

CAPITAL & COAST DISTRICT HEALTH BOARD

Annual Report 2014/2015



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CHAIR AND CHIEF EXECUTIVE'S FOREWORD



It is a pleasure to present Capital & Coast District Health Board's (DHB) Annual Report for the year 1 July 2014 to 30 June 2015. This report provides a summary of our successes and progress against our key performance measures and a detailed account of how the health funding we received has been managed.

The DHB has had a busy and successful year providing quality care and continuing to improve health outcomes for our population. There have been numerous successes and learnings in the past year.

We achieved our financial target of a \$4m deficit. This is the second year the DHB has achieved its budgeted result and is a direct result of hard work and focussed effort by staff right across the organisation.

This year we established a medical day ward at Kenepuru Hospital, building work began for the new national secure youth forensic inpatient mental health service and we opened four additional spaces at the Kenepuru dialysis unit. We also invested in new technology, including installing electronic whiteboards and a suite of other tools to enable us to better respond to and plan for the flow of patients through hospital services.

We met our elective target which has meant nearly 9,000 people have had access to publicly funded elective surgery in the past year. An area of focus is improving access to orthopaedic surgery and this year we invested \$3 million to increase our orthopaedic theatre capacity at Kenepuru Hospital. We were also one of only a few DHBs in the country to achieve the 95 per cent immunisation target for 8 month olds. This is a really important preventative health target and has been accomplished by working collaboratively with our local primary health organisations.

During the year, following intense consultation, the Wairarapa, Hutt Valley and Capital & Coast DHB mental health, addiction and intellectual disability services combined. This is a flagship innovation for New Zealand and the integrated service means clients have access to the same services, irrespective of where they live.

In the community we are working hard to develop clinical care pathways for common medical conditions to improve our patient's journey through the health system, the role of primary care clinicians continues to expand so more care can be provided closer to people's homes and all but one of our general practices in the region are now providing free GP visits for children under 13. We also agreed to integrate our community and hospital laboratory. The new service will see laboratory equipment upgraded in the region which will improve patient experiences, turnaround times, and access to tests results.

Through the Porirua Social Sector Trial the number of children enrolled with the oral health service has increased by carrying out a data matching process between health providers. Within Porirua the number of pre-schoolers enrolled with Bee Healthy Regional Dental Service has increased, notably in the Māori and Pacific populations. This enrolment initiative will be carried out in Wellington, Kapiti and Hutt Valley.

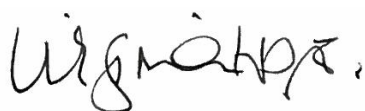
There have been several other initiatives through the Porirua Social Sector Trial which are making a real difference to the health and wellbeing of people living in this community. Every child from Porirua who presents to the emergency department with asthma is followed up by the Porirua Asthma Service, there is additional support for families going through the court process and soap and tissues are being provided to schools to help support and promote good hygiene.

We continue to respond to the changing needs of our ageing population. Following visits from Professor Ian Sturgess, a geriatrician and quality improvement specialist from the UK, we have made further improvements to the way we care for the frail elderly. Work is happening in both the community and hospital which has resulted in better coordination of services across community, primary care and hospital settings and the average length of stay in hospital for this vulnerable group of people is reducing.

The on-going commitment to training our workforce; both present and future, remains a key driver to our success. Over the course of the last year, over 1000 students or trainees spent time at our DHB as part of their studies. There are also many links across the organisation into each of the four universities in and around Wellington, as well as across New Zealand.

Quality and safety is a priority in everything we do. We actively support national patient safety campaigns and are committed to preventing patient harm such as reducing the number of patients who have falls while in hospital. On occasion we do get things wrong; however we learn from these mistakes and change the way we do things to avoid it happening again in the future.

We would like to take this opportunity to thank our staff and our health and social service sector partners for their contribution in the past year and on-going commitment to improve the health of our region.



Dr Virginia Hope MNZM
BOARD CHAIR



Debbie Chin
CHIEF EXECUTIVE

STRATEGIC DIRECTION

OUR VISION

Better health and independence for people, families and communities.

We understand we must work with our communities to help reduce disparities in health status and reduce the incidence of chronic conditions amongst our population while increasing the independence of the people in our district. To achieve our health goals, we have developed a range of specific strategies which include:

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

OUR VALUES

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

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

STRATEGIC GOALS

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

- reduction of health disparities within our population
- integrated delivery of services
- improving the health of children in vulnerable communities, with a particular focus on rheumatic fever, serious skin infection and respiratory conditions
- financial and clinical sustainability
- a culture of collaboration with local and regional partners.

ABOUT CCDHB

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

Currently just over 300,000 people live within the Capital & Coast DHB district, with two thirds of the population in Wellington City, 18% in Porirua and 15% on the Kāpiti Coast. The DHB must assess the health status of the population and determine what funds should be directed to preventing illness and early intervention of illness (via primary health and public health services), while continuing to provide and improve existing hospital and other specialist services.

We are the leading provider of specialist tertiary services for the upper South and lower North Islands, covering a population of about 900,000.

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

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

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

THE HEALTH OF OUR POPULATION

Our DHB is the sixth largest in New Zealand and spans three territories; Wellington City, Porirua City and part of Kāpiti Coast district. The people of the Wellington region enjoy, on average, better health, longer life spans, and lower rates of morbidity and mortality than many other parts of the country. We have fewer than average Māori (11%) and a higher than average Pacific (7%) and Asian (12%) populations.

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

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

- Kāpiti Coast has a large population aged over 65 years.

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

The district population is predicted to increase 8% (24,000 people) by 2026 with the highest growth in Wellington and Kāpiti. Like the country as a whole, our population is ageing and the number of people aged over 65 years is expected to grow by almost 40% (14,000 people) by 2026.

Key health issues for this DHB include:

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

GOVERNANCE OF CCDHB

ROLE OF THE BOARD

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

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

ROLE OF THE CEO

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

GOVERNANCE PHILOSOPHY

Over the past few years, the three Boards have taken a 'whole-of-health system' approach, including integrating clinical and support services where this provides benefits across the system.

Each Board continues to provide governance of local services and all three Boards provide collective governance over services that are shared or integrated, ensuring local accountability.

Integrated service approaches are intended to deliver:

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

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

BOARD STRATEGY

IMPROVE CHILD HEALTH AND CHILD HEALTH SERVICES IN THE WELLINGTON REGION

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

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

BETTER ELDER CARE

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

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

INTEGRATED CARE

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

- CCDHB has been working with primary health organisations to integrate primary, secondary, tertiary and public health care. We want to encourage the more rapid development of integrated care pathways that can prevent unnecessary admissions and adverse events.
- We want to expand these services to include:
- Integrated family health care centres that provide access to a variety of services in one location and eventually focus on keeping people well, as well as treating people when they are sick. We would like to begin with a pilot for an integrated family care centre in Porirua.
- Better access to information that promotes wellness and good personal health, at all points across the health continuum.
- Better access to mental health services.

EMPOWERED SELF-CARE

As chronic diseases become more prevalent, it is important that patients are actively engaged in their care. We want to see greater recognition of the capacity of the patient in guiding and managing their own care, as well as better sharing of information and decision-making, and more opportunities for preventive care. We want to assess the increasing evidence for the impact of preventative activities in primary care e.g. in pre-diabetes and in reducing cardio-vascular disease risk. Other initiatives we would like to see include:

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

ENHANCED CLINICAL LEADERSHIP

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

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

CONTINUOUS OUTCOME EVALUATION AND MONITORING

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

BOARD AND COMMITTEE MEETING ATTENDANCE

July 2014 - June 2015

Board member	Board (11 meetings)	CPHAC (5 meetings)	DSAC (5 meetings)	HAC (7 meetings)	FRAC (10 meetings)
Dr Virginia Hope++	11	3	3	7	10
Dr Derek Milne	9	5	5	6	8
Dr Judith Aitken	8	-	-	2 *	9
Mr David Choat	11	4	4	-	-
Mr Peter Douglas++	9	1 **	1 **	-	5
Ms Helene Ritchie	10	4	4	-	-
Mr Darrin Sykes++	6	-	-	-	9
Ms Sue Kedgley	9	-	-	5	-
Mr Chris Laidlaw	9	5	5	-	-
Mr Nick Leggett +	10	-	-	1 **	-
Mr Roger Jarrold	10	-	-	-	7
Dr Margaret Wilsher	6	-	-	-	-

Note:

- not a member

* new member of the committee from Jan 2015

** ceased committee membership

+ Board representative, Sub-Regional Pacific Strategic Health Advisory Group

++ Board representatives, Māori Partnership Board

OUR PEOPLE

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

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

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

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

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

GOOD EMPLOYER OBLIGATIONS REPORT

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

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

A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity and we have an equal employment opportunities focus within the relevant policies. Training and

development opportunities are offered to all staff, and personal performance and development plans are done annually.

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

As a good employer the DHB values professionalism through leadership. Therefore unacceptable employee behaviour is not tolerated. We have updated our suite of HR policies and guidelines related to discipline, performance, code of conduct, harassment prevention, and protected disclosures this year. We are also taking a proactive approach to reduce the incidence of bullying and harassment within our organisation.

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

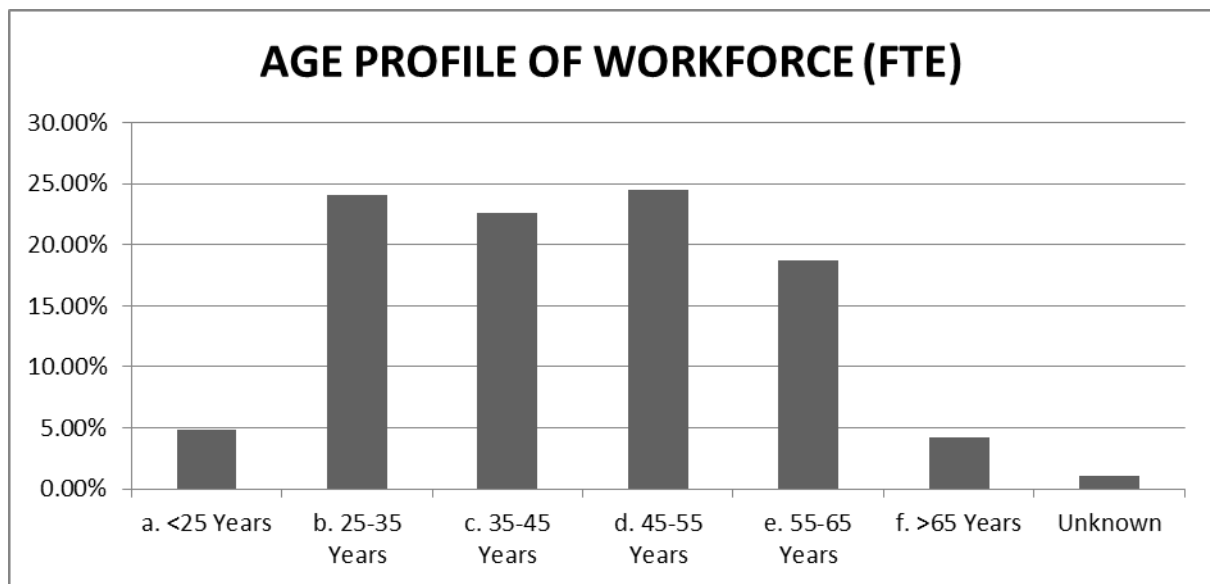
The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation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

WORKFORCE PROFILE

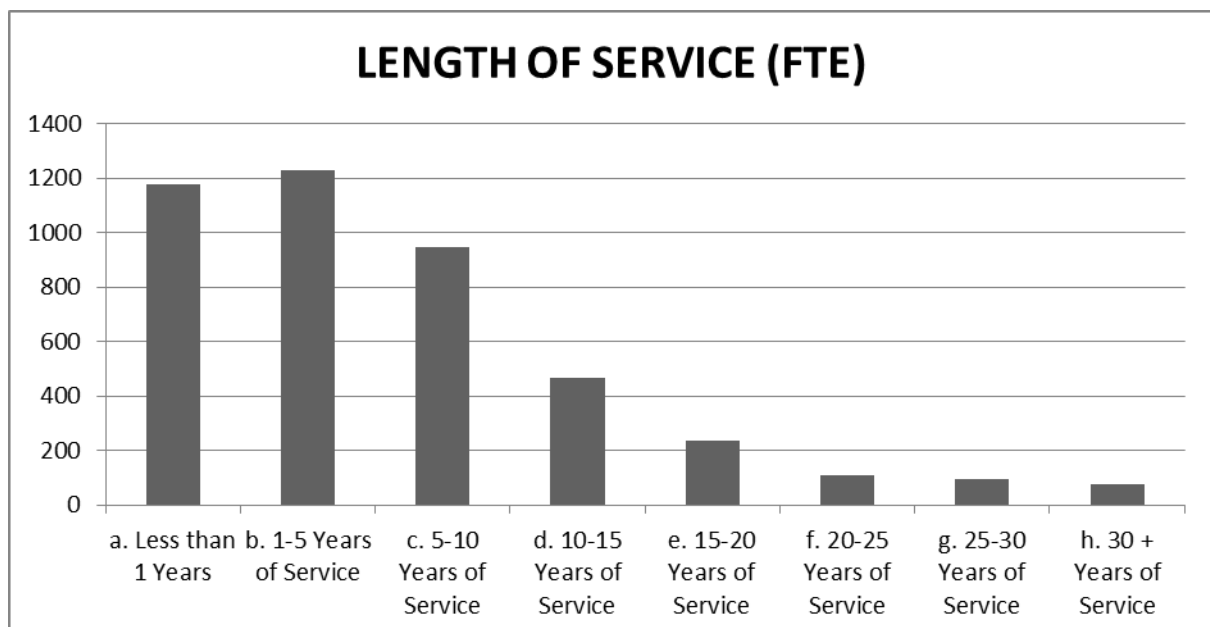
Full Time Equivalent (FTE) Staff Numbers

	2015	2014	2013	2012	2011	2010	2009
Medical	640.89	618	87.71	563.58	524.16	510.32	490
Nursing	1945.95	1895	1909.99	1804.96	1789.38	1791.15	1639.69
Allied Health	762.16	767	759.87	727.11	705.54	684.84	645.75
Other	997.65	877	1011.13	958.46	957.16	968.29	971.31
Total	4346.65	4257	4268	4054	3976	3954	3746

