Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Capital & Coast District Health Board

Annual Report

2005/06

Together, Improve the Health and Independence of the People of the District

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Our Vision	Better health and independence for people, families and communities	
Our High Level Outcomes (Health Goals)	Reduce disparities in health status	Reduced incidence and impact of chronic conditions
Our Strategies	Focusing on people through integrated care	Supporting and promoting healthy lifestyles	Working with our communities
	Developing our workforce	Updating our hospitals	Managing our money
Our Mission	Together, improve the health and independence of the people of the district	
Our Values	Focusing on people and patients	Innovation	Living the Treaty
	Professionalism	Action	Excellence

Chairman's Foreword

It gives me great pleasure to be able to introduce to you Capital & Coast DHB's 2005/06 Annual Report. This provides an opportunity to outline the key strategic issues which we at C&C DHB have had to address during the year, and what might be on the horizon in the next planning period. I can report considerable progress toward achieving the targets in our strategic and annual plans, and can confidently underscore the Board's commitment to providing the best possible service to our community.

It has been a difficult year, with constant pressure to contain expenditure in the face of increasing community expectations for more and better health services. We have this year been able to virtually break even financially, but it must be emphasised that there is a significant underlying operational problem which must be dealt with to avoid future blowouts. The Board, management and staff have worked hard to improve operating practices and search for efficiencies during the operating year, but there is still a substantial gap to close.

Our achievements during the past year are reflected throughout this Annual Report – and many of those include working closely and productively with the community and with community-based service providers. Major achievements during 2005/06 include: the continuing strengthening of PHOs; working with the community to devise plans to improve the array of mental health services; the large-scale rollout of the MeNZB immunisation campaign; the establishment of the Care Coordination Centre; increased work on the management of diabetes; and the completion of contracting for lab tests in the community.

Significant opportunities exist in the years ahead to build on this spread of services and the models of health care delivery which are being developed. We will be working closely with communities, private sector healthcare providers, and a range of other agencies to ensure these opportunities result in genuine improvements in the health of people in this district.

We will also be working closely with neighbouring DHBs to increase the level of regional cooperation, and to ensure there is a truly regional approach to the future development and delivery of services. C&C DHB is the regional provider of 'tertiary' services for the central region of New Zealand, with a population of 900,000 people. An active and evolving regional approach has an important role to play in avoiding wasteful duplication and inefficiency.

A unique 'once-in-a-generation' opportunity also exists to significantly evolve our hospital services. The Hospital Redevelopment Project has already created a new health centre at Paraparaumu (the Kapiti Health Centre which opened in 2003) and expanded and reconfigured facilities at Porirua (significant extensions at Kenepuru Community Hospital, which have mostly opened during the 2005/06 year). Work is now well underway on the new main building on our Newtown site in Wellington – a massive structure which is due for completion at the end of 2008.

These projects are not about bricks and mortar – they are about creating flexible facilities which can be adapted to accommodate the inevitable changes in medicine, surgery and diagnostics in the decades ahead. They provide us with a unique opportunity to re-cast the ways in which we deliver health services.

For each of these projects it has not simply been a case of constructing, then moving in and delivering services in the same way as before. Instead there has been a significant focus on thinking through the philosophy of how and where services are delivered, and refining our models of care for delivering those services.

So, for example, at Kenepuru we have not only constructed a facility, but also restructured our approach to service provision - which has enabled us to increase the number of outpatient and day surgery cases on-site in Porirua. This allows many thousands of patients each year to access services closer to where they live.

A major focus for this DHB in the years ahead will be on the change management needed in preparation for the opening of the new Wellington Hospital. The pressure to complete a change management programme will be a challenge for us all, if we are to make best use of our new regional hospital investment. We are determined to get this right, and it will be a focus of our energies between now and the opening. It is of strategic importance to secure close relations between the primary care sector and the hospitals. The PHOs and other providers across the primary care system must work closely with our hospital staff to ensure a seamless service with good access for all, and to treat people at the most appropriate place in the continuum.

In closing I would like to pay tribute, and express my sincere thanks, to the Board members, to the community representatives on our advisory committees, and to the CEO and her staff. All of these individuals and groups have worked resolutely on the achievements to date, and each will be responsible for rising to the challenges ahead. I would also like to extend my thanks to the Māori Partnership Board for their advice and guidance on Māori issues. And I wish to express my gratitude and admiration to the communities and health service providers who work alongside us – their commitment to the health of this district is unwavering.

Bob Henare
Chairman

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About Capital & Coast DHB

Introduction

Capital and Coast District Health Board is one of 21 District Health Boards (DHBs) established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act (NZPHD Act) 2000. We serve a population of about 270,000 residents and provide some specialist services for a regional population of about 900,000 people.

Every District Health Board has the following objectives (under section 22 of the New Zealand Public Health and Disability Act):

- to improve, promote, and protect the health of people and communities.
- to promote the integration of health services, especially primary and secondary health services.
- to promote effective care or support for those in need of personal health services or disability support services.
- to promote the inclusion and participation in society and independence of people with disabilities.
- to reduce health disparities by improving health outcomes for Māori and other population groups.
- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.
- to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services.
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services.
- to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.
- to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.
- to be a good employer.

Governance

The Board of Capital & Coast DHB is responsible for the governance of the organisation and is accountable to the Minister of Health. The governance structure for DHBs is set out in NZPHD Act. The Capital & Coast DHB Board consists of eleven members and they have overall responsibility for the organisation's performance. Seven of the members are elected as part of the three yearly local body election process (last held in October 2004) and four are appointed by the Minister of Health.
The Board has a number of committees. These are made up of Board members, DHB staff and community representatives. Three of these committees are established under the requirements of the NZPHD Act 2000, i.e. they are statutory committees. The Board is required to publish when and where it, or any of its statutory subcommittees, is meeting.

Iwi/Māori are represented from a governance perspective by the Māori Partnership Board. The Māori Partnership Board is made up of representatives from Te Atiawa, Te Atiawa ki whakarongotai, Ngati Toa and Rauru Tetere (Wellington Taurahere Grouping). We have a written agreement in place with the partnership board that outlines our commitment to working together to improve Māori health and the health of the wider DHB community.

The Board has a number of statutory committees as follows:

Hospital Advisory Committee (HAC)

The HAC is a statutory committee covering hospitals within our DHB. The HAC monitors the financial and operational performance of the hospitals and assesses strategic issues relating to the provision of hospital services.

Community and Public Health Advisory Committee (CPHAC)

The role of the CPHAC, which is also a statutory committee, is to provide the Board with advice on the health and disability needs of our region's population. The committee reports on anything significant that may affect our population's health and it also advises the board on which issues are most important. The CPHAC advises the Board on how services funded and/or provided by the DHB, and the DHB's policies, will impact our population. The Committee also analyses relevant reports and makes recommendations to the Board. The CPHAC makes sure that any advice it provides the Board is consistent with the national strategies and government policy.

Disability Support Advisory Committee (DSAC)

The role of the DSAC, another statutory committee, is to tell the Board about the needs of the people with disabilities in our region and prioritise the use of the money provided for those with a disability. The committee makes sure that the services provided or funded, and the policies adopted, promote the inclusion and participation of people with disabilities in our society, and maximise their independence.

Other Committees

In addition to the statutory committees identified above, we have also established two other advisory committees to enhance the governance function of the Board. These are:

- Finance, Risk and Audit Committee (FRAC), and
- Remuneration Committee (RC).

To ensure the cohesiveness of the governance function, the Board Chair and Committee Chairs meet regularly.

Meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend as observers. Occasionally these groups may need to have discussions for which public attendance is not appropriate – for example matters which are commercially sensitive. The exclusion of the public from those sessions is allowed for under the NZPHD Act.

Details of Board and statutory advisory committee meetings (agendas, minutes, membership, attendees) are publicly available on our website: www.ccdhb.org.nz

Planning and Funding C&C DHB services

The Planning and Funding arm of the DHB is responsible for determining the health and disability service needs of the District and for funding those services. The Planning and Funding Directorate manages contracts with all providers of services, including our own Hospital & Health Services. The Directorate also initiates specific health improvement projects with different communities and builds partnerships with the community, service providers and other DHBs. The Planning and Funding Directorate is also responsible for arranging access to specialist services that are not delivered in the District.

Government policies and priorities guide the planning and funding of health and disability services, through such mechanisms as the National Service Framework, which sets out the criteria for access to services. Within this framework, the Planning and Funding Group's core activities are to:

- determine the health and disability needs of the community and to reflect national health and disability strategies in meeting local needs;
- involve the community through consultation and participation, in identifying service gaps and developing strategic plans for services;
- allocate funding to services and manage contracts with service providers; and
- monitor and evaluate service delivery.

The Planning and Funding Team maintains relationships and enters contracts with a range of private, religious, welfare and other non-governmental organisations which, along with the DHB itself, provide services to meet the health needs of our communities.

Two major contributors to the provision of health services within the district are Primary Health Organisations (PHOs) and Non-Government Organisations (NGOs).

- PHOs are central to the implementation of the DHB's Primary Health Care Strategy. Six PHOs have been established in the District, and they cover about 95% of the population. The District's PHOs allow for community representation at governance level, and they continue to improve access to a range of community-based, primary care services.

* NGOs offer an alternative to the commercial or government sector especially in primary care, mental health and disability support sectors. We work together with NGOs on several levels, providing a network for information flow and representation in specific areas of interest. Some NGOs provide training, and many NGOs initiate and participate in inter-sectoral work.

Funding for Public Health Services, Disability Support Services for people under 65 years and some other services is made available directly to the providers from the Ministry of Health, without the involvement of our Planning and Funding Team.

Our Hospital and Health Services

Our provider arm – Hospital and Health Services (HHS) - provides a range of inpatient, outpatient, community, and day programme services to our resident population of around 270,000 people. In some cases tertiary services are provided to the wider central region population of around 900,000 people. Local services are provided by the HHS in community settings, outreach clinics, Kapiti Health Centre, Kenepuru Community Hospital and Wellington Regional Hospital.

Each year HHS makes a contract with the Planning and Funding Directorate, specifying the range and volumes of health services to be delivered. The health services are organised and managed by dedicated teams providing Mental Health Services; Medical and Surgical Services; Ambulatory Services; Child Health Services; Women's Health Services; and Clinical Support Services. Our front line staff are assisted by a range of support services, all of which play a vital in meeting the health needs of our District.

On an average day:

- Over 120 patients are admitted to our hospitals. 40 of these are ‘day patients’, receiving treatment or surgery which is not expected to require an overnight stay.
- About 60 patients undergo surgery
- 950 outpatients are seen
- More than 250 patients are examined in radiology
- 40 patients are seen by our mental health community teams
- 2,800 lab tests are performed in the hospital labs (in addition to the 3,400 community lab tests each day)
- 100 patients have their vision checked
- About 130 people are assessed at Wellington Hospital Emergency Department, and more than 90 are assessed at Kenepuru Community Hospital’s Accident & Medical Clinic
- 3 patients are admitted to the Intensive Care Unit at Wellington Hospital
- 6 patients are flown to, or from Wellington Hospital
- 10 babies are born
- 30 infants are cared for in Wellington Hospital’s neonatal unit
- More than 650 medical records are processed
- 8,000 phone calls are answered by telephonists
- 5,000 letters are processed in the mailroom
- 1,300 clean sheets are sent out from the hospital’s own laundry
- 1,900 meals are prepared and distributed (1,150 at Wellington Hospital, and 750 at Kenepuru Community Hospital).

Key Achievements

In July 2004 we identified six key strategic objectives that would remain a focus until 2006. This section reports on the progress we have made towards those objectives.

The six strategic objectives are:

1) Reducing disparities
2) Achieving integrated care
3) Sustaining financial performance
4) Improving quality
5) Progressing the new regional hospital
6) Developing workforce

Each objective is considered in turn below:

1) Reducing disparities

Capital & Coast DHB delivers community, primary, secondary and tertiary health and disability services to 250,000 people in its district, with tertiary services extending to a further 650,000 people in neighbouring DHB areas.

Most people in the C&C DHB district enjoy very good health status, compared to national averages. However significant disparities exist – with high health needs in parts of Porirua and south-east Wellington – and also among Māori, Pacific and low-income groups. Reducing these disparities has been a key focus of our work, and substantial progress has been made.

For both Māori and Pacific populations we have developed strategic plans, which are being progressively implemented. In both cases, the focus is on four key areas:

I. Improving access
II. Improving decision-making processes
III. Building capacity
IV. Improving the responsiveness of services.

I: Improving Access

- Improved treatment for diabetes has seen the number of diabetes-related amputations fall from 100 four years ago, to 22 in the past year.
- Better access to primary care has, since 2003, resulted in a 20% reduction in ambulatory sensitive admissions for those aged over 65. For Pacific the reduction is 35%.
- Sexual health, youth health and pacific health initiatives are linked to a 20% reduction in low birth weight babies since 2003. For Pacific the reduction is 45%.
- The above factors also contributed to a 35% reduction in teenager mothers amongst Māori since 2003.

II: Improving decision-making processes

- To help address Māori disparities, the relationship between the Māori Partnership Board and the C&C DHB Board has been strengthened. In addition the DHB has worked with other agencies to improve services – an example is work with Wellington City Council which secured $600k in funding for SPARC "push play" initiatives in this district. Funding.

- To help address Pacific disparities, extensive community engagement has occurred with seven Pacific Island communities. This has resulted in targeted community-led responses to health need, such as the Pacific Youth Strategy, Niue Island fitness programme, Tuvalu/ Tokelau and Samoan Smokefree Programmes. The DHB is also working with other agencies to improve services, an example being work with NZIS to implement a pilot health and exercise programme "Shake It, Beat It, Learn It".

III: Building capacity

- C&C DHB led a number of regional initiatives for Māori, including the Central region Māori Workforce Skill Profile project.

- The DHB has also implemented management and leadership training for Māori, with 30 Māori Health Workers on track to achieve NZIM level 5 certification by August 2007.

- A workforce plan for Pacific peoples – 'Future Hope – Future Gain' - has been developed, and is being implemented.

IV: Improving the responsiveness of services.

- Three Māori providers in the C&C DHB district have now achieved accreditation.
- Additional services have been developed:
    - Māori led GP services – Wellington/Kapiti
    - Māori diabetes services – Wellington/Kapiti
    - Māori A&D services – Wellington/Porirua
    - Māori Mental Health community Support services – Wellington
- Clinical positions have been established within the DHB's Whanau Care Services for a cardiac Liaison Nurse and an Aged Care Manager.

