Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

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

E nga Iwi, e nga reo, e nga huihui Tangata
Tena koutou, Tena Koutou, Tena Koutou

2006/07 was a very demanding year for this District Health Board. Yet through it all, the response from our staff was uniformly professional, with a resolute focus on the thing which draws us all together: the health and wellbeing of all those we were engaged to serve.

I would like to acknowledge and thank our colleagues in other Boards, both regionally and nationally. The Chairs and CEOs of the central region, especially the Hutt DHB with whom we work closely, have been very supportive of C&C DHB and keen to collaborate on our collective interests.

Changes at Board level

Bob Henare, who was appointed Chair in 2001, retired and his broad contribution to our work and numerous other significant spheres in the public sector in December 2006, was widely acknowledged. Bob was one of the two Maori representatives appointed by the Minister to C&C DHB.

His role in the establishment of a thriving Maori Partnership Board – now indispensable to the way C&C DHB works – was celebrated by all, and we wish him and his family all the best in the years ahead.

I want to record my debt of gratitude to our wise and highly esteemed Kaumatua, Sam Jackson, and to my Board colleagues for their advice and assistance to me and to senior managers since the Minister appointed me to succeed Bob in January 2007.

Early in 2007, the Minister appointed Peter Douglas, CEO of Te Ohu Kaimoana, as one of the two Board members with statutory responsibility for Maori. Along with the far-sighted Kiri Parata, Peter made a distinctive contribution to our work this year.

Ken Douglas was appointed as Deputy Chair, and I would like to thank him and the other Board members who chair our three statutory committees – Hospital, Community & Public Health, and Disability Advisory Services – and Margaret Faulkner for her leadership of the important Finance and Risk Assurance Committee (FRAC) and Remuneration Committee. During the year, Fuimaono Karl Puloto-Endemann generously offered to cede to the Treaty partner as chair of CPHAC and was ably succeeded by Kiri Parata. Board members all belong to at least one of these statutory committees and alongside the external community members contribute a great deal to the advice available to the whole Board.

For over six years, C&C DHB has been quite clear about our key foci: to advance and sustain the good health and wellbeing of Maori, Pacific peoples, and those who live in low income households. Across the whole organisation, the needs of these three populations are given as much priority as we can provide.

Maori

The Maori Partnership Board continues to go from strength to strength. Under the able leadership of Herani Demuth, it ensured the safe journey of Te Plan II and provided invaluable advice for C&C DHB on where the most instructive performance and service delivery measures should be focused.

"The vision of Te Plan II is 'Whanau ora' (healthy families) as espoused in He Korowai Oranga and Te Plan 2002–07. A future Maori generation that lives longer is the aim and tamariki as the central theme, is key in driving Te Plan II forward and motivating us all to do more of the things that are working and less of the things that aren't."

Te Plan II 20007–2012

We have rich sources of data on which to draw in order to focus and track the progress we must make in respect to Maori. Without the sustained interest, commitment and critical advice of the Maori Partnership Board we would not have achieved as much as we did this year. We look forward to enhancing this key relationship in future.

The Maori unit in the Planning and Funding division of the DHB is an active and determined group of managers, analysts, facilitators, community representatives and whanau supporters. They offer Board members and staff the means to increase our responsiveness to the tangata whenua. They also offer expert perspectives on how to improve the wellbeing of Maori in this district and more widely.

Pacific

The people of the wider Pacific are not only very diverse, but often have particular needs in many fields such as child health. Here we acknowledge the benevolent and supportive advice of Hon Luamanuvao Winnie Laban and her sustained interest in this DHB and its growing Pacific communities. We are very grateful for the Minister's continued dedication to the Government's broad health goals.

"We are seeds of the Pacific and we shall never be lost"

Pacific Communities: Strong Pasifika Families week, 2007

Over the year, our relationship with the many communities of the Pacific was consistently reinforced by the pragmatic and greatly valued approach of Board member Fuimaono Karl Puloto-Endemann, Pacific Manager Lee Pearce, Pacific Island representatives on our advisory committees, Pacific workers in PHOs, our HHS Pacific Support Service and hospital based Pacific staff. Their willingness to identify a strategic approach to Pacific wellbeing, and then put that into practice on the ground, has been the hallmark of their relationship with C&C DHB, and it is acknowledged and appreciated.

People in low income households

Very largely because of the strong community orientation of so many Planning and Funding staff and the responsiveness of clinicians and researchers, the Board was able to make progress in the interests of our third most significant population of need: those in low income households.

We have a very large number of closely managed contracts with a plethora of community-based service providers, and it is a tribute to the thoughtful relationship management and careful monitoring by Planning and Funding staff that these contracts are generally so productive.

We need to add more energy to this work in future, but there are very encouraging indications of how effectively well-timed, well-led preventative action, and a determined endeavour by managers and staff, can break down administrative and other barriers, to the benefit of our citizens.

Comments from occupants of homes insulated by C&C DHB as part of the Healthy Homes project:

We have noticed reduced power consumption and a huge difference in living conditions and health.

The insulation has made a massive improvement in the comfort of our home and health of our children.

The insulation helped keep the home warm even during harsh frosts.

We have saved $400 in energy costs between March and August.

We notice less coughing due to asthma for our children, and not as many doctors visits.

The asthma rate dropped off markedly in two children, and there has been no croup where there was in the past.

No sickness this year. Also much less use of the inhaler.

The work of the managers and staff of the Planning and Funding division and their community colleagues is beginning to generate real and sustainable success, and we can now report significant reductions in the risk and rate of avoidable hospital admissions and the incidence of debilitating conditions (such as amputations) and pernicious diseases (such as diabetes and some forms of cancer).

Hospital-based services

On the one hand, everyone can see the physical manifestations of our huge building plans: at Paraparaumu, in Porirua and in Newtown, the new hospital buildings are a daily tribute to the work of the Project Director Liz Maddison, her highly skilled team, and the architectural and construction workers.

The whole project is complex, and the Board applauds the fact that it has been a successful exercise in logistical management, with absolute commitment to budgetary imperatives.

On the other hand, the challenges of planning and designing the transition of people, equipment and information systems into the new hospital buildings, while at the same time keeping the services running, cannot be understated. Over the coming year, the Board will need to ensure that the leadership and support for key managers, as well as the engagement of our critically important clinical and support staff, are strong and effective.

The Board is under no illusions about the sharp difficulties it faces over 2007/08 and beyond because of the ongoing impact of costs associated with the new hospital, changes in service demand and our past inability to resolve supply problems. The Board, in a much closer working relationship with key clinical and management staff, must now make more sustained efforts to balance the legitimate expectations of our citizens against severe historical limitations and still-unrealised, but crucial, systems and service plans.

2006/07 was marked by significant industrial action in one or the other part of our business. Over the coming year the Board hopes to forge a much more positive and mutually satisfying relationship with our vitally important nurses and doctors, and with all the skilled support and technical staff who work with them. There is scope for real partnership and respect for each others' perspectives. As I said earlier, we all need to focus on the thing which draws us all together: the health and wellbeing of all those we were engaged to serve.

Community-based activities

There has been much to celebrate over the past year, especially the continued growth in the number of our District's PHOs (now seven) . The innovative plan to give DHBs responsibility for the provision of health services from primary to tertiary levels is now nearly seven years old. There can be no question that its potential to benefit citizens by requiring the establishment of integrated processes of patient care from home, to PHO, to hospital, and back, is beginning to be realised.

C&C DHB Management

Changes at the Executive Management Team level have put additional burdens of responsibility on individuals and the leadership group as a whole, but we enter 2007/08 with professional managers who daily ensure that the Board is well informed and its high level vision for C&C DHB actively pursued.

I would like to thank the Chief Executive, Margot Mains. She was very ably supported by the expertise and commitment of the Executive Management and Hospital & Health Services Teams. These groups have consistently displayed great dedication to healthcare delivery and have worked especially hard this year to respond to some challenging issues.

Every month the Board has joined the Chief Executive as she honours the work done in many different parts of our organisation. Lots of this work is unsung in that politicians and the public might not get to hear about it, even though they all benefit from the lively, innovative and steadfast contribution so many have demonstrated. Not only have many of the innovative practices actually saved money, but better than that, they have shown the capacity of our staff for excellence in all they do.

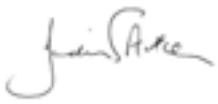
Conclusion

The continued confidence of the Minister is greatly appreciated. The Board fully respects its role as a Crown agent and is keenly aware of its ultimate accountability to Parliament.

All the elements of successful and sustained provision of responsive, affordable and accessible health services, as well as the means to tackle the embedded social and other determinants of health status, are here in Capital & Coast. We look forward with enthusiasm to 2007/08, when we will continue to serve our diverse communities and fulfill the promise of our staff and all they work for.

Arohanui

Judith Aitken
Chair
Capital & Coast DHB



Margaret Faulkner
Board Member
Capital & Coast DHB

Capital & Coast
District Health Board

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About C&C 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 the NZPHD Act. The Capital & Coast DHB Board consists of 11 members who have overall responsibility for the organisation's performance. Seven Board members are elected as part of the three-yearly local body election process and four are appointed by the Minister of Health.

The Board has a three statutory committees established under the requirements of the NZPHD Act 2000. 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, which 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 statutory committees are as follows:

Hospital Advisory Committee (HAC)
The HAC committee advises the Board on the financial and operational performance of the hospitals. It was also expected to provide advice on strategic issues relating to the provision of hospital services.

Community and Public Health Advisory Committee (CPHAC)
The role of the CPHAC is to provide the Board with advice on the health and disability needs of our region's population. The CPHAC advises the Board on how services funded and/or provided by the DHB, and the DHB's policies, are likely to impact our population. The CPHAC was expected to ensure that any advice it provides the Board is consistent with national strategies and government policy.

Disability Support Advisory Committee (DSAC)
The role of the DSAC is to advise the Board about the needs of people with disabilities in our region and recommend priorities for resources provided for those with a disability. The committee is expected to advise on whether policies and the services, 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 there are two other advisory committees. These were:

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

To ensure the cohesiveness of the governance function during 2006/07, the Board Chair and Committee Chairs met regularly.

Meetings where the Board or any of its statutory committees make decisions are open for the public to attend as observers. The exclusion of the public from those sessions is allowed for under the NZPHD Act, Schedule 3 Clause 32.

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

Planning and Funding C&C DHB services

During 2006/07 the Planning and Funding arm of the DHB was responsible for determining the health and disability service needs of the District and for funding those services. The Planning and Funding Directorate managed contracts with all providers of services, including our own Hospital and Health Services. The Directorate also initiated specific health improvement projects with different communities and built partnerships with the community, service providers and other DHBs. The Directorate was also responsible for arranging access to specialist services that were 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, in 2006/07 the Planning and Funding Directorate's core activities were 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 Directorate maintained relationships and entered 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. Seven PHOs have been established in the District and they cover about 96% of the population. The District's PHOs include 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 and Disability Support Services for people aged under 65 years, and for some other services, is made available directly to providers from the Ministry of Health.

Our Hospital and Health Services

Capital and Coast DHB itself owns and operates a very large service provider – the Hospital and Health Services (HHS). In 2006/07 this provided a range of inpatient, outpatient, community, and day programme services to our resident population of around 270,000 people. In some cases tertiary services were provided to the wider central region population of around 900,000 people. Local services were provided by the HHS in community settings, outreach clinics, Kapiti Health Centre, Kenepuru Community Hospital and Wellington Regional Hospital.

Each year HHS develops 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. In 2006/07 our front line staff were assisted by a range of support services, all of which play a vital role in meeting the health needs of our district.

Improvements in health status and outcomes

Population groups in C&C DHB often have lower levels of disease and hospitalisation rates compared to national averages. While we have made progress in some areas over the last year there continues to be an unacceptable gap between Maori and Pacific populations and others across many indicators of health. We are continuing our focus on reducing disparities for Maori, Pacific and low income populations.

We continue to see encouraging trends in health outcomes in the following areas:

For children in our district

- More mothers are continuing with some breastfeeding until babies are six months of age. Artificial feeding of babies at six weeks amongst Maori has declined over the last three years and,artificial feeding, at six months, has declined for all ethnic groups.
- Vision testing pass rates Maori, Pacific and Asian children at Year 7 have shown small, sustained increases over the last three years.
- The oral health of children has increased with the percentage of Maori children without fillings increasing at both five years old and at Year 8. Oral health for Pacific children in Year 8 has improved with increases in the percentage without fillings and decreasing decayed, missing or filled teeth. These improvements have been sustained over three years.
- Low birth weight rates amongst infants of 'Other' ethnicity have decreased in the last three years.

For adults in our district

- Ischaemic heart disease hospitalisations have decreased relative to the national average for the 'Other' ethnic group. This decrease has been sustained over four years.
- Hospitalisations for heart attacks have decreased relative to the national average for the 'Other' ethnic group. The rate was higher than average in 2003, but has decreased year on year to sit below average in 2006.
- Stroke hospitalisations for adults over 55 in the 'Other' ethnic group have decreased relative to the national average.

Preventable hospitalisations

- Ambulatory sensitive hospitalisations[1] have decreased for some population groups:
  - All children under five years (Maori, Pacific and Other), these rates have decreased year on year from 2003 to 2006.
  - Maori children aged five to 14 years - The decreases have been small but sustained over four years.
  - Maori and 'Other' adults aged 65 to 74 years - Ambulatory sensitive hospitalisations have declined overall from 2003 to 2006.
- Population preventable hospitalisations[2] have decreased for:
  - Pacific children under five years (sustained decreases over four years).
  - Maori adults aged 65 to 74 years have shown a decrease over the last three years.
  - Other adults aged 65 to 74 have shown a sustained decrease over four years.

1 - Ambulatory sensitive hospitalisations are those which are sensitive to prophylactic or therapeutic interventions delivered in a primary health care setting, or other ambulatory services, for example early diagnosis, immunisation, screening. It is encouraging to see decreases in ambulatory sensitive hospitalisations, which suggests improvements in access and / or quality of primary care for these groups.

2 - Population preventable hospitalisations are those that result from diseases largely preventable by population-based health promotion strategies. Decreasing population preventable hospitalisations suggests that public health / health promotion approaches are having some effect for these groups.

Key Achievements

Capital & Coast DHB's District Strategic Plan 2006-2012 sets out the goals and strategies which will underpin the DHB's planning and activities during this period.

In this section of the Annual Report we highlight some of the key achievements relating to those stated goals and strategies during 2006/07. These key achievements are considered under the following headings:

- Health Goal 1: Reduce disparity in health status
- Health Goal 2: Reduce incidence and impact of chronic disease

- Strategy 1: Focusing on people through integrated care
- Strategy 2: Supporting and promoting healthy lifestyl
- Strategy 3: Working with communities
- Strategy 4: Developing our workforce
- Strategy 5: Updating our hospitall
- Strategy 6: Managing our money

Please note: These goals and strategies are shown in their full context in our Operational Framework – the chart on the first page of this Annual Report.

Health Goal 1: Reduce disparity in health status

Our Health Needs Assessment shows that the district population has on average a high health status compared with the rest of New Zealand. However this average conceals a significant minority of people with very low health status. As a result, reducing disparities is one of two key health goals in our District Strategic Plan (DSP).