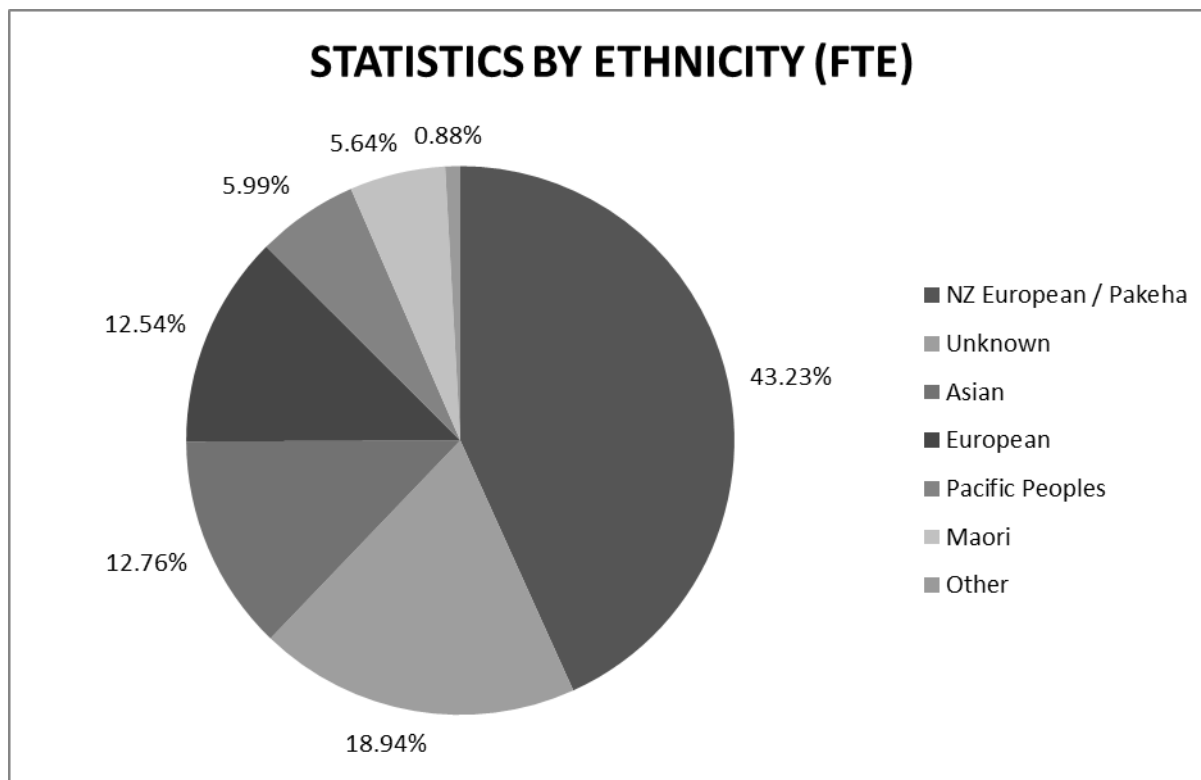
Age Profile of Workforce



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2015	2014	2013	2012	2011	2010	2009
Female	73%	72%	73%	73%	73%	73%	72%
Male	27%	28%	27%	27%	27%	27%	28%

PERFORMANCE HIGHLIGHTS

Capital & Coast DHB continues to provide high quality and timely services for our population. In 2014/15:

- Amenable (avoidable) mortality rates continue to decrease.
- The burden of tooth decay in 12 year olds decreased.
- Capital & Coast DHB ranked second best out of twenty DHBs on the immunisation health target, with 95% of eight month olds receiving their vaccination on time.
- All but two general practices in Capital & Coast DHB have a diabetes care improvement plan. These plans include regular monitoring of diabetes care and outline strategies and services that will improve diabetes care in the practice.
- Capital & Coast PHOs made significant progress against the smoking advice in primary care health target, with 88% of smokers with a general practice appointment in the last twelve months receiving advice to quit – an increase of 16% from the previous financial year.
- Capital & Coast DHB exceeded the improved access to elective surgery health target with 8,969 elective surgeries delivered to the DHB population.
- The average length of stay targets for acute and elective admissions to Wellington and Kenepuru Hospitals were met and average length of stay in our hospitals continues to decrease. At the same time, our acute readmission rate remains lower than the national average.
- All Capital & Coast residents with long-term support needs received a comprehensive clinical [InterRAI] assessment and a completed care plan.

MINISTER'S HEALTH TARGETS

Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. They provide a focus for action.¹

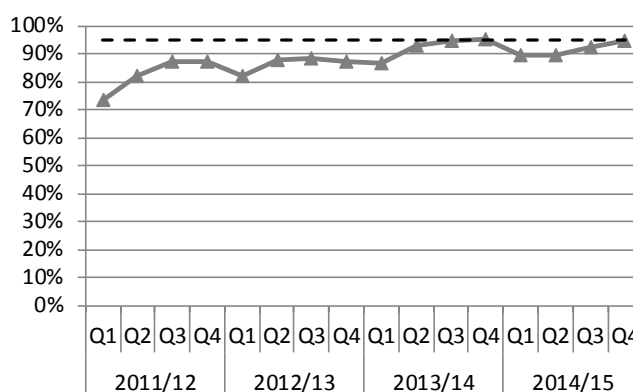
Shorter stays in Emergency Departments

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

Target: 95%

2014/15 Performance: 91%

Shorter stays in ED Capital & Coast DHB



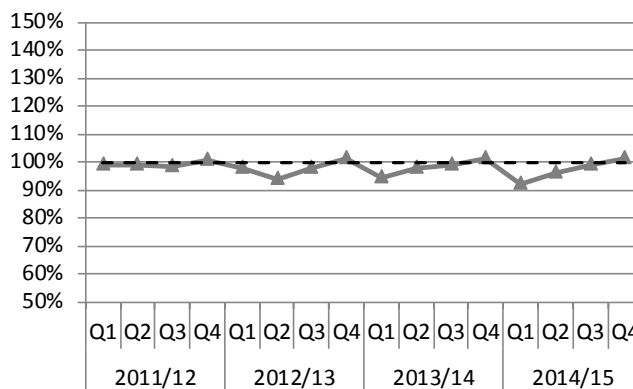
Improved access to elective surgery

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

Target: 8,884 (graph - 100%)

2014/15 Performance: 8,969

Improved access to elective surgery Capital & Coast DHB



¹ Quoted from the Ministry of Health, <http://www.health.govt.nz/new-zealand-health-system/health-targets>

Increased immunisation

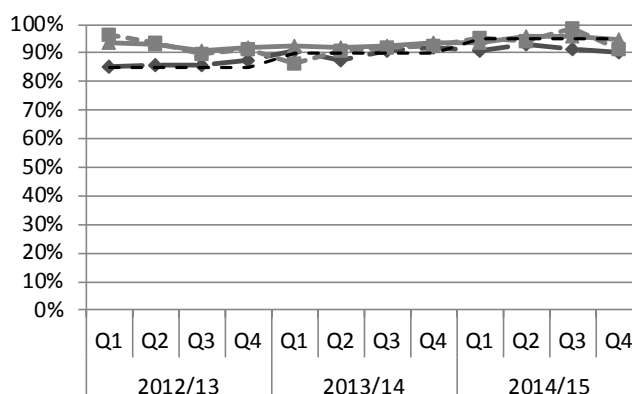
85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014.

Target: 95%

2014/15 Performance: 95%

—◆— Māori —■— Pacific
—▲— Total - - - Target

Increased Immunisation Capital & Coast DHB



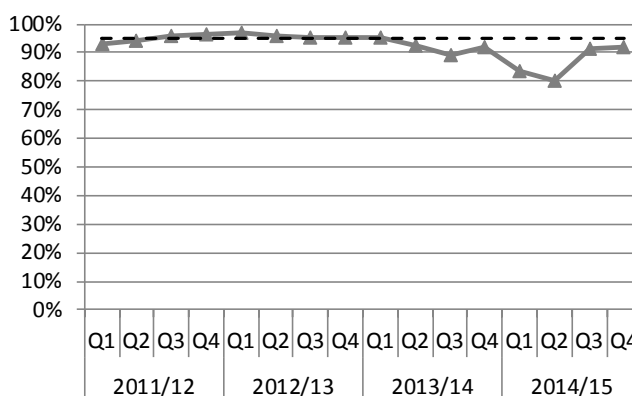
Better help for smokers to quit – Hospital

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

Target: 95%

2014/15 Performance: 87%

Better help for smokers to quit - Hospital Capital & Coast DHB



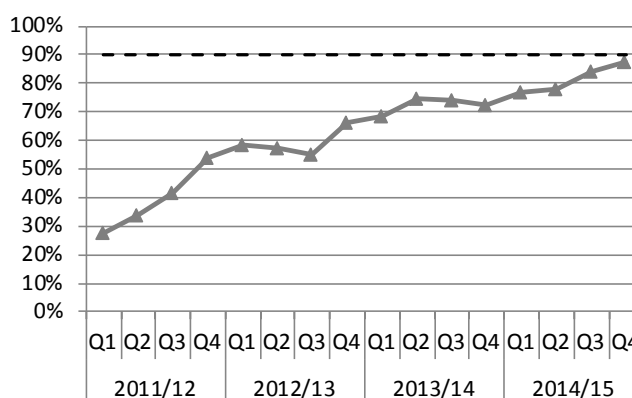
Better help for smokers to quit – Primary Care

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

Target: 90%

2014/15 Performance: 88%

Better help for smokers to quit - Primary care Capital & Coast DHB



More heart and diabetes checks

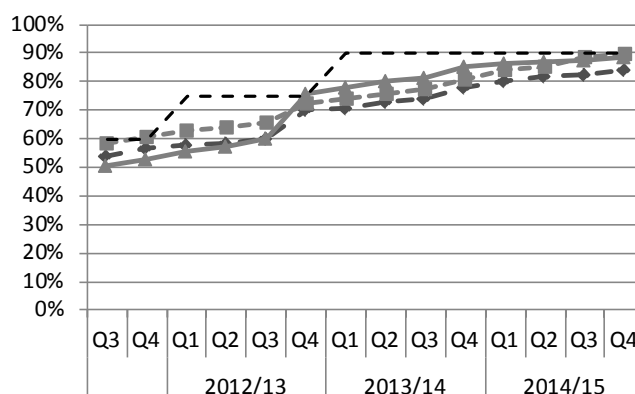
90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Target: 90%

2014/15 Performance: 89%

—◆— Māori —■— Pacific
—▲— Total - - - Target

More heart and diabetes checks Capital & Coast DHB



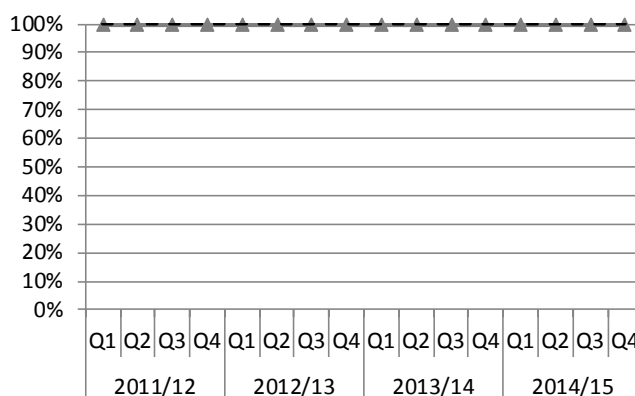
Shorter waits for cancer treatment

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

Target: 100%

2014/15 Performance: 100%

Shorter waits for cancer treatment Capital & Coast DHB



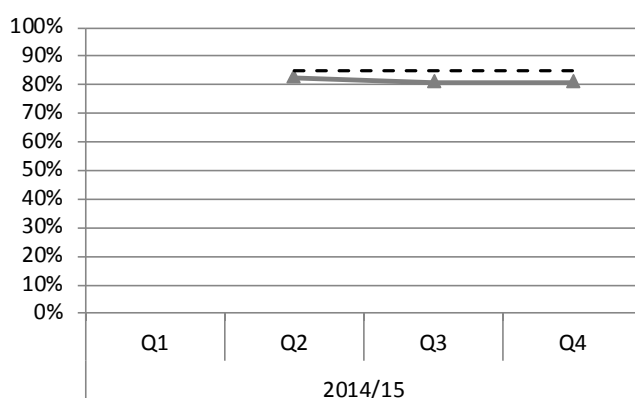
Faster cancer treatment

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.

Target: 85% by July 2016

2014/15 Performance: 81%

Faster cancer treatment Capital & Coast DHB



IMPACTS AND OUTCOMES

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

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

POPULATION HEALTH OUTCOME: IMPROVED HEALTH EQUITY

What difference will we make for our population?

Overarching across the three components of our strategy is a focus on patient-centred care. This incorporates an outcome of improved health equity, to ensure the gains in health of our population are across all groups. Inequalities in access to and decisions over resources are the primary cause of health inequalities. Differential access to health services – and in the quality of care provided to patients – also contribute to unequal health outcomes. These structural inequalities may explain more of ethnic inequalities in health than is often recognised.

Although the overall Wellington sub-region has a relatively affluent, healthy population, there are pockets of deprivation concentrated in parts of Porirua, the south eastern suburbs of Wellington, parts of the Hutt Valley such as Naenae and Wainuiomata, and parts of Masterton. Over half of the Pacific population live in the most deprived areas and 29 percent of Māori live in the most deprived areas.

Māori and Pacific peoples die on average ten to fifteen years earlier than non-Māori non-Pacific, and experience significantly higher acute admission and avoidable mortality rates. Although access to some health care services has improved, outcomes often remain worse for Māori and Pacific.

We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

In addition to the outputs described in the following Statement of Performance, recent initiatives in our sub-region that we are undertaking to improve equity outcomes include:

- A subregional equity report, which contains a suite of equity indicators, including ASH rates. By improving our monitoring of disparities, we will be able to more effectively plan activities and reduce existing disparities.

- A project that aims to reduce the number of people who do not attend (DNA) outpatient appointments, as Māori and Pacific have higher DNA rates than other ethnicities.

The Porirua Social Sector Trial, which aims to reduce the ASH rates and ED admissions of Porirua residents. The trial will achieve these aims through collaboration between various social services, including housing, education, police, and health services.

Impact measures – The DHB measures progress through:

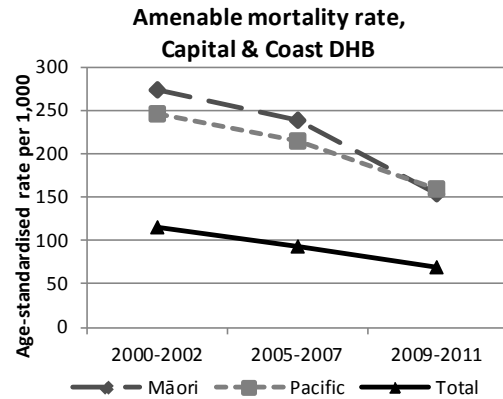
A reduction in amenable mortality rates for Māori & Pacific

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

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

Amenable mortality rates in Capital & Coast DHB have decreased by 40% since 2000-2002. However, Māori and Pacific amenable mortality rates are still more than 2.5 times higher than other ethnicities, indicating that Māori and Pacific are not receiving equitable coverage or quality of healthcare.

This measure links to the Early Detection & Management and Intensive Assessment & Treatment output classes.



Amenable conditions are defined by the Ministry of Health and exclude people aged over 75 years.

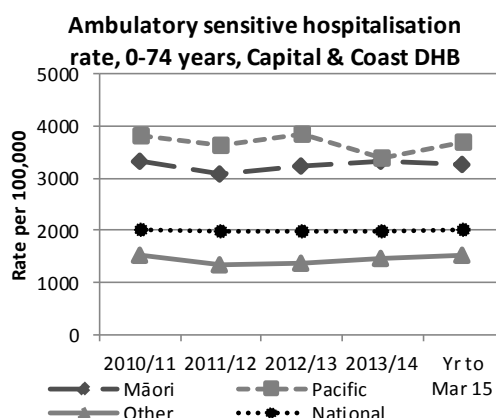
A reduction in the ambulatory sensitive hospitalisation (ASH) rates (0-74)

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

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

In Capital & Coast DHB, our overall ASH rate is lower than the national ASH rate. However, our ASH rate for Māori and Pacific is more than twice the rate for other ethnicities, and this disparity has remained constant over the last four years.

