	2.5	1.2
Ms ‘Ana Coffey	Elected	25.5	25.5	1.8	1.8
Mrs Sue Driver	Elected	25.5	25.5	2.5	1.1
Ms Sue Kedgley	Elected	25.5	25.5	2.3	1.4
Ms Kim Ngarimu	Appointed	25.5	25.5	2.1	2.3
Mr Darrin Sykes	Appointed	25.5	25.5	2.2	2.8
Board member who left during 2017/18					
Mr Roger Jarrold	Appointed	-	25.5	-	3.4
		296.9	322.4	26.2	26.2

Committee members (other than Board members and employees)	DSAC fees ($) 2019	DSAC fees ($) 2018	HSC fees ($) 2019	HSC fees ($) 2018
Dr Tristram Ingham	0.7	0.7	1.4	0.4
Mr Bob Francis	0.9	0.4	-	-
Mr Fa’amatuainu Tino Pereira	-	-	1.4	0.2
Ms Suzanne Jane Emirali	-	-	0.2	-
Dr Margaret Southwick	-		0.2	-
	1.6	1.1	3.2	0.6

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 2018/19 within specified $10,000 bands were as follows:

Salary band	Number of Employees 2019	Number of Employees 2018	Salary band	Number of Employees 2019	Number of Employees 2018
100 – 110	306	167	330 – 340	10	11
110 – 120	157	115	340 – 350	13	8
120 – 130	120	90	350 – 360	9	4
130 – 140	73	54	360 – 370	8	4
140 – 150	61	48	370 – 380	2	3
150 – 160	42	37	380 – 390	2	3
160 – 170	38	38	390 – 400	4	1
170 – 180	31	22	400 – 410	2	4
180 – 190	16	22	410 – 420	2	2
190 – 200	19	18	420 – 430	3	2
200 – 210	24	23	430 – 440	-	2
210 – 220	10	12	440 – 450	2	2
220 – 230	18	17	450 – 460	4	2
230 – 240	18	18	460 – 470	2	2
240 – 250	21	25	470 - 480	3	-
250 – 260	17	13	490 - 500	2	-
260 – 270	25	17	500 – 510	-	1
270 – 280	13	8	510 – 520	1	1
280 – 290	17	16	530 – 540	1	1
290 – 300	11	11	620 – 630	1	1
300 – 310	10	13	630 – 640	1	2
310 – 320	6	10	650 – 660	1	1
320 – 330	9	5		1,135	856

Of the 1,135 employees shown above, 576 are or were medical or dental employees and 559 were neither medical nor dental employees. This represents an increase of 279 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 2,144 compared with the actual total number of 1,135.

24 CESSATION PAYMENTS

During the year ended 30 June 2019, 17 (2018: 19) employees received compensation and other benefits in relation to cessation totalling $0.3m (2018: $0.3m).

No Board members (2019: nil) received compensation or other benefits in relation to cessation (2018: $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 $96.4m compared with a budgeted deficit of $15.9m.

Revenue was greater than budget in most categories, including the Funder Arm new contracts, other DHB and other government revenues. Additional revenue was received from MOH to support MECA increases implemented during 2018-19, funding support for increased capital charge plus funding for mental health pay equity implementation. All additional revenue had equivalent costs.

Expenditure was over budget for the following reasons:

- A $67m provision was made for the remediation of Holidays Act compliance
- Impact of the nurses and junior doctors' strikes.
- 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, higher than budget MECA increases and unmet savings targets
- Infrastructure & Non Clinical expenses were over budget due to unmet savings targets
- 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 higher than budget, due to unmet pharmaceutical savings plus mental health pay equity implementation funded by the MOH.

Statement of changes in Equity

The equity movement for the year was an equity injection of $14.1m from the Crown, less an equity repayment of $3.5m to the Crown and a total comprehensive revenue and expense deficit of $101.7m.

Statement of financial position

Employee entitlements has increased significantly due to a Holidays Act remediation provision of $67m.
The decrease in intangible asset was mainly due to a $6m write-off for investment in the National Oracle System.

Statement of cash flows

The net cash flow from operating activities was lower than budget mainly due to higher cash paid to employees and increased capital charge.

The net cash flow from investment activities was higher than budget due to increased capital spend to address deferred capital expenditure from previous years.

The net cash flow from financing activities was less than budget due to a lower than forecast equity injection from the Crown.

26 EVENTS AFTER BALANCE DATE

There were no significant events after the balance date.

NOTES TO THE FINANCIAL STATEMENTS

In thousands of New Zealand Dollars

27 SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual	2019 Actual	2018 Actual	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Revenue										
Crown	12,144	10,619	234,054	214,113	782,997	733,864	114,292	109,386	1,143,486	1,067,981
Other	-	-	-	-	18,136	23,499	-	-	18,136	23,499
Total revenue	**12,144**	**10,619**	**234,054**	**214,113**	**801,133**	**757,363**	**114,292**	**109,386**	**1,161,622**	**1,091,480**
Expenditure										
Personnel	159	96	3,009	1,821	500,962	464,882	1,610	975	505,739	467,774
Depreciation	-	-	-	-	36,419	34,161	-	-	36,419	34,161
Capital charge	-	-	-	-	29,805	24,373	-	-	29,805	24,373
Provider payments	10,546	9,102	207,975	197,215	67,835	57,020	100,408	99,826	386,764	363,163
Other	670	628	13,962	14,253	204,350	197,128	6,747	8,235	225,729	220,244
Total expenditure	**11,375**	**9,827**	**224,945**	**213,289**	**839,370**	**777,564**	**108,765**	**109,035**	**1,184,456**	**1,109,715**
Net surplus/(deficit)	**768**	**792**	**9,108**	**823**	**(38,238)**	**(20,201)**	**5,527**	**351**	**(22,834)**	**(18,235)**
Extraordinary adjustments										
Holidays Act provision					(67,161)				(67,161)	
NOS Impairment					(6,379)				(6,379)	
Impairment losses on revalued assets					(5,350)				(5,350)	
Revaluation of Land & Buildings						113,105				(113,105)
Net surplus/deficit	**768**	**792**	**9,108**	**823**	**(117,128)**	**92,904**	**5,527**	**351**	**(101,724)**	**94,870**

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

NOTES TO THE FINANCIAL STATEMENTS

In thousands of New Zealand Dollars

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2019 Actual	**2019 Budget**	**2018 Actual**	**2019 Actual**	**2019 Budget**	**2018 Actual**	**2019 Actual**	**2019 Budget**	**2018 Actual**	**2019 Actual**	**2019 Budget**	**2018 Actual**
Opening balance	(431,079)	(431,079)	(402,517)	(14,765)	(14,765)	(16,084)	50,016	50,016	41,008	(395,828)	(395,828)	(377,593)
Surplus/(deficit)	(121,416)	(34,151)	(28,562)	524	-	1,319	19,169	18,287	9,008	(101,724)	(15,864)	(18,235)
Closing balance	**(552,495)**	**(465,230)**	**(431,079)**	**(14,241)**	**(14,765)**	**(14,765)**	**69,185**	**68,303**	**50,016**	**(497,552)**	**(411,692)**	**(395,828)**