The Board places a high priority on reducing illness and disease among populations with high health needs such as Māori, Pacific peoples and people who live in areas that are considered to be deprived. There is also a focus on refugees and new migrants.

To address this disparity we undertook initiatives in the following areas in 2006/07:

- Primary care
- Afterhours care
- Improving youth participation in health service planning and youth health
- Maori health strategies
- Whanau care service
- Pacific health

Primary Care:

PHOs

- We now have seven PHOs in our DHB district with the establishment of a Maori PHO and 96% of the population are enrolled in a PHO.
- In Porirua, funding increased primary care capacity has been effective in enabling more people to access primary care.
- In Kapiti there are still people unable to enrol in a PHO despite investment and we are actively working to increase GP capacity in 2007/08.
- Visits to GPs and practice nurses in our District PHOs total 19,101 per week.
- The hours for youth health services in Kapiti and Wellington have been increased, and an additional school-based clinic has been supported in Porirua/Tawa.
- There has been increased funding for medication management, involving pharmacists through PHOs.
- All general practices are now on the same funding formula, as a result of additional funding to reduce the cost for people aged 25-44 years, who are enrolled in 'interim' practices (the final step in this phased approach).
- We have had success with our graduate nurse programme and the placement of graduates in the primary care setting.
- The appointment of an experienced nurse in Work and Income Porirua Service Centre has been a successful initiative.
- Primary mental health services were continued with a focus on Maori, Pacific and low income people and additional funding was provided to expand youth primary mental health services.
- PHOs increased the percentage of the eligible population accessing Care Plus - a national initiative to improve the care management for patients with long term conditions such as diabetes and heart disease - from 21% in 2005/06 to 53% in 2006/07.
- Successful breast screening initiatives in both Porirua and Wellington South targeting Maori and Pacifc women in collaboration with Regional Public Health.

Immunisation

- Immunisation rates for Maori, Pacific and Other population groups in our DHB are consistently higher, when benchmarked against the national rates, for children aged six weeks and three months, which is attributed to a number of organisations working together. Immunisation rates in areas of high deprivation (NZ Dep measure) were consistently higher than the national average and demonstrates the effective targeted approach by a number of providers in those areas .
- Support has been provided for improved immunisation coordination and outreach.

After Hours Care:

- The 24/7 Accident & Medical service at Kenepuru has been maintained and the DHB is investigating options to strengthen this service.
- C&C DHB has funded and supported access to after hours care in Wellington through the Emergency Department between 11pm and 8am to ensure access and support the workforce and services while alternative service options and capacity issues are explored.

Improving youth participation in health service planning and youth health:

- The Youth Health Advisory Group has been actively involved in key strategic projects including: planning for Healthy Eating, Healthy Action (HEHA), the Journey Forward (our mental health plan), and oral health service options.
- We have supported youth support workers in youth health services.
- Established diabetes clinics (outpatient) in a youth-friendly setting in Wellington.
- Established WATCH service in Wellington District Court as a pilot programme for young adults with drug and alcohol issues.

Maori Health strategies:

- In 2006/07 we have strengthened the working relationships between the Board of C&C DHB and the Maori Partnership Board, increased Maori Health support services within the hospital to full capacity, and supported Maori workforce development and training opportunities.
- C&C DHB has made good progress toward the implementation of its Maori health strategy, Te Plan 2002-2007.
- Our next Maori Health strategy entitled Te Plan II (2007 – 2012) is due for publication in 2007/08.

Whanau Care Service:

- We saw the completion of a three year planned development in Whanau Care services at Wellington Hospital. The service is now at full capacity, offering clinical advocacy in cardiac and aged care, social worker expertise and non-clinical/cultural care and support to Maori patients and their whanau. This service now has the capacity to extend to Kenepuru and an initial trial to grow the service in-line with need has progressed.

Pacific Health:

- The Pacific MeNZB campaign was very successful with 97% of Pacific children/youth receiving the first dose, 93.3% second dose and 89.4% receiving the third dose. This was attributed to innovative Pacific approaches by Pacific providers and collaboration with Primary care, Regional Public Health and PHO providers as to the best way to engage with Pacific communities. Examples include Soup Evenings, funding of sports events such as Street Ball, Kilikiti, Rugby 7's and Creekfest.
- Pacific Breastfeeding Service was established 1 July 2006 to provide a Pacific delivered service to improve breastfeeding rates of Pacific woman and their babies in the C&C DHB district through an integrated approach that included: development of Pacific health workforce, education and promotion, linkages with Pacific providers.
- All Pacific women referred to the Pacific Breastfeeding Service receive advice and information from a Pacific Lactation Consultant who advocates for breastfeeding and child health. The Pacific Lactation Consultant supports all Pacific patients (and their families) during their stay at our hospitals.
- A Pacific Diabetes Fono was held in November 2006, with over 300 Pacific people attending and where the Pacific community identified a brand 'Eat Rite, Eat Lite, Left, Rite' and formed a Pacific Diabetes Steering group which has now become an official arm of the national organisation Diabetes New Zealand.

- Pacific Paediatric initiative began in July 2006, adopting an integrated approach where all children admitted to Children's Wards were visited and followed up in the community. Families and parents of these children have been an integral part of the success as they worked with the various agencies and NGOs with the assistance of staff.
- Since the Pacific children's health programme began there has been a downward trend in hospital admissions for Pacific children in the under 5yrs and 5-14 age groups, and this initiative is being featured in the Ministry of Health NZ Health and Disability 2007 Report.

Health Goal 2: Reduce incidence and impact of chronic disease

The second health goal of our DSP is reducing the number of people who develop an on-going illness or disease, and when an illness or disease does develop, reducing the impact on people's lives. This enables people to maximise opportunities for independence and to maintain or improve their quality of life, particularly for high health need populations.

To address this goal we targeted funding to the following areas in 2006/07:

- Reducing the incidence and impact of diabetes on people and their families.
- Implementing the New Zealand Guidelines Group National Guidelines for cardiovascular risk modification.
- Improving the respiratory health of the district.
- Improving Mental Health.

Reducing the incidence and impact of diabetes on people and their families:

- A district-wide Healthy Eating, Healthy Action (HEHA) Plan has been developed and a broad range of initiatives and intersectoral work continues, aimed at reducing the incidence of diabetes.
- Uptake of diabetes annual checks increased overall and we continued to support a Pacific-specific service through hospital into the community.
- We have expanded diabetes education services and introduced clinics at the Evolve youth health service.
- We continued Maori-specific diabetes services, supported a workshop through the Local Diabetes Team and Maori roopu continued in Wellington and Porirua, offering peer/whanau support.
- A review of the impact of investment into diabetes services has been undertaken to inform future developments.

Implementing the New Zealand Guidelines Group National Guidelines for cardiovascular risk modification:

- PHOs were funded to support further development of systems to screen high risk populations for cardiovascular risk and offer appropriate interventions.
- The DHB provided additional funding for cardiovascular risk modification in Porirua.
- Pacific smoking cessation services were established.

Improving the respiratory health of the district:

- C&C DHB contributed to 'healthy housing' projects in Kapiti, Porirua and Wellington.
- We coordinated planning to improve flu vaccination uptake and reduce asthma and other respiratory diseases.
- An initiative to reduce avoidable hospital admissions in Pacific children was funded.

Improving Mental Health:

- We have established three community recovery houses, including a specific house for Maori, run by non-government organisations, as an addition to our mental health acute and crisis service continuum.
- The community acute recovery houses now provide genuine choice for people experiencing a mental health crisis, and have taken significant pressure off Te Whare O Matairangi.
- Patients have commented enthusiastically on the quality of the service in the low-stress environment of the houses. In particular, the peer-run recovery house, a first for the Wellington region, has set new standards in acute care.
- A Short Term Assessment and Recovery Service (STARS) has been planned and modelled in collaboration with stakeholders. This is an alternative to acute admission to hospital and is more suitable for intensive services than the community recovery houses.
- Regional Youth Court liaison service completed.

Strategy 1: Focusing on people through integrated care

We continue to work towards providing services and programmes that are integrated across health provider, geographical, professional and other boundaries, both within the sector and intersectorally.

Key initiatives contribruting to this strategy in 2006/07 were:

- The Care Coordination Centre.
- Working with health service providers.
- Integrated home and community care.

Care Coordination Centre (CCC)

Since September 2005 the CCC has gone through a significant establishment period which incorporated the establishment of the Care Manager Service and the roll out of the Restorative Packages of Care. A package of care is a collection of services designed specifically to meet the needs and achieve the goals of individual clients and their family and whanau. The aim is for the services to be wrapped around the client so that the client and their family experience a seamless continuum of care.

This new service model has involved a large amount of workforce development within the CCC, process development and engagement both within the organisation and community, so everyone understands and is operating the new service model. The CCC is now at the stage of being able to look beyond initial establishment to achieving the wider service gains envisaged for this model.

CCC has now established satellite offices in Kapiti and Wellington as well as the central office in Porirua. It is undertaking work to address the unique care needs of our Maori and Pacific population and reduce barriers to access to community services for Maori and Pacific older people. During 2006/07 we set up a partnership relationship with the Whanau Care service and the Pacific Support Service to facilitate inpatient assessment prior to discharge.

The TARGET tool (Towards Achieving Realistic Goals in Elders Tool) has been introduced as a phone based, and a face to face, goal facilitation tool for Packages of Care.

Working with providers:

- We worked with PHOs to develop a draft chronic care management framework and action plan.
- Primary care providers contributed to service developments in palliative care through the establishment of a very successful Palliative Care Forum.
- To help address the burden of cancer the DHB and Regional Screening Service have jointly planned to increase the uptake of screening services (breast cancer screening and cervical cancer screening).
- The Central Region Cancer Network was established in 2006/07 (a collaboration of the Central Region DHBs).

Integrated home and community care:

- The recruitment of a Geriatrician has enabled increased community visits within the Wellington region. Further recruitment in late October 2007 will increase Geriatrician availability in the Porirua region. This means people can see specialist Geriatricians in their own home, and also (where appropriate) it supports primary care to care for patients, thereby preventing avoidable admissions to hospital.

Strategy 2: Supporting and promoting healthy lifestyle

By addressing factors such as lifestyle choices and social and community influences we could potentially reduce the impact, and the incidence, of illnesses such as diabetes, stroke, and heart diseases that have such a debilitating impact on our populations. To address these factors we work with the Regional Public Health Unit of Hutt Valley DHB to implement the public health programme for priority areas. Three key areas we are currently focussing on are:

- Shake It, Beat It, Learn It.
- Encouraging healthy behaviours.
- Oral health.

Shake It, Beat It, Learn It:

The pilot for this programme, launched in 2006, provided a health and exercise service delivered to Pacific peoples and communities in the C&C DHB. The pilot was delivered by the New Zealand Institute of Sport (NZIS). The aim of the pilot was to improve Pacific people's health by incorporating weekly exercise, health checks, health promotion and living healthy lifestyles and was designed and delivered according to the needs of the pilot community groups.

- Shake it – Exercise to Pacific music
- Beat It – Understand the implications of unhealthy eating, maintain current health status and prevent deterioration or onset of chronic disease
- Learn It – Developing a workforce from within the community

- 15 Pacific people, selected from within the pilot communities, graduated with a beginning foundation qualification in Exercise and Health Promotion. The course was delivered by NZIS and Regional Public Health.
- A formal evaluation of the pilot is being scoped with funding from the Ministry of Health.

Encouraging healthy behaviours:

- We supported intersectoral initiatives through PHOs, with local Government, school-based programmes and support for early childhood centres to improve nutrition and physical activity, stage youth events and enable the promotion of healthy lifestyles.
- There is ongoing work in the district to reduce the rate of smoking and exposure to tobacco smoke.

Oral health:

- We have worked with pre-school groups and providers to provide oral health education and increase early enrolment
- A successful pilot oral health promotion project has been implemented in Island Bay using best practice health promotion, education and associated resources, and coordinated with scheduled childhood immunisation visits.

Strategy 3: Working with our communities

We work with communities, and with agencies which actively participate within them such as local councils, the Ministry of Social Development, Housing New Zealand, SPARC, ACC and local schools to advance a number of important health issues.

Key areas where we have provided support and investment in 2006/07 are:

- Improving the environment in which people live, work and play.
- Supporting broader social projects with a positive impact on community health.
- Relationships, Participation and Consultation.
- Implementing family violence strategies.

Improving the environment in which people live, work and play:

- C&C DHB is working on the Cannon's Creek campus redesign project – alongside Porirua City Council, Housing NZ, the Ministry of Social Development, Porirua Healthlinks, health and social service providers and the Eastern Porirua Residents and Ratepayers Association. The concept plan has been completed with input from community and urban planning/architectural expertise via workshops.
- Primary Health Organisations are supporting many different programmes and initiatives with Maori, Pacific, low income families and many community groups.
- Youth initiatives led by refugee communities to support health and wellbeing.

Supporting broader social projects with a positive impact on community health:

- We supported intersectoral action to reduce the barriers to healthy choices, income and health, healthy housing, urban planning projects.
- Intersectoral projects to improve employment and income include:
    - PATHS - a project reducing the impact of illness and disability in income and employment
    - CART – A project supporting hard to reach Maori access health and social services.
    - WATCH – a collaboration between C&C DHB, Ministry of Justice and Work and Income to improve outcomes for young adults with drug and alcohol and other social issues.
- Mahi ki te Ora Cadetships.
- Rangatahi project with Wesley Community Action, to engage young people with complex social problems through physical activity and intensive support with whanau.
- Homelessness Prevention Strategy, including improved outreach services and work to improve support for prisoner reintegration in Wellington.

Relationships, Participation and Consultation:

- The Maori Partnership Board and C&C DHB Board have agreed a joint action plan. One result of this plan has been the development of Maori Health indicators, which provide a tool for monitoring progress the DHB is making in relation to Maori health.
- Development of, and consultation on, the second Maori Health Plan was a major focus this year. Te Plan II (2007–12) has been completed and due for release in 2007/08.
- A plan for engaging with Maori and communicating Maori health progress has been scoped for implementation in 2007/08. The underlying intent of this development is to ensure engagement occurs in a planned and constant way and messages about Maori Health delivery, health gain and achievements are captured and disseminated in a constant way and from a strengths-based, positive position.

Implementing family violence strategies:

- We have policies in place regarding the assessment and treatment of victims of family violence for child abuse and neglect for partner violence.
- We have appointed a family violence programme advisor.

Strategy 4: Developing our workforce

Our workforce development focuses on contributing to innovative service delivery models. Within workforce development our objective is that services be provided by the most cost-effective trained workforce. Our workforce plans integrate the actions contained in the national DHB "Future Workforce Plan".