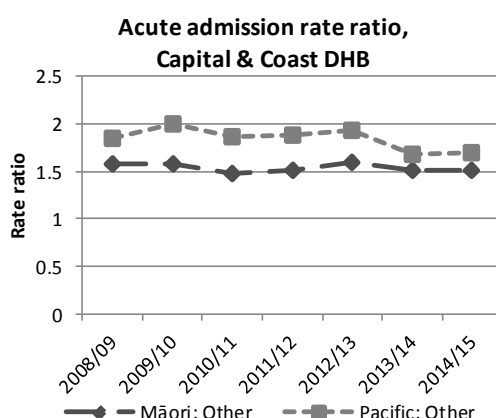
This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in the rate of acute admissions for Māori & Pacific compared to non-Māori non-Pacific

Māori and Pacific are at least one-and-a-half times more likely to be admitted acutely to hospital than non-Māori non-Pacific. Positively, the acute admission rate ratio for Pacific has decreased over the last couple of years, but the ratio for Māori has remained the same. This disparity reflects both social and economic inequities and inequities in access to health services.

This measure links to the Prevention Services and Early Detection & Management output classes.

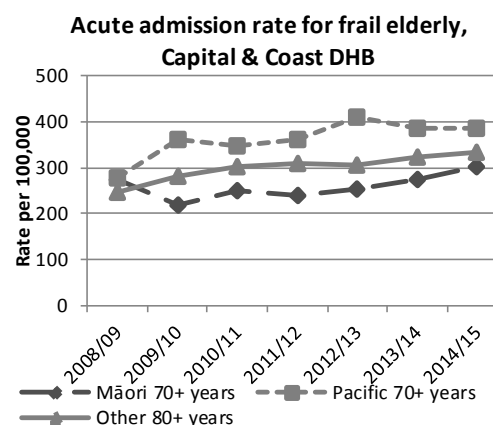


A reduction in acute medical admission rates for Māori and Pacific frail elderly²

Rates of acute medical admissions are high across all groups and particularly for Pacific Peoples. Rates for Māori 70+ are declining, which is positive.

By improving the clinical management of frail elderly in the community, we expect that acute admission rates for frail elderly will decrease.

This measure links to the Rehabilitation & Support output class.



POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH

What difference will we make for our population?

Preventative health services provide the population with health literacy, or an understanding of how their daily choices affect their health, and protect the population to keep them healthy. Healthy eating, active living, and not smoking are some of the factors which can prevent diseases or poor health in the longer term.

Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disease, heart disease and strokes. Supporting the population to say no to tobacco smoking is an important opportunity to target improvements in the health of populations with high need and to improve Māori health.

Current trends indicate sustained increases in obesity in New Zealand's adult population. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy. Supporting the population to maintain healthier body weight through improved nutrition and physical activity levels is fundamental to improving the health and wellbeing of the population and to the prevention of chronic conditions and disability at all ages.

² Age groups have been set based definitions used in current programmes of work for frail elderly.

Measures – The DHB measures progress through:

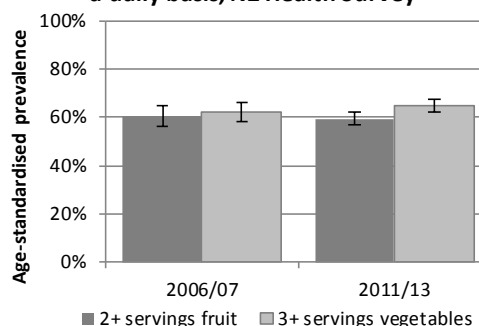
An increase in the percentage of adults 15+ consuming 2+ fruit and 3+ vegetable servings daily

Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect people against obesity, CVD, diabetes and some common cancers and contributes to maintaining a healthy body weight. Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.

The number of adults consuming fruit and vegetables on a daily basis has not changed significantly over the last five years. By providing education and support for people to live healthily, we expect that the consumption of fruit and vegetables will increase.

This measure links to the Prevention Services output class.

Proportion of adults in the sub-region that consume fruit and vegetables on a daily basis, NZ Health Survey



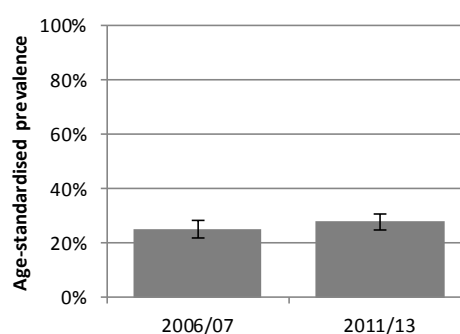
A reduction in obesity prevalence amongst the population 15+

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 it has been described as an epidemic.

The most recent NZ Health Survey shows that there is no significant difference in obesity rates between the three DHBs. Adults have a much higher obesity rate than children in all three. By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

This measure links to the Prevention Services and Early Detection & Management output classes.

Obesity prevalence in adults in the sub-region, NZ Health Survey



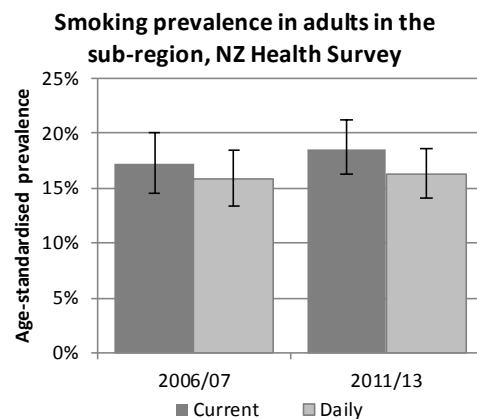
A reduction in smoking rates for the sub-region's 15+ population

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

Census 2013 data shows that in our sub-region, smoking prevalence in Māori (30%) and Pacific (24%) are higher than the average smoking prevalence (14%) in our sub-region.

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

This measure links to the Prevention Services output class.



A decrease in the number of vaccine preventable disease notifications

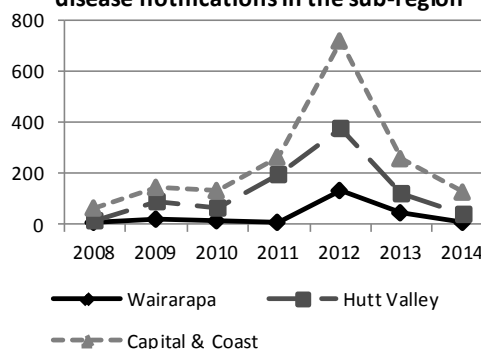
In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications has returned to previous levels in 2014.

In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will decrease.

This measure links to the Prevention Services and Early Detection & Management output classes.

Number of vaccine-preventable disease notifications in the sub-region



Source: Environmental Science & Research surveillance reports

POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH: IMPROVED CHILD AND YOUTH HEALTH

What difference will we make for our population?

Outcomes for the current generation of children and young people will determine the future success or failure of the community and society as a whole. The relatively short periods of time which gestation, infancy, childhood and adolescence occupy have more power to shape the individual than much longer periods of time later in life.

The health status of young people and expectant mothers is most strongly influenced by environmental determinants of health outside of the services the DHB provides. However the DHBs have a focus on influencing change that supports healthier environments; on ensuring younger populations have a healthy start to life; and on addressing the inequalities between population groups to improve overall population outcomes.

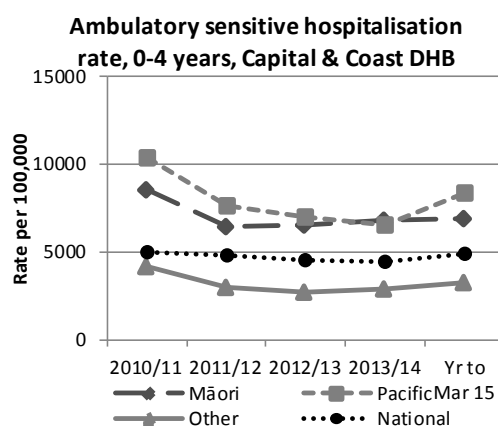
Measures – The DHB measures progress through:

A reduction in ambulatory sensitive hospitalisations of children (0-4)

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

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

This measure links to the Prevention Services and Early Detection & Management output classes.



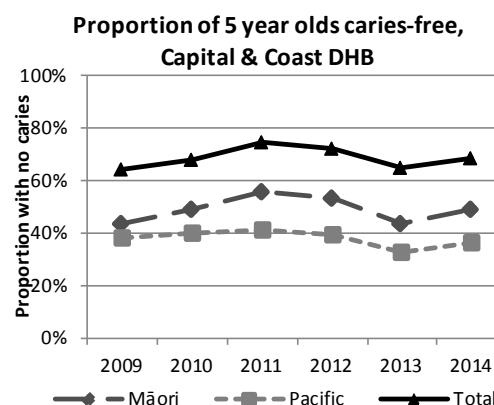
An increase in the proportion of children caries free at five years

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

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

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

This measure links to the Early Detection & Management output class.

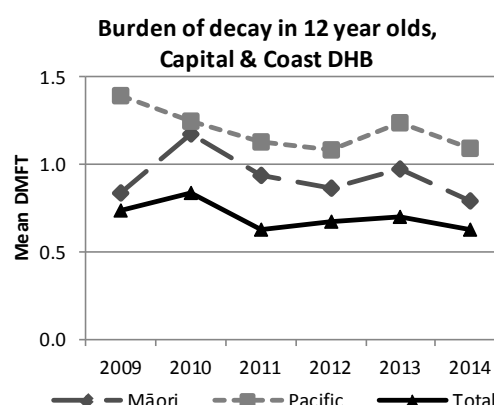


A decrease in the mean number of decayed, missing or filled teeth (DMFT) at Year 8

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

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

This measure links to the Early Detection & Management output class.



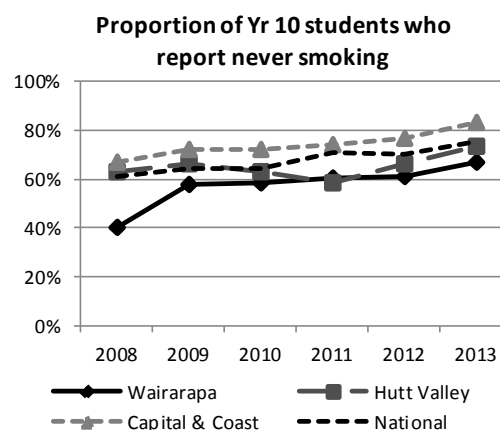
An increase in the proportion of year 10 students who report never smoking

Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.

A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.

The proportion of year 10 students who report never smoking has increased over the last five years across all three DHBs, which is positive.

This measure links to the Prevention Services output class.



POPULATION HEALTH OUTCOME: EMPOWERED SELF-CARE

What difference will we make for our population?

The impact of long-term conditions in terms of quality of life and cost to the health system is significant. Early diagnosis and intervention and improved disease management provide major opportunities for improving health outcomes; particularly for Māori and Pacific people, who have disproportionately higher rates of many long-term conditions.

Empowering people to manage their long-term conditions and seek appropriate intervention early will result in a reduction in the proportion of the population seeking urgent care or requiring acute admission to hospital. Improving access to alternative pathways of care will ensure people are being given the right treatment in the right place; improving health outcomes, reducing pressure on hospital resources and enabling investment in other priority areas.

Measures – The DHB measures progress through:

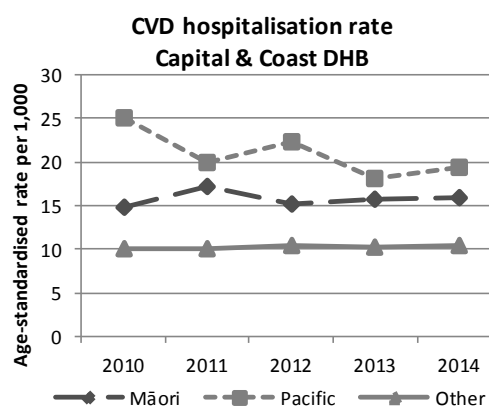
A reduction in the hospitalisation rate for cardiovascular disease (CVD)

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

One of the Health Targets is to provide CVD risk checks for the eligible population (65+ years). By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

In Capital & Coast DHB, Māori and Pacific have a higher rate of CVD hospitalisation than other ethnicities. The inequity between Māori and 'Other' has stayed the same over the last four years, whilst the inequity between Pacific and 'Other' has decreased.

This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in the hospitalisation rate for diabetes

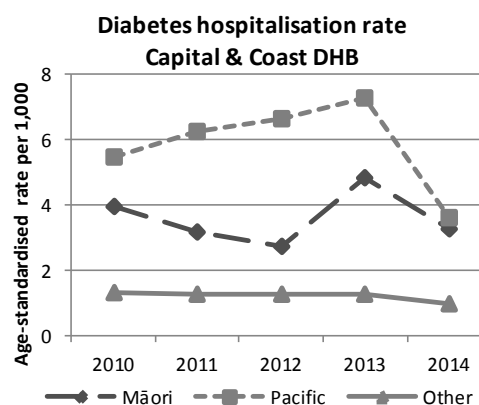
Diabetes is defined by the body's inability to control blood glucose. Diabetes is a chronic condition, which can cause kidney failure, eye disease, foot ulceration and a higher risk of heart disease if not well managed.

Supporting people to manage their diabetes well reduces acute admissions to hospital.

The number of diabetics has been increasing at a rate of approximately 8% a year.

All but two general practices in Capital & Coast DHB have a diabetes care improvement plan. These plans include regular monitoring of diabetes care and outline strategies and services that will improve diabetes care in the practice. Diabetes admission rates increased for Māori and Pacific over the last few years, but have since dropped to below the 2010 rate, which is good.

This measure links to the Prevention Services and Early Detection & Management output classes.

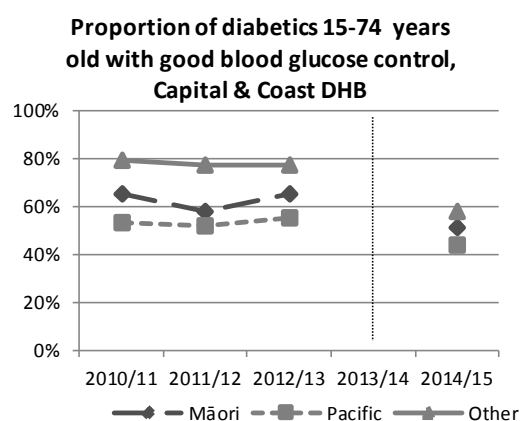


Increased proportion of diabetics checked with satisfactory or better blood glucose control (HbA1c less than or equal to 64 mmol/mol)

Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as lower limb amputation, kidney failure and blindness, and will improve people's quality of life.