Māori Health

- The working relationship between the C&C DHB Board and the Māori Partnership Board (MPB) continues to strengthen. This has resulted in an agreed work programme, priority health gain indicators and targets for improvement. Activities during 2005/06 included a priorities hui, a joint workshop with Pacific leaders and a quarterly newsletter.
- The co-ordination of assessment and treatment for elderly Māori has improved, with two new positions created in Whanau Care Services to focus on this.
- Child health has improved, with the transition of three Māori providers to the Well Child Schedule - thus achieving a significant increase in funding that is now equitable to other Well Child providers. In addition, a new Well Child service is now operating in Wellington.
- Access to general practice services has been strengthened with an increase in Māori enrolment in our PHOs to 77%, the establishment of two new services in Wellington, and support to increase nursing and administration capacity at a third general practice.
- Our support for youth health services led to the employment of Māori peer support workers. As a result Māori youth have significantly increased their use of services.

Pacific Health

- Taeaomanino Trust, a Pacific provider of social services, is now providing mental health services for children and young people, together with alcohol and drug services for Pacific peoples. This service has been established through a joint agreement with the Ministry of Education and Department of Child Youth and Family.
- A number of services are now specifically designed to meet the needs of our Pacific communities. For example:
    - Diabetes Services have developed a Pacific Outreach Initiative and community-based diabetes clinics have been expanded;
    - a Pacific breastfeeding service has been developed which is integrated with other hospital and community services; and

* Smoking cessation programmes targeted to the needs of Pacific communities. These have been developed through our work with regional public health.
  - Programmes such as 'Strong Pasifika Families Week' and Samoan Kilikiti, which focus on Pacific health, have received our support alongside that of other government agencies.
- There has been an improvement in Mental Health Services for Pacific communities with the development of the Pasifika Team and Vaka Pasifika. Pacific Mental Health Services have also expanded to include Child and Adolescent Mental Health Services.

Primary health care (including Primary Health Organisations (PHOs))

- Over 90% of people in the district are now enrolled in one of the six PHOs which have been established. Two new general practice services have been established in Wellington and an additional GP registrar position was funded in Kapiti.
- The DHB is working closely with PHOs to develop an integrated approach around the prevention and management of chronic disease. This is a key area of focus in terms of the DHB's focus on reducing disparities.
- C&C DHB has worked closely with a PHO Advisory Group to ensure a more inclusive approach to planning. This has played an important role in guiding major developments such as the Mental Health & Addiction Service Development Plan (The Journey Forward), the After Hours Working Group, Income & Health Working Group, and the Porirua Health Cluster.
- The Kenepuru Accident & Medical Centre has opened providing people who live in the northern half of the district with access to after-hours primary care which is integrated with secondary care.
- Additional hours are now funded for outreach nurses working with homeless people in Wellington, and a primary care service is operating during the evening at the Soup Kitchen.

Child health and youth health

- A successful campaign to introduce MeNZB immunisation for children and young people has achieved high levels of uptake with coverage tracking at or above the national average.
- Access to mental health services for children and young people has been improved through the appointment of key staff and our involvement in joint projects with other government agencies.
- Serious skin infections in children have been significantly reduced, subsequent to the launch of a programme jointly developed with Hutt Valley DHB and Regional Public Health. The skin infection programme strongly emphasises the importance of hand washing – which is also a key factor in our Pandemic Planning work. As a result the two projects, which have been extensively taken to local schools, have been mutually supportive in promoting hand washing.
- The Porirua-based ear van has been replaced, and the service improved. This has resulted from cooperative work between the DHB, Regional Public Health, the Porirua community, and donors (Variety Club and Rotary).

- We have increased support for early intervention and funded extra clinical hours at Kapiti Youth Support. School health clinics continue in four Porirua secondary schools and young people in the inner city have access to Māori peer support workers, primary mental health and GP services at "Evolve", a Wellington-based youth health service.
- A Youth Health Advisory Group, established at the behest of the DHB, has provided useful input to DHB projects such as planning for MeNZB, the DHB Strategic Plan and District Plan, a primary sexual health review and The Journey Forward.
- Primary sexual health services for people under 25 years have been reviewed, and improved service specifications have been put in place with current providers.
- Children and young people were involved in an annual planning hui focusing on diabetes that was lead by the DHB's Diabetes Team.

2) Achieving integrated care

We aim to reduce delays or disruptions in patient treatment. As a result we have placed a high priority on integrating the care that patients receive when different services are involved in their treatment.

Chronic Care Management

A Chronic Care Framework is now in development. An example of what can be achieved with this is the Integrated Care Coordination Centre for people with chronic illness, which is now in place:

- The CCC has a single point of entry (replaces multiple entry points under previous approaches to providing this care).
- It has been accompanied by the development of a single assessment process across all relevant services using InterRAI software.
- The single assessment process reduces unnecessary re-assessment, and builds a clear picture across services for each patient.
- The approach to care management of chronic illness has been designed to ensure that goals and outcomes are achieved.
- Individualised packages of care are developed for each patient, factoring in all aspects of their health
- The approach focuses on restoration of function, rather than just on providing support
- Specific services such as palliative care, stroke services and specialist care for older people have been reconfigured so that they integrate with the CCC approach.

Mental Health

- We are now implementing The Journey Forward, a five year mental health service development plan which was developed via extensive consultation with the public in 2005/06.
- This redevelopment of services will create a fuller continuum for acute care, including the establishment of community recovery houses.
- The DHB is also implementing primary mental health initiatives, such as a mental health social worker in Wellington.
- The DHB's Home Based Acute Treatment Team underwent an independent evaluation, which showed that this service is a leader nationally.
- The DHB produced "Mind Your Head" an educational DVD resource to support young people with psychosis.
- Improvements have been made in the process for moving patients from prisons and from the community forensic team into adult community care. This resulted from improved processes and increased staffing.
- The alignment of DHB-provided services has been improved, including reduced pressure on acute inpatient services.

Promoting Healthy Lifestyles

- C&C DHB has worked with Hutt Valley DHB to implement innovative public health programs, such as Health Promoting Schools and Kapiti-youth injury prevention.
- Implemented Healthy Eating - Healthy Action Rangatahi programme (CART) Wellington – which focuses on high risk and hard to reach youth.
- The DHB's own facilities have been made smokefree, and healthy food policies have been implemented.

Diagnostic tests and images

- With Hutt Valley DHB, we have completed consultation and awarded the first laboratory contract to cover the greater Wellington region - including Wellington, Porirua, Hutt Valley and the Kapiti Coast. This is a capped contract for referred services, which corrects an historical anomaly that previously saw our public hospitals pay for tests ordered by private specialists.
- An information technology project has begun across the DHB to digitalise and automate X-ray and radiology images so that these can be distributed across hospitals. Through this initiative clinicians will be able to access patient information from any location, reducing delays in diagnosis and treatment.

3) Sustaining financial performance

Capital & Coast DHB is committed to the wise use of financial resources, and takes seriously its duty to use public monies responsibly and for the maximum public benefit.

- Achieved budget/break even targets over last four years
- Achieving over $6m annual efficiency targets in the HHS over last four years
- Reinvested $2m annually in new initiatives, predominantly in primary and community services
- Produced a breakeven DAP before asset disposal
- Future deficits are forecast to be in line with the approved business case for the Hospital Redevelopment Project.

4) Improving quality

Quality is a central focus for any organisation providing services to the public. We have developed a wide range of initiatives which aim to ensure that families and individuals receive high quality services.

Accreditation, benchmarks, credentials and awards

- Child health services have confirmed their membership of the International Cancer Oncology Group. The service also successfully overcame an outbreak of GRSA in the Neonatal Intensive Care Unit.
- C&C DHB has the first DHB radiology service to achieve International Accreditation NZ (IANZ) without the need for corrective action.
- Ministry of Health referral guidelines have been met by the Ophthalmology Department, following new processes developed by Ambulatory Care Services.
- Three Māori providers have achieved accreditation with Quality Health New Zealand, Te Wana and/or the Royal New Zealand College of General Practitioners.
- Two Māori providers have won recognition or awards for their innovative services. Hora Te Pai won the Whanau Rahi Award for innovative services to Māori and Menenga Pai presented their model of care for Māori with mental illness at the THEMHS conference in Adelaide.
- National benchmarks have been achieved in nursing and midwifery across Women's' Health and Midwifery Services. The Service is providing primary and hospital midwifery services to approximately 700 women each year. The Service also implemented and audited the Maternity Care Plan, and organised an international conference.
- The Mental Health Commission published a positive evaluation of Home Based Treatment (HBT) provided by our Mental Health Service, and HBT was successfully expanded.

Practices and procedures to improve quality

- Improvements have been achieved in triage times and patient wait times, flowing from work done by a re-design group established by Clinical Support Services.
- The risk and management of handling injuries has been improved by Health and Safety services through improvements in the knowledge of causes or risks, the quality of reporting, and the support provided. Our Health and Safety service have also retained secondary status in the Partnership Programme run by ACC.
- Our regional Genetics Service has been secured, with new funding and negotiation of an agreement with other DHBs across the lower North and upper South Islands.
- The problem of over-occupancy in the acute inpatient mental health ward has been addressed – with patient numbers having stayed within agreed limits during 2006. A taskforce set up to address the problem has introduced system changes, forward planning and improved collaboration between health providers. Further residential and home-based support services are now able to provide extra options for people who need acute care.
- As part of the government's Orthopaedic Initiative our Medical and Surgical Service completed 100 additional joint replacements.
- A strategic framework is being developed for primary care, including an evaluation method that focuses on participation in local policy, planning and service delivery, and developing collaborative approaches with other agencies.
- An in-patient risk assessment tool, DASA, was trialed by Mental Health Services in conjunction with Victoria Forensic Mental Health Services (Australia).

Service development

- Access to intensive care has been improved for elective patients.
- Medical Surgical Services have developed the Hospital Palliative Care Service and Breast Service.

5) Progressing the new regional hospital

Our development of hospital services across three different sites presents considerable challenges as we must also maintain existing services, ensuring that they are provided in a safe and professional manner.

Newtown Hospital

- A series of smaller projects were completed in advance of the main building at Newtown, including the Short Stay Unit and the Blood & Cancer Centre Building.
- The contract for the main building was let to Fletcher Construction Ltd (FCL). It is expected that construction will be completed by the end of 2008.

Kenepuru Community Hospital

- Stages I and II at Kenepuru Community Hospital have been completed. These included:
  - a new 24 hour Accident & Medical Centre,
  - children's ambulatory care (including specialist child development team),
  - 30 consulting rooms and two procedure rooms,
  - replacement of washing and sterilising equipment (to support increased day surgery),
  - relocation of specialist AT&R,
  - new allied health treatment and assessment facilities
  - an education centre, to bring community and hospital closer together.
- The construction contract for Stage III, the Kenepuru Psycho-geriatric building, was let in March 2006 and this work is due for completion in October 2006.
- Also set to begin replacement of the dental unit, addition of an extra operating theatre, and upgrading a ward floor to a 40 bed unit.
- A Cardiac Rehab Service has been established at Kenepuru and approval has also been obtained to extend services at the Porirua Dialysis Unit.

Kapiti Health Centre

- This facility, which opened in 2003 as part of the Hospital Redevelopment Project, continues to serve the needs of the local community.

6) Developing workforce

With an international shortage of doctors, nurses and other health workers, we have set out to improve information about our workforce, build relationships to improve co-ordination, and further develop our Māori and Pacific workforce,

Māori workforce

- Our workforce initiatives have supported 15 Māori Health workers through the NZIM Diploma in Frontline Management Programme and two Primary Nursing Scholarships.
- The makeup and skill of our local and regional Māori workforce has been captured through a Central Region Māori Workforce Survey.

Pacific workforce

- A framework has been developed for a new Pacific provider to promote healthy living and lifestyle.
- Workforce development for Pacific providers has been supported, including IT training and events that promote health as a career option.
- The C&C DHB Pacific Workforce Plan 'Future Hope Future Gain' is now being implemented.

Recruitment and retention

- Recruitment has improved in a number of areas, such as nursing staff in Clinical Support Services, a Neonatologist in Child Health Services, recruitment and retention of Mental Health services staff.
- There has been a continuation of placements in PHOs for new graduate nurses (internships). Nurse Practitioner Candidates have been established in Diabetes and Palliative Care.

Training and professional development

- A new nursing structure has been implemented including the appointment of a Clinical Nurse Educator and a Professional Development Unit with Nurse/Midwifery lecturers forming the basis of staffing. Lecturer portfolios have been developed for specialities such as cancer, haematology and diabetes.
- A training programme for Team Leaders has been introduced to educate them in their responsibilities under the Hazardous Substances & New Organisms Act (HSNO). Approximately 70 staff are now trained. A programme is also underway to train Approved Handlers HSNO, with 55 staff trained.

Statement of Service Performance

We are required by the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 to report annually on our Service Performance against the targets in our Statement of Intent. The following performance report records achievement levels relating to the targets identified in our Statement of Intent for 2005/06 – 2007/08.

The range of performance areas and targets included in our Statement of Intent reflect priority activities and areas for improvement. Performance measures and milestones are selected based on our primary goals (health outcomes) and strategies as outlined in our District Annual Plan and/or our longer term District Strategic Plan.

In the following pages, our actual performance for the year ended 30 June 2006 is measured and performance ratings assigned. We continue to develop ways to measure performance that are appropriate to the needs of all our stakeholders. The Audit Office has audited this performance report for accuracy and reasonableness.

Strategic objectives

Our strategic objectives (as outlined in our District Strategic Plan) are based on Government expectations, local health requirements (as identified in our Health Needs Assessment), and our plans to make services more effective and efficient. These objectives have a focus on the areas of health and disability that we believe have the greatest potential for gains in the health and wellbeing of our communities.

We have included in our Statement of Intent, a selection of measures to assess our performance for 2005/06. These performance measures can be linked to any of the three outputs of the DHB. These outputs are DHB Governance, DHB Planning and Funding (P & F), and Hospital and Health Services
(Provider). The Audit Office audits the accuracy and reasonableness of our reported achievements for these measures as recorded in the Statement of Service Performance (SSP). The performance measures included reflect our response to local health needs and priorities, and cover the following:

- reducing disparities in health status;
- achieving integrated care;
- improving quality;
- progressing the new regional hospital developments;
- developing our workforce;
- achieving and sustaining financial performance; and
- meeting targets for selected indicators of DHB Performance.