During 2006/07 we concentrated our efforts on:

- Maori workforce
- Pacific workforce
- Primary care nursing workforce
- Health workforce development
- Mahi ki te Ora Cadetships

Maori workforce:

- We offered a Maori Leadership and Management Training programme – 12 of the 15 inaugural students of this C&C DHB Frontline Management programme delivered by New Zealand Institute of Management (NZIM) have completed their course and have graduated with a Diploma in Frontline Management. A further 15 students commenced a second Diploma in Frontline Management programme in mid 2007.
- C&C DHB led the same programme on behalf of the Central DHBs. A total of 30 Maori health workers will complete a Diploma in Frontline Management programme by mid-late 2007. This will significantly increase the capability available to the sector and provide greater opportunity for Maori representation and participation in management / leadership positions within our region.
- For the second year, the Maori Health Development Group supported a nursing scholarship for Maori nurses working in Primary Care.
- A joint research project with Victoria University led to the development of a career progression framework for Maori staff within our hospitals.
- The central region has also developed a set of good practice guidelines for regional collaboration.

Pacific workforce:

- C&C DHB continues to support Pacific providers through Pacific Provider Development Funding.

Primary care nursing:

- C&C DHB is supporting candidates to gain Nurse Practitioner registration. These candidates are progressing well and one nurse has applied to the Nursing Council for registration.
- An initiative has been developed between C&C DHB, Whitireia Polytechnic and the Ministry of Social Development to encourage nurses to return to the workforce after some time away.

Health workforce development:

- 120 managers and team leaders employed by C&C DHB have now completed a leadership management programme.
- We have implemented a clinical leadership programme.
- A 'valuing staff' recognition programme was implemented in July 2006 and the Board recognises the contributions of individuals and teams with awards at its monthly Board meetings .
- A Mahi ki te Ora Cadetship programme has been implemented with the Ministry of Social Development with over 20 participants in the first intake. This bipartite partnership supports new employment opportunities in the primary and community health sectors.

Mahi ki te Ora Cadetships

The aim of the Mahi ki te Ora Cadetship programme is to provide Work and Income clients with opportunities to take on fixed term employment as cadets within the primary and community care health sector. There are two sectors of society that are targeted for this pilot programme: young adults and adult/sole parents. The age range for young adults is 15-24 years and includes any young adult sole parents as well.

For those cadets who are new to the workforce and/or health sector, C&C DHB also provides foundational training which includes a selection of entry level topics relevant to the health sector. Following on, C&C DHB will coordinate a training and development package for each cadet.

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 are 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.

Strategy 5: Updating our hospitals

We are developing new buildings at Kenepuru and Newtown to ensure staff, patients and visitors have a safe and pleasant environment that meets the needs of a modern healthcare system. We have completed facility development at Kapiti. We are also improving our information system deployment with a particular focus on the hospitals.

In 2006/07, a number of smaller projects were carried out, as well as construction being advanced on the main building at Newtown.

The team worked with the Quantity Surveyor and the C&C DHB Director of Finance to monitor and manage the project within the extraordinary escalation trend identified in 2004-05. Approval for additional budget to cover this unmanageable cost push was received early in the year, moving the budget from $303m to $346m. As a result, work has commenced on completion of several outstanding projects at Kenepuru.

In 2006/07 our focus was on:

- Kenepuru site development
- Newtown site development
- Change management
- Information system development

Kenepuru site development:

Progress on the projects at Kenepuru included:

- Expansion of the Maternity Unit by 2 beds.
- A regional Psychogeriatric Unit was completed and occupied.
- Two wards were upgraded.
- A contract for the development of a five-chair dental unit, an additional operating theatre and the residual upgrade of the sterile production unit, was in place by end of March 2007 and work commenced in April.

Newtown site development:

- Work on the hospital has progressed significantly with the concrete structure having reached its full height, external claddings to Levels 2 and 3 commenced early in the year to provide weather protection for the work to begin on the internal linings. Installation of service ducting, piping, cable trays and fire sprinklers up to level 4 were significantly advanced by the end of June 2007.

Change Management:

- The change management team has worked with the hospital staff to identify and co-ordinate the minutiae of tasks involved in migrating from the old hospital to the New Regional Hospital. The team has also undertaken the successful movement and migration of the various departments at Kenepuru involved in the smaller building projects referred to above.
- The new PACs digital imaging system has been successfully implemented in Radiology and has been rolled out to Emergency Department and ICU. The complete implementation is dependent on the finalisation of Stage 1 of the electronic health record.

Information system development:

- C&C DHB implemented a new patient management system in November 2006.
- A pilot of electronic referrals from a local GP practice to C&C DHB continues and in 2007/08 we will be scoping the impact of extending this to other GPs in the region.
- A pilot of providing GP access to hospital electronic health record has been successful and we are scoping the impact of extending this capability in 2007/08.

Strategy 6: Managing our money

As a Government organisation it is critical that we are prudent in the way we spend money on health services to provide the necessary care for our people. We seek to improve our efficiency while maintaining the quality and effectiveness of the services we provide.

The DHB recorded an operating deficit of $12.9m compared with the budget surplus of $13m with both revenue and expenditure higher than budgeted. A major part of 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 of $13m. Increased revenue was primarily due to additional revenue for Mental Health services relating to additional beds & escorts within the forensic rehabilitation and intellectual disability services. Cost increases were primarily due to medical & nursing personnel costs. Medical Personnel costs relating to additional duties payments for covering RMO shortage and nursing personnel relating to Mental Health services including escorts. Clinical supply costs were also high including a blood product price increase above FFT and higher usage during the year.

We are committed to investing in health and disability services in order to accelerate change. These investments contribute to our ability to improve health outcomes, be responsive to changing health needs and maintain a sustainable financial position.

In 2006/07 we focused on 3 key areas

- Efficient service delivery initiatives
- Service reconfigurations
- Revenue realisation

Efficient service delivery initiatives:

- Implementation of an integrated medical laboratory service for primary referred laboratory tests between C&C DHB and Hutt Valley DHB.
- Achievement of compliance with the Elective Services Performance Indicators.
- Establishment of the Extended Day Surgical Unit, to facilitate elective throughput.
- Establishment of a High Acuity Unit within the surgical wards.
- Increased access to and utilisation of primary care to minimise avoidable hospitalisations.
- Quality Quest Awards – a competition to recognise and publicly acknowledge the excellent quality improvement initiatives which have taken place in our services during the past 12 months – they support our work to improve awareness, understanding and commitment to a quality improvement culture at all levels of our Board's health and disability sector.
- Redesign of systems of care to support delivery of quality services:
    - Patient care coordination service established to focus on discharge management and case management of complex cases in our hospitals
    - Development of the High Dependency Bay in the medical wards
    - Establishment of the Extended Day Surgical Unit.
    - Standardisation of materials management.

Service reconfigurations:

- We worked collaboratively with central regional DHBs on reviews of cardiology, renal and plastics services and are planning to work collaboratively to develop a 10 year regional clinical services plan during 2007/08.
- We established two pilot projects to gain a better understanding, from a patient's perspective, of the journey of patients from a GP through the hospital system and back to the GP. These projects, focusing on cardiothoracic and acute medical patients aim to improve the quality of the patient journey through our system and ensure effective service delivery.

Revenue realisation:

- We established a successful Revenue Office to maximise the collection of revenue from other agencies such as ACC, National Breast Screening Programme and the Clinical Training Agency.
- Investment in information technology to ensure we are capturing all work undertaken in our hospitals appropriately.

Statement of Service Performance

The Statement of Service Performance sets out Capital & Coast DHB's key milestones and performance measures as described in the Statement of Intent for the period 1 July 2006 to 30 June 2007. Whilst our forecast performance targets are expressed in specific terms, actual performance is likely to vary, positively or negatively, in each case.

Link to the District Strategic Plan

A wide ranging consultation process was undertaken during 2005/06 to review and redesign the Capital & Coast District Strategic Plan. This plan is our blueprint as we improve existing services and start new ones to meet the changing needs of our population. This report provides a mix of milestone measures, outputs, and key performance indicators, outcome measures that signal improvements in the health of our population.

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

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DHB Priority : Reduce Disparities in Health Status

High health need populations are Maori, Pacific peoples, refugees and new migrants, and people who live in areas that are considered to be deprived. There are differences in the health of these people across the district compared to other ethnic groups. In 2006/07 the DHB monitored the following milestones and indicators to ensure progress is being made to reduce health disparities.

The following achievements are a combination of output measures and outcome measures, by improving the outputs it is expected that the outcomes will also improve. For example, the number of Avoidable Hospitalisations [3] at Capital & Coast DHB reflects the access different ethnic groups have to preventative health services. Decreasing Avoidable Hospitalisation rates may indicate that people's access to health services has improved.

Milestone	Achievement
We will implement a programme to reduce asthma admissions for Pacific children. Date: September 2006 Output Class: Funder/Provider	**Achieved** The Pacific Paediatric Initiative that commenced during 2006 was an integrated initiative with the Pacific Support Service in the Hospital and Pacific and Mainstream Providers in the community. The aim was to reduce the high number of admissions to hospital that could be avoided by early primary health care. Pacific children with asthma admissions and readmissions are included in this group. The programme commences when a child is admitted with the Pacific Health team addressing issues and commencing discharge planning with the aim of preventing readmission. The team is the centre point of contact and refers onto other health and social services in the community. We expect that this initiative will lead to decreasing readmissions in the future.
We will develop an acute and crisis service continuum in our Mental health Service, establishing new acute community services. Date: March 2007 Output Class: Funder/Provider	**Achieved** As an alternative to acute admission to hospital Mental Health Services, we have established three community recovery houses as an addition to our acute and crisis service continuum. These houses are run by non-government organisations (NGOs) and provide 12 places per day in total and include a specific house for Maori. A Short Term Assessment and Recovery Service (STARS) has been planned and modelled in collaboration with stakeholders. STARS is an alternative to acute inpatient admission and is more suitable for intensive services than the community recovery houses. We have selected a preferred provider and a decision on contracting this service is expected in July 07.

3 - Ambulatory Sensitive Hospitalisations (ASH).

We will agree a plan with Hutt Valley DHB to reduce hearing loss in our district's Maori and Pacific children. Date: October 2006 Output Class: Funder	**Not Achieved** Our Regional Public Health service delivers hearing services in line with the Well Child Health service specification to children in our area. No specific plan has been developed to reduce hearing loss in our district's Maori and Pacific children although the model of care delivered has been adjusted from a treatment based model to a community model. This has led to increased visibility of the Ear Van and attendance at screening by both the parent and child which enhances the opportunities for health promotion at the time of the visit.

Key performance measures

Avoidable Hospitalisations,[4] rate per 1000 population.
Partially achieved.

Output class: Funder

'Avoidable Hospitalisations' include conditions such as asthma, poor dental health, skin infections, cervical cancer. Note: Data is not yet available for the 2006/07 financial year. Actual data is provided by calendar year. Targets set were largely met by the outcomes. C&C DHB achieved the target for children under 5 years and people aged 65-74 years. The rate for 5-14 years has improved but the target was not achieved.

The disparity is particularly apparent for Pacific children and although their rate is higher, it is decreasing over time and the inequality reducing. We have initiatives in place to attempt to reduce the Pacific rates for children which include the hospital Pacific Health team, a new breastfeeding support service for Pacific families, Pacific health plans in all PHOs with regular reporting against the actions, and investment to expand Pacific primary health care services - including immunisation services.

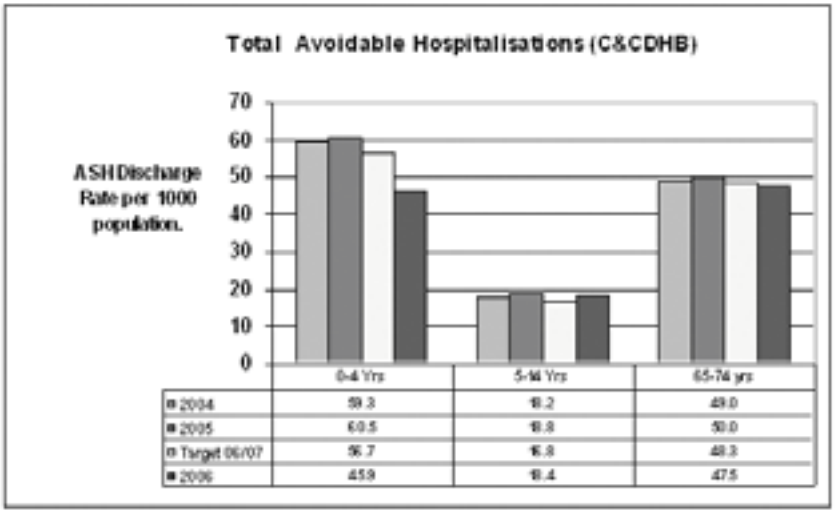
For children aged under 5 years, Avoidable Hospitalisation rates are significantly better for Maori, and not significantly different for Pacific children when compared to the 'New Zealand total' rate.

The rate for Pacific children aged 5 to 14 years is significantly worse than the 'New Zealand total' rate for that age group. Initiatives targeted at this group include: strengthening Pacific primary care capacity to action PHO level Pacific Health plans, youth health services and school health services, healthy housing initiatives, and a joint project to reduce skin infections with Hutt Valley DHB.

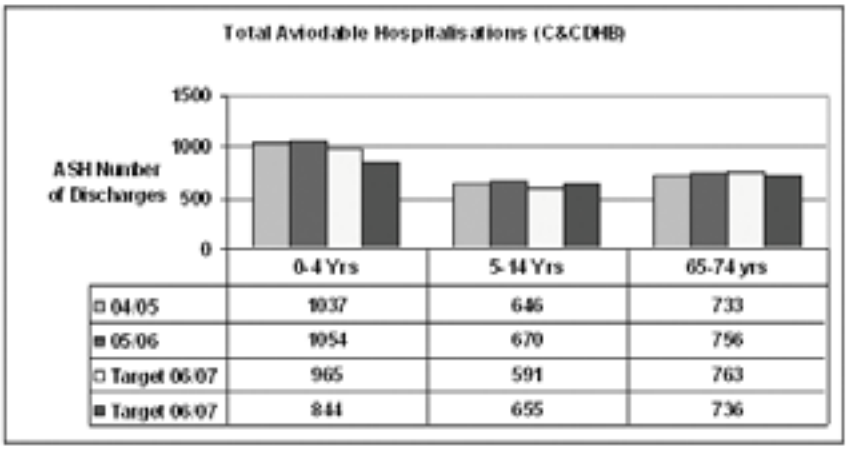
The rate for Pacific people aged 65 to 74 years is significantly worse than the 'New Zealand total' rate. Initiatives targeted at this group include: improving access to affordable and appropriate primary health care, Care Coordination Centre streamlining access to appropriate support, Church and community-based health initiatives including exercise and self management support. The rate for Maori in this age bracket is not significantly different than the 'NZ total' rate. Strategies to decrease hospital admissions are: Maori outreach services to provide care for older Maori. A Maori-specific coordinator for disability support and a Maori cardiac navigation programme.

4 - Ambulatory Sensitive Hospitalisations (ASH).

The tables below illustrate the progress that C&C DHB has made since 2003 and compares our progress with the total New Zealand rates. The most recent data available for this indicator is by calendar year and is sourced from the Ministry of Health National Minimum Data Set.