Fewer Māori and Pacific have good blood glucose control when compared to other ethnicities.

This measure links to the Prevention Services and Early Detection & Management output classes.



Results from 2010/11 to 2012/13 are presented as a rate of diabetics who had an HbA1c test. This measure was then revised from 2013/14 to be a rate of all enrolled diabetics, which resulted in a drop in reported performance. There was also a delay in developing reporting with the new methodology, so results for 2013/14 are not available.

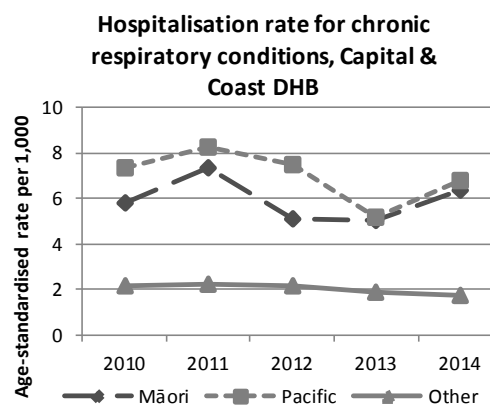
A reduction in the age standardised hospitalisation rate for chronic respiratory conditions

The most common chronic respiratory conditions include asthma and chronic obstructive pulmonary disorder (COPD).

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

In Capital & Coast DHB, the rate of chronic respiratory hospitalisation for Māori has varied over the last five years. Rates for Māori and Pacific are approximately three times higher than the rate for other ethnicities.

This measure links to the Prevention Services and Early Detection & Management output classes.



HEALTH SERVICES OUTCOME: SERVICES CLOSER TO HOME

What difference will we make for our population?

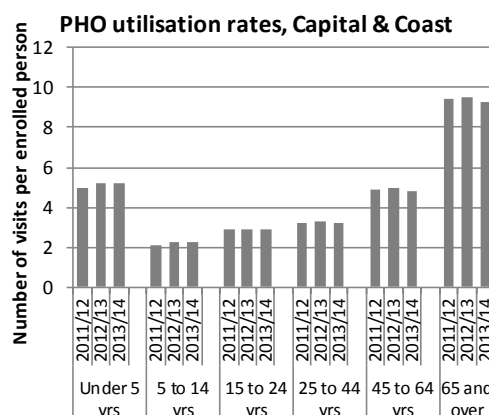
We are working to better integrate health services across the continuum to better provide the services patients require closer to their homes. When services are delivered closer to the patient's home they can better access services and have a relationship of trust with their regular GP, nurse or other clinician. This allows patients to use services when they need them and empowers them to manage their health.

Measures – The DHB measures progress through:

The utilisation rate of primary care by age group

When people are able to access primary care when they need it, they can receive treatment earlier, have better continuity of care, and sometimes even prevent a hospital admission. Improved utilisation of primary care appropriate to the needs of the age group reflects patients' ability and willingness to visit their medical home of primary care for their medical treatment.

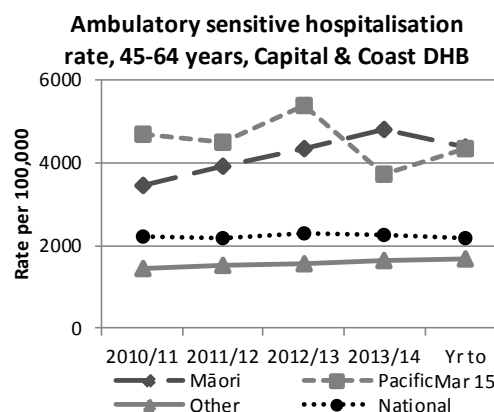
This measure links to the Early Detection & Management output class.



A reduction in ambulatory sensitive hospitalisations of adults (45-64)

Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.

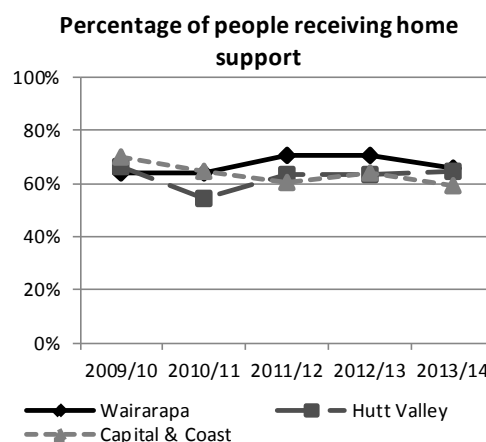
This measure links to the Prevention Services and Early Detection & Management output classes.



Maintain or increase the proportion of patients receiving home based support services of those 65+ who receive DHB funded home based support or aged residential care services

When people receive the adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities.

This measure links to the Rehabilitation & Support output class.



HEALTH SERVICES OUTCOME: QUALITY HOSPITAL CARE AND COMPLEX CARE FOR THOSE WHO NEED IT

What difference will we make for our population?

Improved patient-focused, clinically driven pathways will provide the flexibility for early intervention and planned readmission where clinically appropriate, and will support improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to establish more stable lives.

Overseas experience shows that systemic changes to the way care is offered to patients can lead to measurable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia, and hospital-acquired infections in patients.

Measures – The DHB measures progress through:

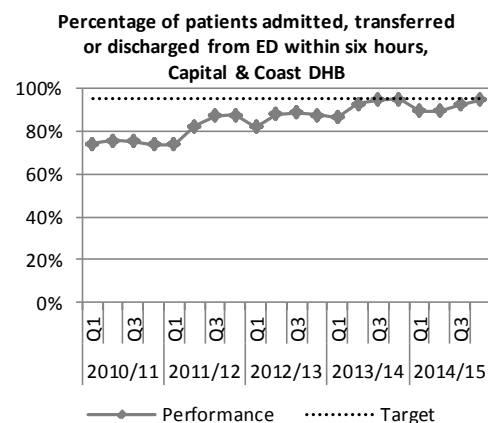
The percentage of patients admitted, transferred or discharged from the Emergency Department within six hours

Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through DHB services. It also demonstrates a commitment to addressing the needs of patients and valuing their time.

Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through management of acute demand in the community, improved capacity in ED and supported discharge into services in the community.

Our performance on the Shorter Stays in ED health target has increased by 20% since the target was introduced, and in quarter 4 of 2014/15 we met the target, with 95% of patients admitted, transferred, or discharged from ED within six hours.

This measure links to the Intensive Assessment & Treatment output class.



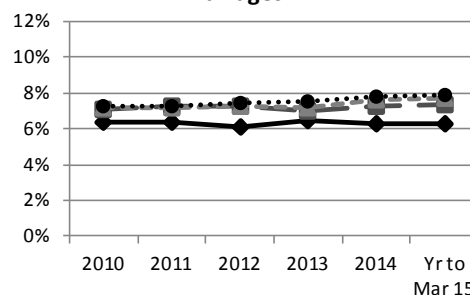
A reduction in the standardised rate of acute readmissions within 28 days, Total & 75+

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

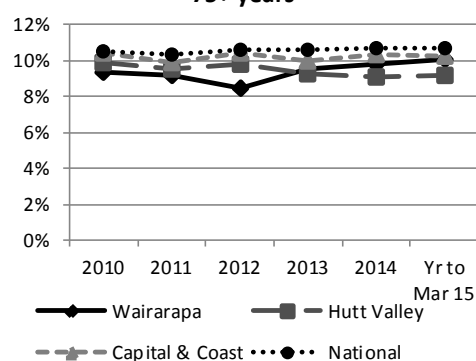
The standardised acute readmission rate has remained at about 6.5% for Wairarapa and 7% for Hutt Valley and Capital & Coast over the last five years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased (see Statement of Performance),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

This measure links to the Intensive Assessment & Treatment output class.

Standardised acute readmission rate, all ages



Standardised acute readmission rate, 75+ years



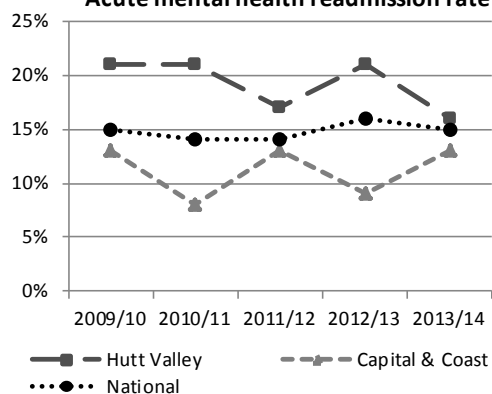
A reduction in the rate of acute readmissions within 28 days to Mental Health Services

Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital.

This indicator helps identify if investigation into the functioning of the system is needed to determine any areas in which it might be breaking down. Improved performance on this measure demonstrates better whole of system performance.

This measure links to the Intensive Assessment & Treatment output class.

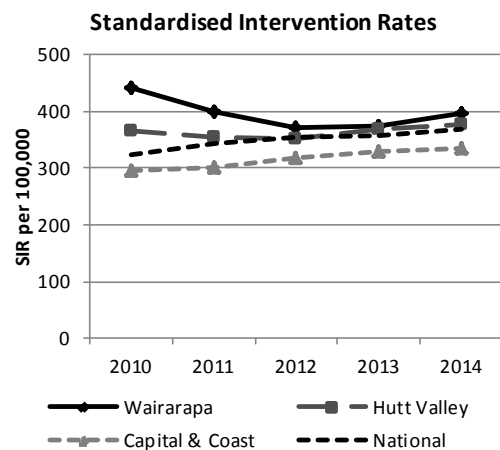
Acute mental health readmission rate



Maintain or increase standardised intervention rates (SIR) for elective services

One of the areas of focus for elective services is the level of service being provided to the DHB's population (as measured by Standardised Intervention Rates), and the level of service being provided for identified key conditions, including cardiac procedures, major joint replacement and cataract procedures. Capital & Coast DHB's standardised intervention rate is lower than the national average.

This measure links to the Intensive Assessment & Treatment output class.



STATEMENT OF PERFORMANCE

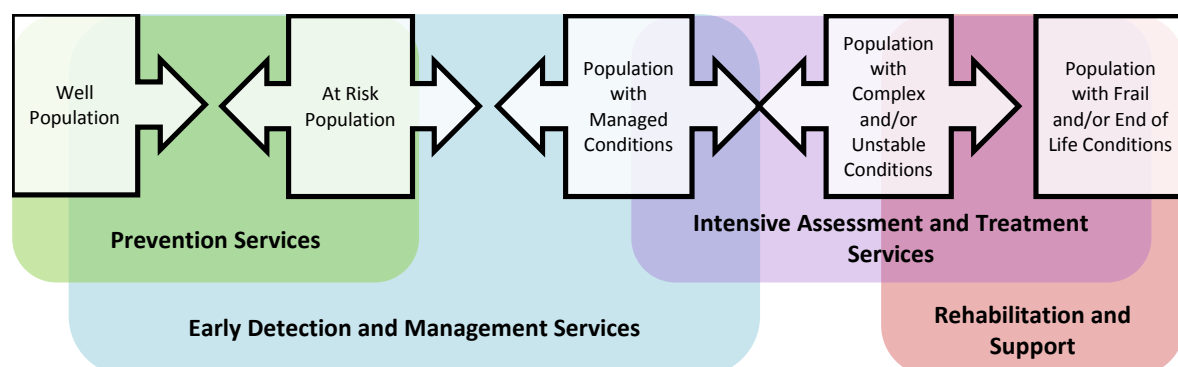
OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

In the Statement of Performance, we evaluate our performance (outputs) against the targets that we set in the Statement of Performance Expectations in our 2014/15 Annual Plan. We choose outputs that will make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking to achieve over the longer term. These outputs also cover areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. The outputs here provide a picture of the health service activity across the whole of the Capital & Coast health system.

Our four Output Classes and their related services are:

1. Prevention Services
 - Health promotion and public health services
 - Immunisation services
 - Smoking cessation services
 - Screening services
2. Early Detection and Management Services
 - Primary care (GP) services
 - Oral health services
3. Intensive Treatment and Assessment Services
 - Medical and surgical services
 - Cancer services
 - Mental health and addictions services
4. Rehabilitation and Support Services
 - Disability services
 - Health of older people services

Scope of DHB Operations – Output Classes in the Continuum of Care



VOTE HEALTH ESTIMATES OF APPROPRIATIONS

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

INTERPRETING OUR PERFORMANCE

Types of measures

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

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T

We have identified new measures in 2014/15 with a † symbol. These measures were introduced in the 2014/15 Annual Plan and did not appear in the 2013/14 Annual Report. Our 2013/14 performance has therefore not been audited by Audit New Zealand.

Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly. But, by standardising for age, we can see what the rates would have been if the two

populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

FINANCIAL PERFORMANCE (\$000S)

Revenue	2013/14 Actual	2014/15 Budget	2014/15 Actual
Prevention	8,991	7,786	7,399
Early Detection and Management	177,733	187,656	184,070
Intensive Assessment and Treatment	692,993	668,925	707,319
Rehabilitation and Support	95,940	113,449	97,439
Total	975,657	977,816	996,227
Expenditure	2013/14 Actual	2014/15 Budget	2014/15 Actual
Prevention	9,003	7,845	7,399
Early Detection and Management	177,741	188,923	184,070
Intensive Assessment and Treatment	698,828	670,904	711,313
Rehabilitation and Support	95,982	114,144	97,427
Total	981,554	981,816	1,000,209

OUTPUT CLASS 1: PREVENTION SERVICES

Description

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

Context

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. It has been estimated that 70% of health funding is spent on long-term conditions. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The majority of chronic conditions are preventable or could be better managed. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors. It is important to note that these avoidable risk factors and other determinants of health are influenced not just by what we do in our DHB, but also by wider health and social services and the social environment. These risk factors are preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. These prevention services also support people to address any risk factors that contribute to both acute events (e.g., alcohol-related injury) and the development of long-term conditions (e.g., obesity or diabetes). High health need and at-risk population groups (low socio-economic, Māori, and

Pacific) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Along with collaborative relationships with other state sector and community organisations and businesses, preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

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

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

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

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

How we measure the performance of our Prevention Services:

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Health promotion and public health services	The number of new client referrals to public health nurses in primary/intermediate schools ^{bc}	V	2013: 1,234	2014: 1,105 ^d	2014: 1,258	Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
	The percentage of infants breastfed at 6 months ^e	C	74% [†]	59% ^f	70%	Achieved
Immunisation services	Health Target: The percentage of eight month olds fully vaccinated	C	93%	95%	95%	Achieved
	The percentage of enrolled people over 65 years vaccinated against flu ^g	C	65%	70%	65%	Not Achieved
	High Needs		64%		61%	Not Achieved
	The percentage of Yr 7 children provided Boostrix vaccination in schools ^b	C	2013: 67%	2014: 70%	2014: 70%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose) ^b	C	2013: 64%	2014: ≥60% ^h	2014: 61%	Achieved
Smoking cessation services	Health Target (Better Help for Smokers to Quit – Hospital): The percentage of hospitalised smokers receiving advice and help to quit	C	92%	95%	87%	Not Achieved
	Health Target (Better Help for Smokers to Quit – Primary Care): The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking	C	72%	90%	88%	Not Achieved
Screening services	The percentage of eligible children receiving a Before School Check	C	91%	90%	85%	Not Achieved
	High Need		83%		87%	Not Achieved
	The percentage of eligible women (25-69) having cervical screening in the last 3 years ⁱ	C	79%	80%	80%	Achieved
	Māori		60%		63%	Not Achieved
	Pacific		62%		66%	Not Achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years ⁱ	C	69%	70%	70%	Achieved
	Māori		63%		64%	Not Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
	Pacific		64%		64%	Not Achieved

Comments on performance

Health promotion and public health services

Public health nurses continue to respond to the community's needs in primary and intermediate schools. Referrals to public health nurses are made by teachers, health professionals, social workers, and caregivers. The public health nurses make weekly visits to Decile 1-3 (students with lowest family income) schools and fortnightly visits to Decile 4-6 schools. The public health nurses also provide an email and phone service for Decile 7-10 (highest income) schools.