Performance targets are linked to priorities of the DHB as set out in the District Annual Plan (DAP) for 2005/06 – 2007/08. They include:

- A selection of the indicators of DHB performance developed by the Ministry of Health;
- Indicators of DHB's operations (measures of service access, efficiency and patients' satisfaction with our hospital and health services); and
- The Price-Volume Schedule of services to be delivered by our provider arm - the Hospital and Health Services (HHS).

DHB Priority : Reducing disparities

The Board has maintained a focus on reducing disparities between various ethnic groups in access to services and health outcomes. We are aligning our core activities within the strategic direction outlined in our District Strategic Plan 2006/12.

We expect improved participation by Māori in decision making in primary care, improved mental health, and increased capacity and capability of Māori workforce.

Participation by Māori in decision-making in Primary Health

It is important to involve Māori in developing service delivery especially at primary care level to make services more responsive to needs of Māori.

Māori Governance – PHO	**Achieved**
A progress report that evidences active participation by Iwi/Māori in PHO planning, development, implementation, funding and delivery of services to meet the needs of Māori whanau more effectively. Output: DHB Governance Timeliness: June 2006	• A progress report was presented to the Board in June 2006 All PHOs within our district have Māori participation at the governance level. This includes Iwi, Māori community and Māori provider representation. • Iwi/Māori have a continuing role within PHOs that link existing PHO, local and National strategies with the development of services to improve the health and meet the needs of Māori and their whanau. • Every PHO has a Māori Health Plan developed actively by or in consultation with Māori in the PHO and community. • Service developments and reviews of specific primary care services (e.g. primary sexual health services, youth health services, primary nursing services) have specific Māori consultation and input.
Māori Health Plans - PHOs 100% of PHOs with Māori Health Plans that have been agreed to by the DHB and report that the plans are being implemented by the PHO and monitored by the DHB. Output: DHB Governance Timeliness: June 2006	**Achieved** • We have reviewed and agreed Māori Health Plans with all PHOs by June 2006. These plans are currently being implemented. • The PHO Māori health plans are focused on the delivery of improved Māori Health outcomes as outlined in our Māori Health Strategy (Te Plan). • We have begun to monitor progress and will continue to do so over the next few years to ensure our strategies and those of the PHOs are delivering the intended benefits.

DHB Priority : Reducing disparities

Improving Māori Health

Disparity between Māori and others is quite marked and our focus is on reducing disparities between various ethnic groups in access to services and health outcomes.

Obesity Programme Establish obesity intensive programme in Porirua. Output: Planning & Funding Timeliness: December 2005	**Partially Achieved** • While we have not established the obesity intensive programme as originally envisaged due to funding constraints, we have implemented an enhanced Healthy Eating– Healthy Action (HEHA) project in Porirua in early 2006.
Whanau Care Services (WCS) Develop advocacy in the hospital and health service that will support Māori patients with transport, language and facilitation to improve patient satisfaction and reduce barriers. Output: Planning & Funding Timeliness: December 2005	**Achieved** • We developed further our advocacy services for Māori within our hospital and health services. These provide additional clinical and non-clinical support for Māori patients and their whanau. • Staff levels have increased by two during the year with an Aged Care Manager – Māori appointed in February 2006 and a Cardiac Liaison Nurse – Māori appointed in April 2006. • Infrastructure development and relationship management is in progress at the end of 2005/06.
Kaupapa Māori CSS Intensive day programme for Mental Health established for Tangata whai ora. Output: Planning & Funding Timeliness: December 2005	**Achieved** • The Menenga Pai Charitable Trust was established under a Whanau Model in 2004. We have provided ongoing support as part of the process entailed for development. The service is targeted to tangata whaiora with high needs and challenging behaviours. The service uses the whanau ora health approach, and is funded using a community support model. It is provided in a large house which can accommodate around 17 people. • Te Roopu Pookai Taaniwhaniwha is a day activity service based in Porirua. In 2005/2006, additional staffing (0.86 FTE) was funded as a one-off. We also invested in infrastructure development. Sustainable funding is being investigated for 2006/2007.

DHB Priority : Reducing Disparities

Development of Māori Health workforce and Māori Health Providers

We will report to the Ministry of Health on developments in our Māori Health workforce

Māori Health Workforce Plan We will provide a copy of the DHB Māori Health Workforce Plan (or agreed regional Māori Workforce Plan), or timeframe to complete the Plan. Output: Planning & Funding Timeliness:Dec 05 & Jun 06	**Achieved** • Our Māori Health Workforce Plan was provided to the Ministry of Health in February 2006. • It outlines a range of initiatives related to career development for Māori and looks to provide a platform on which to build the capacity and capability of the Māori workforce. • By way of an example, capacity building funding was used to support the NZIM Diploma in Frontline Management (Level 5) programme for 15 local Māori health workers in early 2006.
Māori Workforce Report on achievements based on key deliverables in the DHB (or Regional) Māori Workforce Plan, or if the plan is being developed, describe at least two key DHB Māori health workforce initiatives that the DHB has achieved. Output: Planning & Funding Timeliness: Dec 05 & Jun 06.	**Achieved** • The report on the Māori Workforce Plan was presented in June 2006 as an integral element of the first monitoring report on our Māori Health Strategy (Te Plan 2002-07) • One of the initiatives outlined in the report was the use of MPDS (Māori Provider Development Programme) funding to survey the Central Region Māori Workforce. Capital & Coast DHB led this initiative on behalf of the five DHBs in the Central Region. A Central Region Māori Workforce Profile has been completed and a report prepared, with feedback to be provided to the sector in 2006/07. • Another project was completed in 2005/06 looking at the development of a career progression framework for Māori staff within the DHB's provider arm (HHS). This will greatly assist in improving the DHB's response to Māori workforce issues and challenges.

DHB Priority : Reducing Disparities

Continue Primary Health Organisation (PHO) development in the District

PHOs are key elements of the Primary Care Strategy and usually the first point of contact for people requiring health services.

PHO - Clinical Performance Indicators Implement Government programme of clinical performance indicators in PHOs by agreeing a national set of indicators. Output: Planning & Funding Timeliness: March 2006.	**Achieved** • All six of the PHOs in the Capital & Coast District are participating in the national PHO performance programme. Preparation began in 2005 and the programme was implemented from January 2006. • Data collection and reporting by PHOs on clinical performance indicators has started following agreement on those indicators between the Ministry of Health, PHOs and DHBs.
PHO - Mental Health Service Development Expand primary mental health services delivery in the district to include mental health services for youth to be provided by a PHO and Alcohol & Drug Services to be provided by another PHO. Output: Planning & Funding Timeliness: March 2006.	**Achieved** • Five of the District's PHOs had additional primary mental health services funded through the Ministry of Health's primary mental health project with PHOs in 2005. • In addition, expanded access to primary mental health services (including drug and alcohol linkages) for youth has been developed in Wellington (through SECPHO and "Evolve"); through Kapiti Youth support and through primary mental health youth services (Capital PHO, Tumai mo te Iwi PHO and Kapiti PHO). • At the end of the year a link-worker was funded to trial improved access to Drug and Alcohol Services and a range of other support services for young people appearing in court. This initiative is part of a wider inter-sectoral project in Wellington.

DHB Priority : Achieving Integrated Care

We are committed to ensuring services are provided in an integrated manner to improve outcomes for patients. We will take a whole of DHB approach in developing and providing services to our communities, which will work across providers and will not be affected by the location of care. Our initial focus is going to be mental health services and services for older people, including services provided in peoples' home.

We expect improved coordination of services for older people and improved services for people who suffer stroke.

Continue to implement the Board-approved Integrated Home and Community Care initiative.

Specialist Health Services Specialist health services for older people; stroke service, care coordination centre and care manager services established. Output: Planning & Funding Timeliness: December 2005.	**Partially Achieved** • Apart from the stroke service, all services have now been established and have been operational for several months. • The Care Coordination Centre commenced operation in September 2005. It provides a single point of entry for referrals for access to community-based health services. The role of the centre is to undertake assessment, care planning and service coordination for people who need community based health and disability services in Kapiti, Porirua and Wellington. • The specialist health service for older people commenced in November 2005. • The rehabilitation arm of the stroke service has been established and the acute arm of the service will now progress to implementation a little later in 2006.

Develop a Five–Year District Plan for mental health and addiction services.

Mental Health Plan Final version of the report including detailed action plan completed and approved by the Board. Output: Planning & Funding Timeliness: October 2005.	**Achieved** • The Journey Forward Mental Health Strategic Plan was approved by the Board in November 2005, a month behind schedule due to intense stakeholder interest and the need to fully include a wide range of views. • The implementation plan was established in January 2006 with a leadership group of key stakeholders and a system-wide change management process. • The implementation plan sets out seven key workstreams including development of acute and crisis services; information and co-ordination; addiction service development; improving access to primary and mental health services; promotion and prevention; working towards recovery; and quality and evaluation.

DHB Priority : Improving Quality

We are committed to funding and providing quality health and disability services. There are a number of quality and risk management programmes in place that help in optimising the quality and safety of care and services provided by the DHB. During 2004/05, we achieved accreditation by Quality Health New Zealand and certifiication by the Ministry of Health (required under the Health and Disability Services (Safety) Act 2001).

We expect to reduce the near misses and mistakes in Hospital by providing training to analyse causes which result in near misses and mistakes.

Improve clinical risk management and reduce adverse events.

Clinical Risk Management Analysis technique to understand the basic reason for adverse events (Root Cause Analysis) training provided to identified HHS and PHO risk representatives to reduce the number of adverse events. Output: Planning & Funding Timeliness: June 2006.	**Achieved** • In October 2005 nine of our staff undertook Root Cause Analysis training. This was provided by the New South Wales RCA training network. • We are now awaiting the development of a New Zealand Train the Trainers workshop in Root Cause Analysis (RCA) to enable this skill to be shared more widely across providers in our district. • This has been one of several strategies to reduce the number of adverse events. The total number of events for the 2005/06 year has been 6,529 compared to 6,880 in 2004/05.
Medication Errors Medication errors (mistakes in administering medicine to patients) prevention strategies identified and action plan developed to reduce the number of medication errors and improve health outcomes for people who are admitted in the Hospital. Output: Planning & Funding Timeliness: June 2006.	**Achieved** Our current strategies have effected a reduction in medication error events with the total number of events for 2005/06 being 315 compared to 365 in 2004/05. Our Action Plan included: • Research study into nurse administration of medications – with recommendations now being addressed by theDirector of Nursing and Midwifery office. • Development of improved pharmacy system and software for preparation of chemotherapy products – a finalist in this year's Health Innovation Awards. • Improved reporting to the Medications Review Committee and Quality Improvement Group.

DHB Priority : Progressing the New Regional Hospital Developments

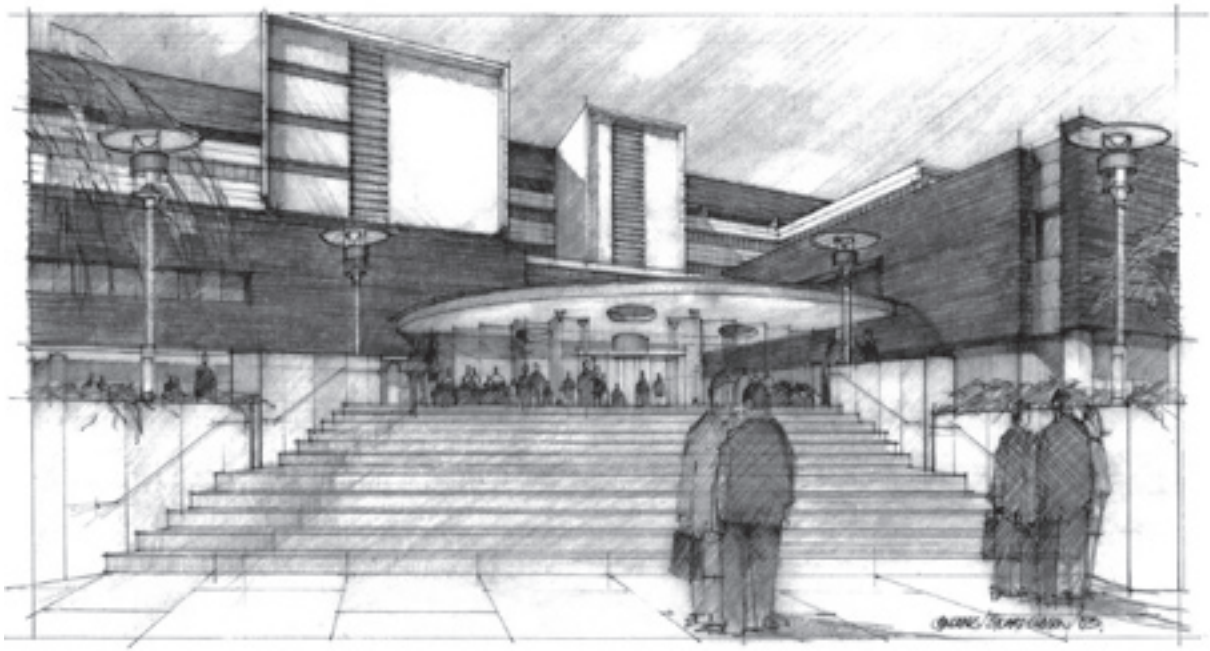
The redevelopments of the deteriorated hospital buildings is a priority to provide good healing spaces for people who use hospitals and people who look after our patients. The project has to date proceeded in accordance with the Crown approval of May 2002; the approved Master-Plan (Ministers of Health and Finance – 8 May 2003); and the approved scheme design (December 2003).

We expect to use the physical development of a new infrastructure as an opportunity to develop new ways of working especially using the short stay unit for observation.

Continue with Wellington Hospital (Newtown) Developments.

