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MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

# 2019/20 – 2022/23 Statement of Intent

## incorporating the 2019/20 Statement of Performance Expectations

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


MidCentral District Health Board | Te Pae Hauora o Ruahine o Tararua

This Statement of Intent sets out the District Health Board's strategic intentions for the next four years, the nature and scope of the District Health Board's functions and operations and how these will be managed.

The Statement of Performance Expectations sets the annual performance expectations of MidCentral District Health Board. This Statement of Performance Expectations identifies what is intended to be achieved and how performance will be assessed for the year. It has been amended to reflect the District Health Board's approved Annual Plan for the 2019/20 year.

The Statement of Intent and Statement of Performance Expectations are presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004.

*Signed on behalf of the Board:*

Dot McKinnon
Chair
MidCentral District Health Board

Brendan Duffy
Deputy Chair
MidCentral District Health Board

Dated: 5 November 2019


MidCentral District Health Board | Te Pae Hauora o Ruahine o Tararua



November 2019

MidCentral District Health Board
Board Office, Heretaunga Street
PO Box 2056
Palmerston North Central
Palmerston North 4440
NEW ZEALAND

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# 1. STRATEGIC DIRECTION

## INTRODUCTION

MidCentral District Health Board operates as an agent of the Crown and was established under the New Zealand Public Health and Disability Act 2000 (the Act). The District Health Board has four key functions:

i. assessment of health needs, planning and monitoring of health and disability services for its population
ii. funding and purchasing health and disability services
iii. providing health and disability services through a directly managed Crown owned public hospital, and home and community based services
iv. governance, administration and management of the MidCentral District Health Board in regard to the functions noted above

The Act sets out the objectives of District Health Boards. They include:

- improving, promoting and protecting the health of people and communities
- promoting the integration of health services, especially primary and secondary care services
- seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- promoting effective care or support of those in need of personal health services or disability support
- promoting the inclusion and participation in society and the independence of people with disabilities
- reducing health disparities by improving health outcomes for Māori and other population groups

District Health Boards formally set out how they will deliver on their strategic intentions outlined in their Statement of Intent, which has a four year outlook. Statements of Intent are prepared in accordance with the provisions of the Crown Entities Act 2004 as amended in 2013, and include an annual Statement of Performance Expectations.

The annual Statement of Performance Expectations identifies the bundles of services that the DHB plans, promotes, funds and provides for known as "output classes", which broadly reflect the population health continuum of care. These are:

- Prevention services
- Early detection and management
- Intensive assessment and treatment
- Rehabilitation and support

### Links between outputs and outcomes

A key role of the health sector is to make positive changes to the health status of the population. Many of the determinants of health are beyond the DHB's influence; Government priorities, national policy and decision-making, other public sectors and individuals, families and whānau themselves all have a part to play in making gains on health status and sustaining a healthy population.

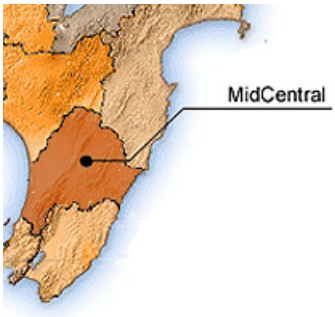
As a major funder and provider of public health and disability services in MidCentral's district, the decisions the DHB makes have a significant impact on its population and, if well planned and coordinated, the DHB will contribute to an improved, effective and efficient health care system.

MidCentral DHB's vision of '*quality living - healthy lives – well communities'* provides a strategic view of where the DHB wishes to direct its planning, funding and provision of health and disability services to meet its objectives under section 8 of the New Zealand Public Health and Disability Act 2000 and the New Zealand Public Health and Disability Amendment Act 2010.

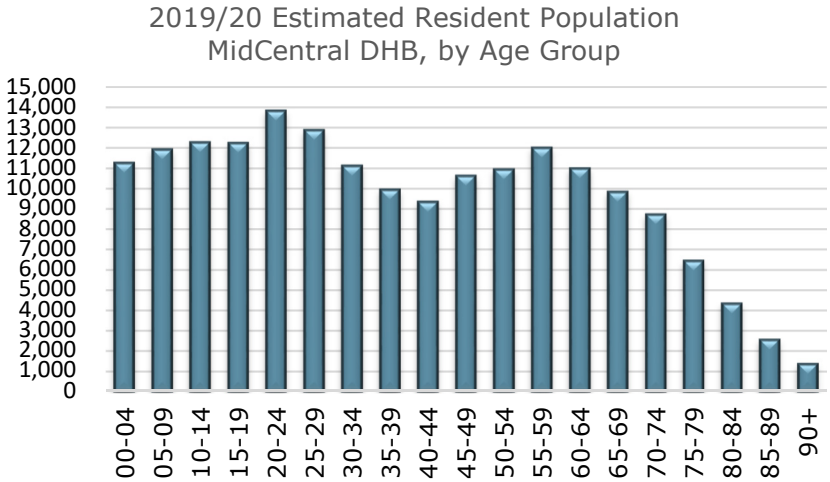
An outline of the DHB's strategic intentions is provided in the following section, identifying the outcomes that it is seeking to contribute to, based on its knowledge and understanding of the health status and health care needs of the population.

# OUR POPULATION AND STRATEGIC INTENTIONS

## Our Population

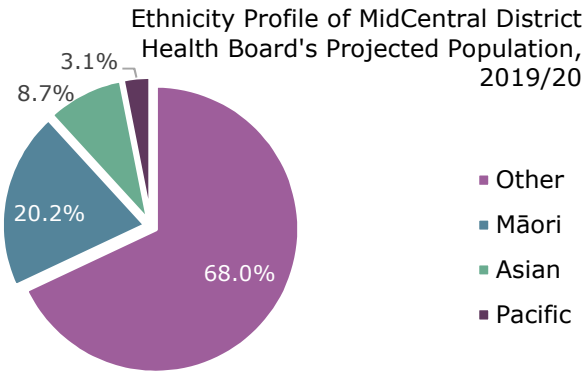



The estimated resident population in MidCentral's district for the 2019/20 year is 182,110 people[1]. Over half (52.3 percent) of our estimated population is aged under 40 years, while around 18 percent are aged 65 years and over. Just over half of our people live in the Palmerston North City district, and there is a steady increase in migration to the Horowhenua district and Ōtaki ward of the Kāpiti Coast district. Compared to the rest of New Zealand, MidCentral's district has a slightly higher proportion of Māori (20%) and people aged 65 and older living in the area.




| Territorial Local Authority Area / Ward | Percent of Total Estimated Population | Median Age |
|---|---|---|
| Palmerston North City | 50% | 33.6 |
| Horowhenua District | 18% | 47.2 |
| Manawatu District | 17% | 41.0 |
| Tararua District | 10% | 42.1 |
| Ōtaki Ward – Kāpiti Coast District | 5% | 48.1 |

[1] Ministry of Health: DHB Population Projections, 2018 Population Series Update




## *Health Status Overview*

Key findings from our Health Needs Assessment and the Equity Snapshot undertaken by the DHB identify that health inequities are experienced by our Māori and Pacific people and by people facing socio-economic disadvantage. Māori are least advantaged in our district with respect to both socio-economic opportunities for good health as well as mortality outcomes.

In terms of each local authority area, inequities are evident in the Horowhenua district (as they have high proportions of Māori, Pacific and socio-economically disadvantaged people among their residents), and, notable disadvantage may be emerging in the Tararua district.

The health status of our population has been gradually improving over time (as it has been for New Zealand overall). This is indicated by reducing age-adjusted mortality rates. The main conditions causing mortality are:

- Circulatory diseases
- Cancers
- Respiratory diseases
- Injuries and accidents

These conditions are the same for the population overall and for disadvantaged populations. Therefore, these are the conditions which should be focused on to improve the health of the greatest numbers of people in those populations.

Additionally, the engagement processes that we have undertaken with our communities as part of our locality planning across the district revealed four key themes as the main issues of concern relating to their health and wellbeing. Those are:

- **Access to primary care:** easy and timely access to my healthcare practice, build and maintain a trusted relationship with my healthcare practice, and reduce the barriers of time, distance and transport on access
- **Access to Mental Health and Addictions support in our community:** easy and timely access to mental health and addiction services locally, reduce the presence and impact of drugs, and increase early intervention and prevention
- **Value the power of communication**: increase the awareness of how to get to the right help at the right time, people have a positive experience of healthcare from a joined-up system, and people feel well informed and can better manage their health and wellbeing
- **Encourage, support and maintain the health and wellbeing of our community**: improve management of long term conditions, encourage and support healthy eating, physical activity and spiritual health, provide children with the best possible start, and have healthy and safe environments.

# Our Strategic Framework

We are committed to our purpose of

***Better health outcomes, better health care for all***

***He whakapai ake i te hauora, hei oranga mō te katoa***


and our vision of

***quality living, healthy lives, well communities***

***Kia pai te noho, Kia ora te tangata, Kia ora te hapori***

We strive to continuously improve our health system as part of the wider health sector and social service network through our four strategic imperatives:

- Achieve equity of outcomes across our communities
- Achieve quality and excellence by design
- Partner with people and whānau to support health and wellbeing
- Connect and transform primary, community and specialist services

Key enablers to our success in achieving our goals are our ***people, partners, information, stewardship and innovation***. These in turn are underpinned by our core values of being ***compassionate, respectful, courageous and accountable***

Our Strategy identifies what we are working toward over the next ten years:

*The future we want – a ten year outlook*

All people and whānau have a health care home

Everyone has the opportunity to achieve equitable health outcomes

People, families and whānau have a positive experience of the health care system

Our health care system is grounded in continuous quality improvement and clinical excellence

Our people are recognised for innovative approaches to health care

People make healthy choices and stay well longer

People are experts in their own lives and are partners in their health care

An integrated health care system operating as one team

More services closer to home

We will have an adaptable and responsive health care system

## *Aligning Strategic Themes*

The New Zealand Health Strategy (2016) provides an overarching direction for the New Zealand public health system.

Other key national health strategies that inform and guide our work include He Korowai Oranga – the Māori Health Strategy, the New Zealand Disability Strategy (2016 – 2026), 'Ala Mo'ui – Pathways to Pacific Health and Wellbeing (2014-2018) and the Healthy Ageing Strategy (2016).

MidCentral DHB's Māori Health Strategic Framework - *Ko Ao, Ka Awatea*, 2017 – 2021 which is consistent with He Korowai Oranga, sets the direction and support for realistic solutions to address challenges in health care and achieve equity of health outcomes across communities. *Ko Ao, Ka Awatea* identifies three strategic goals that we are seeking to achieve over time. These are:

- Māori providers are active leaders in defining priority investment areas to improve Māori health
- A consistent and integrated approach for cultural competency across primary, secondary and tertiary services will be delivered, monitored and maintained
- Barriers are identified, measured and removed through integrated health and social commitment to whānau wellbeing

In aligning our work to the national strategies, we also acknowledge our obligations and commitments to Te Tiriti o Waitangi and the UN Convention on the Rights of Persons with Disabilities.

## *Strategic Planning Intentions*

The high level planning intentions and key focus areas for MidCentral are summarised below. These areas reflect our local population health approaches and services and align with the national direction and the strategic priorities.

**Equity strategy**. The DHB will progress its equity strategy – equity of access, equity of experience and equity of outcomes – through its equity and data driven planning and service delivery projects. The DHB's focus will be on reducing health inequities for our population who identify as Māori or Pacific people and for those who are facing socio-economic disadvantage. The DHB will also be progressing the key actions with regard to equity of access identified as part of the locality planning engagement process with our communities.

**Financial performance**. The DHB will progress its planned programme of work to achieve the budgeted year result (or better) and support sustainable financial performance through implementing the DHB's comprehensive Performance Improvement Programme comprising four key workstreams: improving value programme, improving quality and reducing variation, workforce and culture, and, expenditure reduction.

**Capital planning**. The DHB will continue to build its capacity to fund strategic investment over and above that supported by refresh of assets from depreciation funding. We will also work with the Ministry of Health to further progress the priority major capital projects - the Mental Health in-patient unit and the Acute Services Block at Palmerston North Hospital.

**Planned care and patient flow**. The DHB will continue to make improvements in system-wide patient flow – particularly in support of more connected and responsive care for individuals living with long term health conditions, and, services that can better manage the demand for acute and urgent care. We will also focus our efforts on improving the DHB's capacity to better meet the prioritised clinical need for planned surgery for our local population, working with our primary care partners and other DHBs where necessary to meet demand for specialist interventions.

**Integrated service model**. The DHB will further progress development of the integrated service model to be delivered by service cluster and enabler groups, consistent with progressing our Strategy and each of their strategic Health and Wellbeing Plans.

While our four strategic imperatives identify the way in which we intend carrying out our business, the DHB will be focusing on the following priorities.to achieve our strategic planning intentions.

- **strengthening our financial position**
- **reducing inequities in health outcomes and engagement with the health system**
- **addressing the needs of targeted priority populations**
- **addressing our acute care demand**
- **minimising the impact of long term conditions**
- **supporting our communities**

We are committed to addressing health inequities and needs of our population, by:

- Designing interventions to address people's circumstances (i.e. be designed to fit the people targeted), rather than by tackling their diseases
- Helping clinicians to improve their interactions with consumers
- Increasing the focus on health promotion and disease prevention
- Working with intersectoral partners to impact on determinants of health
- Delivering services based on the type of people who live within each locality area
- Planning for increasing workloads caused by population ageing, growth in population, unmet health need and other factors (e.g. changing socio-economic situation)

These priorities will underpin the DHB's key programmes of work and approaches we will take to improve the health and wellbeing of our population. They will be reflected in each of the 5-year strategic Health and Wellbeing plans being developed in 2019 by the service cluster groups. Collectively, and together with support from the enabler groups and other key partners, they will deliver on an Integrated Service Model across the district to achieve the intended outcomes and impacts outlined in Figure 1.

## Outcomes and Impacts

The following diagram outlines our Outcomes Framework. It identifies the end results for our communities that we intend (outcomes) and the intermediate outcomes (impacts or consequences) resulting from the outputs or activities we provide or contribute to. That is, what difference we intend to make as a District Health Board with responsibilities to improve, promote and protect the health of people and communities.

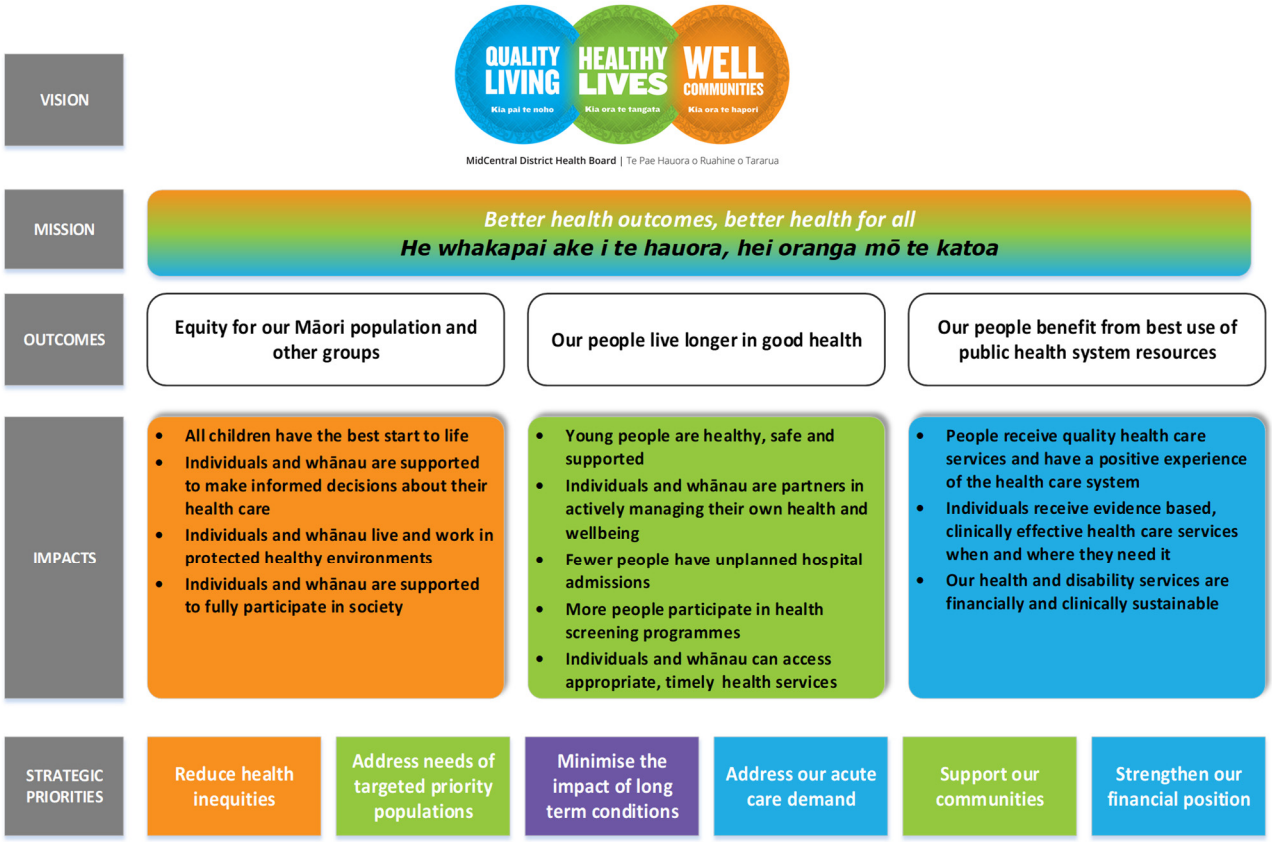



*Figure 1: MidCentral District Health Board Outcomes Framework, 2019*

This Statement of Intent which has a four year horizon, and the annual Statement of Performance Expectations and subsequent Statement of Performance (including financial performance) identify and report the key measures that are used to monitor the DHB's progress toward achieving our strategic intentions and the impacts in the more immediate term and the outcomes over a longer period.