Immunisation services

Capital & Coast DHB achieved the eight month old immunisation Health Target. Primary Health Organisations (PHOs) are being supported and encouraged to implement initiatives to increase immunisation coverage. Immunisation education is provided for primary health care nurses and hospital staff that have immunisation responsibilities. Primary healthcare providers also receive a list of children who are overdue for immunisation so that they can follow up to ensure that the children receive their immunisations.

The influenza vaccination period was extended by the Ministry of Health in 2014/15 due to a prolonged flu season. As a result, we expect the percentage of enrolled people over 65 years vaccinated against flu to increase over the next quarter (September 2015). PHOs continue to support practices to provide influenza vaccination for at-risk patients.

The Regional Public Health Immunisation team work in schools ensures that HPV and Boostrix vaccinations are completed in a timely manner and according to all national protocols. The team met the targets for both vaccination programmes in the 2014 calendar year.

Smoking cessation services

Capital & Coast DHB did not achieve the Health Target for smoking cessation advice in hospital. To improve performance on this target, the hospital has implemented a more consistent approach to documentation of smoking status and advice given, and have made changes to patient discharge summaries.

Capital & Coast DHB did not achieve the Health Target for smoking cessation advice in primary care. However, PHOs have made significant progress on this target, with performance increasing by 16% between 2013/14 and 2014/15. Compass Health PHO is providing clinical leadership and support for all PHOs and primary care services in Capital & Coast DHB.

Screening services

Capital & Coast DHB was close to achieving the B4School check targets. In 2014/15 there was increased sharing of information between GP practices, Māori health providers and Plunket. There has been increased utilisation of the Plunket mobile van together with the partnership of the

Hearing and Vision team, targeting children living in the most deprived areas. This 'One Stop' service ensures a complete assessment is conducted seamlessly with children and whānau. A Working Group will continue to meet regularly and support the programme in finding new and more effective and efficient ways of working across the community, continue to improve performance, and ultimately improve outcomes for all children.

Capital & Coast DHB achieved the target for breast and cervical screening for the total population, but Māori and Pacific screening rates did not meet the target. To improve our screening rates, the screening service has implemented data matching with primary care, 'priority' women days for Māori, Pacific, and women living in the most deprived areas, and monthly Saturday clinics for women who cannot attend during working hours. Mobile rosters have changed so that screening is more accessible to priority women. Independent service providers, such as Mana Wahine, work to locate and assist priority women to engage with screening services.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT

Description

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

Context

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

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health

checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.

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

How we measure the performance of our Early Detection & Management Services:

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Primary care services	The number of DHB-domiciled population enrolled in a PHO	V	280,161	283,078	281,844	Not Achieved
	Māori		28,834	29,779	29,112	Not Achieved
	Pacific		21,882 [†]	22,047	21,758	Not Achieved
	The percentage of the PHO enrolled population enrolled in Care Plus	C	6%	≥5%	4.5%	Not Achieved
	The ratio of nurse and GP visits by high need patients versus non high need patients ^j	C	1.14	≥1.10	1.12	Achieved
	Health Target: The percentage of the eligible population assessed for CVD risk in the last five years	C	85%	90%	89%	Not Achieved
	Local Measure: The percentage of practices with a diabetes care improvement plan	Q	62%	100%	97%	Not Achieved
Oral health services	The percentage of children under 5 years enrolled in DHB funded dental services ^k	C	2013: 42%	2014: 85% 2015: 85%	2014: 59%	Not Achieved
	The percentage of adolescents accessing DHB funded dental services	C	2013: 73%	2014: 85% 2015: 85%	2014: 74%	Not Achieved

Comments on performance

Primary care services

Capital & Coast DHB did not meet the target for the number of DHB-domiciled population enrolled in a PHO. These targets were set with population projections based on the 2006 Census, which

overestimated the 2014/15 population by approximately 5,000 people in Capital & Coast DHB compared to the latest projections from the 2013 Census. Enrolment rates are 94% for the total population, 88% for Māori, and 98% for Pacific.

The target ratio of nurse and GP visits by high need patients versus non high need patients was not achieved. The ratio indicates that 'high need' patients (Māori, Pacific, and those living in the most deprived areas) are visiting primary care services more than non-high need patients, which is good. During 2014/2015, 'very low cost access' funding was provided to practices for which at least half of the enrolled population was identified as 'high need'. This funding allowed practices to have low consultation fees, which reduced the financial barriers to accessing primary health care for the 'high need' population.

All but two general practices in Capital & Coast DHB have implemented diabetes care improvement plans. These plans are developed and implemented by general practices to provide quality care and management for enrolled patients with diabetes.

Oral health services

The preschool oral health enrolment target in 2014/15 was not achieved. However, the Oral Health Service has made significant progress on this target, with performance increasing by 17% between 2013/14 and 2014/15. Initiatives to increase pre-school enrolments include data-matching with primary care, enrolling newborns, collaboration with Well Child Tamariki Ora providers, working with early childhood centres, and developing internal IT and administration systems. In addition, work on the Porirua Social Sector Trial by Compass Health PHO has contributed to the increase in enrolments.

Capital & Coast DHB did not achieve the target for the percentage of adolescents accessing DHB funded dental services. To improve performance, the Oral Health Service is working with contracted Private Dental Practices to identify areas with low access rates and ways to improve utilisation. There are also sub-regional initiatives to raise awareness of 'FREE dental care for under 18 year olds'.

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT

Description

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

Context

Equitable and timely access to intensive assessment and treatment can significantly improve a person's quality of life, either through early intervention (i.e., removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e., major joint replacements to relieve pain and improve activity).

Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

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

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

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

How we measure the performance of our Intensive Assessment & Treatment Services:

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Medical and surgical services	Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	92%	95%	91%	Not Achieved
	Health Target: The number of surgical elective discharges	V	8,734	8,884	8,969	Achieved
	The standardised average length of stay for inpatients (days) ^l - Acute	T	3.62	3.81	3.49	Achieved
	Elective		3.17	3.18	3.12	Achieved
Quality measures	The percentage of "DNA" (did not attend) appointments for outpatient first specialist assessments	Q	6% [†]	6%^m	5%	Achieved
	Māori		12% [†]		11%	Not Achieved
	Pacific		13% [†]		11%	Not Achieved
	The number of Hospital Acquired Pressure Injuries ⁿ	Q	61 [†]	0	71	Not Achieved
	The number of central line acquired bacteraemia infections in ICU	Q	2	0	4	Not Achieved
	The rate of inpatient falls causing harm per 1000 bed days	Q	1.25 ^o	≤1.37	1.10	Achieved
	The rate of identified medication errors per 1000 bed days	Q	0.93 ^o	≤0.86	0.94	Not Achieved
Cancer services	Shorter Waits for Cancer Treatment – The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	100%	100%	Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
	Health Target: Faster Cancer Treatment – The percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks ^p	T	New measure	85% by June 2016	81%	Not Achieved
Mental health and addictions services	The number of people accessing secondary mental health services	V	9,785 [†]	10,000	9,995	Not Achieved
	Māori		2,072 [†]	2,174	2,118	Not Achieved
	Pacific		741 [†]	716	749	Achieved
	Percentage of people admitted to an acute mental health inpatient service who were seen by mental health community team in the 7 days prior to the day of admission	Q	63% [†]	75%	54%	Not Achieved
	Percentage of people discharged from an acute mental health inpatient service who were seen by mental health community team in the 7 days following the day of discharge	Q	70% [†]	90%	59%	Not Achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services who are seen within eight weeks ^q	T	85% [†]	95%	86%	Not Achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services who are seen within eight weeks	T	74% [†]	95%	55%	Not Achieved

Comments on performance

Medical and surgical services

Capital & Coast DHB did not achieve the ED Health Target in 2014/15. A severe and drawn-out winter season in 2014 impacted on bed capacity and the hospital's ability to admit patients in a timely manner. The target was consistently met for patients who were not admitted. The number and

proportion of patients requiring admission is increasing, and 35% of all ED visits required admission to hospital in 2014/15. Work continues to improve the models of care in specialty areas.

Quality measures

Capital & Coast DHB continues to provide high quality and timely care to patients. In 2013 the Health Quality & Safety Commission (HQSC) introduced a campaign that focusses on improving patient safety in medications, falls, health acquired infections, and perioperative harm. Our fall rates are lower than they were in 2013/14. Going forward, the Pressure Injury Working Group is working on 'care process auditing' (used for falls in 2014/15) and a pressure injury sticker to reinforce best practice.

All of the central line acquired bacteraemia (CLAB) infections in ICU were reviewed and were caused by prolonged insertion and complex patients. Adherence to best practice guidelines for the insertion of the central line and the maintenance of the line once inserted has not decreased.

With the introduction of new auditing processes, we can assess where to improve medication errors, and the Clinical Practice Committee will be focussing on this piece of work in 2015/16.

Cancer services

Capital & Coast DHB continue to meet the Shorter Waits for Cancer Treatment target. We are improving patient flow processes and are confident of achieving the Faster Cancer Treatment Health Target by June 2016.

Mental health and addictions services

Capital & Coast DHB did not meet the targets for the number of people accessing secondary mental health services. These targets were set with population projections based on the 2006 Census, which overestimated the 2014/15 population by approximately 5,000 people in Capital & Coast DHB compared to the latest projections from the 2013 Census.

To increase the percentage of people who are seen pre- and post- mental health inpatient admission, Capital & Coast DHB has made improvements to data collection and business processes. The percentage has since increased to 75% for the year-to-date July 2015. In addition, to improve follow-up care after an inpatient admission, the DHB has implemented comprehensive inpatient client reviews that include community teams, and weekly conferences led by community and inpatient clinicians.

OUTPUT CLASS 4: REHABILITATION AND SUPPORT

Description

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services

may be provided at home, as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Context

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions. As a result, effective support services will help to reduce demand for acute services and improve access to other services and interventions. Support services will have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. It will also free up resources for investment into early intervention, health promotion, and prevention services that will help people stay healthier for longer. Our DHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that our DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Outputs

Health of older people services: These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports.

How we measure the performance of our Rehabilitation & Support Services:

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Health of older people services	The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	Q	100%	≥95%	100%	Achieved
	The number of InterRAI assessments	V	5,912	5,741 ^r	3,163 ^s	Not Achieved
	The number of people receiving home and community support services	V	3,000	3,004 ^r	3,139	Achieved
	The number of days of Short-term Care (respite beddays, day respite, and community day activity support) ^t	V	19,068 [†]	19,154 ^r	19,463	Achieved
	The number of subsidised aged residential care bed days	V	551,067	557,434 ^r	564,146	Achieved
	The percentage of residential care providers meeting three year certification standards ^u	Q	94%	≥91%	94%	Achieved
Disability services	The number of Disability Forum meetings (sub-regional and local)	V	2	2	4	Achieved

Comments on performance

Health of older people services

Capital & Coast DHB continues to exceed the target for the percentage of older people with long-term support needs who have had an interRAI assessment. The actual number of assessments is dependent on the needs of the older population so this measure is descriptive rather than aspirational.

The number of people receiving home and community support services has remained stable. The number of respite days provided to support carers continues to grow. The increase in residential bed days is being monitored.

Nine residential care providers (27%) in Capital & Coast DHB have four year certification, 22 have three year certification, and the remaining two facilities have two year certification.

Disability services

Our priority in 2014/15 has been engagement with the local community. Capital & Coast DHB was part of four sub-regional and local Disability Forum meetings in 2014/15. This engagement has helped us to improve the partnership between staff and communities in service development and planning.

^a ABC for Smoking Cessation Quick Reference Card, PHARMAC

^b To provide an overview of public health services in the sub-region, this Annual Report presents a subset of the activities that Regional Public Health undertook in 2014/15. Please refer to the 2014/15 Regional Public Health Annual Report at www.rph.org.nz for a more comprehensive description of Regional Public Health's activities in the 2014/15 year.

^c This measure is aligned with the school (calendar) year rather than financial year.

^d Target is estimated volumes, rather than a true 'target'.

^e Plunket data only, for exclusive, full and partial breastfeeding.

^f National target

^g Baseline as at December 2012

^h Target aligned to national target

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

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

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

^l This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2015 (2014/15 performance).

^m This is a long-term target as this measure is one of the "headline indicators" in the DHBs' equity report.

ⁿ This measure has been updated from 'The number of hospital acquired pressure sores and ulcers' to reflect new terminology. The methodology for the measure remains the same.

^o Note that the 2013/14 falls and medication error rates in the 2013/14 Annual Report incorrectly omitted data from one ward. The rates shown here have been corrected to include all wards.

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

^q This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2015 (2014/15 performance).

^r This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.

^s Note that there have been changes in the recording and reporting of the number of InterRAI assessments. The methodology for 2014/15 gives an underestimate of performance compared to the methodology for the target.

^t Only includes volume paid as fee for service and excludes bulk-funded dedicated respite beds (6 Beds in Capital & Coast).

^u Excluding new providers and facilities as these are required to have a one year certification.

[†] These measures were introduced in 2014/15 and did not appear in the 2013/14 Annual Report. Our 2013/14 performance has therefore not been audited by Audit New Zealand.

STATEMENT OF RESPONSIBILITY

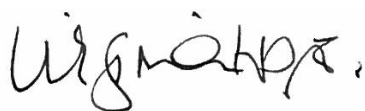
For the year ended 30 June 2015:

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

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

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

In the opinion of the Board and Management of Capital & Coast District Health Board, the annual Financial Statements and the Statement of Performance for the year ended 30 June 2015, fairly reflect the financial position and operations of Capital & Coast District Health Board.



Dr Virginia Hope MNZM - Board Chair
30 October 2015



Debbie Chin - Chief Executive
30 October 2015



Roger Jarrold - Finance, Risk and Audit Committee Chair
30 October 2015



Tony Hickmott - Chief Financial Officer
30 October 2015

INDEPENDENT AUDITOR'S REPORT

To the readers of the Capital and Coast District Health Board's financial statements and performance information for the year ended 30 June 2015

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

We have audited:

- the financial statements of the Health Board on pages 56 to 100, that comprise the statement of financial position, statement of contingent liabilities and assets, and statement of commitments as at 30 June 2015, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 16 to 51.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board:

- present fairly, in all material respects:
 - its financial position as at 30 June 2015; and
 - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

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

Some significant performance measures of the Health Board, (including some of the national health targets, rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

Qualified opinion on the performance information about "better help for smokers to quit – hospital" in the prior year

In respect of the 30 June 2014 comparative information only, our audit of the reported performance for national health target "better help for smokers to quit – hospital" identified errors which indicated that the report results for the year ended 30 June 2014 are likely to be materially overstated. We were unable to quantify the extent of any overstatement, and our audit opinion on the statement of service performance for the year ended 30 June 2014 was modified accordingly.