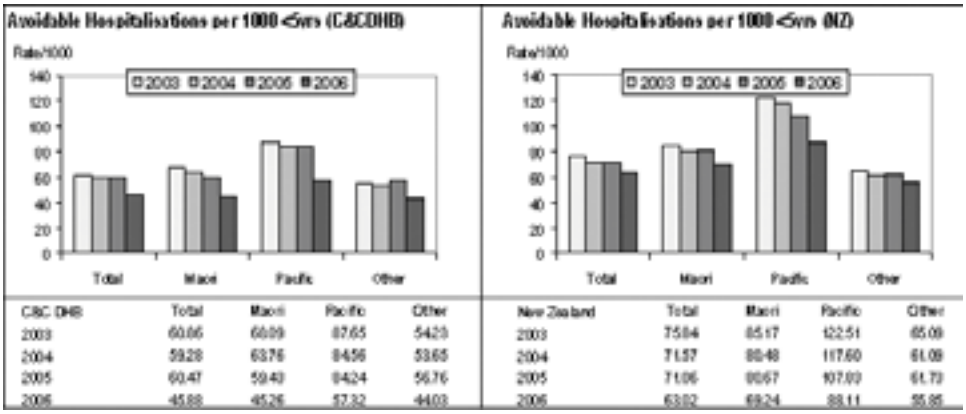


Avoidable Hospitalisations[5]**, number of discharges.**
Partially achieved.
Output class: Funder
Data is not yet available for the 2006/07 financial year. Actual data is provided by calendar year. Targets set were largely met by the outcomes. C&C DHB has exceeded the target for children under 5 years with 210 fewer avoidable hospitalisations in 2006/07 compared with 2005/06. Our target was also met for people aged 65-74 years. The rate for 5-14 years has improved but the target was not achieved.



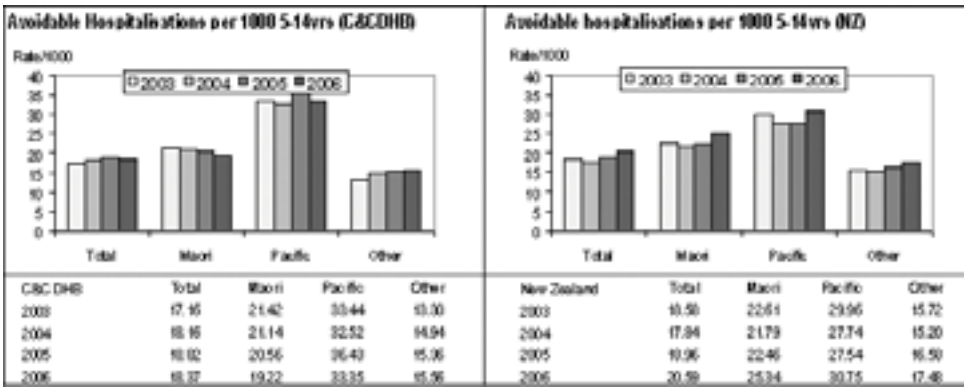
5 - Ambulatory Sensitive Hospitalisations (ASH).

Avoidable Hospitalisations[6] by Ethnicity & Age



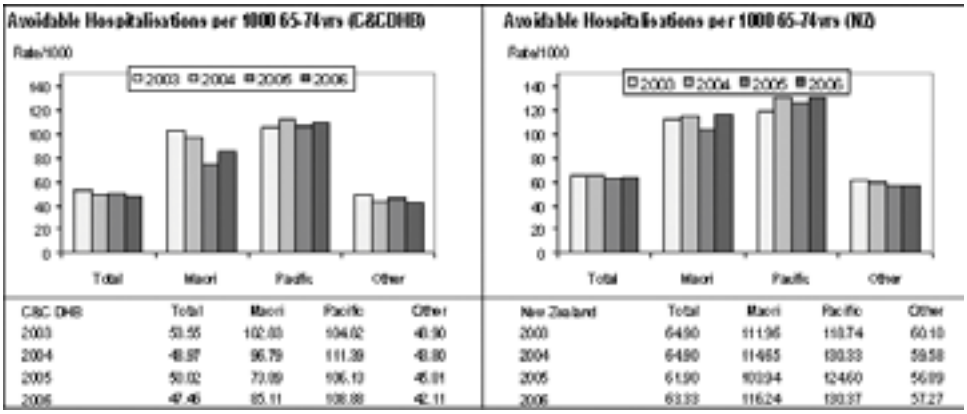
C&C DHB	Total	Maori	Pacific	Other
2003	60.66	66.09	87.65	54.23
2004	59.28	63.76	84.56	53.65
2005	60.47	59.43	84.24	56.76
2006	45.88	45.26	57.32	44.03

New Zealand	Total	Maori	Pacific	Other
2003	75.84	85.17	122.51	65.09
2004	71.57	80.48	117.60	61.08
2005	71.06	80.67	107.09	61.73
2006	63.02	69.24	88.11	55.85



C&C DHB	Total	Maori	Pacific	Other
2003	17.15	21.42	33.44	13.30
2004	18.16	21.14	32.52	14.94
2005	18.02	20.56	36.43	15.06
2006	16.37	19.22	33.35	13.56

New Zealand	Total	Maori	Pacific	Other
2003	18.58	22.61	29.96	15.72
2004	17.94	21.79	27.74	15.20
2005	18.96	22.46	27.54	16.59
2006	20.59	25.34	30.75	17.48



C&C DHB	Total	Maori	Pacific	Other
2003	53.55	102.03	104.02	48.90
2004	48.97	96.79	111.39	43.80
2005	50.02	73.09	106.13	45.01
2006	47.46	85.11	108.88	42.11

New Zealand	Total	Maori	Pacific	Other
2003	64.90	111.96	110.74	60.10
2004	64.90	114.65	120.33	59.58
2005	61.90	103.94	124.60	56.89
2006	63.33	116.24	130.37	57.27

6 - Ambulatory Sensitive Hospitalisations (ASH).

Capital & Coast District Health Board
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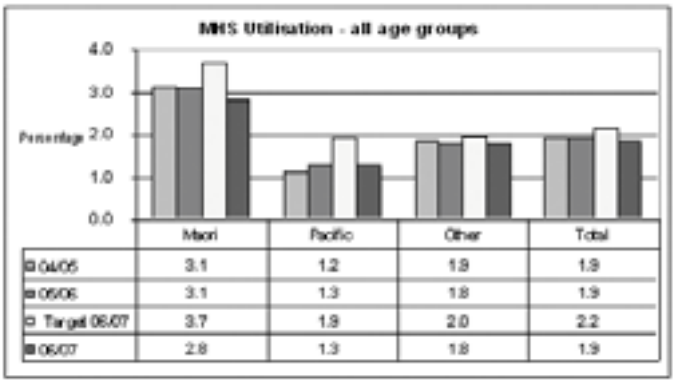
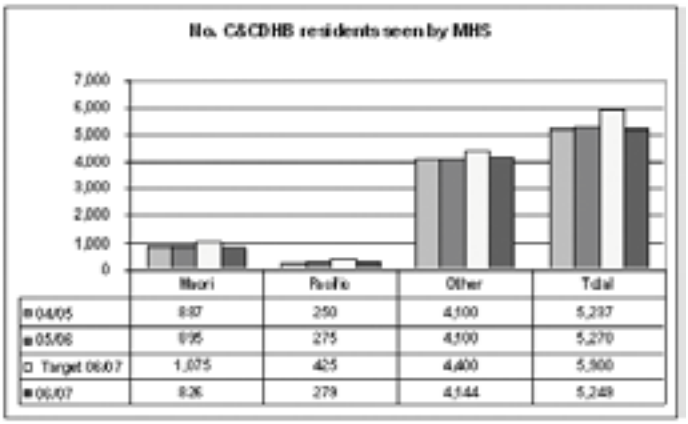
Mental Health Service Utilisation by C&C DHB Residents (%)
Not achieved
Output class: Funder

The percentage of the C&C DHB population and number of patients accessing C&C DHB's Mental Health Services has remained static and targets to increase access have not been met. To tackle this issue and as part of our 'Journey Forward', more accessible models of care for Maori are being considered. There is an extensive project involving community teams, aimed at making it easier for people to get mental health assessments earlier, and ensuring people can leave mental health services with appropriate community supports in place. Community teams will be adjusting their assessment and case management processes over the next 6-12 months to meet these goals.



	Maori	Pacific	Other	Total
04/05	3.1	1.2	1.9	1.9
05/06	3.1	1.3	1.8	1.9
Target 06/07	3.7	1.9	2.0	2.2
06/07	2.8	1.3	1.8	1.9

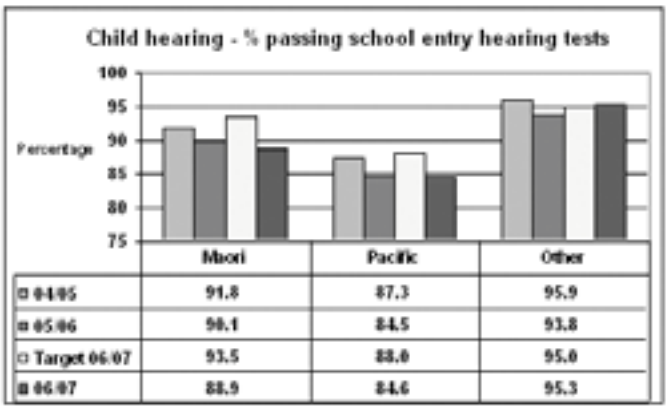
Number of C&C DHB residents seen by C&C DHB's Mental Health Service
Not achieved
Output class: Provider



	Maori	Pacific	Other	Total
04/05	887	250	4,100	5,237
05/06	995	275	4,100	5,270
Target 06/07	1,075	425	4,400	5,900
06/07	836	279	4,144	5,249

Percentage of children passing school entrant hearing tests
Achieved
Output Class: Funder

The 2004/05 data has been updated for C&C DHB as previously this measure was reported as a combined C&C DHB and Hutt Valley DHB number. The Ear Van is a key strategy for improving access to hearing and vision screening for Maori and Pacific children in our high needs areas. Over the last 10 years the ear van has been based in schools and the child has been seen by the nurse. In the last year we have moved to a community based model where the Ear Van is parked in community areas to improve visibility and both the child and parent or care giver attend for screening. We expect this new model to help improve our outcomes. Performance on this measure is within 5% of target.



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DHB Priority : Reduced Incidence and Impact of Chronic Conditions

Chronic diseases, such as diabetes, cardiovascular disease and cancer, are leading causes of illness and impose a disproportionate burden on Maori and Pacific populations. Better prevention and management of these diseases at the population level, and in primary health care/community settings for groups at the highest risk will contribute directly to reducing outcome inequalities. This goal is aligned to our District Strategic Plan and the Minister's priorities.

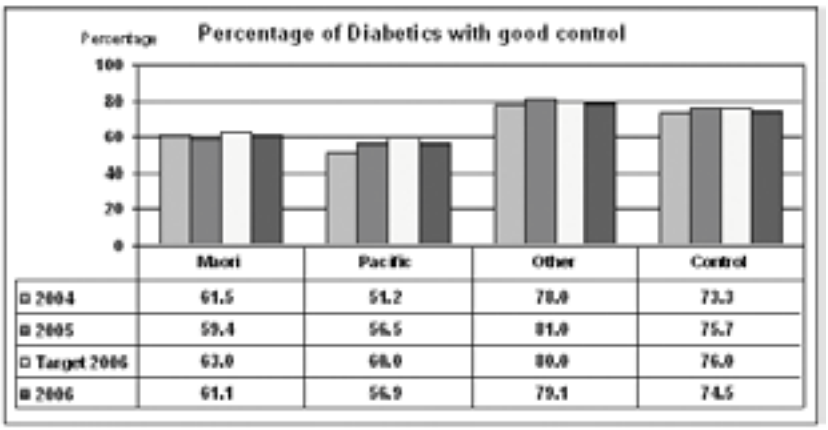
Milestone	Achievement
We will develop a Patient Navigator Service for Maori and Pacific people with cancer Date: October 2006 Output Class: Provider	**Partially achieved** The Patient Navigator service is a system for high health needs people to find access to cancer services. We have undertaken a scoping project to help shape the development of this service but the implementation of the service been deferred until 2007/08.
We will further implement our diabetes services and increase uptake of annual checks Date: October 2006 Output Class: Funder	**Achieved** During 2006 diabetes Services have been strengthened through: • Funding investment in the local diabetes team (LDT) infrastructure. • Additional diabetes nurse educator resource for children targeting patients currently at high school, those transitioning to adult clinics after high school, and university students. • Improved access for Maori through proactive advocacy. • Increased self-management through resources to support proactive self-management. • Working intersectorally to reduce obesity and by working with entire whanau. • A Maori provider commencing opportunistic screening of all Maori over 35 years. • Assistance with transport and advocacy for some enrolled diabetics assisted attendance at clinics. • Weekly podiatry clinics for clients, providing regular neurological and vascular testing as well as palliative podiatric care and ulcer management. Due to the collective efforts of podiatrists, nursing staff, general practitioners and liaison with caregivers and extended family members, the overall health and well being of patients' lower limbs have been outstanding. There have been outstanding results re improving access to annual reviews for Pacific peoples from 660 to 738 over the last twelve months. Initiatives included raising community awareness and primary/secondary intervention – e.g. Outreach Clinics.

We will implement the National Guidelines for cardiovascular risk modification Date: November 2006 Output Class: Funder	**Achieved** The C&C DHB Board has endorsed the implementation of the NZ Guidelines Group recommendations for cardiovascular risk factor modification as one of the top priorities for reducing the burden of cardiovascular disease in our district. The overarching aim of implementing the guidelines is to decrease the community risk of cardiovascular events over the next 10 years. In 2005/06 the DHB invested $75,000 in a Porirua (PHARMAC-led) joint project between two PHOs to provide relevant services to implement the risk reduction interventions. In 2006/07 the DHB has supported a cardiovascular risk working group. Its role is to advise the DHB on how to facilitate the development so that sufficient information, resources and enthusiasm are present. Addressing these issues is an ongoing process. As a DHB we ensure that every PHO has a performance plan and a clinical governance group is part of the performance plan requirement. The clinical governance groups ensure that cardiovascular risk guidelines are disseminated into the medical practices in the PHO and discuss how to put them into practice.

Key performance measures
Diabetes - Percentage diabetics with good control
Not achieved
Output Class: Funder

Data for this measure is collected by calendar year and analysed in the 3rd quarter.
The current indicator for diabetics with good control is the percentage of diabetics with an HbA1c equal to, or less than, 8. We achieved 74.5 percent against a target of 76 percent. This year the measurement of this indicator has changed from “HBA1c less than 8%” to “HBA1c equal to or less than 8%”. Trend data has been adjusted to reflect the new definition.