## *Our Approach*

In delivering our strategic intentions and priorities, the DHB intends reflecting a stronger, targeted population and locality-based approach working with individuals, family and whānau, our intersectoral partners and communities of interest to address the socio-economic determinants of health and to achieve better equity and wellbeing.

We want to make better use of data and shared information in support of service planning, delivery and decision-making with, for and by individuals, consumers, whānau and health care partners.

We will progress implementation of our Digital Strategy – Te Awa with the priority on stabilising our existing information technology environment and establishing work programmes to build a new operating model.

We will be implementing a range of workforce planning and organisational development strategies to ensure we have

- a positive and productive working environment, driven by a values-based, patient-centred culture
- credible, capable and engaged leadership that is strongly connected with the teams they lead
- a sustainable workforce that meets both current and future capability and capacity needs, and is reflective of the communities we serve
- a capable, accountable, empowered and supported workforce, where diversity is supported and embraced
- system-level improvements in healthcare driven by working together, better and smarter

## Partnerships

The DHB is committed to fulfilling its obligations under the Treaty of Waitangi and this effect will continue to work at a governance level in partnership with our Māori Relationship Board – Manawhenua Hauora – a consortium of the four Iwi within our district: Ngāti Kahungungu ki Tamaki Nui a Rua, Ngāti Raukawa ki te Tonga, Rangitaane o Manawatu and Rangitane o Tamaki Nui a Rua, and, Muaūpoko.

At a leadership and operational level we will partner with our Māori Health Directorate (Pae Ora), our emerging Hauora Māori cluster, Raukawa Whānau Ora and Te Tihi o Ruahine Whānau Ora Alliance (comprising nine Iwi, Hāpu and Māori organisations) to improve the health and wellbeing of whānau, advance our collective equity agenda, and to address the health inequities experienced by Māori across our district. We are also committed to including Māori and Māori providers in all planning and service development.

As socio-economic and environmental factors contribute around 60 percent to health outcomes[2], the role of other partners in health and social services cannot be underestimated. We are committed to working collaboratively with a range of important partners to the health and wellbeing of our population – including our consumers, patients, families, whānau, primary and community health providers, Non Government Organisations, local and district Councils, other DHBs, and, central Government agencies such as the Ministries of Education, Social Development, Justice, Police, Environment and Oranga Tamariki.

The DHB is also committed to continuing to work with our Central Primary Health Organisation who, through working with general practice teams across the district, is a key partner in our collective endeavours to provide the best possible health and disability support services and achieve our common goals.

## Population Health Care Continuum and Public Health

Our Integrated Service Model places an emphasis on the full continuum of care, with particular focus on integrating population and public health approaches.
In the next few years we will be seeking to strengthen "upstream" interventions to support our population to stay well by better equipping individuals, whānau and communities to lead healthy lives. This is reflected in the Health and Wellbeing plans of each Cluster. These plans provide a three to five year outlook and link directly to MidCentral's Strategy. The Health and Wellbeing plans cover the full continuum of care, from health promotion and disease prevention, early detection and management through to rehabilitation, support and end of life care.

[2] "Breaking the dependency cycle: Tackling health inequalities of vulnerable families" by the Deloitte Centre for Health Solutions

## Integrated Service Model and Clinical Leadership

The Integrated Service Model is also about bringing together clinical leadership and consumer voices and enabling them to drive planning and service development. Each Cluster has a Clinical Executive partnered with an Operational Executive, and the supporting Cluster Alliance Groups have consumer and clinician members. The Clusters will also use a variety of mechanisms to ensure they hear the voice of people, whānau and communities. A key avenue for engagement with our communities is via the locally based Health and Wellbeing community groups and forums that have been established following the locality planning process undertaken earlier.

At the DHB level, clinician and consumer leadership is supported by a Clinical Council and a Consumer Council. These bodies are advisory to the DHB Board. The Consumer Council's role is to support the DHB's commitment to involve consumers across the full spectrum of planning, service development and service delivery.

## Key Enablers

One of the key enablers to achieving our Strategy is our Digital Health Strategy – Te Awa established in 2018. This outlines a portfolio investment approach to deliver a range of capabilities and initiatives across a five-year set of horizons that support implementation of the DHB's Strategy and integrated service model. The Digital Health Strategy is consistent with national strategies, regional and local strategic and service planning priorities.

Another key enabler to achieving our Strategy is our Health Workforce and Organisational Development Plan. This identifies a range of actions under four key domains relating to our workforce, leadership, our working environment and the way we work together. The Organisational Development Plan is being refreshed ready for implementation in the 2019/20 year.

## Regional and Sub-regional Collaboration

As one of six District Health Boards (DHBs) in the Central Region, we continue to collaborate on the strategic and operational planning to deliver work programmes where there are benefits to the health and wellbeing of our collective populations. We also collectively consider and plan for identified service or clinical vulnerabilities and/or shared service arrangements that could contribute to improvements in service quality and financial health of the DHBs. Regional collaboration is essential if we are to achieve equity of outcomes for our region's population.

The Central Region[3] developed a clearly defined vision for the Central Region - *Central Region DHBs leading together to achieve New Zealand's healthiest communities – and* a strategy for achieving that vision over the course of the next 3-5 years. The Central Region has positioned the development of the regional strategy in the context of an evolving strategic environment for health care nationally. The strategic objectives of the Central Region are:

- Ensuring a digitally enabled health system
- A clinically and financially sustainable health system
- An enabled and capable workforce

As a more formalised sub-regional arrangement, Whanganui and MidCentral DHBs are committed to working together on strategic issues and have formalised this intention in the centralAlliance Strategic Framework, 2015 - 2025.

[3] The Central Region comprises MidCentral, Whanganui, Hawke's Bay, Wairarapa, Hutt Valley and Capital & Coast District Health Board catchment areas.

It sets out the overall strategic direction for the sub-region, focusing attention on areas of health gain and clinical viability/sustainability of services delivered to our shared communities of interest.

As well as service priorities, the centralAlliance intends introducing some key enabler areas that are important in supporting centralAlliance activity. These areas are:

- Digital Information Systems
- Workforce (particularly medical and nursing)
- Funding arrangements

It is intended that joint mechanisms be developed for each of these areas to form a guide that supports service-led development and to operationalising the centralAlliance Strategic Framework.

# 2. MANAGING OUR BUSINESS

This section provides an overview of our responsibilities as stewards of District Health Board (DHB) assets and public funds, our commitments as a good employer, shared services arrangements and ownership interests.

## *Scope of Services*

MidCentral DHB principally serves an estimated population of 182,110 people (2019/20) residing in the Territorial Local Authority districts of Palmerston North City, Manawatu, Tararua, Horowhenua and the Ōtaki Ward of the Kapiti Coast District.

The DHB has its base hospital located in Palmerston North city.

The Ministry and DHBs fund services for eligible people according to the obligations set out in the Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement between DHBs and the Minister of Health. The Health and Disability Services Eligibility Direction 2011, issued by the Minister, sets out the eligibility criteria applying to publicly funded health and disability services.

The availability and level of publicly funded health and disability support services are determined in line with the requirements outlined in the Service Coverage Schedule. Any exemptions from the Service Coverage Schedule, and/or significant service change proposals are subject to particular protocols and will be signalled in the DHB's Annual Plan for discussion with the Ministry of Health and, where necessary, Ministerial approval.

MidCentral DHB provides, or arranges for the provision of, the following broad range of services.

- Diagnostic, therapeutic and support services – personal health
- Disability support services
- Emergency ambulance services
- Health and support services for older people
- Health emergency coverage
- Immunisation services
- Maternity services
- Mental health and addiction services
- Oral health services
- Palliative care
- Pharmacy services
- Primary health care services
- Provision of equipment, modifications and other supplies and services
- Public health and prevention services
- Screening services
- Specialist medical and surgical services (including emergency medicine, medical and radiation oncology)
- Travel and accommodation services

MidCentral provides some services to neighbouring DHB populations, such as radiation oncology, chemotherapy or haematology services provided by the Regional Cancer Treatment Service on behalf of Hawke's Bay, Whanganui and Taranaki DHBs.

The centralAlliance arrangements with Whanganui DHB also has MidCentral providing some specialist medical and surgical services, cancer services and public health / health protection services.

Some of the more highly specialised, lower volume services are provided only at the larger tertiary hospital centres, such as Auckland DHB.

In order to carry out its functions and obligations, and to deliver on its strategic intentions, MidCentral DHB has organised its operations into seven service Cluster groups and five Enabler groups. These are:

- Acute and Elective Specialist Services *Uru Arotau*
- Cancer Screening, Treatment and Support *Uru Mātai Matengau*
- Hauora Māori *Paiaka Whaiora*
- Health Ageing and Rehabilitation *Uru Whakamauora*
- Mental Health and Addictions *Uru Rauhi*
- Primary, Public and Community Health *Uru Kiriora*
- Women, Children and Youth *Uru Pā-Harakeke*

- Corporate and Finance Services
- Digital Services (Information and communications technology)
- People and Culture
- Quality and Innovation
- Strategy, Planning and Performance

Refer to the earlier section on our approach to delivering these services that are geared to supporting our work toward our Strategy and implementing an Integrated Service Model for the health and wellbeing of our communities.

## *Funding and Financial Management*

Government funding, via the Ministry of Health, is the main source of DHB income. MidCentral's share of the national population based funding pool is around four percent. This funding is supplemented by revenue agreements with ACC, research grants, donations, training subsidies and patient co-payments. Clear signals from Government are that DHBs are to operate within existing resources and approved financial budgets. As with other DHBs, this expectation presents a significant challenge for MidCentral DHB with growing financial pressures from increasing demand for services, treatment costs and wage settlements.

Financial management systems and processes are subject to both internal and external audit as part of the DHB's approved internal audit programme and the annual reporting process. Monthly financial reporting is provided to DHB executives and the Ministry of Health and governance oversight of financial management is provided by the Board via the Finance, Risk and Audit Committee of Board.

The Crown Funding Agreement (CFA) is the output agreement between the Crown and a DHB. The Crown (the Minister of Health) agrees to provide funding in return for service provision as specified in the agreement. The CFA links the Annual Plan to the funding and performance requirements of the DHB, and incorporates the Service Coverage Schedule and the Operational Policy Framework as part of the CFA.

## *Investment and Asset Management*

MidCentral DHB will enter the 2019/20 year with a balance sheet showing cash and cash equivalents of $27.0m. We will utilise accumulated cash resources to fund strategic investment over and above that supported by refresh of assets from depreciation funding.

MidCentral DHB's Long Term Investment Plan (LTIP) was finalised in October 2016. We anticipate reviewing and refreshing this plan in 2020.

Our planned long term strategic investment in mental health facilities and site redevelopment has an indicative price of $399m over ten years as currently scoped. Bridging the gap between strategic goals and current capability will necessitate both a return to sustainable operating surpluses and the careful stewardship of other capital investment.

Other clinical and infrastructure capital expenditure will be guided by the Asset Management Plan in the short term and the LTIP in the medium/long term. The indicative capital programme is set out in the following section.

## *Shared Service Arrangements and Ownership Interests*

MidCentral DHB has a part ownership interest in the Central Region Technical Advisory Service Limited (TAS), Allied Laundry Services Limited and NZ Health Partnerships Ltd. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time. Should it decide to do so, it would first consult with the Minister of Health.

## *Risk Management*

MidCentral DHB has a formal risk reporting and accountability framework in place. Risks are monitored at a governance level via the Finance Risk and Audit Committee and operationally at executive leadership level, clinical governance groups and service management. Risk management principles and practices form part of the risk management strategy and are supported by existing planning and operational processes. The risk management and reporting system meets current Australian / New Zealand Standard requirements *(AS/NZS ISO 31000 – Risk Management - Principles and guidelines* and HB 228:2001) relating to risk management.

A routine internal audit programme is also carried out and risk mitigation activities are incorporated into the annual planning process as well as into projects and programmes of work across the DHB.

## *Performance Measurement and Reporting*

MidCentral DHB has established systems for internal performance measurement and management at all levels of the organisation, measured at various frequencies throughout the year as appropriate.

Regular reporting of financial and non-financial performance results, measures as well as monitoring progress against our strategic intentions and Annual Plan occurs at executive and Board levels. We also report our performance results and progress against planned activities to the Ministry of Health on a quarterly basis in relation to the expectations and deliverables contained in the Non-Financial Monitoring Framework and Performance Measures for the year to which it refers.

In accordance with the annual Operational Policy Framework for DHBs, MidCentral DHB also has systems in place to ensure we meet our reporting obligations to the Minister, Ministry of Health and other regional and national health agencies in relation to the operations of the DHB (such as DHB Shared Services, Health Quality and Safety Commission etc.) and our obligations in respect of the Crown Entities Act 2004 and as amended by the Crown Entities Amendment Act 2013.

We endeavor to ensure that data and information requirements for all national collections are accurate and complete at the time of submission, and, that they meet relevant standards and business rules for the collection system.

Further, where contracted service providers contribute data relating to publicly funded services, the DHB seeks to ensure compliance with the relevant national data dictionaries and codes. Provider Monitoring Returns are not only submitted to the Ministry's Sector Services as part of the service contract arrangements, but also to the DHB for the purposes of monitoring provider performance.

## *Quality Assurance and Improvement*

MidCentral DHB's approach to quality is embedded in all it does and we will continue to work closely with our primary, secondary and community-based health care providers to strengthen the quality of services across the sector, by bringing organisations and professionals together with the common aim of improving outcomes for patients and service users.

We continue to implement initiatives that support the Health Quality and Safety Commission's national quality improvement programmes including: infection prevention and control, safe surgery, medication safety and reducing harm from falls. In addition, MidCentral DHB is implementing key actions of the National Deteriorating Patient programme and Pressure Injury Prevention programme as well as participating in two key programmes with the Mental Health and Addictions sector – improving transitions of care, and, working toward the elimination of seclusion. MidCentral also participates in other programmes led by the Health Quality and Safety Commission (HQSC): Advance Care Planning, Partners in Care and Building Leadership and Capability.

MidCentral DHB has a core programme of work that contributes to improving the quality, safety and experience of patients' care, performance reporting, resource allocation, staff learning and development and ongoing process improvement work across a range of health services. These include, for example:

- Maternity Quality and Safety Programme
- Incident reporting and management (including adverse events)
- Infection Prevention and Control
- A Clinical Governance Framework
- Quality Standards for Diabetes Care
- Morbidity and mortality reviews (including participating on national review committees)
- Customer relations service (including feedback, compliments and complaints management)
- Patient experience surveys
- HQSC quality and safety markers and quality indicators
- Programme and Project Management
- Clinical and Consumer Councils
- Accreditation, certification and credentialling
- Clinical policies, protocols and guidelines
- Cluster Alliance Groups

Publication of an annual Quality Account, in conjunction with the DHB's primary and community partners, documents a review of our performance against key quality indicators and highlights a range of quality improvement initiatives that were undertaken in the year.

MidCentral DHB retains certification under the Health and Disability Services (Safety) Act 2001, and continues work to ensure providers (including its own provider) meet the requirements of the Provider Quality Specifications and broader health and disability service standards.

## *Being a Good Employer*

MidCentral DHB continues to implement a strategy that builds on the significant achievements of the last ten years. Our new executive leadership structure is now in place and our services have been organised into a number of cluster groups to deliver on our strategy through an integrated service model.

An Organisational Development Plan is in place to support our strategic direction, vision and values. This plan outlines the work environment we seek to provide for our people to enable them to be successful in their roles, and in their careers, and to maximise the contribution our people make as a key enabler to the achievement of our Strategy.

MidCentral DHB takes its role as an employer seriously and invests a lot of resources and time into our people – both on a group and individual basis. A staff engagement survey undertaken in the 2018 year has helped to inform a refresh of the Organisational Development Plan ready for implementation from the 2019/20 year.

We are committed to meeting our statutory, legal and ethical obligations, including providing equal employment opportunities (EEO). This is supported by our EEO policy, our good employer practices relating to recruitment and our policies and procedures around having a safe and healthy working environment for our staff. By way of example, we were pleased to have won the award for the Positive Inclusion category with our entry in the 2018 Diversity Awards run by Diversity Works New Zealand. This focused on the work of our Rainbow Forum in making our DHB a more inclusive workplace for LGBTQ+ staff. We have also set up and communicated throughout our DHB contact details about the range of networks and support people that have been set up with the objective of representing and supporting our diverse wokforce, for example, our Kaimahi Māori Forum, Spiritual Care, and support for differently abled staff.