Cancer Centre and Short Stay Unit Complete and occupy Cancer Centre and Short Stay Unit. Output: DHB Provider. Timeliness: September 2005.	**Achieved** •The new Blood and Cancer Centre was occupied in July 2005. The Short Stay Unit was completed in August 2005 and new protocols and procedures were developed. • Both buildings were officially opened by the Minister of Health in September 2005.
Demolition Work Demolish old Cancer Centre and Assessment, Treatment & Rehabilitation unit. Output: DHB Provider. Timeliness: December 2005.	**Achieved** • The Assessment, Treatment & Rehabilitation unit was moved to Kenepuru in August 2005 into temporary accommodation. The Cancer Ward (Ward One) was moved to its temporary location in the Grace Neill Block. • Maycroft Construction demolished the remaining old building prior to the end of December 2005.
Construction of Main Building Commence construction of the main building. Output: DHB Provider. Timeliness: June 2006.	**Achieved** • Although the DHB had difficulties in awarding the main contract at an affordable price, Maycroft Construction was awarded a Preparatory Contract to install the piles up to the level 2 slab. This work began in June 2005. • Work continued throughout the year with the contract for the construction of the main building at Newtown was competitively let to Fletcher Construction in December 2005, with work starting in January 2006.

DHB Priority : Progressing the New Regional Hospital Developments	
Continue with Kenepuru Hospital developments.	
A&M Centre, Main Entrance and Child Health Unit Complete Accident & Medical Centre, Main Entrance and Child Health Unit. Output: DHB Provider. Timeliness: September 2005.	**Achieved** • Stage 1 developments, which were the new main entrance, A&M Centre and the Child Health Unit were operational from August 2005. They were opened by the Minister of Health, Hon Annette King in August 2005.
Psychogeriatric Unit Commence building the psychogeriatric unit. Output: DHB Provider. Timeliness: June 2006.	**Achieved** • Following a competitive tender process, Maycroft Construction Ltd was awarded the contract in January 2006. By the end of June 2006 construction was well underway.



DHB Priority : Workforce

Appropriate number and skill mix of workforce is important for providing services to our people in community and hospital settings. Workforce initiatives are trying to address the shortage and develop appropriate workforce for the future.

We expect improved capacity of Māori and Pacific nurses for high need areas like heart and kidney related diseases and for children.

Improve workforce capacity and capability especially in Hospital & Health Services.

Māori and Pacific Nursing Workforce Increase Māori and Pacific Island nurses by 1% in cardiology (heart diseases), paediatric (children) and kidney related clinical areas. Output: DHB Provider. Timeliness: June 2006.	**Partially Achieved** • Overall there has been an increase in the number of Pacific nurses in these areas (up 20%). As at 30 June 2006 there were two Pacific nurses in Cardiology Services and three in Renal Services, compared to nil and two respectively at the same time last year. However, there was just one Pacific nurse in Paediatrics compared to three at the same time last year. • Overall there has been a decrease in the number of Māori nurses in these areas (down 20%), however numbers have varied throughout the year. At 30 June 2006 there were two Māori nurses in Paediatrics compared to one at the same time last year. However the number of Māori nurses in Cardiac Services fell to two from four. There were no Māori nurses in Renal Services in either year. Recruitment initiatives successfully implemented during the 2005/06 year include the establishment of: • a Nursing and Midwifery Recruitment Unit to effectively recruit, maintain and follow up a pool of candidates who may not have been successful with their first application; and • a nursing Taskforce Team during the winter months to target areas that have higher than usual acuity and occupancy.

DHB Priority : Workforce

Develop our workforce by working with tertiary institutions to provide training programmes to meet future needs.

Post Graduate Nurse Training	**Achieved**
Conduct post-graduate programmes for nurses that support career development in eight specialities including acute care, orthopaedic, cardio-thoracic, ICU, renal, community care, neonatal and peri-operative care. These programmes will run in collaboration with Victoria University. Output: DHB Provider. Timeliness: June 2006.	• Post-graduate programmes for nurses have supported career development for 61 nurses in seven specialities including acute care, orthopaedic, cardio-thoracic, ICU, cancer, neonatal care and paediatrics. • These programmes are running in collaboration with Victoria University of Wellington and Auckland Universities.

DHB Priority : Achieving and Sustaining Financial Performance

It is critical that as a DHB we use our funding and other resources carefully to provide necessary care for our people within the budget. We always seek to improve our efficiency while maintaining the quality and effectiveness of the services we provide.

We expect to improve the use of our staff, blood products and operation theatres.

Achieve planned financial results.

Financial Performance	**Achieved**
Actual financial performance is within budgets for funder, provider and governance functions of the DHB. Output: All DHB Outputs. Timeframe: 2005/06 Year.	The overall DHB financial performance result was a small surplus of $320k. The result was close to budget for all three arms of the DHB, after adjusting for a planned asset disposal which did not occur within the financial year. Had the disposal proceeded it would have led to a larger surplus in the provider arm and the DHB as a whole. The surplus includes $16.3m of asset revaluations, being a part recovery of write downs expensed in a prior year. See the Statement Objectives and Service Performance for overall results and the summary of revenues and expenses by output class.

DHB Priority : Achieving and Sustaining Financial Performance	
Ensure appropriate utilisation of resources including staff, operation theatre and blood.	
Resource Utilisation Implement strategies to manage staffing levels to benchmarking (Nursing Hours Per Patient Day [NHPPD]) and to varying level of occupancy of wards. Output: DHB Provider. Timeliness: June 2006.	**Achieved** • We have implemented strategies to actively manage nursing hours in all clinical areas. The Medical / Surgical services Group is consistently achieving NHPPD targets by daily review and management of nursing resources in line with patient occupancy levels. • Baseline nursing levels have been established and team leaders manage nursing resources accordingly. • In general we have made good progress with achieving NHPPD targets. However, ward relocations and reconfigurations have affected some services, eg. the Women's Health Service. • A dedicated project has been established to assist Mental Health services to meet their targets.
Blood Product Management Develop protocol for blood use (especially red cells and Intragram). Output: DHB Provider. Timeliness: September 2005.	**Achieved** • A standardised request form for Intragram P has been developed in conjunction with the NZBS and implemented in January 2006. Requests are approved in line with the nationally recognised standards. • The current use of red blood cells is in line with national usage. The DHB continues to work with the New Zealand Blood Service (NZBS) and participates in the national audit programme to assist with managing the utilisation of blood products. • Monthly utilisation reports are reviewed by the DHB's Blood Transfusion Committee and specific issues followed up with the relevant clinical areas.
Theatre Utilisation Commence pilot for new starting time for operation theatre. Output: DHB Provider. Timeliness: September 2005.	**Achieved** • We implemented "getting first patient to theatre on time" in August 2005. • We are currently extending on this pilot by completing a process mapping exercise for cardiothoracic patients which aims to get these patients to theatre on time and improve the turnaround times between patients.

Indicators of DHB Performance

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives identified in the various Government strategies. Results, which reflect performance in service access and improvement, are listed below:

Reduce the number of low birth weight babies.

Low Birth Weight Babies

Reduce the rate per 1,000 births in public hospital with low birth weight (below 2,500 grams).

Output: Planning & Funding

Timeliness: 2005 Calendar Yr

Targets (Rate per 1,000)

Māori	52.0
Pacific	42.0
Other	50.0

Actuals (Rate per 1,000)

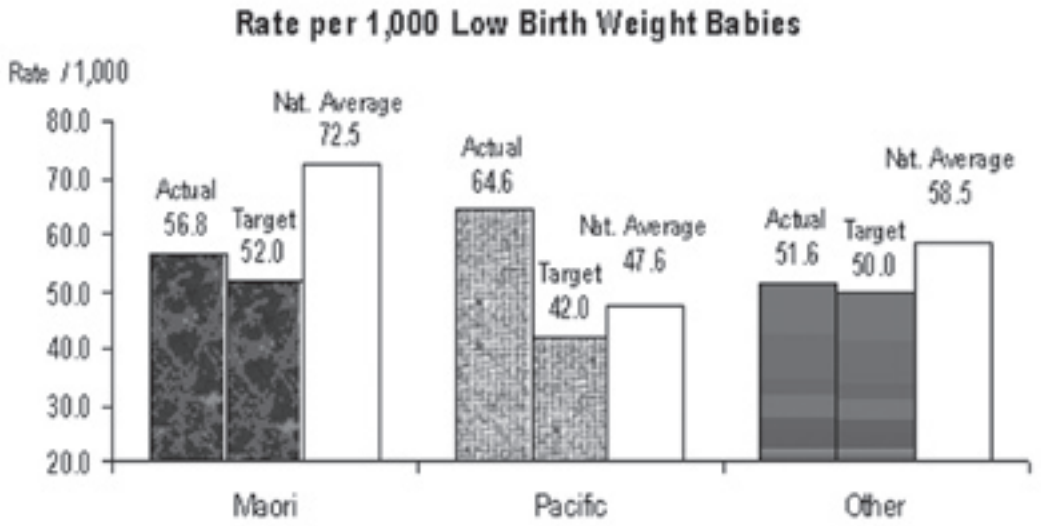
Māori	56.8
Pacific	64.6
Other	51.6

Not Achieved

We did not achieve our targets for this measure. During the year we invested in several initiatives to reduce the number of babies with a birth weight below 2,500grams. These included:

- additional support through targeted contracts with midwifery groups who care for predominantly high needs women;
- integrated midwifery/primary care/well child services (Māori and Union Health) in Wellington and Porirua;
- smoking cessation support – specific training support for smoking cessation for midwives. Additional quit smoking support services for Māori and Pacific mothers are being developed;
- a range of activities to address structural determinants of health – income, housing etc; and
- support for youth-specific services including antenatal support.

While our district's rates for Māori babies, and those in the 'other' ethnicity group are lower than the national average, the rate of low birth weight outcomes for Pacific babies in our district is above the national average. However, the numbers of Pacific babies are relatively small so that rates will fluctuate more for this group.



Indicators of DHB Performance

Improve the Oral Health of the District's Children.

Oral Health – School Entrants

Improve the percentage of child tooth decay (caries) free at age five.

Output: Planning & Funding

Timeframe: 2005 Calendar Yr

Targets 2005 Year
Māori: 45%
Pacific: 35%
Other: 70%

Actuals 2005 Year
Māori: 40%
Pacific: 33%
Other: 67%

Not achieved

We did not meet our 2005 targets for improving the percentage of five year olds who are caries free. This measure is taken at the first dental examination after the child has turned five. While we did not meet our targets we were within 10% confidence intervals for Māori and 'other' ethnic groups.

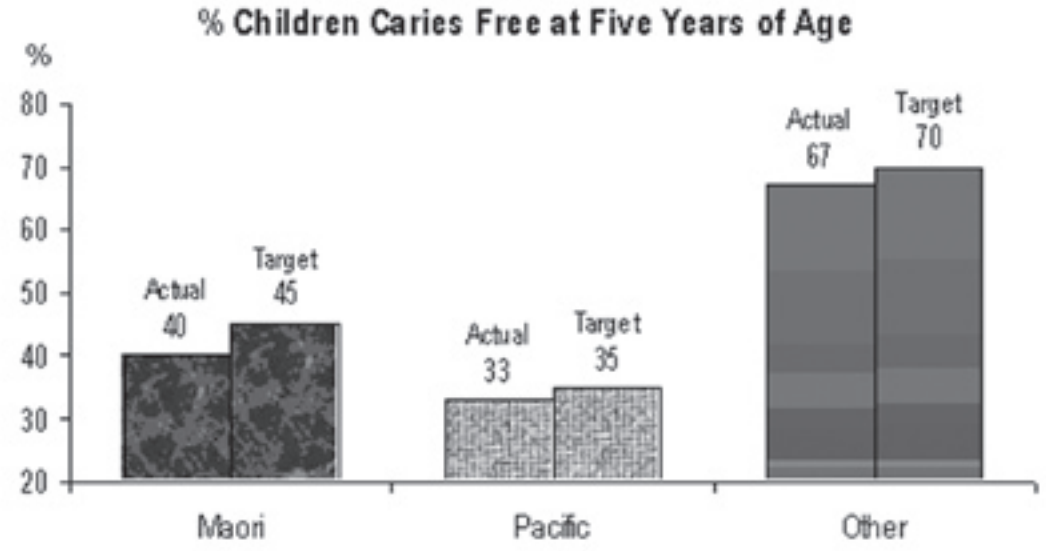
- The overall percentage of children caries free has declined since 2004. For Māori, the percentage caries free increased, though only slightly; for Pacific and Other children the percentage declined slightly. Enrolment figures have also dropped since 2004, which may contribute to the declining caries free percentages. While enrolment with the School Dental Service (SDS) is encouraged from age 2 1/2 years and earlier for the at risk groups (Māori, Pacific, low income), most children do not enroll until age five.

- To increase enrolment into the SDS, Capital and Coast DHB plans to work more closely with Hutt Valley DHB to develop and implement strategies to improve enrolment, especially early enrolment by children beginning at age 2 1/2 years. Other strategies to improve oral health at age five include:

  - Increasing work with pre-school groups, Māori Health and other providers to increase enrolments and provide oral health education.

  - Educating care givers and other health providers on oral health matters for pre-preschoolers; and

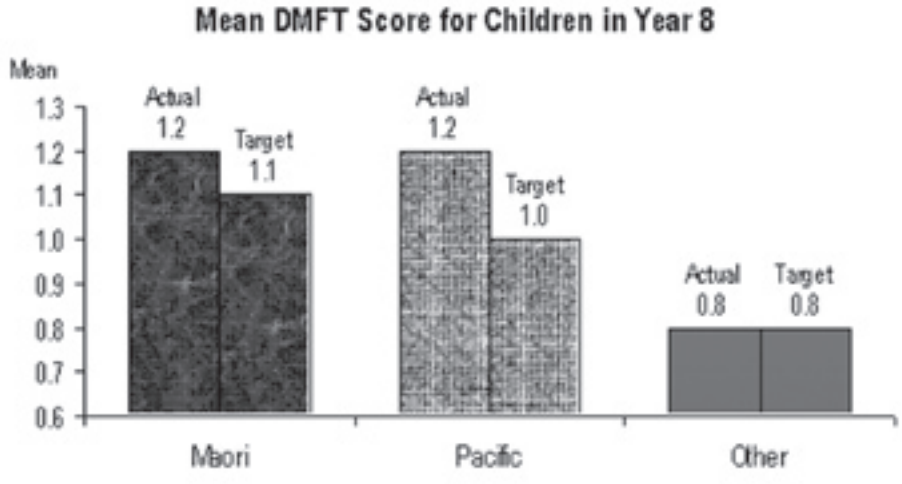
  - Further promoting public health programmes outside of oral health, like Healthy Eating, Healthy Action, to improve child oral health.



Indicators of DHB Performance

Improve the Oral Health of the District's Children.