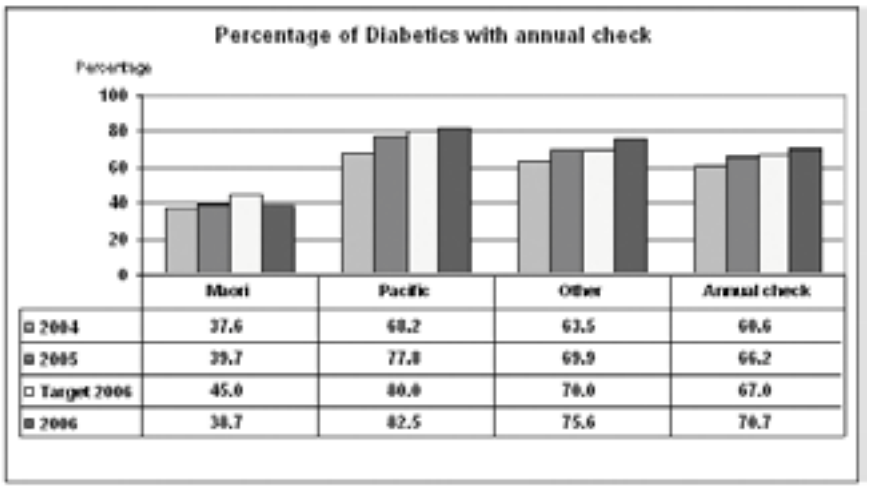
A range of ethnic and locality specific services have been funded to assist in achieving better diabetes management and there is intent to invest more in support for self/whanau management in 2007/08.



	Maori	Pacific	Other	Control
2004	61.5	51.2	78.0	73.3
2005	59.4	56.5	81.0	75.7
Target 2006	63.0	68.0	80.0	76.0
2006	61.1	56.9	79.1	74.5

Diabetes - Registered diabetics with annual check
Substantially achieved
Output Class: Funder

Since 2001, the number of diabetics identified has increased substantially against the number of expected diabetics in the C&C DHB district. This indicator attempts to track how many of the expected number[7] of people with Type 2 diabetes have had their diabetes identified and have received an annual check. This analysis focuses on Type 2 Diabetes since this is mainly monitored and managed at primary care level. Overall the percentage of diabetics receiving annual checks was 70.7 percent against a target 67 percent. It is noted that the target for Maori was not achieved.



	Maori	Pacific	Other	Annual check
2004	37.6	68.2	63.5	60.6
2005	39.7	77.8	69.9	66.2
Target 2006	45.0	80.0	70.0	67.0
2006	38.7	82.5	75.6	70.7

Data for this measure is collected by calendar year and analysed in the 3rd quarter.

7 - The predicted number for the District or for a PHO is based on a model that utilizes national disease prevalence data, developed by the Ministry of Health (MoH).

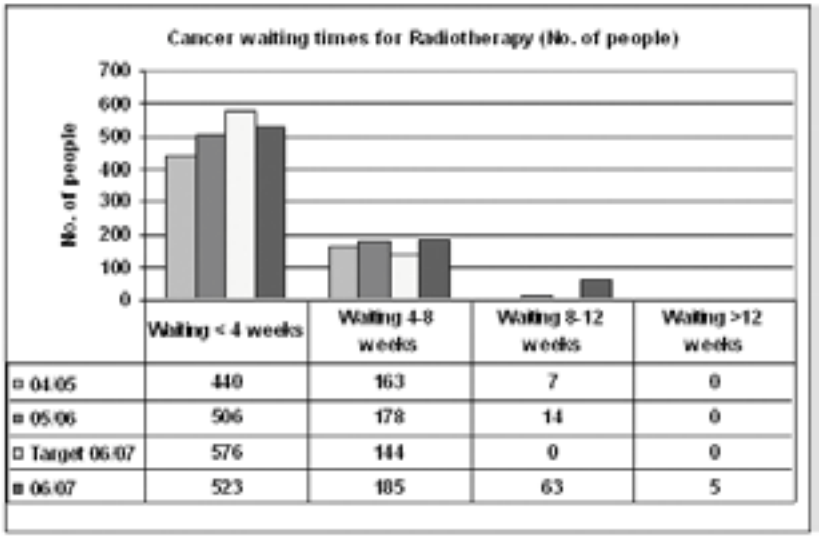
Cancer waiting times - Not achieved
Output Class: Provider

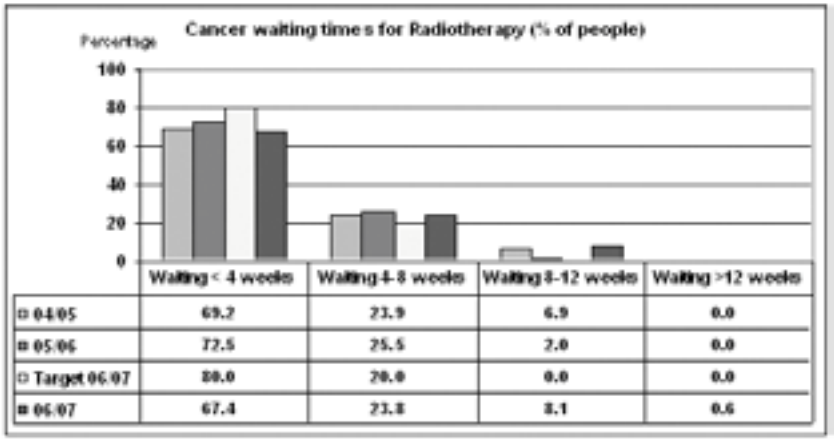
Cancer waiting times have deteriorated during the 2006/07 year with only 67 percent of cancer patients in Category C or above receiving treatment within four weeks of referral against a target of 80% .[8] Capacity has been reached for the two linear accelerators (cancer treatment machines). Further improvements are reliant upon investment in a third linear accelerator. The business case for the Linear Accelerator is having a final review by an independent party.

Data accuracy from decision to treat (usually the first specialist assessment (FSA) or for recurrent disease the subsequent assessment) to commencing radiation treatment is robust.

Long delays in referral to FSA can be misleading as referral can be sent by surgeons at time of diagnosis and FSA by a radiation oncologist may not be appropriate until after the patient has recovered from surgery and all staging investigations completed.

We treated 776 patients versus a target of 720 patients in the 2006/07 year. This was an increase from 698 patients in 2005/06.





8 - Cancer waiting time priority categories: Priority A (Urgent) Priority B (Curative) Priority C (Palliative and other radical) Priority D (Combined chemotherapy and radiation treatment). The cancer waiting time is the time between receipt of referral for First Specialist Assessment (FSA) and the start of radiation treatment for patients who receive the FSA at the Cancer Centre.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

DHB Priority : Focusing on people through integrated care

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

Milestone	Achievement
We will increase the services that can be accessed through the Care Coordination Centre Date: September 2006 Output Class: Provider	**Achieved** During 2006/07 the Care Coordination Centre (CCC) has set up a partnership relationship with the Whanau Care service and the Pacific Support service to facilitate in-patient assessments being carried out by the Care manager Whanau services. Support for the Care manager Whanau Services to sustain this activity and facilitate joint community assessments by the CCC and Whanau Care manager improves the linkages between the in-patient assessment and transition to the community. Work is continuing to set up a similar way of working with the Pacific Support Service. This will be progressed with the recent appointment of a Pacific Care Manager and this will improve access to services for Pacific people. Work is progressing on a joint project with ACC to trial the use of our assessment tool, interRAI. The TARGET tool (Towards Achieving Realistic Goals in Elders Tool) has been introduced as a phone based, and face to face, goal facilitation tool for Packages of Care. The CCC care manager works with the client (or family/whanau as appropriate) to set their goals at the time of the initial assessment and they work out a care plan to meet the client's needs. The CCC continues to apply a proactive, preventative approach to meeting the needs of carers.

We will develop a clearly articulated framework for chronic care management. Date: March 2007 Output Class: Funder/Provider	**Substantially achieved** Chronic conditions are estimated to account for the majority of all premature deaths and up to 70% of all health expenditure. Chronic conditions include: • Non-communicable diseases (e.g. cardiovascular disease, cancer, and diabetes) • Persistent communicable diseases (e.g., HIV/AIDS) • Certain mental disorders (e.g. depression and schizophrenia). The purpose of a Chronic Care Management Framework is to assist implementation of the strategic goal of reducing the incidence and impact of chronic disease by: • outlining the context within which service development will occur and the goals for assessing success • establishing overarching service strategies to achieve the goals • identifying priorities for service development; and • establishing a governance framework to guide the implementation of a chronic care management programme. A draft Chronic Care Management Plan was developed and shared with our PHO Advisory Group in September 2006. The document outlined a suggested set of essential elements and a suggested pathway for development of the chronic care framework. Subsequently a workshop was held to further the discussion in April 2007. The framework is now due for completion by December 2007 and will set out the intended improvements for the next three years. The plan will be reviewed annually as part of the District Annual Plan.

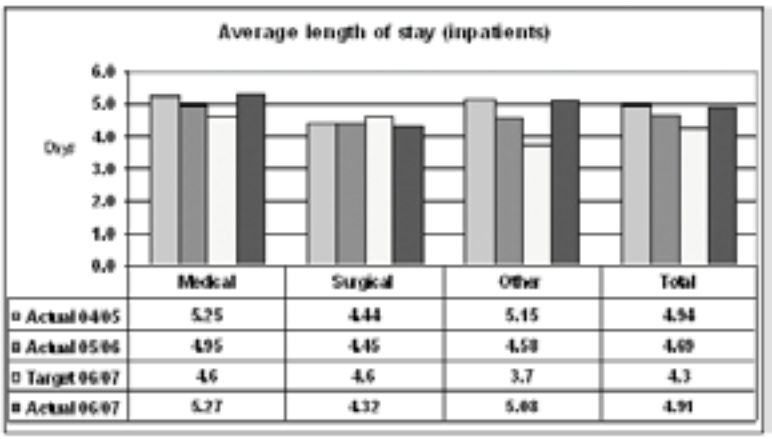
We will establish four pilots for the Quality Patient Journey Date: November 2006 Output Class: Provider	**Partially achieved** Two patient journeys, Cardio-thoracic and Acute Medical, were chosen for 2006/07 and a decision was made to focus on embedding the improvements proposed for these two areas before embarking on further patient journey initiatives. **The Cardiothoracic Patient Journey** The patient journey technique has been used by staff from Cardiothoracic, ICU, Theatres and Cardiology to gain a better understanding, from a patient's perspective, of the journey of a cardiothoracic patient from the GP through the hospital system (Cardiology, ward, theatre, ward) and back to the GP. Detailed process mapping and analysis of data has been compiled. This has presented the journey in a visual way, helping staff to identify some key areas of concern: • cancellations • incomplete pre-assessment • staffing availability. Staff involved have been enthusiastic and invested much effort into the patient journey approach, which has also highlighted some opportunities to improve the interface between the various departments involved in caring for the patient. Clinicians are now able to look at methods for improving the patient flow across all the departments involved.

	Acute medical patient journey The acute medical journey project started in July 2006. It has followed the 'lean thinking' process (3 phases: diagnostic phase, information gathering / patient tracking, and future state development). A big picture workshop was attended by 40 staff from across the patient journey from ambulance to community support. This workshop produced some 'big picture maps' of how patients flow through our hospitals. Detailed tracking of 47 medical patients in the Emergency Department followed in September and 35 inpatients who were medically fit for discharge were tracked in October for the hours or days they remained in hospital from the decision they were medically fit to leave. Analysis of the time that medical patients stay in hospital showed a high proportion of patients stayed of over eight days. A model has been developed which proposes streaming patients into Medical Wards based upon their predicted length of stay. The establishment of a medical assessment and planning unit is proposed as a part of this model to triage patients into the appropriate medical ward. For patients expected to stay over eight days it is proposed to transfer them as soon as possible into the care of the Older Persons' Service (if this is appropriate). Analysis of flow patterns from the Emergency Department to the wards has highlighted the delays in discharging patients from inpatient units. A redesign process was initiated to focus on streamlining discharge processes, for example having paperwork and transport arranged the day before discharge where possible; and exploration of transit lounges and other options for improving the flow of patients from acute wards.

Key performance measure

Average length of stay (inpatients)
Not achieved
Output class: Provider

With the exception of surgical services our Average Length of Stay indicator deteriorated during 2006/07. Patients requiring respiratory care contribute to the medical length of stay. Initiatives to address this include implementation of the patient journey project for acute medical patients and adequate support systems, in the form of improved packages of care delivered by our Care Coordination Centre, for patients in the community. An increasing number of level 3 babies and babies of low gestational age being cared for in our neonatal unit also contribute to the medical length of stay. This data is consistent across the three years reported.



	Medical	Surgical	Other	Total
Actual 04/05	5.25	4.44	5.15	4.94
Actual 05/06	4.95	4.45	4.58	4.69
Target 06/07	4.6	4.6	3.7	4.3
Actual 06/07	5.27	4.32	5.08	4.91

Note: This data excludes day cases and mental health admissions.

DHB Priority : Supporting and promoting healthy lifestyles

The increasing incidence and impact of chronic disease has led to economic and social costs that are increasing at an alarming rate in our district. These costs are particularly apparent among Maori and Pacific peoples. There is a marked inequality in their oral health which is greatest at age five years and decreases by age 12 years. Maori and Pacific people also die much earlier from conditions such as cardiovascular disease and diabetes Type 2 (particularly for people from low-income areas).

By controlling lifestyle choices and social or community influences, we can reduce the impact and incidence of these illnesses and others that have a debilitating impact on our populations. There are risk factors that can be reduced or mitigated, such as tobacco use, low physical activity, poor nutrition, drug and alcohol misuse.

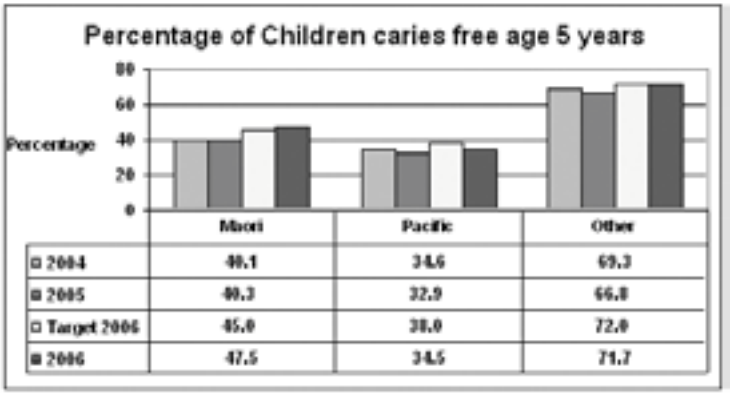
Milestone	Achievement
We will work with Hutt Valley DHB to increase enrolment of children into the School Dental service Date: October 2006 Output Class: Funder	**Achieved** To increase enrolment into the School Dental service (SDS) and the percentage of children caries free, C&C DHB is working together with Hutt Valley DHB, the provider of C&C DHB's School Dental Service, to develop and implement significant changes to the child oral health service, including encouraging early enrolment into the service beginning as early as at birth. Other strategies to improve oral health at age five include: • Increasing work with pre-school groups and providers to provide oral health education and increase enrolments • Further engagement with Maori Health providers and Pacific Health providers to improve enrolment • Educating care givers and other health providers on the importance of oral health for pre-preschoolers through the Oral Health Promotion service provided by Regional Public Health • Further promoting preventative health programmes outside of oral health, like Healthy Eating/Healthy Action initiatives, to improve the oral health of children. A pilot programme "Behind the Smile" is increasing enrolments. It is an oral health promotion project facilitated and implemented by the primary health care team at the Island Bay medical centre. The goal of the project is to improve the oral health status of their enrolled population under 5 years, specifically targeting Maori, Pacific and low income groups. The project has been implemented by using best practice health promotion, education and associated resources coordinating this with scheduled immunisation visits at 5 months, 15 months and 5 years. Regional Public Health supported this by working with the School Dental Service to develop an oral health flip chart resource that could be used by the practice nurse and GPs at the medical centre with their patients.