Key measures around our workforce are closely monitored, and the DHB works in partnership with unions and staff to continue to improve our working environment.

There are seven elements to being a good employer to which the DHB is committed, as demonstrated through its plans, programmes of work, policies and procedures. These are:

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

# 3. STATEMENT OF PERFORMANCE EXPECTATIONS

## INTRODUCTION

District Health Boards formally set out how they will deliver on their strategic intentions outlined in their Statement of Intent (SOI). Statements of Intent are prepared in accordance with the provisions of the Crown Entities Act 2004 as amended in 2013, and include an annual Statement of Performance Expectations (SPE).

The SPE identifies the bundles of services that the District Health Board (DHB) plans, promotes, funds and provides for known as "output classes". These are:

- Prevention services
- Early detection and management
- Intensive assessment and treatment
- Rehabilitation and support

These broadly reflect the population health continuum of care.

The annual SPE and subsequent annual Statement of Service Performance (including financial performance) identify and report the key measures that are used monitor the DHB's progress toward achieving the impacts in the more immediate term and the outcomes over a longer period. The Annual Plan includes the key activities that the DHB intends undertaking toward achieving these outcomes, where they are aligned to the Government planning priorities for the year.

This SPE outlines the services (outputs) the DHB plans, funds, provides and promotes within each Output Class for the year, in order to achieve our strategic intentions as identified in our Outcomes Framework. It details how the DHB proposes to assess its performance for this year (2019/20) against those longer term strategic intentions, organised into the four Output Classes for which the DHB is allocated funds from Vote:Health. The total expected revenue and proposed expenditure for the year is included.

### Relationship between Population Health Continuum of Care and Outputs

The relationship between the continuum of health care, from health promotion and disease prevention activities provided to the general population to progressively more intensive and specialised health and disability services provided to individuals and the corresponding output class, is shown in the following diagram.

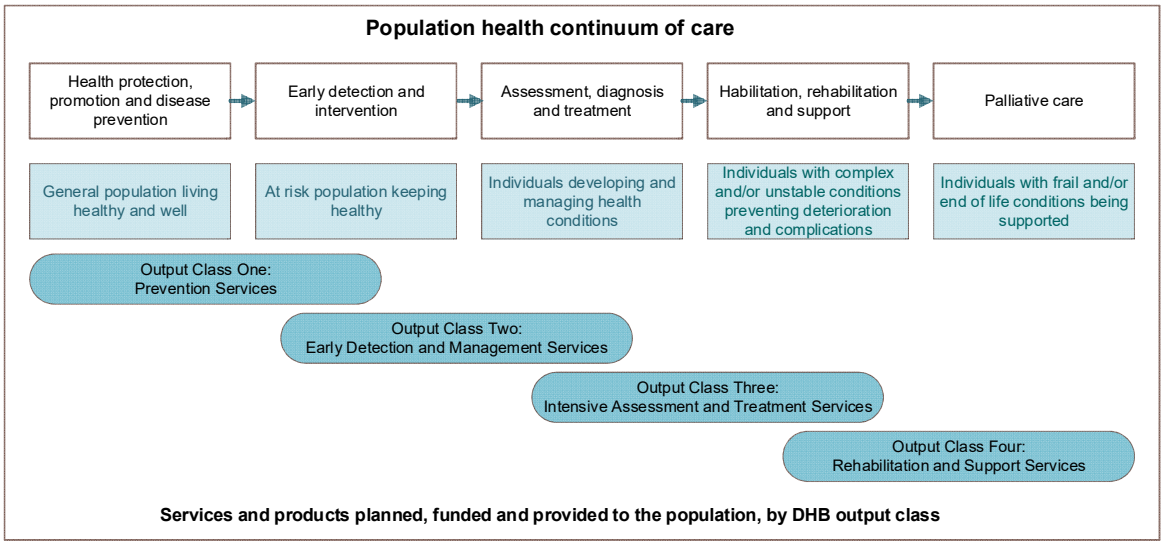



Figure 2: Population Health Continuum of Care

This figure shows that the DHB has obligations to meet the health needs of the population it serves ranging from promoting healthy lifestyles to the general population right through to treating and supporting individuals and their family in end of life care. In doing so, the DHB, as a Crown entity, must respond to the requirements of Parliament and the expectations and priorities of Government for the public health sector.

## Assessing Our Performance

The output measures reflect some of the key activities with the potential to make the greatest contribution to health and wellbeing in the shorter term, and to the health outcomes the DHB is seeking over the longer term. They also include some specific volume measures which indicate the level of 'demand driven' services to which the DHB has to respond and estimates of demand for the coming year rather than a target. In setting performance targets, MidCentral DHB considered the changing demographics of its population, increasing demand for health services and that funding is finite. Targets tend to reflect the objective of maintaining or increasing performance levels against growth in demands coupled with expectations around managing capacity, access and responsiveness as well as ensuring productivity and quality of service.

There are also measures where the DHB wishes to monitor differences between ethnicities and in particular to address inequities in health outcomes and access to services between Māori and non-Māori.

One of the key aspects of measuring MidCentral DHB's performance is to monitor and evaluate our performance over time, identifying trends and patterns and where possible comparing its performance to a national average or target may be appropriate. In some cases, the same measures reported to the Ministry of Health as part of the Non-Financial Performance Monitoring Framework and the System Level Measures are used.

### A note on data quality

In some instances this Statement of Performance Expectations includes updated data for the previous year's actual result and may differ from the reported result in the 2017/18 Annual Report; it was accurate using data that was available at the time of reporting, but may not have been complete for that financial year.

Further, a major programme of work to upgrade applications of key information systems occurred over the second half of the 2017/18 year as part of MidCentral's commitment to the Regional Health Informatics Programme.

During the 2018/19 year a significant remediation action plan was undertaken to stabilise the platforms and comply with data requirements for national collection systems. This involved the Regional Radiology Information System, the Clinical Portal, the Picture Archiving and Communications System and WebPAS – the core Patient Administration System. While every endeavour has been made to ensure that data has been migrated, mapped and subsequently collected and reported in a consistent manner, there may be some instances where figures are re-baselined for the 2017/18 year and for forecasting 2018/19 results and 2019/20 target setting. Therefore some data and results noted in earlier Statements of Performance Expectations and Annual Reports may not be comparable to previous years' reported results. This is noted where applicable.

# 3.1 OUTPUT CLASS: PREVENTION SERVICES

## *Output Class Description*

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population. Prevention services address individual behaviours by targeting physical and social environments to influence health and wellbeing. They include health promotion and education activities to ensure that illness is prevented and inequalities in health outcomes are reduced, statutorily mandated health protection services to protect the public from environmental risk and communicable diseases, and services such as immunisation to help prevent infections and screening programmes to detect disease at early stage.

This Output Class comprises the following outputs:

- Health promotion and education
- Statutory regulation, environmental health
- Population based screening
- Immunisation
- Well child services

**What do we want to achieve? (Goals)**

People make healthy choices and stay well longer

People are experts in their own lives and are partners in their health care

**What difference will we make? (Impacts)**

- All children have the best start to life
- Young people are healthy, safe and supported
- Individuals and whānau are engaged with safe and healthy lifestyles
- More women participate in cervical and breast screening programmes
- Individuals and whānau are supported to make informed decisions about their health care
- Individuals and whānau live and work in protected healthy environments

**How will we measure our progress? (Indicators)**

- Reducing prevalence of tobacco smoking
- Increasing proportion of Māori and Pacific people participating in physical/nutritional programmes
- Increasing proportion of Māori infants exclusively or fully breast feeding
- Reducing equity gap in on time immunisation coverage rates
- Increasing breast and cervical screening coverage rates by Māori and Pacific women
- Increasing enrolment in well child services
- Reducing self-harm hospitalisations by young people
- A high proportion of children receiving a health check

## Our Annual Service Performance Expectations

Meeting our annual service performance expectations will contribute to the achievement of our objectives through measuring the impact of the outputs we deliver over time, which in turn will assist us to realise our strategic intentions and equity in health outcomes for our population.

| Indicators | | 2017/18 Actual | 2018/19 Forecast | 2019/20 Target |
|---|---|---|---|---|
| ***Individuals and whānau are engaged with safe and healthy lifestyles*** | | | | |
| Proportion of Central PHO enrolled population (aged 15-74 years) recorded as "current smokers" in the last 15 months | Māori | 35.6% | 34.5% | ≤30% *E |
| | Non Māori | 15.5% | 14.8% | ≤15% *E |
| Percentage of pregnant women identified as current smokers and seen by Lead Maternity Carers who were offered smoking cessation services | Māori | 76.3% | 70% *E | ≥70% *E |
| | Non Māori | 78.7% | 70% *E | |
| Percentage of people enrolled with CPHO being seen by clinical dieticians and/or by physical activity educators | Māori | 4.5% | 3.9% | ≥4% |
| | Non Māori | 2.8% | 2.7% | ≥2% |
| Percentage increase/decrease in the number of referrals to Green Prescription programmes (Adults and Active Families) for additional physical activity support over the year | Māori | 11.0% | 0.8% | ≤2% |
| | Non Māori | 6.7% | 1.2% | ≤1% |
| Percentage of children identified as obese in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions | Māori | 98.4% | 97% | ≥95% |
| | Non Māori | 96.4% | 95% | |
| ***All children have the best start to life*** | | | | |
| Percentage of infants that are exclusively or fully breast fed at 3 months of age | Māori | 45.9% *M18 | 45% | ≥70% |
| | Non Māori | 63.4% *M18 | 58% | |
| Percentage of infants who receive all Well Child Tamariki Ora core contacts (1 – 5) in their first year of life *W | Māori | 72.9% *M18 | 70% | ≥90% |
| | Non Māori | 81.7% *M18 | 79% | |
| Percentage of high deprivation and total population of eligible children who have received their B4 School Check | High dep | 93.7% | 91% | ≥90% |
| | Total | 92.6% | 90% | |
| ***Young people are healthy, safe and supported*** | | | | |
| Percentage of Year 9 students receiving a health assessment (HEEADSSS) by the school based health service (SBHS) in the calendar year | | 92.7% *C17 | 90% *C18 | ≥95% *C19 |
| Percentage of eligible girls fully immunised for Human Papillomavirus (HPV ) | | 66.9% | 60% *E | ≥75% |
| Rate per 10,000 population aged 10 – 24 years (age standardised) admitted to hospital with intentional self-harm (DHB of Domicile) | Māori | 49.8 *D17 | 53.4 *D18 | ≤50 |
| | Total | 44.3 *D17 | 53.2 *D18 | ≤50 |

| Indicators | | 2017/18 Actual | 2018/19 Forecast | 2019/20 Target |
|---|---|---|---|---|
| ***People are healthier and take greater responsibility for their own health*** | | | | |
| Percentage of eligible 8 month old infants who receive their first course immunisations on time | Māori | 90.4% | 86% | ≥95% |
| | Non Māori | 92.8% | 91% | |
| Percentage of eligible 4 year old children who are fully immunised by 5 years of age | Māori | 92.4% | 90% | ≥95% |
| | Non Māori | 92.8% | 91% | |
| Percentage of the total population aged 65+ years vaccinated for seasonal influenza *S | Māori | 42.4% *S18 | 42% *S19 | ≥75% |
| | Non Māori | 54.9% *S18 | 58% *S19 | |
| ***More women participate in cervical and breast screening programmes*** | | | | |
| Percentage of MidCentral domiciled women aged 25 – 69 years who have had a cervical screening event in the last three years (hysterectomy adjusted population) *J | Māori | 65.1% | 65% | ≥80% |
| | Non Māori | 77.5% | 78% | |
| Percentage of MidCentral domiciled women aged 50 -69 years who have received a mammogram in the last two years (breast screening programme) *J | Māori | 65.1% | 66% | ≥70% |
| | Non Māori | 77.0% | 78% | |

Notes:
*E refers to estimated figure
*D17 and D18 refer to 12 month periods ending December 2016, December 2017 and December 2018
*C17, C18 and C19 refer to 2017, 2018 and 2019 calendar years
*M18 as at March 2018, Ministry of Health: Well Child Tamariki Ora Report
*S refers to influenza season between 01 March and 30 September each year
*W refers to Well Child Tamariki Ora Quality Improvement Framework Indicators, as reported by Ministry of Health
*J as at end of June each year

## Revenue and Expenditure for this Output Class

| Prevention Services | Actual 2017/18 | | Forecast 2018/19 | | Budget 2019/20 | | Outlook 2022/23 | |
|---|---|---|---|---|---|---|---|---|
| | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 |
| Health promotion and education | 5,054 | 5,030 | 5,255 | 5,373 | 5,484 | 5,507 | 5,993 | 6,013 |
| Statutory regulation, environmental health | 4,187 | 4,149 | 4,354 | 4,432 | 4,543 | 4,543 | 4,965 | 4,960 |
| Population based screening | 5,952 | 6,251 | 6,189 | 6,677 | 6,459 | 6,844 | 7,058 | 7,473 |
| Immunisation | 1,562 | 1,566 | 1,624 | 1,673 | 1,695 | 1,715 | 1,852 | 1,872 |
| Well child services | 1,852 | 1,845 | 1,926 | 1,971 | 2,010 | 2,020 | 2,196 | 2,206 |
| **Total Prevention Services** | **18,607** | **18,841** | **19,347** | **20,124** | **20,191** | **20,629** | **22,066** | **22,524** |

# 3.2 OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

## *Output Class Description*

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. They include general practice, community and Māori health services, community diagnostic and pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health services. Early detection and management services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations across the district. These services are focused on, and delivered to, individuals and smaller groups of individuals.

This Output Class comprises the following outputs:

- Primary health care
- Primary community care programme
- Primary mental health and addiction
- Community based oral health services for children and adolescents
- Community pharmacist services
- Community referred testing and diagnostic services

**What do we want to achieve? (Goals)**

People, families and whanau have a positive experience of the health care system

Everyone has the opportunity to achieve equitable health outcomes

All people and whanau have a health care home

More services closer to home

**What difference will we make? (Impacts)**

- Fewer people have unplanned hospital admissions
- Individuals and whanau are partners in actively managing their own health and wellbeing
- Individuals and whanau can access appropriate, timely health services
- More children have better oral health

**How will we measure our progress? (Indicators)**

- Reducing ambulatory sensitive hospitalisations
- Increasing enrolment by Māori with a Primary Health Organisation
- Increasing service utilisation ratio of 'high need' PHO enrolled population
- Containing growth in attendances at the Emergency Department
- Increasing proportion of people with diabetes who have good glycaemic control
- Increasing proportion of eligible adults who have their cardiovascular risk assessed
- Increasing caries free rate in 5 year old Māori and Pacific children
- Increasing percentage of people receiving their diagnostic imaging scan on time
- increasing coverage of enrolled population seen by clinical pharmacists for medicines management

## Our Annual Service Performance Expectations

Meeting our annual service performance expectations will contribute to the achievement of our objectives through measuring the impact of the outputs we deliver over time, which in turn will assist us to realise our strategic intentions and equity in health outcomes for our population.

| Indicators | | 2017/18 Actual | 2018/19 Forecast | 2019/20 Target |
|---|---|---|---|---|
| ***Individuals and whanau can access appropriate, timely health services*** | | | | |
| Percentage of MidCentral population (medium projections) enrolled with any PHO at end of financial year *J | Māori | 86.4% | 87% | ≥90% |
| | Non Māori | 94.4% | 93% | |
| Average consultation rate per month of Central PHO registered patients | Māori | 0.33 | 0.34 | ≥0.34 |
| | Pacific | 0.28 | 0.28 | ≥0.28 |
| | Other | 0.46 | 0.46 | ≥0.46 |
| Percentage of people with accepted referrals for a computed tomography (CT) scan or magnetic resonance imaging (MRI) receive their scan within 6 weeks (42 days) | CT | 89.5% | 60% # | ≥95% |
| | MRI | 100% | 100% | ≥90% |
| ***Fewer people have unplanned hospital admissions*** | | | | |
| Percentage of people assessed at high risk (>15 percent) of cardiovascular disease who have received an annual review *N | Māori | n/a | n/a | ≥70%*E |
| | Non Māori | n/a | n/a | |
| Ambulatory sensitive hospitalisation rate per 100,000 domiciled population, 0 – 4 year old children (non-standardised) | Māori | 6,456*M18 | 6,500 *E | ≤6,600 |
| | Non Māori | 5,421*M18 | 5,200 *E | ≤5,200 |
| Ambulatory sensitive hospitalisation rate per 100,000 domiciled population, 45 - 64 year old adults (standardised) **S | Māori | 8,944*M18 | 8,500 *E | ≤8,000 |
| | Non Māori | 4,112*M18 | 4,100 *E | ≤4,200 |
| ***Individuals and whanau are partners in actively managing their own health and wellbeing*** | | | | |
| Percentage of enrolled people aged 15-74 in the PHO with diabetes and the most recent HbA1c during the past 12 months of equal to or less than 64mmol/mol (good glycaemic control) | Māori | 51.0% | 50% | ≥60% |
| | Non Māori | 64.8% | 62% | |
| Ambulatory sensitive hospitalisation rate (non-standardised) in the 45 – 64 year old population age group for certain cardiac and respiratory diseases, stroke and diabetes*ASH | Māori | 3,987*M18 | 5,000 *E | ≤4,700*E |
| | Non Māori | 2,334*M18 | 2,500 *E | ≤2,400*E |
| Percentage of CPHO enrolled population registered and using e-portal ('Manage My Health' or 'My Indici') *I19 | | n/a | 16% | ≥25% |
| Percentage of patients seen by primary care clinical pharmacists who have had a Medicines Therapy Assessment completed in the year #1 | | n/a | 67% | ≥70% |

| Indicators | | 2017/18 Actual*C17 | 2018/19 Forecast*C18 | 2019/20 Target*C19 |
|---|---|---|---|---|
| ***More children and young people have better oral health*** | | | | |
| Mean score of Decayed, Missing and Filled Teeth of Year 8 children seen in the year | Māori | 0.85 | 0.95 | ≤0.95 |
| | Total | 0.59 | 0.66 | |
| Percentage of 5 year old children seen in the year who are caries free | Māori | 47.6% | 51% *E | ≥64% |
| | Total | 65.3% | 62% *E | |
| Proportion of 0 – 4 year population enrolled with DHB funded oral health service | Māori | 72.3% | 51.7% *D | ≥95% |
| | Total | 102% | 96.0% | |
| Proportion of adolescent population utilising DHB-funded dental services | | 80.3% | 81% | ≥85% |

Notes:

*J as reported for beginning of July each year

# forecast low result for CT scans based on reported data to Ministry of Health from the new Regional Radiology Information System, which is known to have had incomplete data over the year

*N new indicator to take effect from July 2019

**S measurement changed to standardised rate, so the figure reported here for 2017/18 (to March 2018) is different from the non standardised rate reported in the 2017/18 Annual Report

*M18 refers to 12 month period ending 31 March 2018.