Oral Health – Year 8 Pupils Reduce Mean Decayed, Missing and Filled Teeth (DMFT) score at Year 8. Output: Planning & Funding Timeframe: 2005 Calendar Yr Targets 2005 Yr Māori: 1.1 Pacific: 1.0 Other: 0.8 Actuals 2005 Yr Māori: 1.2 Pacific: 1.2 Other: 0.8	**Not achieved** We did not achieve our oral health targets for Year 8 pupils in calendar year 2005. The DMFT score is measured at the last dental examination before the child leaves the school dental service. • While the mean DMFT targets have not been met, mean DMFT increased from 2004 to 2005 for Māori and Other children (which are within 10% confidence intervals of our target), and declined slightly for Pacific children. • Capital and Coast DHB will continue to work with Hutt Valley DHB to develop and implement strategies to improve oral health at age 12. We will continue to: • target the dental service to high risk children and provide higher levels of recall, and preventive activity, for children at the highest risk of oral disease. • engage with Māori Health providers to improve general health.



Indicators of DHB Performance

Diabetes case detection and follow-up to help those most in need.

Diabetes Follow-up

Improve the case detection and follow-up rate. Estimated (by the Ministry of Health) diabetics on Diabetes Register.

Output: Planning & Funding

Timeframe: 2005 Calendar Yr

Targets 2005 Yr
Total: 67.0%
Māori: 50.0%
Pacific: 70.0%
Other: 70.0%

Actuals 2005 Yr
Total: 66.2%
Māori: 39.7%
Pacific: 77.8%
Other: 69.9%

Partially Achieved

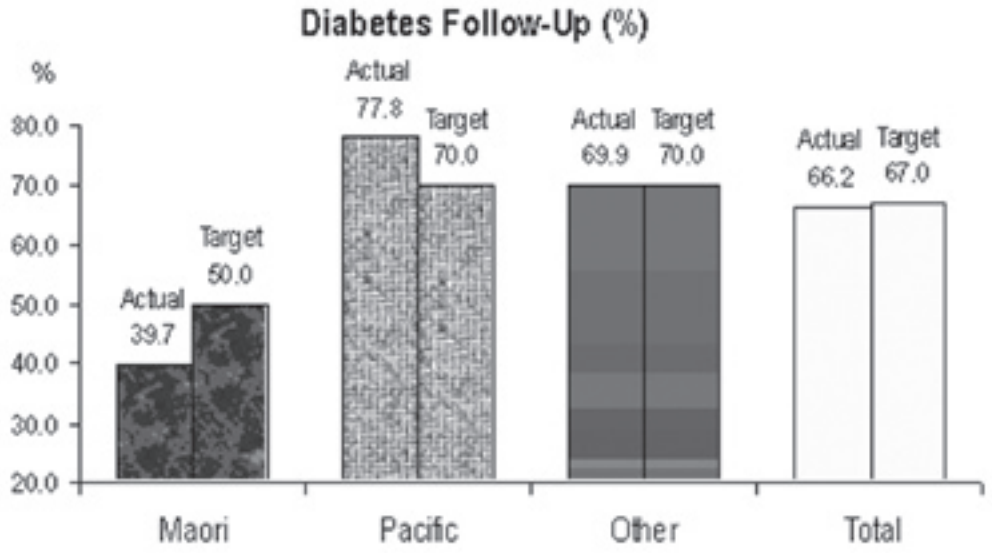
While we did not meet the total follow up target in 2005 the absolute volume of Annual Checks increased by 14% from 4,161 to 4,752. The number of annual checks for Māori was 21% higher than in 2004. The increase in Pacific annual checks was 22%. This highlights some progress in reducing inequalities.

- While we did not meet the target for the total population, it was ambitious under the circumstances. Primary health care providers have noted that 2005 was an extraordinarily busy year with the Meningococcal B programme (MeNZB) rollout, late flu vaccination availability, the implementation of the National Immunisation Register (NIR) and the CarePlus programme placing a lot of extra demand on the primary health care sector.

- Going forward, additional education opportunities will be provided for primary care staff and an additional nurse practitioner position at the primary / secondary interface has been established.

- Regular progress feedback will be provided to practices / services in order to stimulate improved coverage.

- We have also analysed coverage over time, by ethnicity and by PHO and made this available.

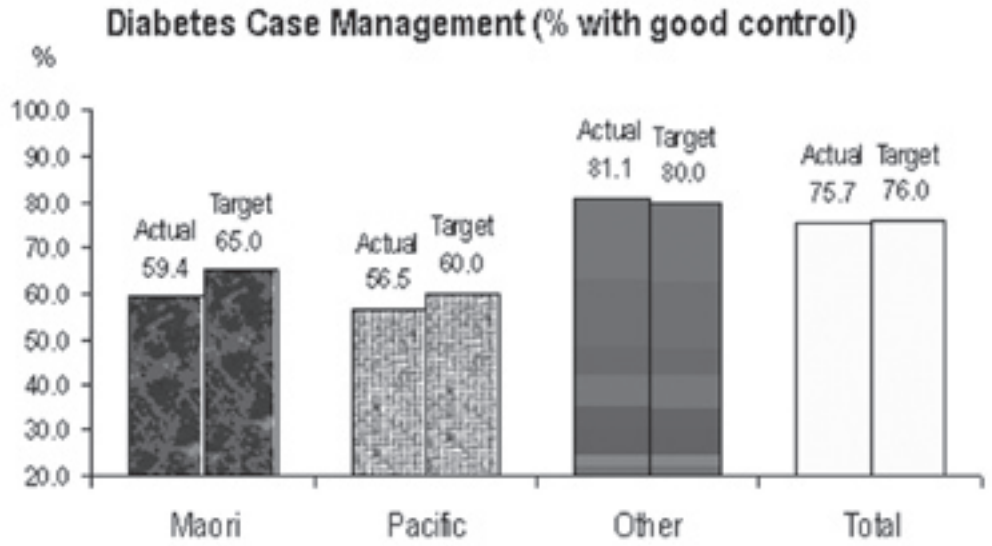


Capital & Coast District Health Board

Indicators of DHB Performance

Strengthening the self-management capability of individuals, family and whanau.

Diabetes Management	**Achieved**
Increase the numbers of people on Diabetes Register that have good blood sugar control (HBA1c level below 8%). Output: Planning & Funding Timeframe: 2005 Calendar Yr Targets 2005 Year Total: 76.0% Māori: 65.0% Pacific: 60.0% Other: 80.0% Actuals 2005 Year Total: 75.7% Māori: 59.4% Pacific: 56.5% Other: 81.1%	• While not all targets for the various ethnic groups have been reached, the overall result is on target. The targets for Māori and Pacific will be influenced by the increase in detection – new people are less likely to have excellent glycaemic control in the first year. Given this effect, the trend for Pacific is positive and the trend for Māori is stable, within 2% of 2005. • Investment in primary care for diabetes has included Māori-specific investment in Wellington, Porirua and Kapiti. These three Māori-specific Diabetes Nurse Educator / whanau services are being evaluated in 2006/07. Mainstream effectiveness for Māori will also be analysed. Several innovative groups have continued to be supported, such as Māori diabetes Roopu self-management, whanau support group at NUHS, and marae-based group at Porirua. A Pacific-specific initiative has been funded working with Pacific people with poorly controlled diabetes as an outreach from the hospital-based Pacific support service. Other DHB and PHO-funded Pacific-specific initiatives such as Healthy Lifestyles Pasifika and church-based groups, include many people with diabetes. • CarePlus and additional capitation to reduce cost barriers for people living with mental illness and often co-existing diabetes will also help support better diabetes management. • These investments and further workforce development will continue to be funded in 2006/07.



Indicators of DHB Performance

Reduce the rate of avoidable loss of vision due to diabetes through screening.

Diabetes Retinopathy Screening

Improve eye screening. Increase the number of people on Diabetes Register that have had eye (retinal) screening in the last two years.

Output: Planning & Funding

Timeframe: 2005 Calendar Yr

Targets 2005 Year

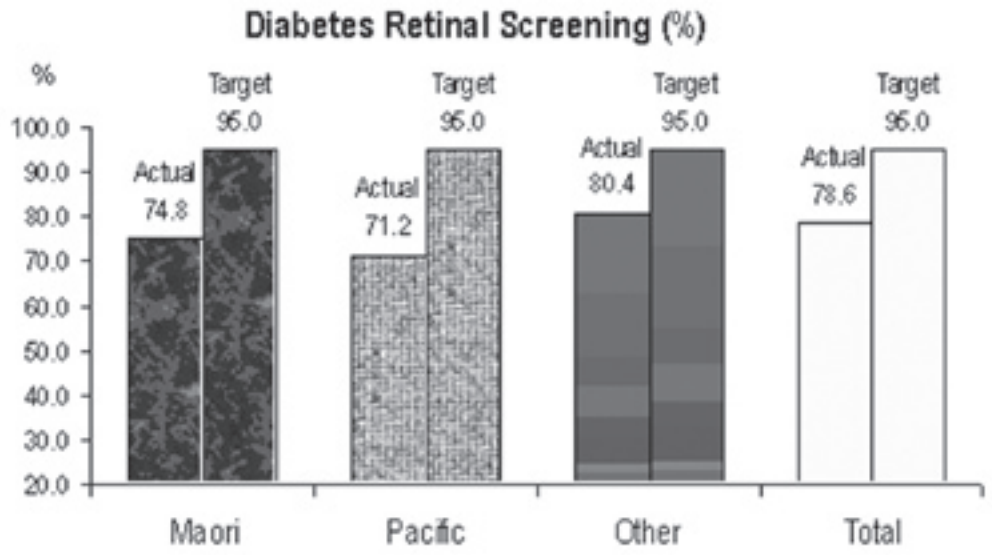
Total:	95.0%
Māori:	95.0%
Pacific:	95.0%
Other:	95.0%

Actuals 2005 Year

Total:	78.6%
Māori:	74.8%
Pacific:	71.2%
Other:	80.4%

Not achieved

- We did not meet our stretch targets for retinal screening in 2005. This was in part due to fewer outreach retinal screening clinics and also to an increase in denominator – i.e. more detection.
- In the light of 2004 results, a review of the retinal screening service involving all key stakeholders was completed in 2005, and the contract was reviewed. The new contract is more prescriptive about the number of outreach clinics and about expectations in our district (as opposed to the 'region').
- Other providers work hard to support the outreach clinics and these are generally influential in overall coverage. During the year a retinal screening clinic was hosted by Porirua Union and Community Health Service with no non-attendances (DNAs). It is anticipated that more focus in primary care on diabetes in 2006 will result in higher coverage.



Capital & Coast District Health Board

Indicators of DHB Performance

Reduce the rate of Ambulatory Sensitive Admissions.

Lung conditions and infections are two common causes of preventable hospital admission. We aim to reduce the number of preventable admissions for children and the elderly by providing appropriate primary care.

Ambulatory Sensitive Admissions

Ambulatory Sensitive Admissions for Children – Discharge rate per 1,000 population.

Output: Planning & Funding

Timeframe: 2005 Calendar Yr

Targets	< 5 yrs	5–14yrs
Māori	62.0	21.0
Pacific	85.0	32.0
Other	53.0	14.0

Actuals	< 5 yrs	5–14yrs
Māori	58.8	20.7
Pacific	77.9	36.0
Other	54.6	15.4

Partially Achieved

- We met three of our six specific targets for Ambulatory Sensitive Hospitalisations (ASH). However our results are generally better than national averages.
- For both age groups the result for Māori children is better than our targets.
- Relatively high ASH in Pacific children has been an ongoing issue for our district despite attempts to improve access to primary care. All PHOs are developing Pacific Health plans. The Pacific Health Service in the hospital is attempting to address preventable admissions through early liaison with families and attention to factors affecting health. Further resources have been applied to identify the main factors affecting avoidable hospitalisation for Pacific children.
- Several insulation programmes are in progress in Porirua with focus on families where there are children with respiratory illness putting them at high risk of admission to hospital. A smoking cessation service for Pacific people is also being developed.
- The DHB invested $400,000 in 2005/06 to improve GP and nurse capacity in Porirua East. This was in addition to investment through projects which support outreach nurses and community health workers in the wider Porirua Basin.
- The DHB is also supporting a skin infection project, aimed to reduce admissions due to cellulitis and abscesses.

Indicators of DHB Operations

Key performance indicators identified below are used to measure service access, efficiency, and patients' satisfaction with our Hospital & Health Services.

Reduce waiting times for elective specialist assessment and treatment.

We aim to deliver services in accordance with the priority of the Government to reduce waiting times for public hospital elective services.

Waiting times – FSA
 	
This indicator is designed to measure the number of people who wait more than six months for their first specialist assessment (FSA) and measures progress on the Elective Services key strategic goal. The number of patients waiting longer than six months for FSA will be 2% or less of the total number of FSA seen.
 	
Output: Provider
 	
Timeframe: 2005/06
	Not achieved
	
	• The number of patients waiting longer than six months for an FSA has decreased from 2,932 in June 2005 to 2,032 at the end of June 2006. The total of 2,032 people waiting equates to 6.7% against the target of 2%. While we have not achieved target, good progress has been made by the implementation of the following:
	
	  • Validation of the wait list;
	
	  • Triage of referrals by a Senior Medical Officer across all specialties to ensure referrals meet the access criteria and returning referrals where appropriate to the GP;
	
	  • Review of the patients waiting > six months and returning these to the GP with a care plan for ongoing management. The DHB has funded any required patient reassessments by the GP.
	
	• There is a detailed plan in place to support the achievement of the target of 2% or less of the total number waiting by 30 September 2006.

Waiting times – Elective Surgery This indicator is designed to measure the number of people waiting longer than six months for elective surgery following assessment and also measures progress on the Elective Services key strategic goal. The number of patients waiting longer than six months for elective surgery will be 5% or less of the total number of Elective surgery performed. Output: Provider Timeframe: 2005/06	**Achieved** • The number of patients waiting six months or longer for elective surgery as at the end of June 2006 is 875. This equates to 4.75% over all specialties against the target of 5%. • Cataract and Joint Initiative volume targets were achieved. • However, waiting time targets have not been achieved in cardiothoracic surgery, ophthalmology, paediatric surgery and urology. Staffing issues within the Anaesthetic Department have impacted on theatre access for elective surgery. There is a detailed plan in place to support the achievement of targets in the above specialties by 30 September 2006. • Activities implemented to support the improvement include validation of the wait list removing patients who no longer require surgery and ensuring correct categorisation of patients.

Indicators of DHB Operations

Increase levels of patient satisfaction and resolve complaints promptly, using feedback to identify areas for improvement.

Patient satisfaction

We regularly measure whether our patients are satisfied with the service they receive during their stay in the hospital. The surveys also help to identify areas that could be improved.

Output: Provider

Timeframe: 2005/06

Target:
85% Overall satisfaction

Actuals:

Inpatient satisfaction	82.1%
Outpatient satisfaction	85.5%
Overall satisfaction	83.8%

Partially achieved

- The overall satisfaction result of 83.8% represents a slight decrease in patient satisfaction from the previous year (84.3%). Both inpatient and outpatient satisfaction were down, however, these results need to be reviewed in the context of the major redevelopment programme underway at all hospital sites in the 2005/06 year.

- The building programme has unavoidably affected the physical environment and has attracted many negative comments and complaints about access to buildings and cleanliness of facilities. The relocation of some clinical services into temporary accommodation has also affected our ability to deliver some services to the high standards that we have been able to achieve in the past.

- This situation is temporary but is affecting the immediate experience of patients and their families during the building process. Complaints have arisen despite the best efforts of all staff to minimise the effects. This is reflected in the drop in ratings for “Offering cultural choices’ and “Internal coordination”.

- Although there has been a reduction in rating this year it is worth noting that the result is well within the control limits in both inpatient and outpatient surveys.

Complaints resolved

This indicator measures the responsiveness to resolving consumer (patient) concerns that are expressed as formal complaints. It helps us to monitor compliance with legal requirements.

Output: Governance

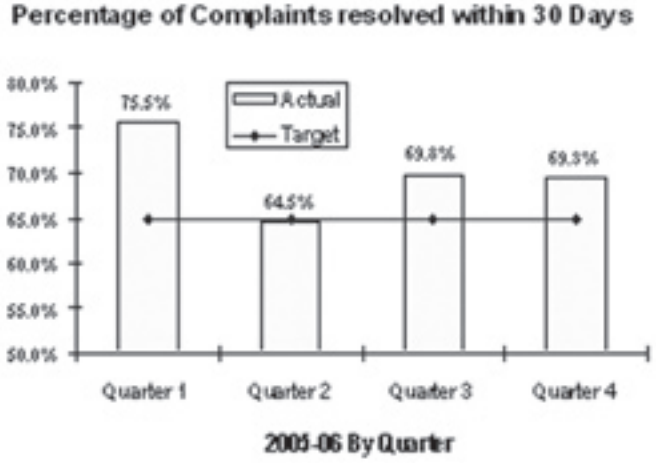
Timeframe: 2005/06

Target:
65% resolved within 30 days.

Actual:
69.6% resolved.

Achieved

- The result for this year is 69.6% up from 60% in 2004/05 and ahead of the target of 65%. This result has been achieved despite a 10% increase in the volume of complaints (many related to the hospital redevelopment programme) and in the absence of any increase in resource.



Indicators of DHB Operations

Did not attends (DNAs)	**Not achieved**
Every year numbers of patients do not attend their outpatient appointments. When a patient does not attend their appointment, the clinical time is not used and access to service reduces as we have a fixed number of outpatient clinics. Output: Provider Timeframe: 2005/06 Targets: Overall: 8.0% Māori: 12.0% Pacific 12.0% Actuals: Overall: 9.1% Māori: 16.7% Pacific: 17.1%	We have had a DNA rate of about 9% for the last three years, one of the lowest for all DHBs. Detailed information shows that the attendance rates for all ethnic groups are better at Wellington Hospital than at Kenepuru Hospital. This can be attributed to: • the mix of acute/elective attendances; • provision of a shuttle service from Kenepuru to Wellington; • improved booking processes; and • increased patient reminders. The attendance rates when compared with 2004/05 have remained consistent. Initiatives in place to reduce DNA rates further include: • improved recording and monitoring of attendance information; • assistance with transport for high needs patients; • improved booking processes, including advice to General Practitioners when patients do not attend so that they can follow-up; • checking with GPs for patients who haven't attended to ensure correct address details; • a Whanau Care service to look specifically at non-attendance in the paediatric services at both Wellington and Kenepuru.

Indicators of DHB Operations

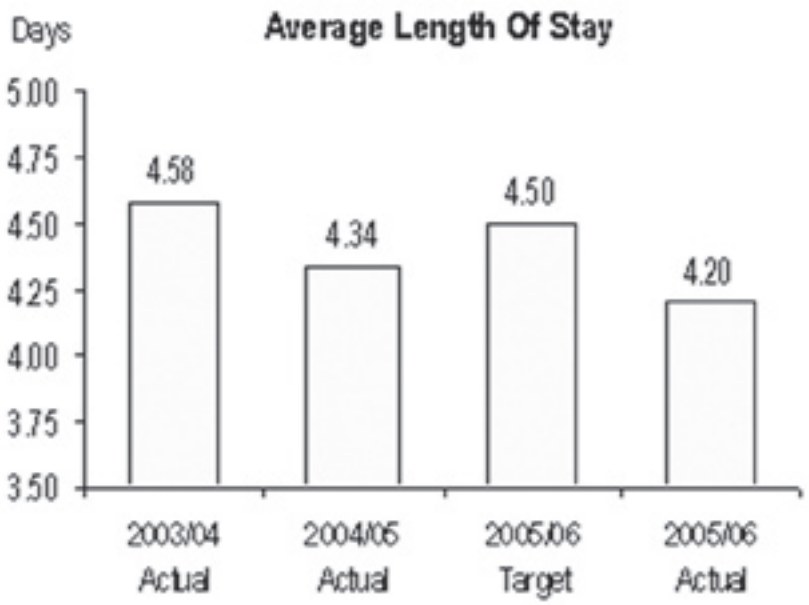
Reduce average length of stay in hospital.

Average Length of Stay

One of the ways of measuring efficiency of our HHS is measuring the average amount of time spent by patients in hospital.
Output: Provider
Timeframe: 2005/06 Year
Target:
4.50 days
Actual:
4.20 days

Achieved

The average length of stay reduced from 2004/05 and was ahead of the target for the 2005/06 year.



Key Contracted Service Outputs

The following table summarises the contracted service outputs for 2005/06 as agreed between the Planning & Funding Arm of the DHB and the Provider Arm (Hospital & Health Services).

Contracted Output / Service Level	Measure / Unit	2005/06 SOI Budget	2005/06 Actual
Medical/Surgical Inpatient	Caseweights	$120,638,296	$128,950,772
Medial / Surgical Outpatient	Attendences/ Procedures	$71,084,973	$70,131,765
Mental Health	FTE / Bed days	$49,773,117	$51,351,259
Emergency Department	Attendances	$7,097,117	$7,919,627
Maternity	Attendences / Procedures	$15,195,908	$15,194,492
Disability Support Services	FTE / Bed days	$9,041,017	$9,098,950
Personal Health	Various	$55,307,964	$57,910,057
Total		$328,135,392	$340,556,922

Note that these figures represent revenue amounts classified by nationally recognised contract purchase unit categories. During the course of the year the DHB's Planning and Funding Team agreed contract variations with the Ministry of Health. This increased the contracted service levels between Planning and Funding and Hospital and Health Services within the DHB, increasing the funding available across a number of categories.

Statement of responsibility

For the year ended 30 June 2006

1. The Board and Management of Capital and Coast District Health Board accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.

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

3. In the opinion of the Board and Management of Capital and Coast District Health Board, the annual Financial Statements for the year ended 30 June 2006, fairly reflect the financial position and operations of Capital and Coast District Health Board.

Bob Henare
Chairperson

Margot Mains
Chief Executive

Calum Laurie
Director of Finance

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Statement of accounting policies

For the year ended 30 June 2006

Reporting Entity

Capital and Coast District Health Board (the DHB)is a Crown Entity in terms of the Crown Entities Act 2004. The financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

Joint Venture Company

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

CRTAS has a total share capital of $600 of which the DHB share is $100. At balance date all share capital remains uncalled. The results of the joint venture company have not been included in the financial statements as they are not considered significant.

Associate Company

Associate companies are entities in which the DHB has significant influence, but not control, over their operating and financial policy decisions. The DHB and Taranaki DHB have an interest in the equity of HIQ Limited which was incorporated on 18 October 2004. The interest in HIQ Limited has been reflected in the financial statements on an equity accounting basis, which shows the share of surplus/deficits in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

Measurement base

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

Accounting policies

The following particular accounting policies which materially affect the measurement of financial results and financial position have been applied:

Budget Figures

The budget figures are those approved by the Board and published in its Statement of Intent. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of these financial statements.

Goods and Services Tax

All items in the Financial Statements are exclusive of Goods and Services Tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as a part of the related asset or expense.

Taxation

The DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from Income Tax under Section CB3 of the Income Tax Act 1994.

Donation, Bequest and Trust Funds

Donations and bequests are recognised as revenue at the point when they are formally acknowledged. Funds received, to which conditions are attached, are acknowledged as revenue, unless the conditions cannot be fulfilled in which case the funds are lodged as DHB's Trust Funds. The use of these funds must comply with the specific terms of the sources from which the funds were derived and are therefore accounted for separately through the DHB's Trust Ledger.

Accounts Receivable

Accounts receivable are stated at expected realisable value after providing for doubtful and uncollectible debts.

Inventories

Inventories are stated at the lower of cost, determined on a weighted average cost basis, and net realisable value after allowing for slow moving and obsolete items. Obsolete items are written off.

Investments

Investments, including that in the joint venture company, are stated at the lower of cost and net realisable value. Any write downs are recognised in the Statement of Financial Performance.

Property, Plant and Equipment

Assets are recorded at cost, or valuation, less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs. Where assets have been revalued, the assessed fair value is used, with the difference between the written down value and fair value being recognised in the Statement of Financial Performance for any reduction, and any gain being taken to a revaluation reserve.

Plant and Equipment

Plant and equipment are revalued every five years (unless a material change in asset value is identified during this period) to reflect their fair value as determined by an independent registered valuer by reference to their highest and best use. Fair value is determined using market evidence or depreciated replacement cost where appropriate.

Revaluation of Land and Buildings

Land and buildings are revalued every five years (unless a material change in asset value is identified during this period) to reflect their fair value as determined by an independent registered valuer by reference to their highest and best use. Fair value is determined using market evidence or depreciated replacement cost where appropriate. Additions between revaluations are recorded at cost.

The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation surplus reverses a previously recognised revaluation decrement, the revaluation surplus is recognised as revenue in the Statement of Financial Performance. Where a revaluation of an asset class results in a debit balance in the asset revaluation reserve for that asset class, the debit balance will be expensed in the Statement of Financial Performance.

Surplus Properties

These properties are recognised at the lower of their cost or their net realisable value.

Disposal of Property, Plant and Equipment

When a property, plant and equipment is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated as the difference between the sale price and the carrying value of the asset.

Depreciation

Depreciation is provided on a straight line basis on all fixed assets other than freehold land and capital work in progress, at rates which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

- Building structure – 1 to 60 years
- Building fitouts – 1 to 25 years
- Plant and equipment – 5 to 15 years
- Leasehold Improvement – 1 to 25 years

The total cost of capital work in progress of a project is transferred to freehold buildings and/or plant and equipment on its completion and depreciated from that date.

Employee Entitlements

Provision is made for the DHB's liability for annual leave, long service leave, sabbatical leave, retirement leave, and continuing medical education leave and expenses. Annual leave and continuing medical education expenses have been calculated on an actual entitlement basis at current rates of pay whilst the other provisions have been calculated on an actuarial basis.

Leases

Finance leases

Leases, where the lessee effectively retains substantially all the risks and benefits of ownership of the leased items, are classified as finance leases. Finance lease assets are recorded at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the Statement of Financial Position. The leased assets are depreciated over the period the DHB is expected to benefit from their use.

Operating Leases

Leases, where the lessor effectively retains substantiality all the risks and benefits of ownership of the leased items, are classified as operating leases. Operating lease expenses are recognised in the Statement of Financial Performance on a systematic basis over the period of the lease.

Financial Instruments

The DHB is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, investments, debtors, creditors and loans. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to financial instruments are recognised in the Statement of Financial Performance. Except for loans, which are recorded at cost, and those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, bank overdrafts, demand deposits and other highly liquid investments in which the DHB invests as part of its day to day cash management.

Operating activities include all transactions that are not investing or financing activities. Cash in-flows include all receipts from the sale of goods and services and other sources of revenue which supports the Board's operating activities. Cash outflows include the payments made to employees, suppliers and for taxes.

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

Financing activities comprise the change in equity and debt capital structure of the DHB.

Cost of Service Statements

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2006, indirect costs accounted for 7.29% of the DHB's total costs (2005: 6.84%).

Capitalisation of interest

The DHB has adopted a policy of capitalising interest costs incurred on debt financing in respect of major capital projects. The interest cost of debt financing for the new regional hospital development project (NRH) has been capitalised to the Statement of Financial Position.

The capitalised interest of $4.6m (2005:$2.2m) has resulted in a reported net profit for the year.

Changes in accounting policies

All policies have been applied on a basis consistent with the previous year, except for Plant and Equipment. The policy for Plant and Equipment has changed from a recording basis of historical cost to one of revaluation. The effect of the change has been to increase the value of Plant and Equipment, and associated revaluation reserve by $8.9m.

Statement of financial performance

For the year ended 30 June 2006 *

	Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
Revenue	1	624,015	591,635	558,785
Expenses	1	620,137	577,624	555,535
Capital charge	16	3,558	5,133	4,872
NET SURPLUS/(DEFICIT)	**1**	**320**	**8,878**	**(1,622)**

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

Statements of movement in equity

For the year ended 30 June 2006 *

	Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
EQUITY AT BEGINNING OF THE YEAR		128,128	129,707	129,750
Net surplus/(deficit) for the period		320	8,878	(1,622)
Revaluations	2(c)	16,133	-	-
Total recognised revenues and expenses for the year		**16,453**	**8,878**	**(1,622)**
Contributions from owners	2(a)	6,373	-	-
EQUITY AT THE END OF THE YEAR		**150,954**	**138,585**	**128,128**

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

Statement of financial position

As at 30 June 2006*

	Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
EQUITY				
General funds	2(a)	211,616	217,191	205,243
Retained earnings	2(b)	(93,856)	(95,668)	(94,176)
Revaluation reserves	2(c)	33,194	17,062	17,061
Total equity		**150,954**	**138,585**	**128,128**
REPRESENTED BY:				
ASSETS				
Current Assets				
Cash		13	-	13
Receivables and prepayments	3	119,648	94,744	115,489
Inventories	4	5,414	4,770	4,609
Trust funds	12(a) & (b)	4,825	4,235	4,382
Total current assets		129,900	103,749	124,493
Non-Current Assets				
Investment in associate company	17	6,862	-	2,134
Property, Plant and Equipment	5	282,835	300,081	220,327
Total non current assets		289,697	300,081	222,461
Total assets		**419,597**	**403,830**	**346,954**
LIABILITIES				
Current Liabilities				
Bank Overdraft		17,038	-	30,472
Payables and accruals	6	38,433	46,169	41,853
Employee entitlements	7	38,568	17,927	26,967
Current portion of term loans	8	53,074	16,611	11,139
Total current liabilities		147,113	80,707	110,431
Non-Current liabilities				
Employee entitlements	7	4,314	3,770	3,941
Term loans	8	117,074	180,665	104,340
Restricted and Trust fund liabilities		142	103	114
Total non current liabilities		121,530	184,538	108,395
Total liabilities		**268,643**	**265,245**	**218,826**
NET ASSETS		**150,954**	**138,585**	**128,128**

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

Statement of cash flows

For the year ended 30 June 2006 *

	Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and other crown entities		581,629	555,270	544,493
Other revenue		21,045	36,364	11,986
Interest received		652	-	643
		603,326	591,634	557,122
Cash was disbursed to:				
Payments to employees and suppliers		590,168	561,280	524,254
Capital charge		3,322	5,023	6,844
Interest paid		4,191	8,034	4,310
GST (net)		(1,439)	169	(20)
		596,243	574,506	535,388
Net cash inflow/(outflow) from operating activities	**9**	**7,083**	**17,128**	**21,734**
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of property, plant and equipment		-	16,008	-
		-	16,008	-
Cash was applied to:				
Trusts		415	-	653
Purchase of property, plant and equipment		49,785	94,494	49,258
Advances to associate		4,118	-	3,561
		54,318	94,494	53,472
Net cash inflow/(outflow) from investing activities		**(54,318)**	**(78,486)**	**(53,472)**

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

	Notes	Actual 2006 $000	Budget 2006 $000	Actual 2005 $000
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Equity Injection		6,000	24,000	-
Proceeds from term loan		66,000	37,356	6,000
		72,000	61,356	6,000
Cash was applied to:				
Repayment of term loan		11,331	-	6,333
Net cash inflow/(outflow) from financing activities		**60,669**	**61,356**	**(333)**
Net increase in cash held		13,434	(2)	(32,071)
Add opening cash		(30,459)	2	1,612
Closing cash balance		(17,025)	-	(30,459)
Made up of:				
Cash		13	-	13
Bank Overdraft		(17,038)	-	(30,472)
Closing cash balance		(17,025)	-	(30,459)

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

Statement of contingent liabilities

as at 30 June 2006*

	2006 $000	2005 $000
Legal proceedings	380	3,310
Personal grievances	20	141
Other	100	63

There are other claims that the DHB is currently contesting which have not been quantified due to the nature of the issues and/or the uncertainty of the outcome. In the event of the Courts finding for the plaintiffs, the Board believes that any damages awarded will be met by its insurers.

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

Statements of commitments

as at 30 June 2006*

	2006 $000	2005 $000
Capital Commitments including New Regional Hospital (NRH)		
Less than one year	46,946	32,066
One to two years	111,962	834
Two to five years	-	-
	158,908	32,900
Finance Lease commitments		
Less than one year	-	49
One to two years	-	-
Two to five years	-	-
	-	49
Operating lease commitments		
Less than one year	1,393	1,796
One to two years	653	963
Two to five years	726	502
Over five years	654	837
	3,426	4,098
Other non-cancellable service contracts		
Less than one year	72,967	22,046
One to two years	16,619	9,926
Two to five years	43,907	6,187
Later than five years	5,050	6
	138,543	38,165
TOTAL COMMITMENTS	300,877	75,212

Note: Other non-cancellable service contracts of less than one year for the year ended 30 June 2006 includes demand driven expenditure commitments. These commitments were not included in the figures for the 2005 year, and therefore 2006 and 2005 figures are not comparable.

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

Notes to the financial statements

for the year ended 30 June 2006

Note 1: Net Surplus/(Deficit)

	2006 $000	2005 $000
Revenue	**624,015**	**558,785**
After crediting:		
Interest income	652	643
Revaluation of buildings	16,257	-
Donations and bequests	57	1,656
Less Expenses		
After charging:		
Remuneration of auditor		
Audit fees	148	108
Assurance related services *	18	5
Depreciation		
Buildings	10,474	10,007
Plant and equipment	9,558	10,364
Loss on sale of fixed assets	79	38
Board members' fees	324	340
Interest expense	4,397	6,866
Interest expense on finance leases	29	89
Rental and operating lease costs	2,609	2,998
Bad debts written off	150	110
Changes in provision for doubtful debts	567	213
Personnel costs	244,217	211,187
Information technology service fees	10,426	4,389
Other operating expenses	122,449	111,716
Provider payments	214,692	197,105
	620,137	**555,535**
Capital Charge	3,558	4,872
Net surplus/(deficit) per Statement of Financial Performance	**320**	**(1,622)**

* Assurance related services performed by the auditor totalled $31,000. $13,000 of those services have been capitalised.

Note 2: Equity

(a) General Funds	2006 $000	2005 $000
Opening balance	205,243	205,243
Contribution from owners	6,373	-
General funds at 30 June	**211,616**	**205,243**

(b) Retained earnings	2006 $000	2005 $000
Retained earnings at 1 July	(94,176)	(92,554)
Operating surplus/(deficit)	320	(1,622)
Retained earnings at 30 June	**(93,856)**	**(94,176)**

(c) Other Movements	2006 $000	2005 $000
Land revaluation reserve		
Opening balance	17,061	17,061
Revaluation	7,208	-
Land revaluation reserve at 30 June	**24,269**	**17,061**
Plant and Equipment revaluation reserve		
Opening balance	-	-
Revaluation	8,925	-
Plant and Equipment reserve at 30 June	8,925	-
Total Revaluation Reserves at 30 June	**33,194**	**17,061**

Note 3: Receivables and prepayments

	2006 $000	2005 $000
Associate company debtor	5,835	6,445
Trade debtors	26,606	16,079
Provision for doubtful debts	(1,894)	(1,327)
Accrued income	2,670	7,824
Prepayments	431	468
Crown equity due (1)	86,000	86,000
	119,648	**115,489**

1 - The write down in the value of a number of buildings has had a significant impact on the equity of the DHB and the Crown has recognised the need to replace this equity. This replacement is in the form of an irrevocable pledge of equity of $86 million to be drawn as and when required. The DHB will use these funds as part of the payments from the Crown to construct the New Regional Hospital.

Note 4: Inventories

	2006 $000	2005 $000
Pharmaceuticals	1,199	1,244
Surgical and medical supplies	4,114	3,260
Other supplies	101	105
Total Inventory	**5,414**	**4,609**

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

Note 5: Property, plant and equipment

	2006 $000	2005 $000
Land		
Land at valuation – revalued as at 30 June 2006	25,105	21,722
Transfers from Surplus Properties	-	295
Total land	**25,105**	**22,017**
Buildings		
Buildings at cost	-	11,709
Buildings at valuation – revalued as at 30 June 2006	116,880	88,878
Accumulated depreciation	-	(10,861)
Total buildings	**116,880**	**89,726**
Leasehold Improvements		
At cost	2,655	2,195
Accumulated depreciation	(811)	(664)
Total Leasehold Improvements	**1,844**	**1,531**
Plant and Equipment		
At cost	6,031	100,405
At valuation – revalued as at 30 June 2006	44,611	-
Accumulated depreciation	(2,672)	(61,937)
Total plant and equipment	**47,970**	**38,468**
Plant and Equipment finance leases		
At cost	1,091	1,091
Accumulated depreciation	(1,091)	(1,042)
Total plant and equipment finance leases	**-**	**49**
Surplus Properties		
At cost	15,492	10,847
Accumulated depreciation	(3,563)	(3,288)
Total surplus properties	**11,929**	**7,559**
Capital Work in Progress		
Buildings	76,963	54,967
Plant and Equipment	2,144	6,010
Total capital work in progress	**79,107**	**60,977**
Total property, plant and equipment		
At cost and valuation	290,972	298,119
Accumulated depreciation	(8,137)	(77,792)
Total carrying amount	**282,835**	**220,327**

Restrictions

The DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. The disposal of any property is subject to the provisions of S40 of the Public Works Act 1981 and Māori Protection Mechanism.

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

Valuation

Buildings are stated at fair value determined by reference to depreciated replacement cost by M J Bevin, MPA, SNZPI (Registered Valuer) of DTZ New Zealand Limited as at 30 June 2006.
Land was revalued at fair value, which was determined by reference to its highest and best use, by M J Bevin, MPA, SNZPI (Registered Valuer) of DTZ New Zealand Limited as at 30 June 2006.

Plant and Equipment was revalued at fair value determined by reference to market value where available, or depreciated replacement cost where a market value was unavailable, by E A Forbes, Dip QS, SNZPI (Registered Valuer) of DTZ New Zealand as at 30 June 2006.

Surplus properties were revalued at fair value determined by reference to market value by E F Gordon, FNZIV (Registered Valuer) as at 30 June 2006.

Note 6: Payables and accruals

	2006 $000	2005 $000
Trade creditors and accruals	31,868	36,648
Capital charge due to the Crown	705	470
Accrued expenses	5,620	4,415
Revenue in advance	240	320
Total payables and accruals	**38,433**	**41,853**

Note 7: Employee entitlements

	2006 $000	2005 $000
Accrued pay	12,345	5,828
Annual leave	20,289	18,217
Retirement and long service leave	5,300	4,648
Other	4,948	2,215
	42,882	**30,908**
Made up of:		
Current	38,568	26,967
Non-current	4,314	3,941
	42,882	**30,908**

Note 8: Term loans

	2006 $000	2005 $000
Crown Health Financing Agency (CHFA)	170,000	104,000
Capital & Coast notes	-	11,000
Finance leases	-	44
Other loans	148	435
Total	170,148	115,479
Less current portion	53,074	11,139
Non current portion	117,074	104,340
Interest Rates Summary:		
CHFA	5.86% - 6.33%pa	5.86%pa
Revolving credit	7.39%pa	6.89%pa
Capital & Coast notes (weighted coupon)	7.90%pa	7.90%pa
Leases	6.00%pa	6.00%pa
Repayable as follows:		
One to two years	62,074	53,267
Two to five years	-	51,073
Five to ten years	55,000	-
	117,074	104,340

The CHFA term liabilities are secured by a negative pledge. Without CHFA's prior written consent the DHB could not perform the following actions in the following areas:

a) Security interest: Create any security interest over its assets except in certain defined circumstances; or
b) Loans and guarantees: Lend money to another person (except in the ordinary course of business and then only on commercial terms), or give a guarantee; or
c) Change of business: Make a substantial change in the nature or scope of its business as presently conducted; or
d) Disposals: Dispose of any of its assets except disposals made in the ordinary course of its business or disposals for full value; or
e) Provided services: provide services to or accept services from a person other than for proper value and on reasonable commercial terms.

The Finance leases are secured over leased assets disclosed in note 5.

Term loans are not guaranteed by the Government of New Zealand.

Note 9: Reconciliation of net surplus/(deficit) after taxation with net cash flow from operating activities *

	2006 $000	2005 $000
Net surplus/ (deficit)	320	(1,622)
Add/(less) non-cash items:		
Depreciation/assets written down	20,032	20,371
Asset revaluation write back	(16,257)	-
Total non-cash items	**3,775**	**20,371**
Add/(less) item classified as investment activity:		
Net loss/ (gain) on sale of fixed assets	78	38
Total investing activity items	78	38
Add/(less) movements in working capital items:		
(Increase)/decrease in receivables and prepayments	(4396)	(1,737)
(Increase)/decrease in inventories	(805)	23
Increase/ (decrease) in payables and accruals	(3,863)	2,465
(Decrease)/Increase in provisions	11,974	2,196
Working capital movement – net	2,910	2,947
Net cash inflow from operating activities	**7,083**	**21,734**

* Reconciling items do not necessarily match movements shown in the financial statements of this report, as not all detailed accrual based entries are shown.

Note 10: Related parties transactions

The DHB is a wholly owned entity of the Crown. The Government, as stakeholder, significantly influences the strategic direction of the DHB as well as being its major source of revenue.

The DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. Where those parties are acting in the course of their normal dealings with the DHB, related party disclosures have not been made for transactions of this nature.

Related party transactions and balances

(a) Funding

Government funding received in the year ended 30 June 2006 was $591m, of which $576m (97%) was received directly from the Ministry of Health. The amount outstanding to the DHB as at 30 June 2006 was $8.7m (2005: $5.3m).

(b) Joint venture company

The DHB purchased services from Central Regional Technical Advisory Services Ltd of $687,508 during the year ended 30 June 2006 (2005: $383,868). There was no outstanding balance as at 30 June 2006 (2005 $Nil)

(c) Associate company

The DHB purchased services from HIQ Limited of $10.4m during the year ended 30 June 2006 (2005: $4.3m for the 8 months to 30 June 2005). The balance owing to the DHB at year end was $5.8m (2005: $6.4m).

The Chairperson of the DHB is the Chairperson of the HIQ Board. The Chief Executive of the DHB is a director on the HIQ Board. The Chief Operating Officer of the DHB was a director on the HIQ Board before resigning as a director in November 2005. He was replaced as an HIQ director by the Director of Finance of the DHB.

(d) Key management and Board members

Other than transactions carried out in the ordinary course of business on normal business terms, there were no related party transactions during the financial period. No related party debts have been written off or forgiven during the year.

One Board member, Brendon Bowkett, commenced an association with Wakefield Hospital during the year as a paediatric surgeon. The DHB purchased services from Wakefield Hospital of $0.089m during the year ended 30 June 2006 (2005 $0.461m). The balance owing to the DHB at year end was $0.002m (2005 $0.017m).

Note 11: Financial instruments

The DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.

The DHB has a series of policies providing risk management for interest rates and the concentration of credit. The DHB is risk averse and seeks to minimise exposure from its treasury activities. Its policies do not allow any transactions which are speculative in nature to be entered into.

Interest rate risk

Interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. This could particularly impact on the cost of borrowing or the return from investments.