We will work with Hutt Valley DHB to implement the HEHA strategy in our district's early child care centres and schools Date: October 2006 Output Class: Funder	**Achieved** Schools are a priority setting for the Healthy Eating Healthy Action strategy and there have been several important developments in recent months: In Term Two of 2007 all schools and Early Childhood Education (ECE) services received Food and Nutrition toolkits and Food and Nutrition professional development workshops were offered. From 1 June 2008 Boards of Trustees need to ensure that healthy food and nutrition is promoted at school and where food and beverages are sold on school premises, ensure that only healthy options are available. In order to support these new developments we have been working with Regional Public Health (RPH) and Victoria University College of Education School Support Services to deliver workshops to all schools and ECE services in the district. It will be mandatory that by 1 June 2008 that any food sold on site in schools is healthy. The MOH has made a Nutrition Fund available and C&C DHB is currently inviting proposals from all primary and secondary schools, ECE services, Kohanga Reo and Pacific Language Nests for grants which will support nutrition/healthy eating initiatives. This fund works in tandem with the Toolkit of information delivered to schools.
We will complete the Kapiti Physical Activity Action Plan and begin implementation Date: October 2006 Output Class: Funder	**Substantially Achieved** Following the development of the Kapiti Physical Activity Strategy, including an implementation plan, C&C DHB is working collaboratively with Kapiti Coast District Council, Sport Wellington Region and Kapiti PHO to implement the plan. A funding proposal to SPARC to access the Active Communities investment fund to part-fund a coordinator to implement the Strategy will be submitted to the next funding round in September 2007. Ratification of the funding proposal by key stakeholders occurred after the February funding round.

Key performance measures
Oral health - percentage of children caries free at 5 years
Partially achieved
Output Class: Funder

For 2006/07, the target was achieved for Maori and Other children. While the outcomes were improved for Pacific children the target was not achieved. We have identified that oral health and dental-related issues are a significant contributor to avoidable hospital admission for Pacific children. Improved targeting of oral health promotion and improved access to primary care services for Pacific children and their families may help address this disparity.

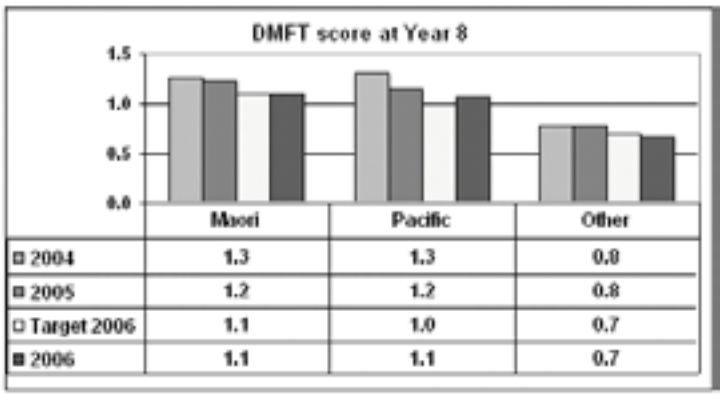
A pilot programme 'Behind the Smile' has been increasing enrolments in school dental clinics for under 5 year olds. It specifically targets Maori, Pacific, and low income groups. When children go to their PHO for immunisations, practice nurses incorporate some oral health education into the visit. Enrolments for C&C DHB children have increased from 81% in February 2007 to 83% in June 2007 due primarily to this pilot.



	Maori	Pacific	Other
2004	40.1	34.6	69.3
2005	40.3	32.9	66.8
Target 2006	45.0	38.0	72.0
2006	47.5	34.5	71.7

Oral health - percentage of children with Decayed, Missing & Filled Teeth (DMFT) at Year 8 – Partially achieved
Output Class: Funder

The DMFT score indicates the average number of decayed, missing and filled teeth per person. For 2006/07, the target was achieved for Maori and Other children. While the outcomes were improved for Pacific children the target was not achieved. Poor oral health at age 5 years is likely to lead to poor oral health at Year 8. C&C DHB is actively working with existing children and adolescent oral health service providers, and primary care providers (including Pacific Providers) to strengthen linkages and coordination across primary care and oral health services.



	Maori	Pacific	Other
2004	1.3	1.3	0.8
2005	1.2	1.2	0.8
Target 2006	1.1	1.0	0.7
2006	1.1	1.1	0.7

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

DHB Priority : Working with our communities

The health outcomes we are seeking can be significantly improved only by a 'whole of society' approach. We are working with people, communities and organisations so that people are more able to stay healthy, manage ongoing illnesses and reduce the factors that lead to poor health. This includes work with the Department of Work and Income, Housing, local councils, Ministry of Social Development and other community agencies.

We expect to improve access to primary care, implement family violence intervention strategies and expand services for our Maori and Pacific populations.

Milestone	Achievement
We will expand primary care capacity to improve access for high needs populations Date: October 2006 Output Class: Funder	**Achieved** We invested $415,000 in additional capacity in Porirua East and extending Te Aro clinic's outreach nurse capacity . Trend analysis of the total number of Maori enrolled with PHO practices have increased since 2003 and the number of visits per year is also increasing.
We will finalise and implement intersectoral Family Violence Intervention Strategies Date: March 2007 Output Class: Funder	**Substantially Achieved** Policies are in place regarding the assessment and treatment of victims of family violence for child abuse and neglect for partner violence. A family violence programme advisor has been appointed and will commence work in August. Posters and brochures related to family violence services are on public display for child abuse and neglect, and for partner violence. A formal training plan is in place for regular ongoing family violence education for DHB staff in maternity, emergency, child health and sexual health services. Midwives in hospitals and the community are having regular workshops on family violence. Screening for family violence occurs. A child protection coordinator has been appointed. The DHB is participating in intersectoral fora on initiatives to reduce family violence and is leading or actively involved in several intersectoral projects addressing determinants of family violence, e.g. income/employment, alcohol and drug, support for high risk families, strengthening families, refugee health and well-being action plan.

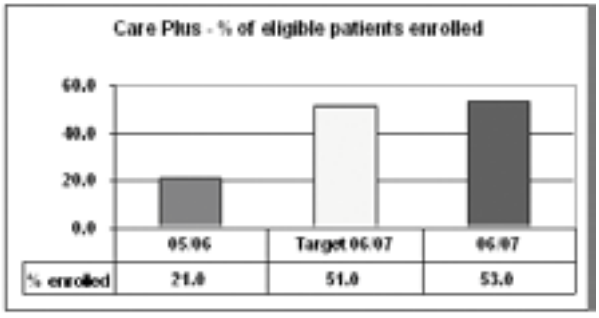
We will improve Whanau care services and Pacific services in out hospitals and the community Date: March 2007 Output Class: Funder/Provider	**Achieved** Phase 2 of the development of the hospital Whanau Care Services was completed and the unit is now operating at full capacity. The Cardiac Liaison Nurse and Disability Support Services Manager were key improvements in 2006/07. The Pacific Workforce employed by the DHB increased by 5.7% in 2006/07.

Key performance measures

Care Plus Coverage
Achieved
Output Class: Funder

Care Plus is a national initiative which aims to improve the care management for patients with long term chronic conditions such as diabetes, heart disease, arthritis, mental illness. PHOs receive extra funds to allow patients on the programme to receive extra care via reduced cost of services and improved access to their doctors and nurses. Care Plus aims to decrease disparities and the impact of chronic illness by improving primary care teamwork and reducing the cost of services for high need patients.

We have exceeded our stated target that 51% of all eligible people in the region will be enrolled. Three of our six PHOs have achieved an enrolment of over 70% of eligible people. The other three of our PHOs have a lower rate and we hope to increase this in the coming year. Capital & Coast are in the process of identifying barriers which are limiting access into the programme for these PHOs and we aim to increase enrolment next year.

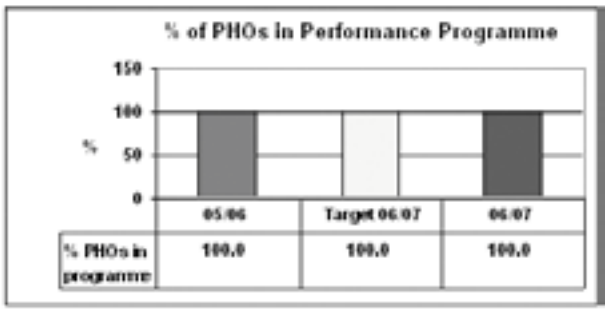


PHO performance programme
Achieved
Output Class: Funder

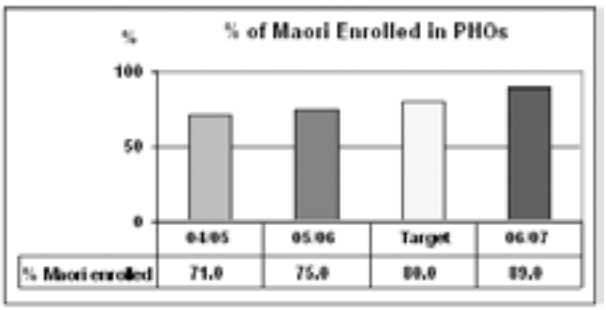
The Performance Programme is an initiative designed to reward quality improvements in PHOs. It is concerned with leadership within each PHO:

- Collecting ethnicity data and reducing disparities.
- Health indicators such as immunization rates, cervical and breast screening rates.
- Financial performance including pharmaceuticals and laboratory tests.

All six PHOs in Capital & Coast's region are enrolled in the programme.



Percentage of Maori enrolled in PHOs
Achieved
Output Class: Funder



Maori PHO coverage was reported as 75% in our District as of Dec 2006. However, there has been further analysis including enrolment of C&C DHB Maori residents in any PHO, including outside our District, and the coverage is 89%.

DHB Priority : Developing our 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.

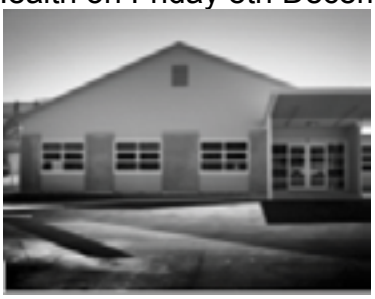
We expect to improve capacity of Maori and Pacific workforce, develop the careers of our staff and recognise achievements by individuals and teams.

Milestone	Achievement
We will implement the Maori health workforce plan and Maori provider Development Framework Date: March 2007 Output Class: Governance	**Achieved** The Maori health work plan and Maori provider development framework have been implemented in 2006/07. There is a full complement of staff in Whanau Care Services (11.6 FTE) including a Manager Maori Health, Personal Assistant, Service Coordinator, Social Worker, Kaiawhina, Community Liaison, Kaitakawaenga, Cardiac Liaison Nurse and Aged Care Manager. The Career Progression Implementation Plan for Maori staff within the hospital and health service has been completed with recommendations to be implemented. A Career Development / Academic Advisor position is to be established to work with Maori across the HHS/Primary Care sector. 12 of 15 local Maori health workers graduated with the NZIM Diploma in Frontline Management in April 2007. A similar programme for a further 15 local participants is to commence July 2007. The job evaluation exercise (benchmarking) is currently underway with Maori providers and the primary care sector. Provider workloads and availability are impinging on the completion of this work. Maori comprised 6.1% or 185 FTE (full-time equivalents) of the C&CDHB workforce and 5% (117 FTE) of the clinical workforce at 30 June 2007.

We will implement an internal career development service Date: September 2006 Output Class: Governance	**Achieved** We have implemented an on-going organisation development and infrastructure development programme • 120 managers and team leaders have now completed the Leadership and Management Programme. • The first Clinical Leaders programme was completed and subsequent programmes planned for 07/08.
We will implement a clinical leadership programme; a service based recognition programme and a regional learning and development programme Date: December 2006 Output Class: Governance	**Achieved** To improve the retention of secondary\tertiary workforces: • A clinical leadership programme was delivered and further programmes are scheduled for 2007/08. • A staff recognition scheme was implemented in July 2006. • Regional learning and development programme for Maori workforce is in place.

DHB Priority : Updating our hospitals

The development of the New Regional Hospital is a priority to provide good healing spaces for people who use hospitals and people who look after our patients. The project has 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).

Milestone	Achievement
We will continue to progress the Wellington Hospital redevelopment with the structure complete to Level H and fit out underway Date: April 2007 Output Class: Governance	**Achieved** We have reached level H (plant room) and the fit out is underway. 
We will complete the new psychogeriatric building at Kenepuru Hospital Date: November 2006 Output Class: Governance	**Achieved** Te Whare Ra Uta (Psychogeriatric Unit) was opened by the Minister of Health on Friday 8th December 2006. 
We will implement the new PACs digital imaging system across all sites Date: December 2006 Output Class: Governance	**Achieved** The new PACs digital imaging system has been implemented across the organisation. Radiological reports are available on patient's electronic health record and digital images are available on the PACs system. Electronic sign off of radiology reports is not available as part of this project and will be part of the electronic health record project, release 2 . Until this is available and to ensure radiology reports are viewed by the the ordering doctor, they will be printed in the radiology department and delivered directly to the ordering doctor.

DHB Priority : Managing our money

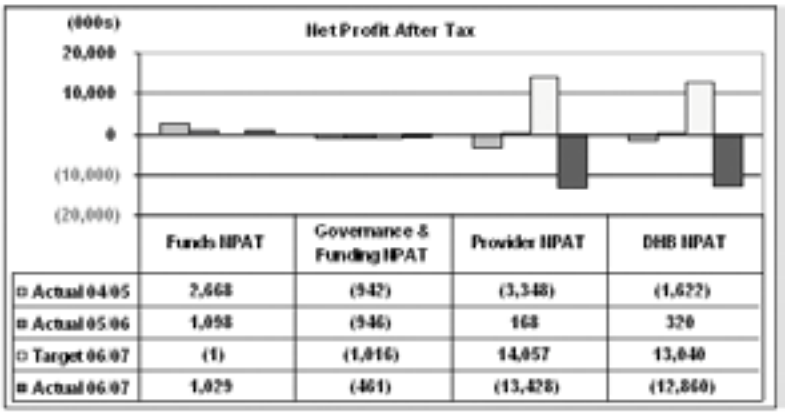
As a Government organisation it is critical that we are prudent in the way we spend money on health services to provide the necessary care for our people. We always seek to improve our efficiency while maintaining the quality and effectiveness of the services we provide.

We expect to improve our efficiency through working collaboratively with other DHBs in our region, improving theatre productivity and benchmarking our service delivery.