*ASH refers to ambulatory sensitive hospitalisations for the following conditions: angina/chest pain, asthma, congestive heart failure, chronic obstructive respiratory disease, diabetes, hypertensive disease, myocardial infarction, other ischaemic heart disease and stroke

#1 new service commenced - clinical pharmacists aligned to General Practice Teams / Integrated Family Health Centres from January 2019

*I19 a number of General Practices / Integrated Family Health Centres are moving to a new Patient Management System over the 2019 year. This will result in a requirement to re-register their patients and could result in variations to registered portal users at time of reporting

*C17, C18 and *C19 refers to the 2017, 2018 and 2019 calendar years respectively. Note the community oral health service changed from a manual data collection system to the electronic oral health clinical information system (Titanium) at the end of 2016. Current and retrospective data anomalies are apparent and being remediated – inconsistent results between years are noted and should not be used for trend analysis or comparison.

*D low level of confidence in this result for Māori children – data by ethnicity held in the system requires verification at time of reporting

## Revenue and Expenditure for this Output Class

| Early Detection and Management | Actual 2017/18 | | Forecast 2018/19 | | Budget 2019/20 | | Outlook 2022/23 | |
|---|---|---|---|---|---|---|---|---|
| | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 |
| Primary health care | 43,856 | 44,120 | 45,601 | 47,125 | 47,588 | 48,308 | 52,008 | 52,744 |
| Child and adolescent oral health | 3,060 | 5,981 | 3,182 | 6,388 | 3,320 | 6,549 | 3,629 | 7,150 |
| School based and youth health services | 2,150 | 2,305 | 2,236 | 2,462 | 2,333 | 2,524 | 2,550 | 2,756 |
| Primary community care | 6,954 | 6,972 | 7,231 | 7,447 | 7,546 | 7,634 | 8,247 | 8,335 |
| Community pharmacy services | 45,656 | 45,770 | 47,473 | 48,887 | 49,542 | 50,114 | 54,142 | 54,717 |
| Community referred testing and diagnostics | 17,290 | 17,628 | 17,978 | 18,829 | 18,761 | 19,301 | 20,504 | 21,074 |
| **Total Early Detection and Management** | **118,966** | **122,776** | **123,699** | **131,139** | **129,090** | **134,429** | **141,079** | **146,776** |

# 3.3 OUTPUT CLASS: INTENSIVE ASSESSMENT AND TREATMENT

## *Output Class Description*

Intensive assessment and treatment services are delivered by a range of secondary and tertiary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a hospital. These services are generally complex and provided by health care professionals that work closely together. They include:

- ambulatory services (including outpatient, district nursing and day services) across the range of secondary assessment, diagnostic, therapeutic, and rehabilitative services
- inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- emergency department services including triage, diagnostic, therapeutic and disposition services

These services are at the complex end of treatment services and are focused on and delivered to individuals.

A proportion of these services are driven by demand which the DHB must meet, such as acute (unplanned and urgent) medical and surgical services and maternity services. Other services are planned (elective) for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

This Output Class comprises the following outputs:

- Mental health and addiction services (secondary)
- Hospital based acute and elective services
- Hospital based maternity services
- Assessment, treatment and rehabilitation services

**What do we want to achieve? (Goals)**

Our health care system is grounded in continuous quality improvement and clinical excellence

An integrated health care system operating as one team

**What difference will we make? (Impacts)**

- Individuals and whanau can access appropriate, timely health services
- Fewer people have unplanned hospital admissions
- Individuals have equitable access to specialist assessment and treatment on time
- Individuals and whānau stay safe in hospital and have a positive experience of the health care system
- Individuals receive evidence based, clinically effective health care services

**How will we measure our progress? (Indicators)**

- Reducing waiting times for specialist assessment and treatment
- Reducing acute bed day utilisation per capita
- Reducing acute admissions and average lengths of stay in hospital
- Improving patient experience of care

## Our Annual Service Performance Expectations

Meeting our annual service performance expectations will contribute to the achievement of our objectives through measuring the impact of the outputs we deliver over time, which in turn will assist us to realise our strategic intentions and equity in health outcomes for our population.

| Indicators | | 2017/18 Actual | 2018/19 Forecast | 2019/20 Target |
|---|---|---|---|---|
| ***Individuals and whānau stay safe in hospital and have a positive experience of the health care system*** | | | | |
| Percentage of people presenting to the Emergency Department who are discharged, admitted or transferred within six hours | | 84.2% | 82% | ≥95% |
| Acute inpatient average length of stay (standardised) – days | | 2.74 *M18 | 2.5 | ≤2.4 |
| Average length of time between referral from acute inpatient services to transfer to AT&R services (days) | | 1.7 | 1.6 | ≤1.5 |
| Average overall scores to the four surveys responded to over the year for each of the patient experience domains | Communication | 8.4 | 8.5 | ≥8.5 |
| | Partnership | 8.5 | 8.5 | ≥8.5 |
| | Coordination | 8.4 | 8.4 | ≥8.5 |
| | Physical & emotional needs | 8.7 | 8.7 | ≥8.5 |
| Surgical site infections per 100 hip and knee operations | | 0.49 | 0.7 | ≤1.0 |
| Average number of in-hospital falls per month causing a fractured neck of femur over the year | | 0.17 | 0.17 | ≤0.12 |
| Hospital acquired bacteraemia rate per 1,000 patients | | 1.68 | 1.7 | ≤1.7 |
| ***People have equitable access to specialist assessment and treatment on time*** | | | | |
| Percentage of the population accessing specialist mental health and addiction services (all ages) | Māori | 5.6% | 6.0% | ≥5.5% |
| | Non Māori | 3.4% | 3.5% | ≥3.5% |
| | Total | 3.9% | 4.0% | ≥4.0% |
| Percentage of people referred for non-urgent mental health and addiction services seen within 3 weeks (DHB Mental Health and Addictions service provider only) | 0-19 yrs | 85.1% | 84% | ≥80% |
| | 20-64 yrs | 93.9% | 83% | |
| | 65+ yrs | 85.3% | 80% | |
| Standardised intervention rates for specific orthopaedic, cardiac and ophthalmology services, per 10,000 population | Major joints | 21.3 *M18 | 21.0 | ≥21.0 |
| | Cataracts | 30.74*M18 | 32.0 | ≥27.0 |
| | Cardiac surgery | 4.28 *M18 | 4.1 | ≥5.0 |
| | Angiography | 33.9 *M18 | 32.0 | ≥34.0 |
| Percentage of people receiving their first cancer treatment (or other management) within 31 days from date of decision to treat | | 88.1% | 85% | ≥85% |
| Percentage of patients waiting greater than four months for their first specialist assessment (as at end June each year) *DC | | 8.8% | 8% | ≤1% |
| Percentage of patients given a commitment to treatment (surgery) but not treated within four months (as at end June each year) *DC | | n/a | 23% | ≤1% |
| Percentage of people accepted for a non-urgent diagnostic colonoscopy receiving (or waiting for) their procedure in 42 working days or less *DC | | 80.3% | 74% | ≥70% |

| Indicators | 2017/18 Actual | 2018/19 Forecast | 2019/20 Target |
|---|---|---|---|
| ***Fewer people have unplanned hospital admissions*** | | | |
| Percentage of Emergency Department presentations resulting in an acute admission to inpatient services | 27.4% | 26% | ≤26% |
| Standardised acute bed days per 1,000 population (DHB of Domicile) | 398.1 | 390 | ≤400 |
| Percentage of acute readmissions to hospital within 28 days of a previous discharge (standardised, all ages, DHB of Service) * | 11.1% *M18 | 12% | ≤12% |
| ***Women giving birth have clinically effective health care services delivered*** | | | |
| Percentage of women (DHB of residence) giving birth at secondary maternity facility ** | 86.9%% (2016) | 84.7% (2017) | ≤84% |
| Percentage of emergency caesarean section deliveries for women giving birth – DHB of residence (calendar year) ** | 16.8% (2016) | 15.0% (2017) | ≤15% |
| Percentage of pre-term term births at Palmerston North Hospital (calendar year) ** | 9.7% (2016) | 9.4% (2017) | ≤9% |

Notes:

*DC refers to the data collection for and interface with the National Booking Reporting System; MidCentral upgraded to the regional WebPAS patient administration system, with a 'go live' date from 08 December 2017. Subsequent data file processing and reporting issues have resulted in data omissions that the forecast result is an estimate only, based on reported national data.

*M18 refers to 12 month period ending March 2018

* Data source: Ministry of Health, OS8 Reports. Applies the Ministry of Health definition and methodology for calculating acute readmissions; this measure is a standardised readmission ratio of the observed number of readmission stays to the predicted number of readmission stays of a DHB, and is derived based on the number of admissions and readmissions for patients presenting to New Zealand hospitals.

** Data source: Ministry of Health 2019: Report on Maternity 2017 (published April 2019). Refers to calendar year, and data is lagged by one year.

## Revenue and Expenditure for this Output Class

| Intensive Assessment and Treatment Services | Actual 2017/18 | | Forecast 2018/19 | | Budget 2019/20 | | Outlook 2022/23 | |
|---|---|---|---|---|---|---|---|---|
| | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 |
| Emergency department | 19,851 | 22,952 | 20,641 | 24,515 | 21,540 | 25,131 | 23,541 | 27,439 |
| Medical services | 63,809 | 60,527 | 66,348 | 64,650 | 69,239 | 66,272 | 75,670 | 72,359 |
| Surgical / ICU / Anaesthetic services | 82,027 | 85,820 | 85,291 | 91,665 | 89,008 | 93,966 | 97,274 | 102,596 |
| Regional Cancer Treatment services | 46,366 | 44,348 | 48,211 | 47,369 | 50,312 | 48,557 | 54,984 | 53,017 |
| Women's and children's services | 35,677 | 36,256 | 37,097 | 38,725 | 38,713 | 39,697 | 42,308 | 43,343 |
| Elder health services | 12,589 | 16,230 | 13,090 | 17,335 | 13,660 | 17,770 | 14,929 | 19,403 |
| Rehabilitation and therapy services | 2,015 | 2,436 | 2,095 | 2,602 | 2,186 | 2,667 | 2,390 | 2,912 |
| Mental health and addiction services | 34,669 | 38,821 | 36,048 | 41,465 | 37,619 | 42,506 | 41,113 | 46,410 |
| Clinical support services | 6,822 | 7,661 | 7,093 | 8,183 | 7,403 | 8,388 | 8,090 | 9,159 |
| Inter district flows | 54,588 | 54,725 | 56,760 | 58,452 | 59,234 | 59,919 | 64,735 | 65,423 |
| **Total Intensive Assessment and Treatment Services** | **358,413** | **369,776** | **372,674** | **394,962** | **388,915** | **404,874** | **425,033** | **442,059** |

# 3.4 OUTPUT CLASS: REHABILITATION AND SUPPORT

## *Output Class Description*

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services such as home-based support services and residential care services for older people. In MidCentral's district, the NASC service is known as "SupportLinks". The rehabilitation and support services also include palliative care services for people with end-stage conditions and services that support people with a disability.

MidCentral DHB contracts for the provision of these services from a wide range of providers, including Arohanui Hospice, rest homes and home-based support agencies.

A key provider of disability support services is Enable New Zealand – a division of MidCentral DHB that provides services across New Zealand. These services include the EASIE Living and Demonstration Centre, equipment and housing modification services for the health and disability sector and disability information services. Enable New Zealand also provides NASC services for people with a disability aged less than 65 years of age.

Rehabilitation and Support services are focused on and delivered to individuals.

This Output Class comprises the following outputs:

- Needs assessment and coordination
- Home based support services
- Age related residential care
- Rehabilitation and lifelong disability services
- Respite and day care services
- Palliative care services

**What do we want to achieve? (Goals)**

We will have an adaptable and responsive health care system

Our people are recognised for innovative approaches to health care

**What difference will we make? (Impacts)**

- Individuals and whānau are supported to fully participate in society
- Individuals and whānau are supported to make informed decisions about their health care
- Individuals who are dying, and their whānau, have access to quality end of life care

**How will we measure our progress? (Indicators)**

- Increasing proportion of eligible individuals receiving on time needs assessments and home based support services
- Containing the proportion of older people living in aged residential care facilities relative to population growth
- Increasing proportion of people referred to community rehabilitation following an acute stroke seen on time
- Increasing access to respite care / carer relief to eligible older people and their whanau
- Sustaining access to specialist and primary care based palliative care

## Our Annual Service Performance Expectations

Meeting our annual service performance expectations will contribute to the achievement of our objectives through measuring the impact of the outputs we deliver over time, which in turn will assist us to realise our strategic intentions and equity in health outcomes for our population.

| Indicators | 2017/18 Actual | 2018/19 Forecast | 2019/20 Target |
|---|---|---|---|
| ***Individuals and whānau are supported to make informed decisions about their health care*** | | | |
| Percentage of older people with a new (urgent and routine) referral to NASC service who wait less than 20 days for an interRAI assessment | 69.6% | 65% | ≥65% |
| Percentage of people aged 65 or older receiving publicly funded long term home-based support services who have a comprehensive clinical assessment and a completed care plan | 98.1% | 98% | ≥95% |
| ***Individuals and whānau are supported to fully participate in society*** | | | |
| Percentage of eligible people aged 65+ years receiving community initiated Packages of Temporary Support (PoTS) as a proportion of total people receiving PoTS | 34.8% | 33% | ≥33% |
| Percentage of people discharged from hospital following an acute stroke and referred to DHB community rehabilitation services that are seen within seven days of discharge | 23.3% | 28% | ≥60% |
| Percentage of population aged 65+ years receiving DHB funded support in long term age related residential care facilities | 5.9% | 5.5% | ≤6% |
| Percentage of total ARC beds utilised by people for dementia care | 12.2% | 12.5% | ≤13% |
| Proportion total needs assessments completed for MidCentral DHB domiciled people that resulted in a service coordination outcome of home based support services | 63.5% | 63% | ≥65% |
| Proportion of MidCentral DHB individuals who had respite care/carer relief as a service coordination outcome following a first assessment during the year | 18.8% | 20% | ≥20% |
| ***Individuals who are dying, and their whānau, have access to quality end of life care*** | | | |
| Proportion of patients referred to the hospital-based Palliative Care team who have a non-malignant diagnosis | 36.8% | 36% | ≥38% |
| Percentage increase/decrease from previous year in the number of new referrals to primary palliative care programme | -16.3% | -8% | n/a |