The issues which resulted in errors in the performance information for the national health target "better help for smokers to quit – hospital" have been resolved for the 30 June 2015 year. However, the issues cannot be resolved for the 30 June 2014 year, which means that the Health Board's performance

information reported in the statement of performance for the 30 June 2015 year, may not be directly comparable to the 30 June 2014 performance information.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 16 to 51:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, including:
 - for each class of reportable outputs:
 - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
 - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
 - what has been achieved with the appropriation; and
 - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2015. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board's financial statements and performance information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

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

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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



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

FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2015

in thousands of New Zealand Dollars

	Note	2015 Actual	Original 2015 Budget	Revised 2015 Budget	2014 Actual
Revenue	<u>1</u>	996,227	985,016	977,816	975,657
Total revenue		996,227	985,016	977,816	975,657
Expenditure					
Clinical supplies		112,656	105,094	105,094	110,685
Employee benefit costs	<u>2</u>	413,360	408,303	407,803	409,095
Infrastructure and non-clinical expenses		52,754	47,115	47,115	55,540
Other operating expenses	<u>3</u>	4,137	4,866	4,866	4,717
Outsourced services		29,060	26,342	25,642	20,693
Payments to other district health boards		67,682	70,790	70,790	67,215
Payments to non-health board providers		258,256	259,095	257,095	253,952
Capital charge	<u>4</u>	8,382	8,483	8,483	8,578
Finance costs	<u>5</u>	16,147	16,683	16,683	16,573
Depreciation and amortisation expense	<u>6,7</u>	37,775	38,245	38,245	34,508
Total expenditure		1,000,209	985,016	981,816	981,556
Surplus/(deficit)		(3,982)	-	(4,000)	(5,899)
Other comprehensive revenue and expense		-	-	-	-
Total comprehensive revenue and expense		(3,982)	-	(4,000)	(5,899)

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

Explanations of significant variances against budget are detailed in note 24.

The 'Original 2015 Budget' column relates to the initial break-even Budget agreed with the Ministry of Health and tabled in Parliament.

The 'Revised 2015 Budget' column reflects the latest Budget numbers with an agreed deficit of \$4m.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2015

in thousands of New Zealand Dollars

	Note	2015 Actual	Original 2015 Budget	Revised 2015 Budget	2014 Actual
Balance at 1 July		115,165	108,049	108,049	118,548
Total comprehensive revenue and expense for the year		(3,982)	-	(4,000)	(5,899)
Owner transactions					
Contribution from the Crown		5,600	-	8,000	6,000
Repayment of equity		(3,484)	(3,483)	(3,483)	(3,484)
Balance at 30 June	18	113,299	104,566	108,566	115,165

The accompanying statement of accounting policies and notes form part of these financial statements. Explanations of significant variances against budget are detailed in note 24.

The 'Original 2015 Budget' column relates to the initial break-even Budget agreed with the Ministry of Health and tabled in Parliament.

The 'Revised 2015 Budget' column reflects the latest Budget numbers with an agreed deficit of \$4m.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2015

in thousands of New Zealand Dollars

	Note	2015 Actual	Original 2015 Budget	Revised 2015 Budget	2014 Actual
Assets					
Current assets					
Cash and cash equivalents	<u>11</u>	19,101	6,471	6,471	12,097
Trade and other receivables	<u>10</u>	45,858	43,933	43,933	44,145
Inventories	<u>8</u>	7,472	8,184	8,184	8,184
Trust and special funds	<u>12</u>	7,619	7,116	7,116	7,116
Total current assets		80,050	65,704	65,704	71,542
Non-current assets					
Property, plant and equipment	<u>6</u>	488,857	506,697	514,697	514,102
Intangible assets	<u>7</u>	22,302	8,609	8,609	14,952
Investments in joint ventures	<u>9</u>	-	-	-	3,955
Total non-current assets		511,159	515,306	523,306	533,009
Total assets		591,209	581,010	589,010	604,551
Equity					
Crown equity	18	422,803	425,174	433,174	420,687
Revaluation reserve	18	23,606	23,606	23,606	23,606
Accumulated comprehensive revenue and expense	18	(333,110)	(336,924)	(340,924)	(329,128)
Total equity		113,299	111,856	115,856	115,165
Liabilities					
Current liabilities					
Trade and other payables	<u>16</u>	68,153	59,339	63,339	81,580
Borrowings	<u>13</u>	34,326	1,248	1,248	71,248
Employee entitlements	<u>14</u>	61,356	61,220	61,220	59,859
Provisions	<u>15</u>	363	2,213	2,213	350
Patient and restricted funds	<u>17</u>	157	-	-	174
Total current liabilities		164,355	124,020	128,020	213,211
Non-current liabilities					
Borrowings	<u>13</u>	305,954	339,107	339,107	269,107
Employee entitlements	<u>14</u>	7,309	5,775	5,775	6,787
Provisions	<u>15</u>	292	252	252	281
Total non-current liabilities		313,555	345,134	345,134	276,175
Total liabilities		477,910	469,154	473,154	489,386
Total equity and liabilities		591,209	589,010	589,010	604,551

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

Explanations of significant variances against budget are detailed in note 24.

The 'Original 2015 Budget' column relates to the initial break-even Budget agreed with the Ministry of Health and tabled in Parliament.

The 'Revised 2015 Budget' column reflects the latest Budget numbers with an agreed deficit of \$4m.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2015

in thousands of New Zealand Dollars

	Note	2015 Actual	Original 2015 Budget	Revised 2015 Budget	2014 Actual
Cash flows from operating activities					
Cash receipts from Ministry of Health and other Crown Entities		978,390	960,332	960,332	955,127
Other receipts		17,752	19,526	12,026	17,790
Cash paid to suppliers		(538,659)	(536,109)	(529,410)	(495,203)
Cash paid to employees		(411,340)	(408,303)	(407,803)	(407,935)
<i>Cash generated from operations</i>		46,143	35,446	35,145	69,779
Goods and Services Tax and other taxes (NET) (a)		2,374	-	-	494
Capital charge paid		(12,579)	(8,928)	(8,928)	(8,928)
Net cash flows from operating activities	11	35,938	26,518	26,217	61,345
Cash flows from investing activities					
Interest received		2,167	907	1,208	1,131
Acquisition of property, plant and equipment		(9,644)	(7,325)	(15,325)	(19,620)
Acquisition of intangible assets		(6,309)	(12,675)	(12,675)	(6,068)
Investment in joint venture		-	-	-	(2,021)
Appropriation from trust and special funds (b)		(521)	-	-	(146)
Net cash flows from investing activities		(14,307)	(19,093)	(26,792)	(26,724)
Cash flows from financing activities					
Contribution from the Crown		5,600	-	8,000	6,000
Borrowings raised		-	-	-	901
Repayment of borrowings		(84)	-	-	(79)
Repayment of equity		(3,484)	(3,484)	(3,484)	(3,484)
Repayment of finance leases		9	-	-	(253)
Interest paid		(16,668)	(16,683)	(16,683)	(16,573)
Net cash flows from financing activities		(14,627)	(20,167)	(12,167)	(13,488)
Net increase/(decrease) in cash and cash equivalents		7,004	(12,742)	(12,742)	21,133
Cash and cash equivalents at beginning of year		12,097	19,213	19,213	(9,036)
Cash and cash equivalents at end of year	11	19,101	6,471	6,471	12,097

(b) 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.

(c) 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 24.

The 'Original 2015 Budget' column relates to the initial break-even Budget agreed with the Ministry of Health and tabled in Parliament.

The 'Revised 2015 Budget' column reflects the latest Budget numbers with an agreed deficit of \$4m.

STATEMENT OF CONTINGENT LIABILITIES AND ASSETS

As at 30 June 2015

in thousands of New Zealand Dollars

	Note	2015 Actual	2014 Actual
Legal proceedings against the DHB		230	200
Other contractual matters		474	125
		704	325

The DHB has been notified of 16 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2015 (2014: 8).

The claims are both patient and employment related. The DHB is contesting the claims, and whilst there is an element of uncertainty as to what the courts may award, the DHB believes that any damages awarded in relation to patient claims will be met by its insurers.

The DHB has no contingent assets (2014: \$nil).

STATEMENT OF COMMITMENTS

As at 30 June 2015

in thousands of New Zealand Dollars

	Note	2015 Actual	2014 Actual
Buildings		13,933	975
Leasehold improvements		306	570
Plant & equipment		1,302	2,584
Intangible assets		688	3,035
Capital commitments		16,229	7,164
Non-cancellable commitments – operating lease commitments			
Not more than one year		2,340	2,819
One to two years		1,728	2,055
Two to five years		1,771	1,675
Over five years		785	-
		6,624	6,549

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Statement of Accounting Policies

Reporting entity

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

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

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

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, 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.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new PBE accounting standards.

Changes in accounting policies

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

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB are as listed below. The DHB has not yet assessed the effect of the new standards and expects it will not be early adopted.

- In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. The DHB has applied these standards in preparing the 30 June 2015 financial statements.

Basis of preparation

The financial statements for the year ended 30 June 2015 were approved by the Board on 30 October 2015.

The financial statements have been prepared for the period 1 July 2014 to 30 June 2015. Comparative figures and balances relate to the period 1 July 2013 to 30 June 2014.

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.

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

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 2014/15 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 22 October 2015 from the Ministers of Health and Finance, which states that deficit support will be provided where necessary to maintain viability.

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

Operating and cash flow forecasts

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

Borrowing covenants and forecast borrowing requirements

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

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

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

Joint ventures

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

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

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

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.

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

Addition to property, plant and equipment

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

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

Disposal of property, plant and equipment

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

Leased assets

Finance Leases

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

Operating Lease

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

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

Subsequent costs

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Depreciation

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

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

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

The residual value of assets is reassessed annually.

Leasehold improvements are depreciated over their lease term.

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

Intangible assets

Research and development

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

Other intangibles

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
Software	3 years
Licences	5 years

Financial instruments

Non-derivative financial instruments

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

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Trade and other receivables

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

Inventories

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

Cash and cash equivalents

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

Impairment

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

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

Calculation of recoverable amount

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

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

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

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

Reversals of impairment

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

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

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

Interest bearing borrowings

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Employee benefits

Short term employee entitlements

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

Defined contribution plans

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

Defined benefit plan

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

Long service leave, sabbatical leave, sick leave, medical education leave and retirement gratuities

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

Annual leave

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

Provisions

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

Restructuring

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

Trade and other payables

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

Derivative financial instruments

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

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

The fair value of interest rate swaps is the estimated amount that the DHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Hedging: cash flow hedges

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

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

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

Income tax

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

Goods and services tax

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

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

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

Borrowing costs

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

Capital charge

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

Revenue

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

Crown funding

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

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

Interest income

Interest income is recognised using the effective interest rate method.

Rental income

Rental income 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 income. Such assets are recognised as income 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 service performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2015, indirect costs accounted for 1.46% of the DHB's total costs (2014: 1.54%).

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

Accounting estimates and judgements

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

Key sources of estimated uncertainty

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

Property, plant and equipment

At each balance date the DHB reviews the useful lives and residual values of its property plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property plant and equipment requires the DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of comprehensive revenue and expense, and carrying amount of the asset in the statement of financial position. The DHB minimises the risk of estimation uncertainty by:

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

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

Retirement, long service leave, sick leave and continuing education

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

Critical accounting judgements in applying the DHB's accounting policies

Leases classification

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

Finance and operating leases

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

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

1 REVENUE

	2015 Actual	2014 Actual
Ministry of Health contract funding	754,035	748,225
Other government	20,332	17,153
Inter district flows (other DHBs)	201,501	192,481
Non government & crown agency sourced	17,551	16,035
Interest income	2,514	1,131
Income from donations	294	632
	996,227	975,657

2 EMPLOYEE BENEFIT COSTS

	2015 Actual	2014 Actual
Direct staff costs (excluding increases in employee benefit provisions)	384,174	383,772
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	14,354	12,239
Contributions to defined contribution plans	12,070	11,391
Increase/(decrease) in employee benefit provisions	2,762	1,693
	413,360	409,095

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

3 OTHER OPERATING EXPENSES

	Note	2015 Actual	2014 Actual
Impairment of trade receivables (bad debts)		-	142
Increase /(decrease) in provision of trade receivables (doubtful debts)	<u>10</u>	122	740
(Gain)/loss on disposal of property, plant and equipment		29	97
Audit fees for financial statements audit		207	194
Fees for other assurance services		6	75
Board member fees	<u>21</u>	370	362
Operating lease expense		2,744	2,644
Other operating expenses		659	463
		4,137	4,717

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

4 CAPITAL CHARGE

	2015 Actual	2014 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 2015 was 8 per cent (2014: 8 per cent)	8,382	8,578

5 FINANCE COSTS

	2015 Actual	2014 Actual
Interest on term borrowings	16,147	16,556
Interest on finance leases	-	17
	16,147	16,573

NOTES TO THE FINANCIAL STATEMENTS

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 2013	25,705	445,253	276	81,435	25,279	577,948
Additions	-	12,564	348	3,790	1,407	18,109
Disposals	-	-	-	(243)	(14)	(257)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2014	25,705	457,817	624	84,982	26,672	595,800
Balance at 1 July 2014	25,705	457,817	624	84,982	26,672	595,800
Additions	-	4,730	151	3,311	1,132	9,324
Disposals	-	-	(11)	(135)	(40)	(186)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2015	25,705	462,547	764	88,158	27,764	604,938
Depreciation and impairment losses						
Balance at 1 July 2013	-	(1,937)	(232)	(37,328)	(14,880)	(54,377)
Depreciation charge for the year	-	(21,298)	(15)	(8,521)	(3,004)	(32,838)
Impairment losses	-	-	-	-	-	-
Disposals	-	-	-	140	-	140
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2014	-	(23,235)	(247)	(45,709)	(17,884)	(87,075)

NOTES TO THE FINANCIAL STATEMENTS

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 2014	-	(23,235)	(247)	(45,709)	(17,884)	(87,075)
Depreciation charge for the year	-	(22,635)	(65)	(9,470)	(3,001)	(35,171)
Impairment losses	-	-	-	-	-	-
Disposals	-	-	11	68	40	119
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2015	-	(45,870)	(301)	(55,111)	(20,845)	(122,127)
Carrying amounts						
At 1 July 2013	25,705	443,316	44	44,107	10,399	523,571
At 30 June 2014	25,705	434,582	377	39,273	8,788	508,725
At 1 July 2014	25,705	434,582	377	39,273	8,788	508,725
At 30 June 2015	25,705	416,677	463	33,047	6,919	482,811

	Freehold land	Freehold buildings	Leasehold Improvements	Plant & Equipment	Furniture & Fittings	Total
Work in progress						
Balance at 1 July 2013	-	3,257	78	352	1,865	5,552
Additions	-	13,289	472	3,833	350	17,944
Transfer from WIP	-	(12,564)	(348)	(3,800)	(1,407)	(18,119)
Balance at 30 June 2014	-	3,982	202	385	808	5,377
Balance at 1 July 2014	-	3,982	202	385	808	5,377
Additions	-	5,789	132	3,337	-	9,258
Transfer from WIP	-	(4,733)	(141)	(3,073)	(642)	(8,589)
Balance at 30 June 2015	-	5,038	193	649	166	6,046

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

Revaluation

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

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

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

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

Buildings revaluation recognised in statement of comprehensive revenue and expense

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

The initial revaluation loss on buildings as at 30 June 2002 of \$65.9m was recognised in the statement of comprehensive revenue and expense. PBE IPSAS 17 states that any subsequent revaluation increase in buildings shall be recognised in the statement of comprehensive revenue and expense to the extent that it reverses a revaluation decrease, of the same asset, previously recognised in the statement of comprehensive revenue and expense. As at 30 June 2015 net revaluation losses of \$0.05m are carried forward to future years.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2015 was \$16.8m (2014: \$16m).

Restrictions

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

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

Leased assets

The net carrying amount of property, plant and equipment held under finance leases is \$nil. (2014:\$0.007m).

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

7 INTANGIBLE ASSETS

	Software	FPSC Shared Services Rights	Licences	Total
Cost				
Balance at 1 July 2013	10,617	2,637	2,464	15,718
Additions	3,513	2,452	103	6,068
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2014	14,130	5,089	2,567	21,786
Balance at 1 July 2014	14,130	5,089	2,567	21,786
Additions	6,209	1,378	280	7,867
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2015	20,339	6,467	2,847	29,653
Amortisation and impairment losses				
Balance at 1 July 2013	(8,443)	-	(1,357)	(9,800)
Amortisation charge for the year	(1,306)	-	(364)	(1,670)
Impairment losses	-	-	-	-
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2014	(9,749)	-	(1,721)	(11,470)
Balance at 1 July 2014	(9,749)	-	(1,721)	(11,470)
Amortisation charge for the year	(2,161)	-	(443)	(2,604)
Impairment losses	-	-	-	-
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2015	(11,910)	-	(2,164)	(14,074)
Carrying amounts				
At 1 July 2013	2,174	2,637	1,107	5,918
At 30 June 2014	4,381	5,089	846	10,316
At 1 July 2014	4,381	5,089	846	10,316
At 30 June 2015	8,429	6,467	683	15,579

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

7 INTANGIBLE ASSETS (CONTINUED)

	Software	Licences	CRTAS	Total
Work in progress				
Balance at 1 July 2013	2,856	75	-	2,931
Additions	5,289	308	-	5,597
Transfer from WIP	(3,788)	(103)	-	(3,891)
Balance at 30 June 2014	4,357	280	-	4,637
Balance at 1 July 2014	4,357	280	-	4,637
Additions	3,713	-	4,862	8,575
Transfer from WIP	(6,209)	(280)	-	(6,489)
Balance at 30 June 2015	1,861	-	4,862	6,723

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

HBL

Health Benefits Limited (HBL) was established in July 2010. HBL is undertaking a Finance, Procurement and Supply Chain (FPSC) shared services project aimed at reducing costs in administrative support and procurement for the public health sector. The FPSC project is to be funded by the 20 DHBs across the country who will be the beneficiaries of these savings. As at 30 June 2015, the DHB has incurred \$6.47m as its share of the project. This funding represents an intangible asset and gives the DHB the right to access shared services.

It was announced that HBL will wind down in June 2015 with its assets and liabilities being transferred to a new company - New Zealand Health Partnerships (NZHP). Each of the 20 DHBs will obtain a direct interest in NZHP based on their proportional contribution to the establishment of the FPSC shared services.

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

Central Region Information Systems Plan (CRISP)

CRISP 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 CRISP 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 CRISP assets and services was amended on 1 December 2014 to transfer the ownership of CRISP assets to the DHBs jointly. As at 30 June 2015, CCDHB had contributed \$4.862m towards capital expenditure which has been recognised as Work in Progress (WIP) in respect of intangible assets.

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

8 INVENTORIES

	2015 Actual	2014 Actual
Pharmaceuticals	1,682	1,828
Surgical & medical supplies	5,631	5,805
Other supplies	159	551
	7,472	8,184

The amount of inventories recognised as an expense during the year ended 30 June 2015 was \$53.0m (2014: \$52.3m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to \$nil (2014: \$nil). There have been no reversals of write-downs.

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

9 INVESTMENTS IN JOINT VENTURES

Carrying amount of investments in joint ventures

	2015 Actual	2014 Actual
Uncalled ordinary share capital	-	-
Advance on redeemable preference shares	-	3,955
	-	3,955

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%)

	2015 Actual	2014 Actual
Non-current assets	67	1,937
Current assets	2,115	3,587
Non-current liabilities	-	-
Current liabilities	1,929	2,245
Net assets/(liabilities)	253	3,279
Income	5,693	4,044
Expense	5,667	3,993
	26	51

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

The DHB's share in contingent liabilities

Central Region TAS has no contingent liabilities. (2014: \$nil)

The DHB's share in commitments

The DHB share of Capital Commitments for CRTAS is \$nil (2014: \$0.5m).

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

10 TRADE AND OTHER RECEIVABLES

	2015 Actual	2014 Actual
Trade receivables from non-related parties	3,327	3,873
Ministry of Health receivables	14,718	14,816
Other DHB receivables	12,584	8,614
	30,629	27,303
Accrued income	10,997	12,409
Prepayments	4,232	4,433
Total receivables	45,858	44,145
Total receivables comprises:		
Receivable from the sale of goods and services (exchange transactions)	31,140	29,329
Receivable from Ministry funding (non-exchange transactions)	14,718	14,816

Trade receivables are shown net of a provision for doubtful debts amounting to \$0.6m (2014: \$0.8m)

The carrying value of receivables approximates their fair value.

As at 30 June 2015, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2015			2014		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	28,558	-	28,558	25,467	-	25,467
Past due 1-30 days	501	-	501	734	-	734
Past due 31-60 days	443	-	443	401	-	401
Past due 61-90 days	512	-	512	388	-	388
Past due > 91 days	1,220	605	615	1,132	819	313
Total	31,234	605	30,629	28,122	819	27,303

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

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

	2015 Actual	2014 Actual
Balance at 1 July 2014	819	489
Additional provisions made during the year	122	740
Provisions reversed during the year	-	-
Receivables written-off during period	(336)	(410)
Balance at 30 June 2015	605	819

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

11 CASH AND EQUIVALENTS

	2015 Actual	2014 Actual
Petty cash	13	13
Bank accounts	74	91
HBL call deposits	19,014	11,993
Cash and Cash equivalents	19,101	12,097

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 Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL 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 HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum working capital facility limit for CCDHB is \$51.9m. (2014:\$51.8m). The highest overdrawn bank balance during financial year 2014/15 was \$6m.(2014: \$31.4m).

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

	2015 Actual	2014 Actual
Surplus/(deficit) for the year	(3,982)	(5,899)
Add back non-cash items:		
Depreciation & amortisation	37,775	34,508
Revaluation gain	-	-
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	(461)	97
Interest income on financial assets	(2,514)	(1,131)
Add back items classified as financing activity:		
Interest expense on financial liabilities	16,148	16,573
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(1,713)	(1,380)
(Increase)/decrease in trust funds	(505)	-
(Increase)/decrease in inventories	712	(165)
Increase/(decrease) in trade and other payables	(11,565)	17,501
Increase/(decrease) in employee benefits	2,019	1,162
Increase/(decrease) in provisions	24	79
Net movement in working capital	(11,028)	17,197
Net cash inflow/(outflow) from operating activities	35,938	61,345

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

12 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.

	2015 Actual	2014 Actual
Non patient funds		
Balance at 1 July 2014	6,961	6,812
Monies received	1,987	2,128
Interest received	300	264
Payments made	(1,767)	(2,243)
Balance at 30 June 2015	7,481	6,961
Patient funds		
Balance at 1 July 2014	155	148
Monies received	177	172
Interest received	2	2
Payments made	(196)	(167)
Balance at 30 June 2015	138	155
Total trust and special funds	7,619	7,116

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

13 INTEREST BEARING LOANS AND BORROWINGS

	2015 Actual	2014 Actual
Current		
Secured Ministry of Health loans	34,000	71,000
Unsecured EECA loans	326	240
Finance leases	-	8
	34,326	71,248
Non-current		
Secured Ministry of Health loans	305,000	268,000
Unsecured EECA loans	954	1,107
	305,954	269,107

Secured loans

The DHB secured loans are from the Ministry of Health. The details of terms and conditions are as follows:

	2015 Actual	2014 Actual
Interest rate summary		
Ministry of Health	3.34% - 6.37%	2.74% - 7.13%
Health Benefit Limited	4.22% - 5.28%	4.55% - 5.07%
Finance leases	6.50%	6.50%
Energy Efficiency and Conservation Authority (EECA)	0%	0%
Loan repayable as follows:		
Within one year	34,326	71,240
One to two years	34,326	34,285
Two to five years	201,628	130,777
Later than five years	70,000	104,045
	340,280	340,347

NOTES TO THE FINANCIAL STATEMENTS

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13 INTEREST BEARING LOANS AND BORROWINGS (CONTINUED)

	2015 Actual	2014 Actual
Analysis of finance leases		
Minimum lease payments payable		
Within one year	-	9
One to two years	-	-
Two to five years	-	-
Later than five years	-	-
Total minimum lease payments	-	9
Future finance charges	-	(1)
Present value of minimum lease payments	-	8
Present value of minimum lease payments payable		
Within one year	-	8
One to two years	-	-
Two to five years	-	-
Later than five years	-	-
Total present value of minimum lease payments	-	8
Term loan facility limits		
Ministry of Health loan	339,000	339,000
Energy Efficiency and Conservation Authority (EECA)	1,280	1,347
	340,280	340,347

Security and terms

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

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

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

The total borrowings with the Debt Management Office is \$339m. Of this \$6m is maturing in November 2015 and \$28m is maturing in April 2016.

NOTES TO THE FINANCIAL STATEMENTS

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EMPLOYEE ENTITLEMENTS

	2015 Actual	2014 Actual
Current liabilities		
Liability for long service leave	1,702	2,010
Liability for sabbatical leave	268	290
Liability for retirement gratuities	1,030	1,000
Liability for annual leave	36,711	35,509
Liability for sick leave	1,096	1,727
Liability for continuing medical education leave and expenses	7,369	8,171
Salary and wages accrual	13,180	11,152
	61,356	59,859
Non-current liabilities		
Liability for long service leave	4,237	3,697
Liability for sabbatical leave	403	350
Liability for retirement gratuities	1,596	1,728
Liability for continuing medical education leave and expenses	1,073	1,012
	7,309	6,787

Defined benefit plans

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

Other employee entitlement liabilities

Liability for salaries and wages accrued is recognised as at current actual salaries.

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

Actuarial valuations have been obtained for the remaining liabilities. The actuarial valuations include a salary growth factor of 2.5%, (2014:3.5%) and a discount rate ranging from 2.97% to 4.29% (2014: 3.42% to 4.95%) 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.

NOTES TO THE FINANCIAL STATEMENTS

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15 PROVISION

	2015 Actual	2014 Actual
Current provisions		
ACC Partnership Programme	363	350
Non current provisions		
ACC Partnership Programme	292	281
ACC Partnership Programme	2015 Actual	2014 Actual
Undiscounted amount of claims at balance date	577	515
Discount	13	18
Central estimate of present value of future payments	590	569
Risk margin	65	62
	655	631

The movement in provisions is represented by:

	ACC Partnership Programme
2014	
Balance at 1 July 2013	552
Additional provisions during the year for the risks borne in current period	308
Decrease in provisions relating to a reassessment of risks in a previous period	321
Subtotal	1,181
Amounts used during the year	550
Total liability	631
(Decrease) / increase in provision	79
	ACC Partnership Programme
2015	
Balance at 1 July 2014	631
Additional provisions during the year for the risks borne in current period	439
Additional provisions relating to a reassessment of risks in a previous period	248
Subtotal	1,318
Amounts used during the year	663
Total liability	655
(Decrease) / increase in provision	24

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15 PROVISION (CONTINUED)

ACC Partnership Programme

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

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

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

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

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

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

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

Average inflation has been assumed as 2.10% for the year ending 30 June 2015. A discount rate of 3% has been used for the year ended 30 June 2015.

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.

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

16 TRADE AND OTHER PAYABLES

	2015 Actual	2014 Actual
Payables under exchange transactions		
Trade payables	6,778	19,553
Income in advance / Deferred Revenue	358	687
Capital charge due to the Crown	-	4,197
Other non-trade payables and accrued expenses	44,431	45,135
Total payables under exchange transactions	51,567	69,572
Payables under non-exchange transactions		
Income in advance	2,416	212
GST and other taxes payables	14,170	11,796
Total payables under non-exchange transactions	16,586	12,008
Total Payables	68,153	81,580

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.

17 PATIENT AND RESTRICTED FUNDS

	2015 Actual	2014 Actual
Patient funds		
Balance at 1 July 2014	155	148
Monies received	178	172
Interest received	2	2
Payments made	(196)	(167)
Balance at 30 June 2015	139	155

Patient funds are held in a separate bank account. Any interest earned is allocated to the individual patient balances. Patient fund transactions during the year ended 30 June 2015 are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as at 30 June 2015, both as an asset and a liability.

	2015 Actual	2014 Actual
Holiday homes funds		
Balance at 1 July 2014	75	72
Monies received	21	18
Interest received	2	2
Payments made	(26)	(17)
Balance at 30 June 2015	72	75
Hutt Valley DHB Portion ¼ of holiday homes total	18	19
Total patient and restricted funds	157	174

NOTES TO THE FINANCIAL STATEMENTS

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18 EQUITY

	2015 Actual	2014 Actual
Contributed capital		
Balance at 1 July	420,687	418,171
Capital contribution	5,600	6,000
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	422,803	420,687
Property revaluation reserves		
Balance at 1 July	23,606	23,606
Balance at 30 June	23,606	23,606
Accumulated surplus / (deficit)		
Balance at 1 July	(329,128)	(323,229)
Surplus / (deficit) for the year	(3,982)	(5,899)
Balance at 30 June	(333,110)	(329,128)
Total equity	113,299	115,165

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

19 OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2015 Actual	2014 Actual
Less than one year	2,340	2,819
Between one and five years	3,499	3,730
More than five years	785	-
	6,624	6,549

During the year ended 30 June 2015, \$2.7m was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2014: \$2.6m)

The DHB:

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

Leases as lessor

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

	2015 Actual	2014 Actual
Less than one year	259	184
Between one and five years	825	626
More than five years	1,044	1,427
	2,128	2,237

During the year ended 30 June 2015, \$2.3m was recognised as rental income in the statement of comprehensive revenue and expense (2014: \$2.2m)

The DHB has:

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

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

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor, approximately 48.05% in 2015 (2014: 55.94%). It is assessed to be a low risk and high quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Interest rate risk

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

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

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

The net fair value of the interest rate swap at 30 June 2015 was nil (2014: \$nil)

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 \$0.50m in 2015. (2014: \$0.03m).

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

At 30 June 2015, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately \$3.4m (2014: \$3.4m). It is estimated that a general increase of one percentage point in the value of NZD against other foreign currencies to which the DHB had direct exposure would have decreased the DHB's surplus before tax by approximately \$0.00086m for the year ended 30 June 2015 (2014: \$0.00025m).

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

20 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.

	2015 Actual							2014 Actual						
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs
Loans:														
NZD fixed rate loan*	5.16	28,000		28,000				5.16	28,000			28,000		
NZD fixed rate loan*	3.43	6,000	6,000					3.43	6,000			6,000		
NZD fixed rate loan*	3.65	9,000			9,000			3.65	9,000				9,000	
NZD fixed rate loan*	4.04	34,000				34,000		4.04	34,000				34,000	
NZD fixed rate loan*	4.15	6,000				6,000		4.15	6,000					6,000
NZD fixed rate loan*	3.72	25,000			25,000			3.72	25,000				25,000	
NZD fixed rate loan*	3.61	8,000					8,000	3.61	8,000					8,000
NZD fixed rate loan*	3.51	34,000					34,000	3.51	34,000					34,000
NZD fixed rate loan*	3.38	28,000				28,000		3.38	28,000					28,000
NZD fixed rate loan*	6.37	62,000				62,000		6.37	62,000				62,000	
NZD fixed rate loan*	6.30	-						6.30	20,000		20,000			
NZD fixed rate loan*	7.13	-						7.13	12,000		12,000			
NZD fixed rate loan*	6.57	-						6.57	11,000		11,000			
NZD fixed rate loan*	6.95	-						6.95	19,400		19,400			
NZD fixed rate loan*	6.39	-						6.39	8,600		8,600			
NZD fixed rate loan*	3.57	28,000					28,000	3.57	28,000					28,000
NZD fixed rate loan*	3.34	36,000				36,000		-	-					
NZD fixed rate loan*	3.37	35,000				35,000		-	-					
NZD unsecured loan	0	1,280	163	163	326	628		0	1,347		240	285	777	45
Finance leases*	6.5	-						6.50	8	8				
		340,280	6,163	28,163	34,326	201,628	70,000		340,355	8	71,240	34,285	130,777	104,045

* These liabilities bear interest at fixed rates.

NOTES TO THE FINANCIAL STATEMENTS

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20 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
2015						
Creditors and other payables	68,153	68,153	68,153	-	-	-
Secured loans	339,000	387,257	47,865	46,242	219,897	73,253
Unsecured loans	1,280	1,280	326	326	628	-
Finance leases	-	-	-	-	-	-
Patient and restricted funds	157	157	157	-	-	-
Total	408,590	456,847	116,501	46,568	220,525	73,253
2014						
Creditors and other payables	81,580	81,580	81,580	-	-	-
Secured loans	339,000	392,803	86,644	45,507	150,063	110,589
Unsecured loans	1,347	1,347	240	285	777	45
Finance leases	8	9	9	-	-	-
Patient and restricted funds	174	174	174	-	-	-
Total	422,109	475,913	168,647	45,792	150,840	110,634

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
2015						
Cash and cash equivalents	19,101	19,101	19,101	-	-	-
Debtors and other receivables	45,858	45,858	45,858	-	-	-
Trust and special funds - bank	546	546	546	-	-	-
Trust and special funds – term deposit	6,900	7,000	7,000	-	-	-
Trust and special funds – debtors	60	60	60	-	-	-
Total	72,465	72,565	72,565	-	-	-
2014						
Cash and cash equivalents	12,097	12,097	12,097	-	-	-
Debtors and other receivables	44,145	44,145	44,145	-	-	-
Trust and special funds - bank	714	714	714	-	-	-
Trust and special funds – term deposit	5,800	5,920	5,920	-	-	-
Trust and special funds – debtors	464	464	464	-	-	-
Total	63,220	63,340	63,340	-	-	-

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20 FINANCIAL INSTRUMENTS (CONTINUED)

Maximum exposure to credit risk

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

	2015 Actual	2014 Actual
Cash and cash equivalents	19,101	12,097
Debtors and other receivables	45,858	44,145
Trust and special funds – bank	546	714
Trust and special funds – term deposit	6,900	5,800
Trust and special funds – debtors	60	464
	72,465	63,220

	2015	2014
Counterparties with credit ratings		
Cash at bank and term deposits	26,547	18,611
AA- (Standard & Poor)	26,547	18,611

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 2015 was \$nil (2014: \$nil), comprising assets of \$nil (2014: \$nil) and liabilities of \$nil (2014: \$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 2015 was \$nil (2014: \$nil) recognised in fair value derivatives.

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

20 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 2015 Actual	Fair value 2015 Actual	Carrying amount 2014 Actual	Fair value 2014 Actual
Trade and other receivables	10	45,858	45,858	44,145	44,145
Cash and cash equivalents	11	19,101	19,101	12,097	12,097
Secured loans	13	(339,000)	(350,414)	(339,000)	(342,998)
Unsecured loans	13	(1,280)	(1,280)	(1,347)	(1,347)
Finance leases	13	-	-	(8)	(9)
Trade and other payables	16	(68,153)	(68,153)	(81,580)	(81,580)
		(343,474)	(354,888)	(365,693)	(369,692)
Unrecognised (losses)/gains			(11,414)		(3,999)

Estimation of fair value analysis

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

Derivatives

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

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

Interest bearing loans and borrowings

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

Finance lease liabilities

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

Trade and other receivables and payables

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

Interest rates used for determining fair value

The entity uses the government bond rate as at 30 June 2015 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2015 Actual %	2014 Actual %
Derivatives	N/A	N/A
	3.34, 3.37, 3.38, 3.43, 3.51, 3.57, 3.61, 3.65, 3.715, 4.04, 4.15, 5.16, 6.37	3.38, 3.43, 3.51, 3.57, 3.61, 3.65, 3.715, 4.04, 4.15, 5.16, 6.295, 6.37, 6.39, 6.57, 6.95, 7.13
Loans and borrowings	6.37	6.39, 6.57, 6.95, 7.13

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21 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:

	2015 Actual	2014 Actual
<i>Board Members</i>		
Remuneration	\$370	\$362
Number of members	12	17
<i>Leadership Team</i>		
Remuneration	\$3,100	\$3,057
Full-time equivalent members	17	14
Total key management personnel remuneration	\$3,470	\$3,419
Total members and full time equivalent personnel	29	31

NOTES TO THE FINANCIAL STATEMENTS

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21 RELATED PARTIES TRANSACTIONS (CONTINUED)

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

Board members

Current board members as at 30 June 2015

		Board Fees		Committee Fees	
		2015	2014	2015	2014
Dr Virginia Hope, MNZM, Chair	Elected	53	53	3	5
Mr Derek Milne, Deputy Chair	Appointed	32	19	3	1
Dr Judith Aitken	Elected	26	26	3	2
Mr David Choat	Elected	26	26	1	2
Mr Peter Douglas	Appointed	26	26	1	2
Ms Helene Ritchie	Elected	26	26	1	2
Mr Darrin Sykes	Appointed	26	26	2	3
Ms Sue Kedgley	Elected	26	15	1	1
Mr Chris Laidlaw	Elected	26	15	2	1
Mr Nick Leggett	Elected	26	15	-	1
Mr Roger Jarrold	Appointed	26	15	2	1

Board members who left during the year

Mr Peter Glensor	Appointed	-	13	-	3
Ms Barbara Donaldson	Elected	-	11	-	1
Ms Margaret Faulkner	Elected	-	13	-	4
Mr Keith Hindle	Appointed	-	11	-	4
Mr Robert Francis	Appointed	-	11	-	1

Crown monitor

Dr Margaret Wilsher	Appointed	32	-	-	-
Ms Debbie Chin	Appointed	-	7	-	-
		351	328	19	34

Committee members (other than Board members and employees)

Hospital Advisory Committee

	2015	2014
Lynn McBain	-	1
Karen Coutts	-	1
	-	2

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

22 EMPLOYEE REMUNERATION

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

	Number of Employees 2015	Number of Employees 2014
100 – 110	141	129
110 – 120	76	63
120 – 130	70	57
130 – 140	45	62
140 – 150	43	42
150 – 160	23	18
160 – 170	23	20
170 – 180	15	16
180 – 190	26	20
190 – 200	22	14
200 – 210	11	9
210 – 220	13	19
220 – 230	20	11
230 – 240	19	20
240 – 250	17	17
250 – 260	5	8
260 – 270	13	11
270 – 280	12	13
280 – 290	7	12
290 – 300	9	10
300 – 310	8	2
310 – 320	4	7
320 – 330	4	5
330 – 340	6	4
340 – 350	7	10
350 – 360	9	3
360 – 370	4	4
370 – 380	4	4
380 – 390	2	1
390 – 400	3	4
400 – 410	1	1
410 – 420	3	1
420 – 430	2	3
430 – 440	-	2
440 – 450	1	1
460 – 470	-	1
480 – 490	-	1
490 – 500	1	-
510 – 520	1	-
520 – 530	-	1
530 – 540	1	1
540 – 550	1	-
550 – 560	1	-
580 – 590	1	-
	674	627

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22 EMPLOYEE REMUNERATION (CONTINUED)

Of the 674 employees shown above, 459 are or were medical or dental employees and 215 are or were neither medical nor dental employees. This represents an increase of 47 staff in total over the previous year.

If the remuneration of part-time employees were grossed-up to an FTE basis, the total number of employees with FTE salaries of \$100,000 or more would be 1,509 compared with the actual total number of 674.

23 TERMINATION PAYMENTS

During the year ended 30 June 2015, 7 (2014: 11) employees received compensation and other benefits in relation to cessation totalling \$0.2m (2014: \$0.3m).

No Board members (2015: nil) received compensation or other benefits in relation to cessation (2014: nil).

24 EXPLANATIONS TO FINANCIAL VARIANCES FROM BUDGET

Section 154(3)(c) of the Crown Entities Act requires the Annual Financial Statements to include the forecast financial statements (Budget numbers) prepared at the start of the financial year for comparison with the actual financial statements. The Budget numbers are obtained from the Statement of Performance Expectation Budget approved by the DHB Board and tabled in Parliament. The 'Original 2015 Budget' column relates to the initial break-even Budget agreed with the Ministry of Health and tabled in Parliament.

However subsequent to the original submission, due to on-going negotiations with the Ministry of Health, the Budget numbers were later revised to reflect an agreed \$4m deficit for financial year 2014/15. The 'Revised 2015 Budget' column reflects the latest Budget numbers and have been disclosed for additional information.

Explanation of significant variances from the 'Revised 2015 Budget' in the Statement of Intent when compared to actual figures for the year ended 30 June 2015 are provided below.

Statement of comprehensive revenue and expense

The DHB recorded a deficit of \$3.9m compared with the budgeted deficit of \$4m.

Revenue for 14/15 was greater than budget due to increased MOH and IDF revenue due to higher levels of activities.

Expenditure was higher than budget for the reasons noted below:

- Personnel and clinical supply costs were above budget due to higher levels of activity as a result of increased acute demand.
- Increased outsourced cost due to higher outsourced services to meet health targets.
- Increased infrastructure costs mainly related to increased facility maintenance and affiliation fees for regional initiatives.

Statement of changes in Equity

- The variance in equity balance is mainly due to the phasing of the Nga Taihoi project over financial years 2014/15 and 2015/16.

Statement of financial position

Major variances were:

- The Cash balance is significantly favourable to budget due to regular review of the supplier payment terms and better cash management.
- Trade and other payables were higher mainly due to the timing of supplier payments.

Statement of cash flows

Major variances were:

- Cash flow from operating activities is in line with the budget.
- Cash flow from investing activities is less than budget due to various National and Regional Information Technology initiatives resulting in less spend.
- Cash flow from financing activities is in line with the budget.

NOTES TO THE FINANCIAL STATEMENTS

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25 CAPITAL MANAGEMENT

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

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

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

NOTES TO THE FINANCIAL STATEMENTS

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26 SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2015 Actual	2014 Actual	2015 Actual	2014 Actual	2015 Actual	2014 Actual	2015 Actual	2014 Actual	2015 Actual	2014 Actual
Revenue										
Crown	7,399	8,991	184,070	177,733	677,940	667,065	97,428	95,940	966,837	949,729
Other	-	-	-	-	29,379	25,928	11	-	29,390	25,928
Total revenue	7,399	8,991	184,070	177,733	707,319	692,993	97,439	95,940	996,227	975,657
Expenditure										
Personnel	144	-	3,089	-	408,269	403,810	1,858	5,285	413,360	409,095
Depreciation	-	-	-	1	37,775	34,509	-	-	37,775	34,510
Capital charge	-	-	-	-	8,382	8,578	-	-	8,382	8,578
Provider payments	7,254	8,454	163,580	159,002	66,456	65,877	88,648	87,834	325,938	321,167
Other	1	550	17,401	18,738	190,431	186,055	6,921	2,863	214,754	208,206
Total expenditure	7,399	9,004	184,070	177,741	711,313	698,829	97,427	95,982	1,000,209	981,556
Net surplus/(deficit)	0	(13)	0	(8)	(3,994)	(5,836)	12	(42)	(3,982)	(5,899)

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

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

NOTES TO THE FINANCIAL STATEMENTS

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Reconciliation to retained earnings (Original)

	2015 Actual I	Provider Original 2015 Budget	2014 Actual	2015 Actual I	Governance Original 2015 Budget	2014 Actual	2015 Actual I	Funder Original 2015 Budget	2014 Actual	2015 Actual I	Consolidated Original 2015 Budget	2014 Actual
Opening balance	(311,181)	(298,936)	(289,737)	(17,160)	(19,573)	(17,221)	(787)	(27,727)	(16,271)	(329,128)	(336,924)	(323,229)
Surplus/(de ficit) for the year	(29,588)	(21,926)	(21,444)	1	-	61	25,605	21,926	15,484	(3,982)	-	(5,899)
Closing balance	(340,769)	(320,862)	(311,181)	(17,159)	(19,573)	(17,160)	24,818	(5,801)	(787)	(333,110)	(336,924)	(329,128)

Reconciliation to retained earnings (Updated)

	2015 Actual I	Provider Updated 2015 Budget	2014 Actual	2015 Actual I	Governance Updated 2015 Budget	2014 Actual	2015 Actual I	Funder Updated 2015 Budget	2014 Actual	2015 Actual I	Consolidated Updated 2015 Budget	2014 Actual
Opening balance	(311,181)	(298,936)	(289,737)	(17,160)	(19,573)	(17,221)	(787)	(27,727)	(16,271)	(329,128)	(336,924)	(323,229)
Surplus/(de ficit) for the year	(29,588)	(23,926)	(21,444)	1	-	61	25,605	19,926	15,484	(3,982)	(4,000)	(5,899)
Closing balance	(340,769)	(322,862)	(311,181)	(17,159)	(19,573)	(17,160)	24,818	(7,801)	(787)	(333,110)	(340,924)	(329,128)