Milestone	Achievement
We will undertake a number of clinical service reviews during the year Date: March 2007 Output Class: Governance	**Achieved** During 2006/07 we have worked collaboratively with the Central Region District Health Boards to review the following services: • Renal • Cardiology • Plastics
We will undertake a review of theatre productivity Date: November 2006 Output Class: Provider	**Achieved** The new Group Manager Theatres and ICU has reviewed operating theatre productivity issues and identified initiatives for improving theatre throughput. Action on these issues is progressing including: • Recruiting additional anaesthetists • Running a second acute theatre • Recruiting additional technicians and • Focusing on theatre start times.
We will undertake an internal and external benchmarking exercise to identify options for improving the use of our limited resources Date: October 2006 Output Class: Funder/Provider/ Governance	**Partially Achieved** Intially we started work on theatres, in patient nursing, allied health and ED we are now collaborating nationally and preliminary work has been done around the NZ health roundtable and we have agreed the aspects of health service delivery to be bench marked.

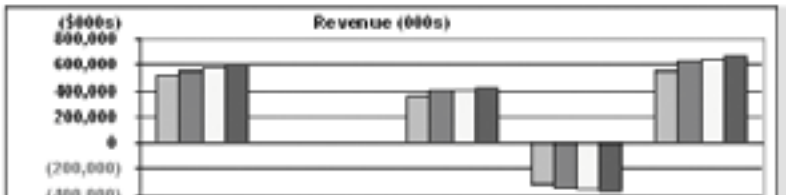
Key performance measure
Net Profit After Tax
Not achieved
Output Class: Governance

The DHB recorded an operating deficit of $12.9m compared with the budget surplus of $13m with both revenue and expenditure higher than budgeted. A major part of 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 of $13m. Increased revenue was primarily due to additional revenue for Mental Health Services relating to additional beds and escorts within the forensic rehabilitation and intellectual disability services. Cost increases were primarily due to medical and nursing personnel costs. Medical Personnel costs relating to additional duties payments for covering RMO shortage and nursing personnel relating to Mental Health Services including escorts. Clinical supply costs were also high included a blood product price increase above FFT and higher usage during the year.



	Funds NPAT	Governance & Funding NPAT	Provider NPAT	DHB NPAT
Actual 04/05	2,668	(542)	(3,348)	(1,622)
Actual 05/06	1,058	(546)	168	320
Target 06/07	(1)	(1,016)	14,057	13,040
Actual 06/07	1,029	(461)	(13,428)	(12,860)

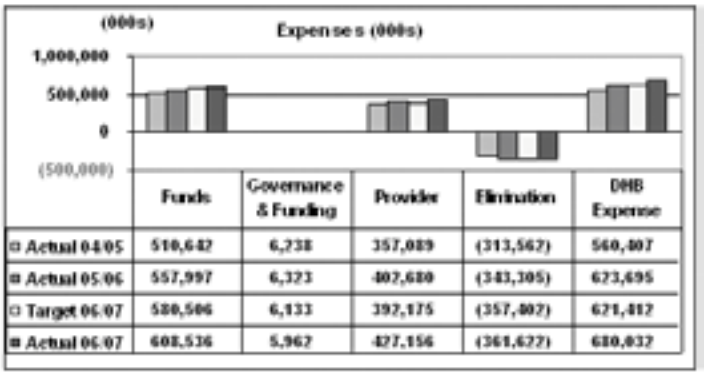
Revenue
Achieved
Output Class: Governance
Actual DHB revenue for 2006/07 was $667.2 compared with the SOI target of $634.5m[9] and revised target of $642.2m. As noted above, increased revenue was primarily due to additional revenue for Mental Health services relating to additional beds and escorts within the forensic rehabilitation and intellectual disability services.



	Funds	Governance & Funding Admin	Provider	Elimination	DHB Revenue
Actual 04/05	513,310	5,296	353,741	(313,562)	558,785
Actual 05/06	559,095	5,377	402,848	(343,305)	624,015
Target 06/07	580,585	5,116	406,233	(357,402)	634,452
Actual 06/07	609,565	5,501	413,728	(361,622)	667,172

9 - The target number for 'revenue' for 2006/07 was not updated when the 2006/07 SOI was retabled in December 2006. It therefore varies from the target in the SOI financial statements.

Expenses
Output Class: Governance



	Funds	Governance & Funding	Provider	Elimination	DHB Expense
Actual 04/05	510,642	6,238	357,089	(313,562)	560,407
Actual 05/06	557,997	6,321	407,680	(343,305)	673,695
Target 06/07	580,506	6,133	397,175	(357,802)	671,812
Actual 06/07	608,536	5,962	427,156	(361,622)	680,032

Statement of Responsibility

For The Year Ended 30 June 2007

1. The Board and Management of Capital & 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 & 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 2007, fairly reflect the financial position and operations of Capital and Coast District Health Board.

Judith Aitken
Chairperson

Date 31/10/2007

Margaret Faulkner
Board member

Date 31/10/2007

Margot Mains
Chief Executive

Date 31/10/2007

Calum Laurie
Director of Finance

Date 31/10/2007

Capital & Coast
District Health Board

Statement of Accounting Policies

For The Year Ended 30 June 2007

Reporting entity

Capital & 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 CW31 of the Income Tax Act 2004.

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 inflows 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 2007, indirect costs accounted for 1.2% of the DHB's total costs (2006: 7.29%).

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 $6.1m (2006:$4.6m) has resulted in a decrease in the reported net deficit for the year.

Comparative figures

To ensure consistency with the current year, certain comparative information has been restated or reclassified where appropriate. This has occurred:

- where classifications have changed between periods, and
- where the DHB has made additional disclosure in the current year, and where a greater degree of disaggregation of prior year amounts and balances is therefore required.

Comparative information has been reclassified accordingly.

Changes in accounting policies

There have been no changes from the accounting policies adopted in the last audited financial statements. All policies have been applied on a basis consistent with the previous year. A change in policy in the 2006 financial statements resulted in Plant and Equipment being revalued resulting in an increase in the value of Plant and Equipment of $8.9m, and associated revaluation reserve.

Statement of financial performance

For the year ended 30 June 2007 *

	Notes	Actual 2007 $000	Budget 2007 $000	Actual 2006 $000
Revenue	1	667,172	642,146	624,015
Expenses	1	675,127	624,919	620,137
Capital charge	16	4,905	4,187	3,558
NET (DEFICIT)/ SURPLUS	**1**	**(12,860)**	**13,040**	**320**

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

Statement of movements in equity

For the year ended 30 June 2007 *

	Notes	Actual 2007 $000	Budget 2007 $000	Actual 2006 $000
EQUITY AT BEGINNING OF THE YEAR		150,954	135,128	128,128
Net surplus/(deficit) for the period		(12,860)	13,040	320
Revaluations	2(c)	(184)	-	16,133
Total recognised revenues and expenses for the year		(13,044)	13,040	16,453
Contributions (to) from owners	2(a)	(3,483)	15,000	6,373
EQUITY AT THE END OF THE YEAR		134,427	163,168	150,954

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

Statement of financial position

As at 30 June 2007 *

	Notes	Actual 2007 $000	Budget 2007 $000	Actual 2006 $000
EQUITY				
General funds	2(a)	208,133	221,242	211,616
Retained earnings	2(b)	(106,716)	(80,999)	(93,856)
Revaluation reserves	2(c)	33,010	22,925	33,194
Total equity		**134,427**	**163,168**	**150,954**
REPRESENTED BY:				
ASSETS				
Current Assets				
Cash		13	-	13
Receivables and prepayments	3	129,469	112,767	119,648
Inventories	4	5,632	5,692	5,414
Trust funds	12(a) & (b)	5,183	4,463	4,825
Total current assets		140,297	122,922	129,900
Non-Current Assets				
Investment in associate company	17	6,862	14,101	6,862
Property, Plant and Equipment	5	368,182	356,998	282,835
Total non current assets		375,044	371,099	289,697
Total assets		**515,341**	**494,021**	**419,597**
LIABILITIES				
Current Liabilities				
Bank Overdraft		1,553	-	17,038
Payables and accruals	6	52,688	51,068	38,433
Employee entitlements	7	42,627	24,109	38,568
Current portion of term loans	8	62,074	117,000	53,074
Total current liabilities		158,942	192,177	147,113
Non-Current liabilities				
Employee entitlements	7	4,402	3,941	4,314
Term loans	8	217,400	134,609	117,074
Restricted and Trust fund liabilities		170	126	142
Total non current liabilities		221,972	138,676	121,530
Total liabilities		**380,914**	**330,853**	**268,643**
NET ASSETS		**134,427**	**163,168**	**150,954**

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

Statement of cash flows

For the year ended 30 June 2007 *

	Notes	Actual 2007 $000	Budget 2007 $000	Actual 2006 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and other crown entities		638,269	599,839	581,629
Other revenue		22,246	43,260	21,045
Interest received		1,085	-	652
		661,600	643,098	603,326
Cash was disbursed to:				
Payments to employees and suppliers		640,951	604,875	590,168
Capital charge		3,541	4,415	3,322
Interest paid		6,330	6,210	4,191
GST (net)		(705)	1,678	(1,439)
		650,117	617,178	596,243
Net cash inflow/(outflow) from operating activities	**9**	**11,483**	**25,920**	**7,083**
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of property, plant and equipment		10	19,340	-
		10	19,340	-
Cash was applied to:				
Trusts		358	5,059	415
Purchase of property, plant and equipment		97,069	105,433	49,785
Advances to associate		4,424	-	4,118
		101,851	110,492	54,318
Net cash inflow/(outflow) from investing activities		**(101,841)**	**(91,152)**	**(54,318)**

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

CASH FLOWS FROM FINANCING ACTIVITIES			
Cash was provided from:			
Equity Injection	-	15,000	6,000
Proceeds from term loan	162,400	50,232	66,000
	162,400	65,232	72,000
Cash was applied to:			
Equity Repaid	3,483		
Repayment of term loan	53,074	-	11,331
Net cash inflow/(outflow) from financing activities	**105,843**	**65,232**	**60,669**
Net increase in cash held	15,485	-	13,434
Add opening cash	(17,025)	1	(30,459)
Closing cash balance	(1,540)	1	(17,025)
Made up of:			
Cash	13	-	13
Bank (Overdraft)	(1,553)	-	(17,038)
Closing cash balance	(1,540)	-	(17,025)

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

Statement of contingent liabilites and assets

As at 30 June 2007 *

	2007 $000	2006 $000
Legal proceedings	491	500

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.

There are no contingent assets at 30 June 2007 (30 June 2006: Nil)

Statement of commitments

As at 30 June 2007 *

	2007 $000	2006 $000
Capital Commitments including New Regional Hospital (NRH)		
Less than one year	61,963	46,946
One to two years	20,000	111,962
Two to five years	-	-
	81,963	**158,908**
Operating lease commitments		
Less than one year	1,125	1,393
One to two years	792	653
Two to five years	811	726
Over five years	501	654
	3,229	**3,426**
Other non-cancellable service contracts		
Less than one year	83,891	72,967
One to two years	14,350	16,619
Two to five years	34,822	43,907
Later than five years	-	5,050
	133,063	**138,543**
TOTAL COMMITMENTS	**218,255**	**300,877**

The DHB is also obliged to fund significant streams of “demand driven” health expenditure. Commitments of this nature, which are non-cancellable, are in place for the purchase of pharmacy, laboratory, and GP services. This expenditure is “demand driven” and therefore not able to be quantified.

Notes to the financial statements

For the year ended 30 June 2007 *

Note 1: Net Surplus/(Deficit)

	2007 $000	2006 $000
Revenue	**667,172**	**624,015**
After crediting:		
Interest income	1,085	652
Revaluation of buildings	-	16,257
Donations and bequests	932	57
Less Expenses		
After charging:		
Remuneration of auditor		
Audit fees	154	148
Audit fees - IFRS	12	
Assurance related services	-	18
Depreciation		
Buildings	11,667	10,474
Leasehold improvements	139	132
Plant and equipment	6,794	8023
Plant and equipment – finance leases	0	49
Other equipment	856	1,085
Surplus properties	313	269
Loss on sale of fixed assets	18	79
Board members' fees	310	324
Interest expense	7,326	4,397
Interest expense on finance leases	19	29
Rental and operating lease costs	2,796	2,609
Bad debts written off	146	150
Changes in provision for doubtful debts	1,615	567
Personnel costs	260,892	244,217
Information technology service fees	11,458	10,426
Other operating expenses	123,766	122,449
Provider payments	246,846	214,692
	675,127	**620,137**
Capital Charge	4,905	3,558
Net (deficit)/surplus per Statement of Financial Performance	**(12,860)**	**320**

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

Note 2: Equity

(a) General Funds	2007 $000	2006 $000
Opening balance	211,616	205,243
(Repayment to)/Contribution from owners	(3,483)	6,373
General funds at 30 June	**208,133**	**211,616**

b) Retained earnings	2007 $000	2006 $000
Retained earnings at 1 July	(93,856)	(94,176)
Operating (deficit) /surplus	(12,860)	320
Retained earnings at 30 June	**(106,716)**	**(93,856)**

(c) Other Movements	2007 $000	2006 $000
Land revaluation reserve		
Opening balance	24,269	17,061
Revaluation	-	7,208
Land revaluation reserve at 30 June	**24,269**	**24,269**
Plant and Equipment revaluation reserve		
Opening balance	8,925	-
Revaluation	(184)	8,925
Plant and Equipment reserve at 30 June	**8,741**	**8,925**
Total Revaluation Reserves at 30 June	**33,010**	**33,194**

Note 3: Receivables and prepayments

	2007 $000	2006 $000
Associate company debtor	13,227	5,835
Trade debtors	30,408	26,606
Provision for doubtful debts	(3,509)	(1,894)
Accrued income	3,089	2,670
Prepayments	254	431
Crown equity due [1]	86,000	86,000
	129,469	119,648

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

	2007 $000	2006 $000
Pharmaceuticals	1,252	1,199
Surgical and medical supplies	4,271	4,114
Other supplies	109	101
Total Inventory	**5,632**	**5,414**

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

	2007 $000	*2006 $000*
Land		
Land at valuation – revalued as at 30 June 2006	25,105	25,105
Total land	**25,105**	**25,105**
Buildings		
Buildings at cost	24,251	-
Buildings at valuation – revalued as at 30 June 2006	116,880	116,880
Accumulated depreciation	(11,838)	-
Total buildings	**129,293**	**116,880**
Leasehold Improvements		
At cost	2,660	2,655
Accumulated depreciation	(950)	(811)
Total Leasehold Improvements	**1,710**	**1,844**
Plant and Equipment		
At valuation – revalued as at 30 June 2006	44,257	44,611
At cost	12,640	6,031
Accumulated depreciation	(10,303)	(2,672)
Total plant and equipment	**46,594**	**47,970**
Plant and Equipment finance leases		
At cost	-	1,091
Accumulated depreciation	-	(1,091)
Total plant and equipment finance leases	-	-
Surplus Properties		
At cost	15,490	15,492
Accumulated depreciation	(3,703)	(3,563)
Total surplus properties	11,787	11,929

Capital Work in Progress		
Buildings	146,059	76,963
Plant and Equipment	7,634	2,144
Total capital work in progress	153,693	79,107
Total property, plant and equipment		
At cost and valuation	394,976	290,972
Accumulated depreciation	(26,794)	(8,137)
Total carrying amount	**368,182**	**282,835**

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 Maori 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 2007, but are recorded at cost less accumulated depreciation.