## Revenue and Expenditure for this Output Class

| Rehabilitation and Support Services | Actual 2017/18 | | Forecast 2018/19 | | Budget 2019/20 | | Outlook 2022/23 | |
|---|---|---|---|---|---|---|---|---|
| | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 | Revenue $000 | Expenditure $000 |
| Needs assessment & service coordination | 3,616 | 3,727 | 3,760 | 3,981 | 3,924 | 4,081 | 4,288 | 4,456 |
| Age related residential care beds | 48,932 | 49,076 | 61,413 | 63,240 | 64,089 | 64,827 | 70,041 | 70,781 |
| Home based support services | 17,049 | 17,095 | 17,727 | 18,259 | 18,500 | 18,718 | 20,218 | 20,437 |
| Rehabilitation services | 16,638 | 16,863 | 17,300 | 18,012 | 18,054 | 18,464 | 19,731 | 20,159 |
| Palliative care services | 3,830 | 4,013 | 3,982 | 4,286 | 4,156 | 4,394 | 4,542 | 4,797 |
| Life long disability services * | 36,762 | 36,153 | 38,225 | 38,615 | 39,891 | 39,585 | 43,595 | 43,220 |
| Respite care services | 3,782 | 3,894 | 3,932 | 4,159 | 4,104 | 4,264 | 4,485 | 4,655 |
| Day services | 2,424 | 2,532 | 2,520 | 2,704 | 2,630 | 2,772 | 2,875 | 3,027 |
| Pay equity adjustment ** | 10,131 | 10,131 | - | - | - | - | - | - |
| Inter district flows | 5,943 | 5,959 | 6,179 | 6,365 | 6,449 | 6,525 | 7,048 | 7,124 |
| **Total Rehabilitation and Support Services** | **149,107** | **149,443** | **155,040** | **159,622** | **161,797** | **163,628** | **176,822** | **178,656** |

* Includes Enable New Zealand

** Pay equity adjustments included with Aged Residential Care providers from 2018/19

# 4. FINANCIAL PERFORMANCE

## 4.1 KEY FINANCIAL PLANNING ASSUMPTIONS

### General

- MidCentral DHB is forecasting a deficit of $21.7m by the end of the 2018/19 year – a significant variance from the budgeted operating deficit of $4.95m. Together with the unavoidable cost drift of Multi-Employer Collective Agreement (MECA) increases and supplier price sustainability this imposes a first call on revenue increases, which will necessitate further efficiencies to maintain financial sustainability in the medium term
- The budget is based on Government policy settings and known Government health service initiatives
- All changes resulting from the ongoing implementation of the Government's health policy including any devolution during the planning year will be at least cost neutral or better to MidCentral DHB
- Any volume growth will be less than or equal to the rate of demographic change
- The 2019/20 year moves on maturing the Integrated Service Model subsequent to the establishment of service Cluster groups in the 2018/19 year to deliver on an Integrated Service Model, supported by Enabler groups. Each Cluster and Enabler group will be responsible for delivering to service expectations within budget. Any further changes to the organisational structure will be provided in the budget
- No material costs have been included for a pandemic or major disaster
- Material compliance costs arising from regulatory and legislative changes are not budgeted
- Business improvement, budgeted savings and other activities will continue with a view to strengthening the DHB's financial position to achieve financial sustainability as the basis for living within its means. To live within available revenue, and accumulate the resources to fund strategic shifts in service delivery and capability, MidCentral DHB will need to continue to generate productivity improvements and expenditure reductions at an increasing rate across all areas of activity, including those that have previously been optimised. Service provision and capacity will continue to be a specific focus in 2019/20
- The following services and priority areas are subject to reviews, business cases or further planning and depending on the outcomes of those, may impact planned operational performance: Mental Health and Addiction Services, Maternity services, Cardiology, Health of Older People, Radiology and Laboratory services, the Regional Cancer Treatment Service and the Regional Health Informatics Programme (Phase 2)
- Potential service changes and/or reconfigurations will be as signalled in the Annual Plan, subject to further review and approval. The 2019/20 budget does not include any financial impact of those potential service changes or reconfigurations and will be managed on a case by case basis. It is anticipated that potential benefits will be realised in the outer years. The Service Change protocols will be followed in accordance with the Operational Policy Framework

- Ongoing improvements in models of care and utilisation of hospital capacity will release resources to support strategic intentions
- Expenditure will be re-prioritised where needed to meet the requirements to support patients with high and complex needs
- A Strategic Property Plan has been adopted by the Board, providing a long term view to achieving required resilience and functionality on the Palmerston North Hospital campus site to meet community needs. Further progress on one of the key priority projects (the Mental Health in-patient unit) is anticipated in the 2019/20 year. The other key projects – the hospital's Acute Services Block and Clinical Services Block re-life have been prioritised for funding in 2021 budgets. Funding prioritisation from the Ministry of Health is awaited.

## Revenue

- An increase of 4.25 percent on the devolved funding allocated to the DHB in 2018/19 has been included in the budget for the 2019/20 year
- 2019/20 funding for MidCentral DHB will include adjustments for the agreed NZNO and PSA Nurses and PSA Allied Health MECAs finalised in 2018/19. It is assumed that additional funding related to additional costs of the Midwives (MERAS) MECA will follow once settlement is agreed and finalised
- For 2019/20 Pay Equity will continue to be washed up by the Ministry and not devolved to the DHB. Revenue will equal expenditure
- Funding will continue in 2019/20 baseline funding for the Care and Capacity Demand Management (CCDM) programme, as indicated in the Ministry contract
- Funding for the Electives Initiative programme is currently budgeted at 2018/19 levels (including volume) and is subject to change following further advice from the Ministry of Health regarding funding to support the new approach to 'Planned Care' that is to take effect from the 2019/20 year
- National prices will be applied wherever applicable both within the DHB and for providers external to the DHB
- Cost for any new initiatives will not be more than revenue unless a business case has been approved for additional expenditure
- Ring-fenced and targeted funding will be monitored and conditions satisfied. The Mental Health Ring Fence will be based on the calculations for 2018/19, adjusted for demographics and cost pressures
- The Government has made no decisions on out-year funding. Planning assumptions are based on funding increases in out-years being at the mid-range of revenue assumptions indicated in our Long Term Investment Plan, adjusted for funded MECA costs

## Personnel costs and outsourced services

- Workforce costs have been budgeted at actual known costs including step increases and changes in applicable Multi Employer Collective Agreements
- Increases in wage and salary movements will be in line with the Government's expectations for pay and employment conditions in the State Sector and national employment relations strategies. Wage and salary increases are no longer affordable and sustainable within base funding. This means that overall, MidCentral DHB's wage increases (including planned step increases and salary increases) will deteriorate the financial position of the DHB

- The size of MidCentral DHB's workforce will be constrained by available funding and the need to balance within an overall personnel cost. It is expected that FTE levels will stabilise during the planning period, with any increases aligned to new revenue, substitution for outsourced personnel, MECA roster requirements or patient demand
- Pay Equity compensation will be provided for Carer Support and Mental Health
- Reliance on outsourced personnel will be reduced with replacement by staff appointments where feasible
- Staffing levels will be managed to minimise the effects of demand fluctuations and growth and we will become increasingly adept at flexing-up to meet spikes in demand
- Any restructuring costs will be met from budgeted operating costs
- The planned staffing levels (full time equivalents, rounded) are as follows:

| MidCentral DHB Staff Group | 2018/19 Budget | 2019/20 Budget | Movement |
|---|---|---|---|
| Medical | 357 | 369 | 12 |
| Nursing and Midwifery | 986 | 1,046 | 60 |
| Allied Health | 439 | 449 | 10 |
| Support | 47 | 48 | 1 |
| Management / Administration | 508 | 538 | 30 |
| **Total** | **2,337** | **2,451** | **114** |

## Supplies and infrastructure costs

- Infrastructure services and procurement functions will operate with emphasis on minimising cost to release funding for other essential activity in the short term
- A programme of improvement measures will be effective in containing or reducing unit costs and usage in key input areas including pharmaceuticals, clinical supplies, other consumables and minor assets
- Utilities costs will benefit from repeatable energy efficiency improvements
- Infrastructure service costs will be constrained by working collaboratively with key providers to ensure that inputs are cost effective and the spend is focused on high benefit areas and less effective projects are minimised
- Exchange rate fluctuations may materially impact the cost of supplies and will be partially offset by procurement saving initiatives, and mitigated by the use of hedging strategies by suppliers.

## Capital Servicing

***Depreciation.*** Depreciation has been calculated in accordance with the MidCentral DHB Accounting Policy, at rates that will write off the cost of the assets over their useful lives. The estimated useful lives for plant, equipment, motor vehicles and fixtures and fittings are between 3 and 25 years, with software amortised over 6 to 10 years.

***Interest rates***. Interest received on deposits is calculated at known and estimated rates with an expected weighted average of 2.12 percent for the 2019/20 year. Interest on loans is calculated at the applicable contracted rates with the lender over the period of the loans.

***Capital charge***. The rate of capital charge will be six percent.

## Investments

Medium to long term investment planning and decisions is reflected in the Long Term Investment Plan that was developed in the 2016/17 year. This will be refreshed in 2020.

During 2019/20 the DHB will complete the realignment of Business Continuity relative to the clusters and post-disaster requirements to ensure that available funding continues to be applied where it is best able to reduce vulnerabilities and address legislative requirements.

MidCentral DHB will continue to plan maintenance of its assets through its Capital Planning and Planned Maintenance Programmes.

The indicative capital investment allocation for the 2019/20 year is as follows:

| **Summary** | **Actual 2017/18** | **Forecast 2018/19** | **Budget 2019/20** | **Budget 2020/21** | **Budget 2021/22** | **Budget 2022/23** |
|---|---|---|---|---|---|---|
| Buildings | 4,458 | 10,066 | 10,205 | 6,590 | 6,906 | 7,404 |
| Clinical | 3,507 | 3,839 | 12,154 | 8,128 | 12,932 | 9,287 |
| Other | 386 | 95 | 300 | 300 | 300 | 300 |
| IT Hardware & Software | 10,360 | 7,989 | 9,358 | 6,540 | 6,005 | 8,300 |
| Vehicles | 43 | 539 | 0 | 0 | 0 | 0 |
| **Total Base** | **18,754** | **22,528** | **32,017** | **21,558** | **26,142** | **25,291** |
| PNH Acute Services | | | | | 59,500 | 59,500 |
| Mental Health Unit | | | 9,600 | 7,750 | 12,650 | |
| Extra Funding | | | (9,600) | (7,750) | (72,150) | (59,500) |
| **Total Planned** | **18,754** | **22,528** | **32,017** | **21,558** | **26,142** | **25,291** |

The capital investment will generally be funded by depreciation, amortisation, Energy Efficiency and Conservation Authority (EECA) loans and from cash reserves. Major securatisable assets such as Linear Accelerators and Medical Imaging equipment will be considered for financial lease funding. The proposed Acute Services Block and Mental Health inpatient buildings are beyond the available resources of MidCentral DHB and will depend upon approval of additional capital injections.

## Digital Services

MidCentral DHB has deployed the core and common regional applications of Clinical Portal, Radiology Information System, Picture Archiving and Communication System, and WebPAS (Patient Administration System). Throughout the 2018/19 year technical, data and reporting remediation activities were undertaken to ensure Ministry of Health compliance and to mitigate the potential of clinical risk.

In 2019/20 there will be significant upgrade projects for the WebPAS (version 10.14 to enable NCAMP19), the Radiology Information System (version 11.3) and Clinical Portal. This will include migration of some regional solutions to public cloud and vendor managed services. These are subject to business case approvals.

Other priorities for Digital Services in the 2019/20 year are to implement the first Horizon of the DHB's new Digital Health Services Strategy - Te Awa (Foundation, 1 – 2 years). This involves stabilising the existing environments, building the portfolio work programmes and defining a new operating model to support execution.

Prioritisation of regional and national initiatives feature in the work programme, including implementation of the National Bowel Screening Information System (for which separate national funding is expected), and making progress on Computer Physician Order Entry, electronic sign off and eMedicines.

This will be balanced against driving the simplification, automation and digitalisation of a complex technology and application environment to support the implementation of the DHB's Strategy and Integrated Service Model as a priority.

## Property, Plant and Equipment

MidCentral DHB will continue to plan maintenance of its assets through its Capital Planning and Planned Maintenance Programmes. Land and buildings (including building/engineering infrastructure services and refurbishments) are re-valued every three years, with the last re-valuation occurring in 2018.

### *Land disposal*

Disposal of land is subject to current legislative requirement and protection mechanisms. MidCentral DHB is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

## National, Regional and Sub-Regional Programmes

### *NZ Health Partnerships Limited*

NZ Health Partnerships Ltd (NZHP), has developed a strategy in consultation with DHBs for future procurement. MidCentral DHB will actively engage and participate in opportunities to achieve business benefits from further collaboration, consolidation and rationalisation of DHB procurement.

### *PHARMAC*

In addition to its existing mandate for funding and management of community pharmaceuticals, PHARMAC has expanded its portfolio to include management of the community and hospital based DHB pharmaceutical budgets. This was effective in the 2018 financial year. The DHB's funding allocation for 2019/20 reflects estimated cost savings from the expansion of the PHARMAC model to manage DHBs' hospital medicines (Budget 2018).

PHARMAC is also mandated to manage procurement of medical devices and the DHB will actively contribute to those initiatives as opportunities arise.

### *Health Workforce New Zealand*

Health Workforce New Zealand priorities have been included in this plan where they are funded under contract (Clinical Training Agency).

### *Health Quality and Safety Commission*

The following Health Quality and Safety Commission programmes have been included in this plan, are consistent with the applicable commitments outlined in the Operational Policy Framework and will be funded from business as usual. These national programmes include:

- Falls reduction and prevention
- Medication safety programme
- Infection prevention and control (including hand hygiene)
- Surgical site infection programme
- Safe surgery
- Hospital inpatient experience surveys and reporting system
- Patient deterioration
- Pressure injury prevention
- Mental Health and Addictions Improvement programme

- Supporting development of sector capability and clinical leadership in quality and service improvement

### *Others*

No financial commitments are expected nor have we provisioned for any contribution that we may make to the work of the Health Promotion Agency.

Any collaborative regional and sub-regional (including centralAlliance) initiatives will be cost neutral; additional costs associated with implementation of the 2019/20 Regional Services Plan as included or referenced in Chapter 2 of the Annual Plan have been incorporated into the budget.

A small provision was made in the 2018/19 year for the preparatory work required for the roll out of the National Bowel Screening Programme. A funding business case will be prepared prior to roll out of the national programme (including the national bowel screening information system), which is anticipated to be from November 2019 in MidCentral's district and for which funding is expected.

### *Central Region's Technical Advisory Service and New Zealand Health Partnerships*

Cost contributions to Central Region's Technical Advisory Service and NZ Health Partnerships Ltd will be in accordance with Board agreements.

### *Allied Laundry Services Limited*

MidCentral DHB has been advised that from 1 July 2019 there will be a four percent unit price increase which we will endeavour to abate by constraining linen volumes. Six District Health Boards (Capital and Coast, Hutt Valley, MidCentral, Taranaki, Whanganui and Hawke's Bay DHBs) will continue being Shareholders in Allied Laundry Services Limited (ALSL). MidCentral DHB will remain owner of the laundry building at Palmerston North Hospital, and leasing this facility to ALSL.

# 4.2 FORECAST FINANCIAL PERFORMANCE

MidCentral DHB is forecasting an operating deficit of $27.0 million at the end of the 2018/19 year. The DHB is budgeting an operating deficit of $12.1 million for the 2019/20 year, and is expecting to return to surplus in 2022/23.

**Statement of Comprehensive Revenue and Expense**
**MidCentral DHB**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| ***Revenue*** | | | | | | |
| Ministry of Health | 558,870 | 589,751 | 619,199 | 643,967 | 666,506 | 689,834 |
| Other Government | 30,257 | 29,260 | 29,132 | 30,297 | 31,358 | 32,455 |
| Patient / Consumer | 613 | 403 | 465 | 483 | 500 | 518 |
| Other | 13,183 | 14,147 | 11,476 | 11,467 | 11,869 | 12,284 |
| Inter-Provider | 2,397 | 4,513 | 4,581 | 4,764 | 4,931 | 5,103 |
| Inter-District Inflows | 45,670 | 46,037 | 46,607 | 48,471 | 50,168 | 51,924 |
| **Revenue** | **650,988** | **684,109** | **711,460** | **739,451** | **765,332** | **792,118** |
| % change | | **5.1%** | **4.0%** | **3.9%** | **3.5%** | **3.5%** |
| ***less Expenditure*** | | | | | | |
| Personnel | 216,667 | 237,581 | 248,304 | 258,236 | 268,566 | 279,308 |
| Outsourced Services | 27,672 | 32,983 | 22,334 | 23,005 | 23,745 | 24,372 |
| Clinical Supplies | 54,982 | 56,933 | 58,892 | 60,815 | 62,747 | 64,288 |
| Infrastructure & Non-Clinical | 77,438 | 84,126 | 81,715 | 84,169 | 86,916 | 89,017 |
| Financing Charges | 11,731 | 11,820 | 10,431 | 10,844 | 11,139 | 11,553 |
| External Provider Payments | 213,351 | 222,707 | 238,766 | 242,852 | 247,751 | 252,718 |
| Inter-District Payments | 58,995 | 59,697 | 63,119 | 65,034 | 66,870 | 68,759 |
| Corporate costs | - | - | - | - | - | - |
| | **660,836** | **705,847** | **723,560** | **744,955** | **767,733** | **790,015** |
| % change | | **6.8%** | **2.5%** | **3.0%** | **3.1%** | **2.9%** |
| **Operating Surplus/(Deficit)** | **(9,847)** | **(21,738)** | **(12,100)** | **(5,504)** | **(2,402)** | **2,103** |

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| Provider | (17,098) | (34,862) | (24,694) | (23,036) | (24,588) | (25,015) |
| Governance | 1,355 | (225) | 1,127 | 0 | (0) | (0) |
| Funder | 5,896 | 13,349 | 11,467 | 17,532 | 22,186 | 27,118 |
| Total Operating Surplus/(Deficit) | (9,847) | (21,738) | (12,100) | (5,504) | (2,402) | 2,103 |

Refer to the following section for the detailed financial statements.

These financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) and the DHB's Accounting Policies (refer to section 4.3.1).

# 4.3 FINANCIAL STATEMENTS AND ACCOUNTING POLICIES

**Statement of Financial Position**
**MidCentral DHB**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| Current Assets | 70,502 | 59,902 | 43,302 | 37,142 | 33,392 | 34,672 |
| Current Liabilities | 76,952 | 86,911 | 87,343 | 87,322 | 87,848 | 88,384 |
| Working Capital | (6,450) | (27,009) | (44,041) | (50,180) | (54,456) | (53,712) |
| Non current assets | 213,880 | 214,196 | 223,785 | 222,614 | 225,857 | 228,048 |
| Assets Employed | 207,430 | 187,187 | 179,745 | 172,435 | 171,401 | 174,336 |
| Non Current Liabilities | 5,949 | 8,077 | 13,368 | 12,195 | 14,196 | 15,661 |
| Equity | 201,481 | 179,111 | 166,377 | 160,240 | 157,205 | 158,675 |
| Funds Employed | 207,430 | 187,187 | 179,745 | 172,435 | 171,401 | 174,336 |

**Statement of Cashflows**
**MidCentral DHB**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| Total Receipts | 647,436 | 680,789 | 710,599 | 738,399 | 764,243 | 790,991 |
| Total Payments | (634,011) | (673,067) | (701,516) | (721,878) | (744,537) | (766,530) |
| Operating Cash flow | 13,425 | 7,722 | 9,083 | 16,521 | 19,705 | 24,461 |
| Investing Cashflow | (16,954) | (3,307) | (23,847) | (20,506) | (21,354) | (20,464) |
| Financing Cashflow | (894) | (901) | (1,688) | (2,175) | (2,102) | (2,717) |
| Net Capital Cashflow | (17,848) | (4,208) | (25,535) | (22,681) | (23,456) | (23,181) |
| Net Cashflow | (4,423) | 3,514 | (16,452) | (6,160) | (3,750) | 1,280 |
| Opening Cash | 27,923 | 23,500 | 27,014 | 10,562 | 4,402 | 651 |
| Closing Cash | 23,500 | 27,014 | 10,562 | 4,402 | 651 | 1,931 |

## Statement of Debt & Equity
**MidCentral DHB**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| Debt: | | | | | | |
| Facility Utilised: | | | | | | |
| Long-Term Debt | | | | | | |
| Ministry of Health | - | - | - | - | - | - |
| EECA | 447 | 200 | 74 | 0 | 0 | 0 |
| | 447 | 200 | 74 | 0 | 0 | 0 |
| Facility Available: | | | | | | |
| Ministry of Health | - | - | - | - | - | - |
| EECA | 447 | 200 | 74 | 0 | 0 | 0 |
| | 447 | 200 | 74 | 0 | 0 | 0 |
| Unused Facility | - | - | - | - | - | - |
| Equity: | | | | | | |
| Opening | 120,857 | 120,224 | 119,592 | 118,959 | 118,326 | 117,693 |
| Net Surplus/(Deficit) | (21,453) | (43,191) | (55,291) | (60,795) | (63,197) | (61,094) |
| Revaluation Reserve | 102,710 | 102,710 | 102,710 | 102,710 | 102,710 | 102,710 |
| Other movements | - | - | - | - | - | - |
| Equity Injection/(Repayment) | (633) | (633) | (633) | (633) | (633) | (633) |
| | 201,481 | 179,111 | 166,377 | 160,240 | 157,205 | 158,675 |

## Statement of Changes in Equity
**MidCentral DHB**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| Balance at 1 July | 120,857 | 120,224 | 119,592 | 118,959 | 118,326 | 117,693 |
| Total comprehensive income | (21,453) | (43,191) | (55,291) | (60,795) | (63,197) | (61,094) |
| Revaluation Reserve | 102,710 | 102,710 | 102,710 | 102,710 | 102,710 | 102,710 |
| Other movements | - | - | - | - | - | - |
| Equity Repayment | (633) | (633) | (633) | (633) | (633) | (633) |
| Balance at 30 June | 201,481 | 179,111 | 166,377 | 160,240 | 157,205 | 158,675 |

## Schedule of Lenders

| Available Facility ($000's) | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| EECA | | | | | | |
| Loan Facility | 447 | 200 | 74 | 0 | 0 | 0 |
| Total Facility | 447 | 200 | 74 | 0 | 0 | 0 |

**Statement of Financial Performance**
**Provider**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| ***Revenue*** | | | | | | |
| Ministry of Health | 30,487 | 33,738 | 31,825 | 33,098 | 34,256 | 35,455 |
| Other Government | 30,225 | 28,925 | 28,533 | 29,674 | 30,713 | 31,788 |
| Patient / Consumer | 613 | 403 | 465 | 483 | 500 | 518 |
| Other | 9,184 | 9,298 | 8,365 | 8,700 | 9,004 | 9,319 |
| Inter-Provider | 2,374 | 4,479 | 4,558 | 4,740 | 4,906 | 5,078 |
| Internal | 289,162 | 301,738 | 313,784 | 326,335 | 337,757 | 349,578 |
| | **362,045** | **378,581** | **387,530** | **403,031** | **417,137** | **431,737** |
| % change | | **4.6%** | **2.4%** | **4.0%** | **3.5%** | **3.5%** |
| ***less Expenditure*** | | | | | | |
| Personnel | 206,112 | 224,901 | 235,064 | 244,467 | 254,245 | 264,415 |
| Outsourced Services | 25,771 | 30,781 | 20,540 | 21,166 | 21,845 | 22,416 |
| Clinical Supplies | 54,957 | 56,914 | 58,867 | 60,790 | 62,721 | 64,261 |
| Infrastructure & Non-Clinical | 74,199 | 71,164 | 65,140 | 66,065 | 68,289 | 69,917 |
| Financing Charges | 10,693 | 10,782 | 9,393 | 9,780 | 10,040 | 10,421 |
| Corporate costs | 7,411 | 18,901 | 23,219 | 23,799 | 24,584 | 25,322 |
| | **379,143** | **413,443** | **412,223** | **426,067** | **441,724** | **456,752** |
| % change | | **9.0%** | **(0.3%)** | **3.4%** | **3.7%** | **3.4%** |
| **Operating Surplus/(Deficit)** | **(17,098)** | **(34,862)** | **(24,694)** | **(23,036)** | **(24,588)** | **(25,015)** |

**Total Provider Division Revenue by Type**

| $000s | MidCentral Health | Primary Health Nursing / Supportlinks | Enable NZ | Total |
|---|---|---|---|---|
| **Funding Division** | **312,495** | **1,289** | **-** | **313,784** |
| **Clinical Training Agency** | **3,770** | **-** | **-** | **3,770** |
| **Ministry of Health** | **17,030** | **-** | **11,025** | **28,055** |
| Personal Health | 9,420 | - | - | 9,420 |
| Public Health | 3,390 | - | - | 3,390 |
| DSS | 4,220 | - | 11,025 | 15,245 |
| **Other Government** | **14,454** | **-** | **18,637** | **33,091** |
| Inter Provider Revenue | 3,300 | - | 1,258 | 4,558 |
| Training Fees and Subsidies | 350 | - | - | 350 |
| Accident Insurance | 5,909 | - | 17,379 | 23,288 |
| Other | 4,894 | - | - | 4,894 |
| **Patient/Consumer Sourced** | **-** | **-** | **-** | **-** |
| **Other Income** | **4,424** | **-** | **4,406** | **8,830** |
| **Total Revenue** | **352,173** | **1,289** | **34,068** | **387,530** |

**Statement of Financial Performance**
**Funder**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| ***Revenue*** | | | | | | |
| Ministry of Health | 528,383 | 556,013 | 587,374 | 610,869 | 632,250 | 654,379 |
| Other Government | 31 | 335 | 463 | 482 | 499 | 516 |
| Other | 402 | 1,736 | 450 | - | - | - |
| Inter-District Inflows | 45,670 | 46,037 | 46,607 | 48,471 | 50,168 | 51,924 |
| | **574,486** | **604,121** | **634,895** | **659,823** | **682,916** | **706,819** |
| % change | | **5.2%** | **5.1%** | **3.9%** | **3.5%** | **3.5%** |
| ***less Expenditure*** | | | | | | |
| Provider and Governance Divisions | 296,244 | 308,368 | 321,544 | 334,406 | 346,110 | 358,224 |
| External Providers | 213,351 | 222,707 | 238,766 | 242,852 | 247,751 | 252,718 |
| Inter-District Outflows | 58,995 | 59,697 | 63,119 | 65,034 | 66,870 | 68,759 |
| | **568,590** | **590,772** | **623,428** | **642,291** | **660,731** | **679,700** |
| % change | | **3.9%** | **5.5%** | **3.0%** | **2.9%** | **2.9%** |
| **Operating Surplus/(Deficit)** | **5,896** | **13,349** | **11,467** | **17,532** | **22,186** | **27,118** |

**Statement of Financial Performance**
**Governance**

| $'000's | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 | Budget 2020/21 | Budget 2021/22 | Budget 2022/23 |
|---|---|---|---|---|---|---|
| ***Revenue*** | | | | | | |
| Government | - | - | 136 | 141 | 146 | 151 |
| Other | 3,597 | 3,112 | 2,661 | 2,768 | 2,865 | 2,965 |
| Inter-Provider | 23 | 34 | 23 | 24 | 25 | 25 |
| Internal | 7,082 | 6,630 | 7,760 | 8,071 | 8,353 | 8,645 |
| | **10,701** | **9,775** | **10,580** | **11,003** | **11,388** | **11,787** |
| % change | | **(8.7%)** | **8.2%** | **4.0%** | **3.5%** | **3.5%** |
| ***less Expenditure*** | | | | | | |
| Personnel | 10,555 | 12,680 | 13,240 | 13,770 | 14,320 | 14,893 |
| Outsourced Services | 1,900 | 2,202 | 1,794 | 1,839 | 1,900 | 1,957 |
| Clinical Supplies | 25 | 19 | 25 | 25 | 26 | 27 |
| Infrastructure & Non-Clinical | 3,239 | 12,962 | 16,574 | 18,104 | 18,627 | 19,100 |
| Financing Charges | 1,038 | 1,038 | 1,038 | 1,064 | 1,099 | 1,132 |
| Corporate costs | (7,411) | (18,901) | (23,219) | (23,799) | (24,584) | (25,322) |
| | **9,346** | **10,000** | **9,453** | **11,003** | **11,388** | **11,787** |
| % change | | **7.0%** | **(5.5%)** | **16.4%** | **3.5%** | **3.5%** |
| **Operating Surplus/(Deficit)** | **1,355** | **(225)** | **1,127** | **0** | **(0)** | **(0)** |

## 4.3.1 MidCentral District Health Board Statement of Accounting Policies

### Reporting Entity

MidCentral District Health Board (MidCentral DHB) is a Crown entity in terms of the Crown Entities Act 2004, is owned by the Crown, and is domiciled in New Zealand. MidCentral DHB was created under the New Zealand Public Health and Disability Act 2000, effective 1 January 2001.

The Group consists of MidCentral DHB, associated entity Allied Laundry Services Limited (ALSL) (17.4% owned) and an investment in Central Region's Technical Advisory Service Limited (TAS) (16.7% owned). In addition, the group includes wholly owned subsidiary Enable New Zealand Limited, which is non-trading. As of November 2002 all the assets, liabilities and activities of Enable New Zealand Ltd were vested in the MidCentral District Health Board. As a result of this Enable New Zealand Ltd has no balances as at 30 June 2019 (2018: nil). The group numbers are therefore the same as the parent numbers.

The group financial statements of MidCentral DHB have been prepared in accordance with the requirements of New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 2013, the Public Finance Act 1989, and the Crown Entities Act 2004.

MidCentral DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

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

### Statement of Compliance and Basis of Preparation

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

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 that the following assets and liabilities are stated at their fair value: land and buildings, and derivative financial instruments (foreign exchange contract).

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

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

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

#### Going Concern

The going concern principle has been adopted in the preparation of these financial statements. The MidCentral DHB, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations in the foreseeable future. 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 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption.

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 requirements of the DHB as set out in the current Annual Plan.

### Basis for Consolidation

#### Associates

Associates are those entities in which MidCentral DHB has significant influence, but not control, over the financial and operating policies. ALSL is an associate company of MidCentral DHB.

The consolidated financial statements include MidCentral DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When MidCentral DHB's share of losses exceeds its interest in an associate, MidCentral DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that MidCentral DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Investments in associates are recorded using the equity method in the parent's financial statements.

**Transactions Eliminated on Consolidation**

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of MidCentral DHB's interest in the entity.

Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

**Foreign Currency Transactions**

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. 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. Foreign exchange differences arising on translation are recognised in profit or loss in the Statement of Comprehensive Revenue and Expense. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

The associated foreign exchange gains or losses follow the fair value gains or losses to either profit or loss or directly to equity.

**Budget Figures**

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

## Summary of Significant Accounting Policies

**Revenue**

*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.

*Goods Sold and Services Rendered*

Revenue from the supply of goods and services is measured at the fair value of consideration received. Revenue from goods sold is recognised when MidCentral DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and MidCentral 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 MidCentral DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by MidCentral DHB.

*Rental Income*

Rental income from strategic assets/assets held for social benefit is recognised in profit or loss on a straight-line basis over the term of the lease.

Lease incentives granted are recognised as an integral part of the total rental income over the lease term on a straight-line basis.

**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
- plant, equipment and vehicles
- work in progress
- fixtures and fittings.

*Owned Assets*

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years. Valuations undertaken in accordance with generally accepted accounting practice and standards issued by the New Zealand Property Institute are used where available. Otherwise, valuations are conducted in accordance with the Rating Valuation Act 1998, which have been confirmed by an independent valuer. Any increase in value of a class of land and buildings is recognised directly in equity unless it offsets a previous decrease in value recognised in profit or loss. 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 profit or loss.

Additions to property, plant and equipment between valuations 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.

Rental property is included in property plant and equipment in accordance with PBE IPSAS as the rental property is held for strategic and social purposes rather than for rental income, capital appreciation or both.

*Disposal of Property, Plant & Equipment*

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

*Leased Assets*

Leases where MidCentral DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses. The capitalised values are depreciated over the period in which the DHB expects to receive benefits from their use.

Operating leases, where the lessor substantially retains the risks and rewards of ownership, are recognised in a systematic manner over the term of the lease.

Leasehold improvements are capitalised and the cost is depreciated over the lease or the estimated useful life of the improvements, whichever is the shorter.

*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 MidCentral DHB. All other costs are recognised in profit or loss as an expense as incurred.

*Depreciation*

Depreciation is charged to profit or loss using the straight line method. Land and work in progress 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 80 years |
| Plant, Equipment and Motor Vehicles | 3 to 20 years |
| Fixtures and Fittings | 3 to 25 years |

The residual value of assets is reassessed annually.

The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Accumulated depreciation at revaluation date is eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

For each property, plant and equipment project, borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

*Intangible Assets*

Intangible assets that are acquired by MidCentral DHB are stated at cost less accumulated amortisation and impairment losses. The intangible assets also include assets whereby they have a right to access shared services provided using the assets funded. These relate to Class "B" shares held in NZ Health Partnerships Limited and Central Region TAS Ltd and are measured at cost, being the amount of funding contributed and will be measured at cost less accumulated amortisation (if required) 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 profit or loss on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite.

Intangible assets with indefinite useful lives are tested for impairment at least annually to determine if there is any indication of impairment. Other 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 | 6 to 10 years |

Realised gains and losses arising from disposal of intangible assets are recognised in profit or loss in the period in which the transaction occurs

**Financial Assets and Liabilities**

*Financial Assets*

Financial assets are classified into the following specified categories. Financial assets "at fair value through profit or loss" (FVTPL), "held to maturity" investments, "available for sale" financial assets, and "loans and receivables". The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. At balance date MidCentral DHB had "held to maturity investments", "loans and receivables" and "assets held for trading: financial instruments".

*Effective Interest Method*

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or where appropriate, a shorter period, to the net carrying amount of the financial asset.

*Loans and Receivables*

Cash, short term deposits and trade and other receivables with fixed or determinable payments that are not quoted in an active market are classified as loans and receivables. Loans and receivables are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any impairment. Interest income is recognised by applying the effective interest rate method.

*Held to Maturity Investments*

Term deposits with fixed or determinable payments and maturity dates that the group has the positive intent and ability to hold to maturity are classified as held to maturity investments.

Held to maturity investments are initially recorded at fair value and subsequently measured at amortised cost using the effective interest method, less any impairment, with revenue recognised on an effective interest method. Investments are classified as "held to maturity" investments.

*Financial Assets at FVTPL*

Financial assets are classified as at FVTPL where the financial asset is either held for trading or it is designated as at FVTPL.

A financial asset is classified as held for trading if:

it has been acquired principally for the purpose of selling in the near future; or

on initial recognition it is part of an identified portfolio of financial instruments that the group manages together and has a recent actual pattern of short-term profit-taking; or

it is a derivative that is not designated and effective as a hedging instrument.

Financial assets at FVTPL are stated at fair value, with any resultant gain or loss recognised in profit or loss. The net gain or loss recognised in profit or loss incorporates any dividend or interest earned on the financial asset.

Derivative financial assets are considered to be financial assets held for trading and are classified as "other financial assets" in the Statement of Financial Position.

*Impairment of Financial Assets*

Financial assets other than those at fair value through profit or loss are assessed for indicators of impairment at each balance sheet date. Financial assets are impaired where there is objective evidence that as a result of one or more events that occurred after the initial recognition of the financial asset the estimated future cash flows of the asset have been impacted.

For financial assets carried at amortised cost, the amount of impairment is the difference between carrying amount and the present value of the estimated future cash flows, discounted at the original effective interest rate.

The carrying amount of the financial asset is reduced by the impairment loss directly for all financial assets with the exception of trade receivables where the carrying amount is reduced through the use of an allowance account. Subsequent recoveries of amounts previously written off are credited against the allowance account. Changes in the carrying amount of the allowance account are recognised in profit or loss.

If in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through profit or loss to the extent that the carrying amount of the investment at the date of impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

*Financial Liabilities*

Financial liabilities are classified as "other financial liabilities".

*Other Financial Liabilities*

Other financial liabilities, including interest bearing loans and borrowings and other payables, are initially measured at fair value, net of transaction costs.

Other financial liabilities are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective interest basis.

*Derecognition of Financial Liabilities*

MidCentral DHB derecognises financial liabilities when, and only when, the DHB's obligations are discharged, cancelled or they expire.

*Derivative Financial Instruments*

The Group enters into a variety of derivative financial instruments to manage its exposure to foreign exchange rate risk.

Derivatives are initially recognised at fair value at the date a derivative contract is entered into and are subsequently re-measured to their fair value at each balance sheet date. The resulting gain or loss is recognised in profit or loss immediately unless the derivative is designated and effective as a hedging instrument. MidCentral DHB does not have any derivatives that are designated and effective as hedging instruments.

A derivative is presented as a non-current asset or a non-current liability if the remaining maturity of the instrument is more than 12 months and it is not expected to be realised or settled within 12 months. Other derivatives are presented as current assets or current liabilities.

*Inventories Held for Distribution*

Inventories held for distribution are stated at the lower of cost and current replacement cost.

*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 MidCentral DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows and the Statement of Financial Position.

*Impairment of Other Tangible Assets*

The carrying amounts of MidCentral 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 profit or loss.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date.

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.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in profit or loss even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in profit or loss is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in profit or loss.

The recoverable amount of MidCentral DHB's receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at the original effective interest rate (i.e. the effective interest rate computed at initial recognition of these financial assets). Receivables with a short duration are not discounted.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach.

For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

*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 an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through profit or loss.

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.

*Borrowing Costs*

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

**Employee Benefits**

*Defined Contribution Plans*

Obligations for contributions to defined contribution plans are recognised as an expense in profit or loss as incurred.

There are a small number of employees that are part of a state defined benefit superannuation plan. The DHB has no legal or constructive obligation to pay future benefits, the Crown guarantees these benefits and as a result the plans are accounted for as a defined contribution plan.

*Long Service Leave, Sabbatical Leave and Retirement Gratuities*

MidCentral DHB's net obligation in respect of long service leave, sabbatical 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, Conference Leave, Sick Leave & Medical Education Leave*

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

*Termination Payments*

Termination Payments are recognised in profit or loss only where there is a demonstrable commitment to either terminate employment prior to normal retirement date or to provide such benefits as a result of an offer to encourage voluntary redundancy.

Termination benefits settled in 12 months are reported as the amount expected to be paid, otherwise they are reported as the present value of the estimated future cash flows.

**Provisions**

A provision is recognised when MidCentral 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 pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

*Restructuring*

A provision for restructuring is recognised when MidCentral 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.

*Revenue Relating to Service Contracts*

MidCentral DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or MidCentral DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability where there is sufficient certainty of a specific obligation to repay.

*Other Liabilities and Provisions*

Other liabilities and provisions are recorded at the best estimate of the expenditure required to settle the obligation. Liabilities and provisions to be settled beyond 12 months are recorded at their present value.

*Insurance Contracts*

MidCentral DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme MidCentral DHB is liable for all its claims costs for a period of two years up to a specified maximum. At the end of the two year period, MidCentral DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

**Taxation**

*Income Tax*

MidCentral DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

*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.

**Expenses**

*Operating Lease Payments*

Payments made under operating leases are recognised in profit or loss on a straight-line basis over the term of the lease. Lease incentives received are recognised in profit or loss over the lease term as an integral part of the total lease expense on a straight line basis.

*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.

*Financing Costs*

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method.

The interest expense component of finance lease payments is recognised in profit or loss using the effective interest rate method.

*Assets Held For Sale and Discontinued Operations*

Immediately before classification as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable PBE IPSAS. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in profit or loss, even when the asset was previously revalued. The same applies to gains and losses on subsequent remeasurement.

A discontinued operation is a component of MidCentral DHB's business that represents a separate major line of business or geographical area of operations or is a subsidiary acquired exclusively with a view to resale.

Classification as a discontinued operation occurs upon disposal or when the operation meets the criteria to be classified as held for sale, if earlier.

*Contingent Assets and Contingent Liabilities*

Contingent liabilities and contingent assets are recorded in the Statement of Contingent Liabilities and Contingent Assets at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote. Contingent assets are disclosed if it is probable that the benefits will be realised.

*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 MidCentral DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

*Cost Allocation*

MidCentral 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.

**Statement of Cash Flows**

The statement of cash flows is prepared exclusive of GST, which is consistent with the method used in the Statement of Comprehensive Revenue and Expense.

GST inflows and GST outflows in the Cash Flow Statement have been shown net as the Board does not believe that showing gross cash flows provides more useful information given that GST is paid net each month.

**Definitions of the terms used in the statement of cash flows are:**

*Cash* includes coins and notes, demand deposits and other highly liquid investments readily convertible into cash and includes all call borrowings such as bank overdrafts used by the organisation.

*Operating activities* include all transactions and other events that are not investing or financing activities.

*Investing activities* are those activities relating to the acquisition and disposal of current and non-current investments and any other non-current assets.

*Financing activities* are those activities relating to changes in the equity and debt capital structure of the organisation and those relating to the cost of servicing the organisation's equity capital.

**Changes in Accounting Policies**

Accounting policies have been consistently applied unless otherwise stated.

**Standards, Amendments and Interpretations Issued but not yet Effective in the Current Period**

Amendments have been issued as part of a project to improve presentation and disclosure requirements under PBE IPSAS. These changes are unlikely to have a material impact on the financial statements and disclosures.

# 4B ALLIED LAUNDRY SERVICES LIMITED

## 4B.1 STATEMENT OF ACCOUNTING POLICIES

### Reporting Entity

The financial statements and notes are for Allied Laundry Services Limited (the Company). It is a profit oriented entity incorporated and domiciled in New Zealand and is a company registered under the Companies Act 1993.

The address of its registered office is 196 Broadway Avenue, Palmerston North, New Zealand. Its principal place of business is 12/50 Ruahine Street, Roslyn, Palmerston North, New Zealand.

The principal activities of the Company during the financial period were the provision of laundry and linen services to Taranaki, Whanganui, Hawkes Bay, MidCentral, Hutt Valley, Capital & Coast and Wairarapa District Health Boards and commercial customers.

### Statement of Compliance and Basis of Preparation

The Company has adopted the New Zealand equivalents to International Financial Reporting Standards - Reduced Disclosure Regime ("NZ IFRS - RDR") as set out in the External Reporting Board's "Accounting Standards Framework".

The financial statements are general purpose financial statements that have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand ("NZ GAAP). They comply with New Zealand equivalents to NZ IFRS - RDR. The Company has elected to report under NZ IFRS - RDR as the Company is a for-profit Tier 2 entity for financial reporting purposes on the basis that it does not have public accountability and is not a large for-profit public sector entity. The financial statements have been prepared in accordance with the requirements of the Companies Act 1993. All reporting concessions have been taken.

The financial statements were approved and authorised for issue by the Board of Directors.
The accounting principles recognised as appropriate for the measurement and reporting of the Statement of Comprehensive Income and Statement of Financial Position on a historical cost basis are followed by the company, unless otherwise stated in the Specific Accounting Policies. The information is presented in New Zealand dollars. All values are rounded to the nearest doolar.

### Specific Accounting Policies

The following specific accounting policies which materially affect the measurement of the Statement of Comprehensive Income and Statement of Financial Position have been applied:

**Revenue**

Revenue comprises amounts received and receivable by the business for goods and services supplied in the ordinary course of business. Operating Revenue is recognised based on the number of laundry items processed and dispatched to customers.

Interest income and expenses are reported on an accrual basis using the effective interest method.

**Expenses**

Operating expenses are recognised in profit or loss upon utilisation of the service or at the date of their origin.

**Inventories**

Inventories are stated at the lower of cost and net realisable value. Cost includes all expenses directly attributable to the manufacturing process as well as suitable portions of related production overheads, based on normal operating capacity. Costs of ordinarily interchangeable items are assigned using the first in, first out cost formula. Net realisable value is the estimated selling price in the ordinary course of business less any applicable selling expenses.

**Trade Receivables**

Trade Receivables are recognised at fair value, then amortised cost, making allowances for doubtful debts.

**Property, Plant and Equipment**

The cost of purchased assets is the value of consideration given to acquire the assets and the value of other directly attributable costs which have been incurred in bringing the assets to the location and condition necessary for their intended service. Costs include financing costs that are directly attributable to the purchase of those assets.

Depreciation is calculated at the following rates:

| | |
|---|---|
| Buildings | 2-8.3% Straight Line |
| Leasehold | 5-20% Straight Line |
| Textiles & Linen | 33% Straight Line |
| Plant | 10-40% Straight Line |
| Office Equipment | 18.6% Straight Line |
| Motor Vehicles | 20% Straight Line |

Work in progress is not depreciated. The total cost of a project is transferred to property and/or plant and equipment on its completion and then depreciated.

The internal controls over the identification and existence of Textiles & Linen stock movements are limited. This therefore has a direct impact on the final value of Textiles & Linen stock as well as the Textiles & Linen depreciation balances.

**Income Tax**

The company is exempt from income tax under Section CW 38 (2) of the Income Tax Act 2007

**Goodwill**

Goodwill represents the excess of the purchase consideration over the fair value of the net tangible assets and intangible assets, acquired at the time of acquisition of a business or an equity interest in a subsidiary or associate company. Goodwill is tested annually for impairment. Brand names are recognised at cost. They are regarded as having indefinite useful lives because there is no foreseeable limit to the period over which they are expected to be useful. They are therefore not amortised. Instead, they are tested annually for impairment.

**Financial Instruments**

1) Recognition, initial measurement and derecognition

   Financial assets and financial liabilities are recognised when the Company becomes a party to the contractual provisions of the financial instrument, and are measured initially at fair value adjusted by transaction costs, except for those carried at fair value through profit or loss, which are measured initially at fair value. Subsequent measurement of financial assets and financial liabilities are described below.

   Financial assets are derecognised when the contractual rights to the cash flows from the financial asset expire, or when the financial asset and all substantial risks and rewards are transferred.

   A financial liability is recognised when it is extinguished, discharged, cancelled or expires.

2) Classification and subsequent measurement of financial assets

   For the purpose of subsequent measurement, financial assets other than those designated and effective as hedging instruments are classified into the following categories upon initial recognition:

   - Loans and receivables
   - Financial assets at Fair value through profit or loss (FVTPL)
   - Held-to-Maturity investments (HTM)
   - Available-for-sale financial assets (AFS)

   All financial assets except for those at FVTPL are subject to review for impairment at least at each reporting date to identify whether there is any objective evidence that a financial asset or a group of financial assets is impaired. Different criteria to determine impairment are applied for each category of financial assets, which are described below.

3) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial recognition, these are measured at amortised cost using the effective interest method, less an allowance for credit losses. Discounting is omitted where the effect of discounting is immaterial. The Company's trade and most other receivables fall into this category of financial instruments.

Individually significant receivables are considered for impairment when they are past due or when other objective evidence is received that a specific counterparty will default. Receivables that are not considered to be individually impaired are reviewed for impairment in groups, which are determined by reference to the industry and region of a counterparty and other shared credit risk characteristics. The impairment loss estimate is then based on recent historical counterparty default rates for each identified group.

**Foreign Currencies**

The financial statements are presented in New Zealand Dollars (NZD), which is also the functional currency of the Company.

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions (spot exchange rate). Foreign exchange gains and losses resulting from the settlement of such transactions and from the re-measurement of monetary items at year end exchange rates are recognised in profit and loss.

**Goods and Services Tax (GST)**

Revenues and expenses have been recognised in the financial statements exclusive of GST except that irrecoverable GST input tax has been recognised in association with the expense to which it relates. All items in the Statement of Financial Position are stated exclusive of GST except for receivables and payables which are stated inclusive of GST.

**Impairment**

For impairment assessment purposes, assets are grouped at the lowest levels for which there are largely independent cash inflows (cash-generating units). As a result, some assets are tested individually for impairment and some are tested at cash-generating unit level. Goodwill is allocated to those cash-generating units that are expected to benefit from synergies of the related business combination and represent the lowest level within the Company at which management monitors goodwill.

Cash-generating units to which goodwill has been allocated are tested for impairment at least annually. All other individual assets or cash-generating units are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable.

An impairment loss is recognised for the amount by which the asset's or cash-generating unit's carrying amount exceeds its recoverable amount, which is the higher of fair value less costs to sell and value-in-use. To determine the value-in-use, management estimates expected future cash flows from each cash-generating unit and determines a suitable interest rate in order to calculate the present value of those cash flows.

Impairment losses for cash-generating units reduce first the carrying amount of goodwill allocated to that cash-generating unit. Any remaining impairment loss is charged pro rata to the other assets in the cash-generating unit. With the exception of goodwill, all assets are subsequently reassessed for indications that an impairment loss previously recognised may no longer exist. An impairment charge is reversed if the cash-generating unit's recoverable amount exceeds its carrying amount.

**Cash and Cash Equivalents**

Cash and cash equivalents comprise cash on hand and demand deposits, together with other short-term, highly liquid investments that are readily convertible into known amounts of cash and which are subject to an insignificant risk of changes in value.

**Employee Benefits**

1) Short-term employee benefits

Short-term employee benefits are benefits, other than termination benefits, that are expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. Examples of such benefits include wages and salaries and non-monetary benefits. Short-term employee benefits are measured at the undiscounted amounts expected to be paid when the liabilities are settled.

2) Other long-term employee benefits

The Company's liability for annual and long service leave are included in other long term benefits as they are not expected to be settled wholly within 12 months after the end of the period in which the employees render the related service. They are measured at the present value of the expected future payments to be made to employees.

The expected future payments incorporate anticipated future wage and salary levels, experience of employee departures and periods of service, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the timing of the estimated future cash outflows. Any re-measurement arising from experience adjustments and changes in assumptions are recognised in profit or loss in the periods in which the changes occur.

The Company presents employee benefit obligations as current liabilities in the statement of financial position if the Company does not have an unconditional right to defer settlement for at least twelve months after the reporting period, irrespective of when the actual settlement is expected to take place.

**Equity, Reserves and Dividend Payments**

Share capital represents the fair value of shares that have been issued. Any transaction costs associated with the issuing of shares are deducted from share capital.

Retained earnings include all current and prior period retained profits.

Dividend distributions payable to equity shareholders are included in other liabilities when the dividends have been approved in a general meeting prior to the reporting date.

Dividends are paid by the company after reviewing the financial position and impact of the dividend on the solvency of the company.

All dividends are approved by the Board before payment.

**Business Combinations**

The Company applies the acquisition method in accounting for business combinations. The consideration transferred by the Company to obtain control of a subsidiary is calculated as the sum of the acquisition-date fair values of assets transferred, liabilities incurred and the equity interests issued by the Company, which includes the fair value of any asset or liability arising from a contingent consideration arrangement. Acquisition costs are expensed as incurred.

The Company recognises identifiable assets acquired and liabilities assumed in a business combination regardless of whether they have been previously recognised in the acquiree's financial statements prior to the acquisition. Assets acquired and liabilities assumed are generally measured at their acquisition-date fair values.

Goodwill is stated after separate recognition of identifiable intangible assets. it is calculated as the excess of the sum of: (a) fair value of consideration transferred; (b) the recognised amount of any non-controlling interest in the acquiree; and (c) acquisition-date fair value of any existing equity interest in the acquiree, over the acquisition-date fair values of identifiable net assets. If the fair value of identifiable net assets exceed the sum calculated above, the excess amount (i.e. gain on bargain purchase) is recognised in profit or loss immediately.

**Provisions and Contingent Liabilities**

Provisions are recognised when the Company has a present obligation or constructive obligation as a result of a past event, it is probable that an outflow of economic resources will be required from the Company and amounts can be estimated reliably. Timing or amount of the outflow may still be uncertain.

Provisions are measured at the estimated expenditure required to settle the present obligation, based on the most reliable evidence available at the reporting date, including the risks and uncertainties associated with the present obligation. Where there are a number of similar obligations, the likelihood that an outflow will be required in settlement is determined by considering the class of obligation as a whole. Provisions are discounted to their present values, where the time value of money is material.

No liability is recognised in an outflow of economic resources as a result of present obligation is not probable. Such instances are disclosed as contingent liabilities, unless the outflow of resources is remote in which case no liability is recognised.

**Statement of Cash Flows**

The Statement of Cash Flows is prepared exclusive of GST, which is consistent with the method used in the Statement of Financial Performance.

The following are definitions of the terms used in the Statement of Cash Flows:

1) Cash is considered to be cash on hand, current accounts in banks, and other highly liquid investments in which the entity invests as part of its day to day cash management. Cash includes borrowings from financial institutions such as bank overdrafts, where such borrowings are on call and are used as part of the day to day cash management.
2) Investing activities are those activities relating to the acquisition, holding and disposal of fixed assets and of investments. Investments can include securities not falling within the definition of cash.
3) Financing activities are those activities which result in changes in the size and composition of the capital structure of the group. This includes both equity and debt not falling within the definition of cash. Dividends paid in relation to the capital structure are included in financing activities.
4) Operating activities includes all transactions and other events that are not financing or investing activities.
5) The reconciliation of the surplus (deficit) after tax with the net cash flow from operating activities is set out in the Statement of Cash Flows.

**Significant Management Judgement in applying Accounting Policies and Estimation Uncertainty**

When preparing the financial statements, management undertakes a number of judgements, estimates and assumptions about the recognition and measurement of assets, liabilities, income and expenses.

Information about estimates and assumptions that have the most significant effect on recognition and measurement of assets, liabilities, income and expenses is provided below. Actual results may be substantially different.

*Impairment*

In assessing impairment, management estimates the recoverable amount of each asset or cash-generating unit based on expected future cash flows and uses an interest rate to discount them. Estimation uncertainty relates to assumptions about future operating results and the determination of a suitable discount rate.

*Useful life of depreciable assets*

Management reviews its estimate of the useful life of depreciable assets at each reporting date, based on the expected utility of the assets. Uncertainties in these estimates relate to technical obsolescence that may change the utility of certain software and IT equipment.

Furthermore, the useful life for linen stocks is based on an assumption that linen stocks last for 36 months (3 years). The policy is based on the life of the total pool of circulating linen stocks and reflects linen life, linen ragging and unidentified stock losses.

*Changes in Accounting Estimates*

There have been no changes in accounting estimates during the reporting period.

**Changes in Accounting Policies**

There have been no changes in accounting policies. All policies have been applied on a basis consistent with those from previous financial statements.

## 4B.2 ALLIED LAUNDRY SERVICES FINANCIAL STATEMENTS

**Allied Laundry Services Limited**
**Statement Financial Performance**

| | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 |
|---|---|---|---|
| | ($) | ($) | ($) |
| Revenue | 10,590,306 | 10,744,303 | 11,276,726 |
| Expenditure | | | |
| Operating expenses | 6,567,436 | 6,985,801 | 7,257,221 |
| Administration | 522,833 | 490,345 | 540,380 |
| Interest & Lease | 367,000 | 365,917 | 376,124 |
| Insurance | 122,418 | 126,836 | 120,000 |
| Non cash (Depreciation) | 2,467,722 | 2,450,708 | 2,291,269 |
| Total linen supply expenditure | 10,047,409 | 10,419,608 | 10,584,994 |
| Operating surplus | 542,897 | 324,695 | 691,732 |
| Non operating expenditure | 391,500 | 409,500 | 414,000 |
| Net surplus | 151,397 | 84,805 | 277,732 |

**Allied Laundry Services Limited**
**Statement Financial Position**

| | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 |
|---|---|---|---|
| | ($) | ($) | ($) |
| Current assets | 1,127,047 | 970,435 | 1,168,415 |
| Current liabilities | 2,759,682 | 2,074,427 | 1,742,994 |
| Working capital | 1,632,635 | 1,103,992 | 574,579 |
| Non current assets | 8,886,769 | 8,616,886 | 8,105,617 |
| Assets employed | 7,254,134 | 7,512,894 | 7,531,038 |
| Non current liabilities | 418,122 | 413,973 | 154,385 |
| Equity | 6,836,012 | 7,098,921 | 7,376,653 |
| Funds employed | 7,254,134 | 7,512,894 | 7,531,038 |

**Allied Laundry Services Limited**
**Statement of Cashflows**

| | Actual 2017/18 | Forecast 2018/19 | Budget 2019/20 |
|---|---|---|---|
| | ($) | ($) | ($) |
| Total receipts | 10,688,323 | 10,783,163 | 11,123,384 |
| Total payments | 7,924,540 | 8,743,266 | 8,993,394 |
| Operating cashflow | 2,763,783 | 2,039,897 | 2,129,990 |
| Investing cashflow | 2,032,013 | 2,128,096 | 1,780,000 |
| Financing cashflow | 691,037 | 29,846 | 309,850 |
| Net cashflow | 40,733 | 58,353 | 40,140 |
| Opening cash | 5,455 | 46,188 | 12,165 |
| Closing cash | 46,188 | 12,165 | 27,975 |

# APPENDIX: DESCRIPTION OF OUTPUT CLASSES

## Output Class: Prevention Services

### *Output: Health Promotion and Education*

Health promotion services support individuals, families/whānau and communities to take control over the factors that influence their health. Health promotion staff utilise the Ottawa Charter and Te Tiriti o Waitangi and other equity tools as frameworks to improve health and to reduce inequality, focusing both on healthy lifestyles and on the physical and social environments in which people live, work and play. This involves advocacy for healthy public policy and for healthy, sustainable communities as well as providing education around risk factors and behaviours that contribute to health and wellbeing.

### *Output: Health Protection, Regulation, Environmental Health and Communicable Disease Control*

Health protection services work within the framework created by the various health-related Acts including the Health Act (1956), Sale and Supply of Liquor Act 2012 and Smoke Free Environments Act 1990 and their associated regulations. The emphasis is around increasing compliance with the legislation in order to protect the health of individuals and of communities. This involves working with a range of agencies to maintain a healthy physical environment, ensuring that food and water are safe to consume, that communities are protected from hazardous substances and are as prepared as possible for emergencies such as earthquakes, floods and pandemics. Surveillance and control of communicable diseases such as measles and influenza are also important functions, with immunisation a key tool in maintaining a healthy population.

### *Output: Population Based Screening*

Screening programmes can detect some conditions, allowing earlier treatment and reducing morbidity and mortality. In some cases (for example, breast screening), screening may detect cancer at an early stage. In others (such as newborn metabolic screening) screening may find conditions which can be treated before the baby develops a preventable illness or disability. For example:

- breast screening reduces the chances of dying from breast cancer by about 30 percent if aged between 50 and 65, and by about 45 percent if aged between 65 to 69
- cervical screening reduces the chances of developing cervical cancer by about 90 percent
- newborn hearing screening picks up hearing impairment in babies and enables certain conditions that can be harmful to babies to be treated at an early stage. This means that help such as parent support groups, hearing aids, cochlear implants and the introduction of sign language can be offered as soon as possible

### *Output: Immunisation*

Publicly funded immunisation services provide National Immunisation Schedule vaccinations together with a range of education and support services to ensure a high immunisation coverage rate for the district's population.

### *Output: Well Child Services*

The Well Child/Tamariki Ora (WCTO) service framework covers screening, education and support services offered free to all New Zealand children from birth to five years, and their families/whānau. Well child services include health education and promotion, health protection and clinical assessment, and family/whānau support.

The services also ensure that parents are linked to other early childhood services such as early childhood education and social support services, if required. Under the current well child national schedule, 12 health checks are offered. Eight of these checks are offered between the ages of six weeks and five years. Additional services are also offered to first time parents and to families who are identified as needing more support.

# Output Class: Early Detection and Management

### *Output: Primary Health Care*

Primary and community services support people to access intervention, diagnostics and treatment and to better manage illness or long term conditions. These services assist people to detect health conditions earlier, making treatment and interventions easier and reducing the complications of injury and illness. For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and is one of the most effective ways to prevent disease through screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the continuum of care, and for improving the management of care for people with long term conditions.

### *Output: Primary Community Care Programmes*

Primary and community care programmes are geared toward initiatives that rely on a team of health care professionals to provide a range of services for people with high health needs, in particular those with a long term condition such as diabetes, respiratory and/or cardiovascular disease, focused on reducing risk of illness and timely diagnosis, assessment and treatment of illness or disease.

### *Output: Community Based Oral Health Services for Children and Adolescents*

Child and Adolescent Oral Health Services cover the provision of a range of dental care to assist the maintenance of a functional natural dentition and to bring about an improvement in oral health status of the population. It includes preventive care, oral health promotion and education, treatment of oral disease and the restoration of tooth tissue. The client group comprises all children in the following age groups:

- pre-schoolers until school entry (to enable access for at-risk children at any age)
- all children of primary school and intermediate school age
- children older than 13 years who do not yet attend secondary school
- adolescents attending school from year 8 up to their 18th birthday, who otherwise would not have access to oral health services

### *Output: Community Pharmacy Services*

Community pharmacies provide medicine management services to people living in the community. MidCentral DHB funds community pharmacies to assess an individual person's need for a medicine, assist with the selection of a medicine appropriate for the individual's needs, prepare and supply subsidised medicine(s) to eligible people, and provide assistance to people so that outcomes from medicines are optimised.

### *Output: Community Referred Testing and Diagnostic Services*

A range of diagnostic services is provided on direct referral from General Practitioners and certain other health professionals to help diagnose a condition or as part of treatment. They include radiology, laboratory and various other specialty diagnostic tests.

# Output Class: Intensive Assessment and Treatment

### *Output: Mental Health and Addiction Services*

Specialist mental health and addiction services are delivered to those eligible people who are most severely affected by mental illness or addiction.

The services include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Mental health and addiction services aim to reduce the impact of mental illness and reduce harm caused by drug and alcohol dependency or addiction through a recovery-focused, consumer oriented approach to early assessment and treatment.

### *Output: Hospital-Based Elective Services (inpatient and outpatient)*

Elective services are medical or surgical services which will improve quality of life for someone suffering from a significant medical condition, but that can be delayed because they are not required immediately. A service becomes known as an "elective" if it is provided seven or more days after the decision to proceed with treatment. Electives do not include services such as disability support, maternity, mental health, primary health or public health programmes.

Access to elective services is based on a referral from a general practitioner, and gives priority to those most in need and who will benefit most. A booking system is therefore used. The referral guidelines and access criteria are part of the national electives programme overseen by the Ministry of Health. A key priority of Government is to ensure equitable access to elective services, deliver more elective surgery as well as to reduce waiting times.

### *Output: Hospital Based Acute Services*

Specialist (acute) medical and surgical services are provided to people of all ages whose condition is of such severity or complexity that it is beyond the capacity and technical support of the referring service. Services intended are to achieve an integrated continuum of care that provides effective shared care across all settings from primary to tertiary, and includes cure of disease, relief of pain, effective screening and prevention of unnecessary or long term complications and access to information by patients and other practitioners. Hospital acute services will also advise and plan for care that prevents or reduces acute exacerbation of chronic disease to minimise likelihood of inappropriate hospital admissions and promote improved quality of life.

### *Output: Hospital Based Maternity Services*

Maternity Services that are funded by DHBs include primary, secondary and tertiary maternity care for pregnant women and their babies until six weeks after the birth. The service supports continuity of care, and is delivered in community, outpatient and inpatient settings. The national Maternity Referral Guidelines identify clinical reasons for consultation with a specialist and are published by the Ministry of Health from time to time.

Hospital-based maternity services are provided at primary, secondary and tertiary levels. Secondary maternity services are those provided where women and/or their babies experience complications that need additional maternity care involving obstetricians, paediatricians, other specialists and secondary care teams. Tertiary maternity services are additional maternity care provided to women and their babies who have highly complex clinical needs and require consultation with and/or transfer of care to a multi-disciplinary specialist team.

### *Output: Assessment, Treatment and Rehabilitation Services*

Multi-disciplinary inpatient assessment treatment and rehabilitation (AT&R) for people with complex medical, cognitive, functional and social needs with the aim of enabling them to live independently in the community. Includes aged, physical, sensory and intellectual AT&R service(s). The AT&R service aims to improve functional independence of patients in usual age-related roles and activities and/or return to the workforce or other activity with limitation of disease progression by active risk factor management and early, effective rehabilitation.

These are services provided to restore functional ability and enable people to live as independently as possible.

# Output Class: Rehabilitation and Support

### *Output: Needs Assessment and Service Coordination*

Needs Assessment is a process of determining the current abilities, resources, goals and needs of a person and defining those needs which are most important to the person. Needs Assessment is provided to:

- a person who has been identified as having a physical, intellectual, sensory or aged related disability (or a combination of these); and
- which is likely to continue for a minimum of six months; and
- results in a reduction of independent function to the extent that ongoing support is required

Service coordination is a process of identifying, planning and reviewing the packages of services required to meet the priorities, needs and goals of the person assessed. The process also determines which of these needs can be met by funded services and which can be met by other services. The process explores all options and linkages for addressing the person's prioritised needs and goals.

### *Output: Home-Based Support Services*

The purpose of the home support services is to promote and maintain the independence of people who are experiencing difficulty caring for themselves because of an illness or chronic medical condition, or as a result of hospitalisation. The home support service is long term support provided by support workers for people with chronic health conditions in their own home or other private accommodation in the community. The service is delivered by private organisations, upon authorised referral following confirmation of eligibility and an individual needs assessment process, and is accountable for the quality of services delivered. The services have a restorative focus that promotes and maintains the independence of the service user.

### *Output: Age Related Residential Care*

Age related residential care (ARRC) beds comprise rest home care beds, dementia care beds and hospital continuing care beds. Psychogeriatric care beds are also available, which provide for more complex care needs.

### *Output: Lifelong Disability Services*

Government, through Vote:Health, funds ongoing support services for people with a wide range of disabilities and impairments. These services are referred to as disability support services for some groups, and long-term support services for others. Support options need to be flexible, responsive and needs based (refer to the earlier sections on Needs Assessment and Service Coordination services, residential care, rehabilitation and home-based support services). They focus on the person and, where relevant, their family and whānau, and enable people to make informed decisions about their own lives.

This output focuses on the services provided by Enable New Zealand – a division of MidCentral District Health Board – in two main areas: disability information and advisory services and equipment modification services. Enable New Zealand provides services to the greater population of New Zealand. The new EASIE Living Centre (opened in February 2016) enjoys a strong community profile regionally and acts as a community hub, engaging with community organisations and service providers to remove the barriers that preclude disabled people from actively participating in their communities.

### *Output: Rehabilitation Services*

These services restore or maximise people's health or functional ability following a health-related event. They include community rehabilitation programmes, physical or occupational therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.

### *Output: Respite and Day Care Services*

Day programme services for older people are planned activities that meet the specific needs and interests of older people, where well-trained staff will assist service users in a stimulating and safe environment. Day programme services are aimed at assisting to maintain independence for older people, are closely integrated with other community support services available to older people and are also a form of support for carers of older people.

Respite care services for people with age related or long term disabilities are based on a 24-hour, 7 day a week service. The service provides both planned and emergency (or crisis) respite care for primary carers/family/ whānau who care for family members with chronic health conditions and long term support needs. The duration of respite is short term and intermittent, or episodic for the service user. Access to respite care is based on need and approved by the Needs Assessment and Service Coordination (NASC) service.

Planned respite care is provided for specific periods as agreed with the primary carers/family/whānau. Emergency respite care is provided in times of crises, e.g. when primary carers/family/whānau are in urgent and immediate need of temporary relief from care-giving.

### *Output: Palliative Care Services*

Specialist palliative care is palliative care provided by those who have undergone specific training and/or accreditation in palliative care or medicine, and who are working in the context of an expert inter-disciplinary team of palliative care health professionals. Specialist palliative care may be provided by hospices (community), hospital-based palliative care services, or paediatric specialist palliative care teams.

Specialist palliative care services are provided to people, their family and whānau when and where their complex palliative care need exceeds the resources of the generalist provider. Generalist palliative care is provided for those with life-limiting illness as an integral part of clinical practice by any health care professional who is not part of a specialist palliative care team (e.g. general practice teams, district nurses, allied health professionals, aged residential care staff etc.). Providers of generalist palliative care services have defined links with specialist palliative care team(s) for the purposes of support and advice, access to education and training, and referral pathways for people with complex needs.

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