The DHB does not consider there is any significant exposure to interest rate risk on its investments.

The interest rates on borrowings are disclosed in note 8. There were no interest rate instruments in place at 30 June 2006.

Credit facilities

As at 30 June 2006, the DHB had committed to an overdraft facility of $35m expiring on 4 October 2007. $15.4m was drawn against this facility at 30 June 2006 leaving $19.6m available (2005: $27.2m was drawn against a $30m borrowing facility).

The bank overdraft is secured by a negative pledge deed entered into between the DHB and the bank.

Currency risk

Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates.

The DHB undertakes transactions denominated in foreign currencies from time to time and exposures in foreign currency arise from these activities. It is the DHB's policy to hedge any such risks using forward and spot foreign exchange contracts to manage these exposures. There were no foreign currency contracts in place at balance date.

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB, causing the DHB to incur a loss.

Financial instruments which potentially subject the DHB to risk consist principally of cash and short-term investments, trade receivables and various off-balance sheet instruments.

The DHB invests in high credit quality financial institutions, local and government stock and limits the amount of credit exposure to any one financial institution. Accordingly, the DHB does not require any collateral or security to support financial instruments with organisations it deals with.

The DHB receives 97% of its revenue from the Crown through the Ministry of Health. Accordingly, the Board does not consider there is any risk arising from the concentration of credit with respect to accounts receivable.

Fair value

The fair value of other financial instruments is approximated by the carrying amount disclosed in the Statement of Financial Position.

Note 12: Trust funds

The DHB administers certain funds and donations on behalf of patients. Patient funds are held in a separate bank account and any interest earned is allocated to the individual patient balances. Patient fund transactions during the year and the balance at 30 June 2006 are not recognised in the Statements of Financial Performance, Financial Position or Cash Flows of the DHB. Donated funds are managed in accordance with each settlor's directives.

(a) Patient funds	**2006 $000**	**2005 $000**
Opening balance	103	82
Monies received	265	222
Interest earned	4	3
Payments made	(239)	(204)
Closing balance	**133**	**103**

(b) Donated funds	**2006 $000**	**2006 $000**
Opening balance	4,279	3,627
Monies received	984	1,422
Interest earned	310	254
Payments made	(881)	(1,024)
Closing balance	**4,692**	**4,279**
Total	**4,825**	**4,382**

Note 13: Board Members' remuneration

The Board of Capital and Coast District Health Board as at 30 June 2006, and those who ceased to hold office during the year ended on that date, are set out below together with details of their remuneration (excluding expense reimbursement), received or receivable, for that period.

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

			2006 $000	2005 $000
Current Board Members				
Bob Henare	Appointed	Chair	54	54
Judith Aitken	Elected	Deputy Chair and Chair - FRAC	36	32
Brendon Bowkett	Elected		25	14
Ruth Bradwell	Elected		26	15
Peter Dady	Elected		25	15
Ken Douglas	Elected	Chair - HAC	26	15
Margaret Faulkner	Appointed	Chair - DSAC	30	36
Ruth Gotlieb	Elected		26	27
Kiri Parata	Appointed		25	15
Fuimaono Karl Pulotu -Endemann	Appointed	Chair - CPHAC	26	15
Helene Ritchie	Elected		25	26
Previous Board Members (term ended Dec 2004)				
John Cody	Appointed		-	13
Karl Geiringer	Elected		-	11
Helmut Modlik	Appointed		-	14
Tino Pereira	Appointed		-	13
Ian Shearer	Elected		-	13
Chris Turver	Elected		-	12
			324	**340**

Legend:

DSAC – Disability Support Advisory Committee
HAC – Hospital Advisory Committee
CPHAC – Community and Public Health Advisory Committee
FRAC – Finance and Risk and Audit Committee

Committee Members' (other than Board Members & Employees) remuneration

	2006 $000	2005 $000
Community and Public Health Advisory Committee		
Herani Demuth	1	1
Ida Faiumu-Isaako	-	1
Linda Hobman	2	-
Sandra Jensen	-	-
Stephen Palmer	-	-
Kiri Parata	1	1
Clive Plucknett	1	-
Puspa Wood	1	-
Disability Support Advisory Committee		
Valerie Bos	2	2
John Forman	-	1
Margaret Guthrie	2	-
Tupu Iaoane	-	-
Jools Joslin	-	-
Liz. Mellish	-	-
Grace Moulton	-	3
Sarah Porter	-	-
Rev. Langi Sipeli	-	-
Wendi Wicks	-	-
Hospital Advisory Committee		
Hilda Broadhurst	2	2
Marion Bruce	2	2
John Cook	3	-
Lynn McBain	2	-
Rose McEldowney	2	-
Don Mackie	-	-
Lani Wills	1	-
Total	22	13

Note 14: Employee remuneration

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

Total remuneration and other benefits $(000)	Number of employees 2006	Number of employees 2005
100 - 110	49	48
110 - 120	36	43
120 - 130	25	24
130 - 140	20	21
140 - 150	18	22
150 - 160	17	8
160 – 170	22	18
170 - 180	18	16
180 - 190	17	14
190 - 200	8	5
200 - 210	11	7
210 - 220	5	8
220 - 230	5	4
230 - 240	4	2
240 - 250	-	1
250 – 260	3	3
260 – 270	1	1
270 – 280	2	2
280 – 290	4	1
290 – 300	3	-
300 – 310	1	-
310 – 320	-	2
320 – 330	-	1
330 – 340	1	1
350 – 360	2	1
360 – 370	1	-
380 – 390	-	1
390 – 400	-	2
460 - 470	1	-
	274	256

The Chief Executive's annual remuneration is in the $400,000 to $410,000 band. However, with one off back pay, and annual leave payout total remuneration is in the above $460,000 to $470,000 band (2005: $390,000 to $400,000).

Of the 274 employees shown above, 235 are or were medical or dental employees and 39 are or were neither medical nor dental employees. This represents an increase of 18 staff in total over the previous year. Of these 15 are or were medical and dental employees and 3 are or were neither medical nor dental employees. The increase reflects salary rate changes in national Collective Agreements for medical and dental staff.

If the remuneration of part-time employees were grossed-up to an FTE basis, the total number of employees with FTE salaries of $100,000 or more would be 401, compared with the actual total number of 274.

Note 15: Termination payments

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board.

Number of employees	Amount Paid
1	1,300.00
1	1,500.00
1	2,000.00
1	2,548.01
1	2,902.59
1	3,276.08
1	3,400.00
1	3,500.00
1	4,812.15
1	5,422.40
1	6,301.96
1	6,369.88
1	7,000.00
1	8,210.80
1	8,700.23
1	10,274.25
1	10,330.74
1	11,743.88
1	12,226.50
1	17,937.50
1	18,706.25
1	18,862.33
1	33,763.96
1	40,000.00
1	61,315.40
1	95,424.75
1	109,343.01
27	507,172.67

Termination payments above include gratuity payments as provided under collective employment contracts, mainly to medical staff.

Note 16: Capital Charge

The DHB pays a capital charge monthly to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2006 was 8.0% (2005: 11%).

Note 17: Associates

The DHB has a significant interest in the following associate:

Associate	Interest 2006	Interest 2005	Nature of business
HIQ Limited	50%	50%	Owns and manages information systems

HIQ Limited was jointly created with Taranaki DHB on 16 October 2004 and has a balance date of 30 June. C&CDHB and TDHB share information services through HIQ Limited. The board of HIQ Limited has equal representation from both DHBs. C&CDHB and TDHB own class A and class B shares in the company.

	C&CDHB	TDHB	Shares on issue
Class A shares	1	1	2
Class B shares	6,862,006	4,640,919	11,502,925

The class A shares represent voting rights and are split evenly between the two DHBs. The class B shares confer the level of contributions and ownership benefits of each DHB. The company is considered to be jointly controlled because of the equal sharing of voting rights conferred through class A shares and is therefore an associate of both C&CDHB and TDHB in accordance with FRS-38: Accounting for Investments in Associates. Each DHB will account for their respective ownership interest as determined by the appropriate value of class A and class B shares held. C&CDHB ownership in HIQ Limited as 30 June 2006 is 55.65%, (2005 44.92%).

Investment in associates

Investment in associate	2006 $000	2005 $000
Opening balance	2,134	-
Equity earnings of associate	-	-
Equity capital contribution	4,728	2,134
Closing balance investment in HIQ Limited	6,862	2,134

The C&CDHB's share of the results of HIQ Limited is as follows:

Share of associate's surplus	2006 $000	2005 $000
Share of net surplus before tax	-	-
Tax expense	-	-
Share of associate's surplus	**-**	**-**

During the year the DHB has entered into several transactions with its associate. The nature of these intra-group transactions and the outstanding balance at the yearend are as follows:

Inter company transactions and balances	2006 $000	2005 $000
Expenditure incurred by C&CDHB to fund the operations	10,426	4,389
Equity issued to C&CDHB	4,728	2,134
Current receivables owing to C&CDHB	5,835	6,445

Note 18: Major budget variations

Statement of Financial Performance

The DHB recorded an operating surplus of $0.32m compared with the budget of $8.9m with both revenue and expenditure higher than budgeted, primarily due to additional revenue allocated by the Crown for various services after the budget estimates were completed. The surplus includes $16.3m of asset revaluations, being a part recovery of write downs expensed in a prior year. Cost increases were primarily due to personnel costs. The variance of the reported result to budget is due to non-completion of a land disposal with an estimated disposal value greater than book value.

Statement of Financial Position

The variance in total equity was due to equity injections, non-completion of the land disposal, and asset revaluations.

The variance of $27m in the term loans is due to lower CHFA borrowing at year end, partly offset by $17m short term funding from the private sector.

Statement of Cash Flows

Cash provided from plant and equipment disposal was lower than budget by $16m due to land disposal not completed during the year.

The favourable variance of $49m in the cash applied to property, plant and equipment is attributed to timing changes on the new regional hospital project in the current year.

Cash provided from term loans was lower than the amount budgeted by $28.6m. This was offset by an overdraft facility of $35m arranged with the ASB bank.

Cash applied to the repayment of term loans was $11.3m higher than the budget due to repayment of outstanding debt.

Note 19: Implementation of international financial reporting standards.

In December 2002 the New Zealand Accounting Standards Review Board announced that New Zealand International Financial Reporting Standards ("NZ IFRS") will apply to all New Zealand reporting entities for the periods commencing on or after 1 January 2007. Entities have the option to adopt NZ IFRS for periods beginning on or after 1 January 2005.

The DHB intends to implement NZ IFRS in its annual financial statements for the year ending 30 June 2008.

Transition Management

The DHB has started a project to:

- assess the key differences in accounting policies under NZ IFRS and current accounting policies;
- determine the impacts on the financial statements from transition; and
- determine and implement processes to deal with any related business impacts.

Changes in accounting policies on transition to NZ IFRS

Currently the DHB has not identified any changes which will have a major impact on it's financial reports. This position should not be regarded as a final position on changes in accounting policies that will result from the transition to NZ IFRS, as some decisions have not yet been finalised where choices of accounting policies are available.

The DHB has not yet completed an exercise to quantify the effects of the differences in accounting policies, and is therefore currently unable to reliably quantify impacts on the financial statements, which will arise from transitioning to NZ IFRS.

The DHB intends to provide further information, including quantifying the impacts of transitioning to NZ IFRS in the DHB's next annual financial statements for the year ending 30 June 2007.

Statement of objectives and service performance

for the year ended 30 june 2006

Summary of revenues and expenses by output class:

	Funding $000	Governance and funding administra-tion $000	DHB Hospital Provider $000	Elimination $000	Total DHB $000
Revenue					
Crown	559,095	5,377	368,324	(343,305)	589,491
Other	-	-	34,524	-	34,524
Total Revenue	**559,095**	**5,377**	**402,848**	**(343,305)**	**624,015**
EXPENDITURE					
Personnel	-	2,299	241,918	-	244,217
Depreciation	-	14	20,017	-	20,031
Capital charge	-	-	3,558	-	3,558
Other	557,997	4,010	137,187	(343,305)	355,889
Total expenditure	**557,997**	**6,323**	**402,680**	**(343,305)**	**623,695**
Net surplus/(deficit)	**1,098**	**(946)**	**168**	**-**	**320**

Reconciliation to retained earnings:

	Funding	Governance and funding administration	DHB Hospital Provider	Elimination	Total DHB
Opening retained earnings	2,580	(3,191)	(93,565)	-	(94,176)
Less deficit for the year	1,098	(946)	168	-	320
Closing retained earnings	**3,678**	**(4,137)**	**(93,397)**	**-**	**(93,856)**

Good Employer Policies

In accordance with its obligations under Section 22(1) (k) of the New Zealand Public Health and Disability Act 2000, the DHB is required to be a good employer.

The policies operated designed to assist in meeting this objective are comprehensive and include an extensive ‘healthy workforce’ programme for employees who may be injured or sick for extended periods, the active provision of a safe, secure and smoke free working environment and protection from harassment in the workplace.

The DHB acknowledges and supports the right to equal opportunities, privacy, fairness and equity in the management of the employment relationship, and recognises cultural differences and diversity and the needs of ethnic and minority groups. Regular internal and external audits are undertaken to ensure legislative and policy requirements are met.

* DHBs are required to differentiate their funding broadly into hospital and non hospital activities. To recognise and give effect to C&C DHB as a funder of both hospital and non hospital activities two sets of books (ledgers) are maintained which require intra-DHB revenues and costs to be ‘eliminated’.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT TO THE READERS OF CAPITAL AND COAST DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2006

The Auditor-General is the auditor of Capital and Coast District Health Board (the Health Board). The Auditor-General has appointed me, Rudie Tomlinson using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board, on his behalf, for the year ended 30 June 2006.

Unqualified opinion

In our opinion the financial statements of the Health Board on pages 20 to 77

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
    - the Health Board's financial position as at 30 June 2006;
    - the results of its operations and cash flows for the year ended on that date; and
    - its service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 26 September 2006, and is the date at which our opinion is expressed.

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

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements.

We evaluated the overall adequacy of the presentation of information in the financial statements. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board as at 30 June 2006. They must also fairly reflect the results of its operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001, section 43 of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Independence

When carrying out the audit we followed the independence requirements of the Auditor General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

In addition to the audit we have carried out assurance assignments reviewing the tender processes over the new regional hospital and the laboratory integration project, which is compatible with those independence requirements.

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

R L Tomlinson
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Better health and independence for people, families and communities