Note 6: Payables and accruals

	2007 $000	2006 $000
Trade creditors	2,923	4,393
Capital charge due to the Crown	2,069	705
Accrued expenses	47,546	33,095
Revenue in advance	150	240
Total payables and accruals	**52,688**	**38,433**

Note 7: Employee entitlements

	2007 $000	2006 $000
Accrued pay	14,158	12,345
Annual leave	23,069	20,289
Retirement and long service leave	5,333	5,300
Other	4,469	4,948
Total employee entitlements	**47,029**	**42,882**
Made up of:		
Current	42,627	38,568
Non-current	4,402	4,314
	47,029	**42,882**

Note 8: Term loans

	2007 $000	2006 $000
Crown Health Financing Agency (CHFA)	279,400	170,000
Other loans	74	148
Total	**279,474**	**170,148**
Less current portion	62,074	53,074
Non current portion	**217,400**	**117,074**
Interest Rates Summary:		
CHFA	5.81% - 7.31%pa	5.86%pa- 6.33%pa
Revolving credit	8.14%pa	7.39%pa
Leases	6.00%pa	6.00%pa
Repayable as follows:		
One to two years	28,000	62,074
Two to five years	80,000	-
Five to ten years	109,400	55,000
	217,400	**117,074**

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

	2007 $000	2006 $000
Net surplus/ (deficit)	(12,860)	320
Add/(less) non-cash items:		
Depreciation/assets written down	19,769	20,032
Asset revaluation write back	-	(16,257)
Total non-cash items	**19,769**	**3,775**
Add/(less) item classified as investment activity:		
Net loss/ (gain) on sale of fixed assets	18	78
Total investing activity items	18	78
Add/(less) movements in working capital items:		
(Increase)/decrease in receivables and prepayments	(5,397)	(4,396)
(Increase)/decrease in inventories	(218)	(805)
Increase/ (decrease) in payables and accruals	6,024	(3,863)
(Decrease)/Increase in provisions	4,147	11,974
Working capital movement – net	4,556	2,910
Net cash inflow from operating activities	**11,483**	**7,083**

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 2007 was $645m, of which $631m (98%) was received directly from the Ministry of Health. The amount outstanding to the DHB as at 30 June 2007 was $10.4m (2006: $8.7m).

(b) Joint venture company

The DHB purchased services from Central Regional Technical Advisory Services Ltd of $580,768 during the year ended 30 June 2007 (2006: $687,508). There was no outstanding balance as at 30 June 2007 (2006 $Nil)

(c) Associate company

The DHB purchased services from HIQ Limited of $11.5m during the year ended 30 June 2007 (2006: $10.4m). HIQ Limited purchased services from the DHB of $3.0m during the year (2006 $1.5m). The balance owing to the DHB at year end was $13.2m (2006: $5.8m).

The Chairperson of the DHB was the Chairperson of the HIQ Board until retiring in December 2006. The Chairperson of the DHB from December 2006, the Chief Executive and the Director of Finance of the DHB are directors on the HIQ Board.

(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.

A Board member, Brendon Bowkett, has an association with Wakefield Hospital as a paediatric surgeon. The DHB purchased services from Wakefield Hospital of $1.921m during the year ended 30 June 2007 (2006 $0.089m).The balance owing by the DHB to Wakefield Hospital at year end was $0.516m (2006 $0.002m).

A Board member, Ken Douglas, is a Board member of two suppliers to the DHB, being Air New Zealand and New Zealand Post Limited. Transactions with Air New Zealand are through a third party, and transactions with New Zealand Post during the year totalled $0.201m (2006 $0.009m).

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 2007.

Credit facilities

As at 30 June 2007, the DHB had committed to an overdraft facility of $35m expiring on 4 October 2008. $0.0m was drawn against this facility at 30 June 2007 leaving $35m available (2006: $15.4m was drawn against a $35m 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 96% 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 ended 30 June 2007 are not recognised in the Statements of Financial Performance, but are recorded in the Statement of Financial Position of the DHB as at 30 June 2007, both as an asset and a liability. Donated funds are managed in accordance with each settlor's directives.

(a) Patient funds	2007 $000	2006 $000
Opening balance	133	103
Monies received	301	265
Interest earned	5	4
Payments made	(285)	(239)
Closing balance	**154**	**133**

(b) Non patient trust funds	2007 $000	2006 $000
Opening balance	4,692	4,279
Monies received	1,388	984
Interest earned	330	310
Payments made	(1,381)	(881)
Closing balance	**5,029**	**4,692**
Total	**5,183**	**4,825**

Note 13: Board Members' remuneration

The Board of Capital and Coast District Health Board as at 30 June 2007, 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.

			2007 $000	2006 $000
Current Board Members				
Bob Henare	Appointed	Chair Resigned December 2006	18	54
Judith Aitken	Elected	Chair from December 2006 and Chair – FRAC until March 2007	47	36
Brendon Bowkett	Elected		25	25
Ruth Bradwell	Elected		26	26
Peter Dady	Elected		26	25
Ken Douglas	Elected	Chair – HAC.	28	26
Margaret Faulkner	Appointed	Chair – DSAC Chair – FRAC from March 2007	30	30
Ruth Gotlieb	Elected		27	26
Kiri Parata	Appointed	Chair – CPHAC from March 2007	27	25
Fuimaono Karl Pulotu -Endemann	Appointed	Chair - CPHAC until March 2007	27	26
Helene Ritchie	Elected		23	25
Peter Douglas	Appointed (April 2007)		6	-
			310	**324**

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 and Employees) remuneration

	2007 $000s	2006 $000
Community and Public Health Advisory Committee		
Herani Demuth	5	1
Ida Faiumu-Isaako	-	-
Linda Hobman	3	2
Stephen Palmer	-	-
Kiri Parata	-	1
Clive Plucknett	-	1
Puspa Wood	1	1
Disability Support Advisory Committee		
Valerie Bos	3	2
Margaret Guthrie	3	2
Jools Joslin	-	-
Liz. Mellish	2	-
Sarah Porter	-	-
Rev. Langi Sipeli	-	-
Hospital Advisory Committee		
Hilda Broadhurst	5	2
Marion Bruce	3	2
John Cook	3	3
Lynn McBain	3	2
Rose McEldowney	-	2
Lani Wills	-	1
Total	**31**	**22**

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 2007	Number of employees 2006
100 - 110	48	49
110 - 120	40	36
120 - 130	34	25
130 - 140	27	20
140 - 150	20	18
150 - 160	23	17
160 - 170	14	22
170 - 180	15	18
180 - 190	26	17
190 - 200	13	8
200 - 210	15	11
210 - 220	4	5
220 - 230	5	5
230 - 240	1	4
240 - 250	8	-
250 - 260	3	3
260 - 270	-	1
270 - 280	5	2
280 - 290	3	4
290 - 300	2	3
300 - 310	2	1
320 - 330	3	-
330 - 340	-	1
350 - 360	2	2
360 - 370	-	1
400 - 410	1	-
460 - 470	-	1
	314	**274**

The Chief Executive's annual remuneration is in the $400,000 to $410,000 band (2006: $400,000 to $410,000, however, with one off back pay, and annual leave payout total remuneration was in the above $460,000 to $470,000 band)

Of the 314 employees shown above, 264 are or were medical or dental employees and 50 are or were neither medical nor dental employees. This represents an increase of 40 staff in total over the previous year. Of these 29 are or were medical and dental employees and 11 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 476, compared with the actual total number of 314.

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	3,095
1	3,281
1	3,233
1	5,098
1	5,206
1	5,569
1	5,937
1	7,089
1	8,388
1	8,497
1	9,500
1	11,365
1	13,524
1	14,392
1	15,788
1	19,086
1	29,000
1	33,312
1	38,909
1	45,436
1	45,655
1	100,000
22	431,360

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 2007 was 8.0% (2006: 8%).

Note 17: Associates

The DHB has a significant interest in the following associate:

Associate	Interest 2007	Interest 2006	Nature of business
HIQ Limited	50%	50%	Owns and manages information systems

HIQ Limited was jointly created with Taranaki DHB on 18 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&C DHB	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 2007 is 55.65%, (2006 55.65%).

Investment in associates

Investment in associate	2007 $000	2006 $000
Opening balance	6,862	2,134
Equity earnings of associate	-	-
Equity capital contribution	-	4,728
Closing balance investment in HIQ Limited	**6,862**	**6,862**

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

Share of associate's surplus	2007 $000	2006 $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 year end are as follows:

Inter company transactions and balances	2007 $000	2006 $000
Expenditure incurred by C&CDHB to fund the operations	11,458	10,426
Equity issued to C&CDHB	-	4,728
Current receivables owing to C&CDHB	13,227	5,835

Note 18: Major budget variations

Statement of Financial Performance

The DHB recorded an operating deficit of $12.9m compared with the budget surplus of $13m with both revenue and expenditure higher than budgeted.

A major part of 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 of $13m.

Increased revenue was primarily due to additional revenue for Mental Health services relating to additional beds & escorts within the forensic rehabilitation and intellectual disability services.

Cost increases were primarily due to medical & nursing personnel costs. Medical Personnel costs related to additional duties payments for covering RMO shortages and nursing personnel related to Mental health services including escorts. Clinical supply costs were also high and included a blood product price increase above the Ministry's Future Funding Track together with higher usage during the year.

Statement of Financial Position

The variance in total equity was due to an equity repayment direction by the Ministry of Health and the non draw down of equity. Non-completion of the land disposal and higher costs lead to the below budget result which is reflected in change in Retained Earnings.

The variance of $27m in the term loans is due to higher CHFA borrowing at year end. The increased borrowing was available due to a revised debt/equity funding split for the NRH, approved after budget preparation. Payables, accruals and employee entitlements at $20m higher than budget result mainly from employee entitlement provisions, and the take up of accruals for the New Regional Hospital. Increased debtor levels with the Ministry of Health and the associate company HIQ Limited caused most of the $17m variance of Receivables and Prepayments.

Statement of Cash Flows

The operating cash outflow variance resulted from higher than anticipated inflationary impact on costs, and costs of additional projects and initiatives. These extra costs were not offset by additional funding from the Ministry.

Cash provided from property, plant and equipment disposal was lower than budget by $19m due to land disposal not completed during the year.

The favourable variance of $8m 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 higher than the amount budgeted by $112m. This was offset by not drawing equity of $15m and includes the roll-over of the $53m recorded against repayment of term loans.

Cash applied to the repayment of term loans was $53m 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 is implementing NZ IFRS in its annual financial statements for the year ending 30 June 2008. In complying with NZ IFRS for the first time, the DHB will restate amounts previously reported under current New Zealand accounting standards (NZ GAAP) using NZ IFRS. This requires a restatement of opening balances as at 1 July 2006 with the transitional adjustments recognised retrospectively and mainly against retained earnings at that date. The amounts/transactions incurred during the year ending 30 June 2007 will also be restated and will impact the income statement and balance sheet for that period. However, transitional adjustments relating to those standards where comparatives are not required will only be made at 30 June 2007.

Transition Management

The DHB has 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 its' 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.

Impact of Transition to NZ IFRS

The purpose of this disclosure is to highlight the expected impact to the DHB as a result of transition from current policies to NZ IFRS based on the standards that exist at the date of issue of these financial statements. This note only provides a summary of the significant potential impacts resulting from transition to NZ IFRS and should not be taken as an exhaustive list of all differences between existing NZ GAAP and NZ IFRS

The estimated impact of transition to NZ IFRS from existing NZ GAAP is set out below. The table details the estimated impact on Equity, Total Liabilities and Total Assets as at the date of transition.

Estimated Impact on the DHB's Equity, Total Liabilities and Total Assets on transition to NZ IFRS on 1 July 2006

	Capital	Reserves	Retained Earnings	Total Equity	Total Liabilities	Total Assets
	$000	$000	$000	$000	$000	$000
Total reported under NZ GAAP	211,616	33,194	(93,856)	150,954	268,643	419,597
NZ IFRS adjustments	-	-	159	159	(159)	-
Total NZ IFRS adjustments	-	-	159	159	(159)	-
Restated totals under NZ IFRS at 1 July 2006	211,616	(33,194)	(93,697)	151,113	268,484	419,597

The estimated impact on the DHB's Equity, Total Liabilities and Total Assets on transition to NZ IFRS for the year ended 30 June 2007 has not been prepared.

Changes in accounting policies on transition to NZ IFRS

The DHB will not be adopting hedge accounting under NZ IFRS. Accordingly, the hedge liability of $0.159m under NZ GAAP which expired in April 2007 is required to be included in retained earnings under the NZ IFRS policies.

Note 20: Summary Revenues And Expenses By Output Class And Reconciliation To Retained Earnings

Summary of revenues and expenses by output class:

	Funding $000	Governance and funding administration $000	DHB Hospital Provider $000	Elimination* $000	Total DHB $000
Revenue					
Crown	609,339	5,501	393,754	(361,622)	646,972
Other	226	-	19,974	-	20,200
Total Revenue	**609,565**	**5,501**	**413,728**	**(361,622)**	**667,172**
EXPENDITURE					
Personnel	-	2,234	258,658	-	260,892
Depreciation	-	6	19,763	-	19,769
Capital charge	-	-	4,905	-	4,905
Other	608,536	3,722	143,830	(361,622)	394,466
Total expenditure	**608,536**	**5,962**	**427,156**	**(361,622)**	**680,032**
Net surplus/(deficit)	**1,029**	**(461)**	**(13,428)**	**-**	**(12,860)**

Reconciliation to retained earnings:

	Funding	Governance and funding administration	DHB Hospital Provider	Elimination	Total DHB
Opening retained earnings	3,678	(4,137)	(93,397)	-	(93,856)
Less deficit for the year	1,029	(461)	(13,428)	-	(12,860)
Closing retained earnings	**4,707**	**(4,598)**	**(106,825)**	**-**	**(106,716)**

* DHBs are required to differentiate their funding broadly into hospital and non hospital activities. To recognise and give effect to CCDHB 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 AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2007

The Auditor-General is the auditor of Capital and Coast District Health Board (the Health Board). The Auditor General has appointed me, Terry McLaughlin using the staff and resources of Audit New Zealand, to carry out the audit on his behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health Board for the year ended 30 June 2007.

Unqualified opinion

In our opinion:

- The financial statements of the Health Board on pages 55 to 83:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect:
        - the Health Board's financial position as at 30 June 2007; and
        - the results of its operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board on pages 26 to 53:
    - complies with generally accepted accounting practice in New Zealand; and
    - fairly reflects for each class of outputs:
        - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
        - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 31 October 2007, 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 and statement of service performance 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 and the statement of service performance. 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 and statement of service performance. 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 statements and statement of service performance disclosures are adequate.

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

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. 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 and a statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board as at 30 June 2007 and the results of its operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

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.

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

Terry McLaughlin
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand